REPORT FROM

OFFICE OF THE CITY ADMINISTRATIVE OFFICER

Date: October 10, 2024

CAO File No. 0150-12573-0001
Council File No. 20-0769-S2
Council District: All

To: The Mayor and Council

From: Matthew W. Szabo, City Administrative Officer

Reference: Los Angeles County Department of Public Health (DPH) Requests Dated August 31, 2023 and June 26, 2024

Subject: **PROPOSED CITY-COUNTY PUBLIC HEALTH SERVICES AGREEMENT**

RECOMMENDATIONS

That the Council, subject to the approval of the Mayor:

1. Request the County, and authorize the CAO and CLA, with the assistance of the City Attorney, to negotiate the following terms to result in either a) changes to the proposed June 2024 Public Health Services Agreement as drafted by the County; or b) a supplemental agreement with the County to provide public health services while addressing undefined liability for the City, accountability measures, and a standard of performance that recognizes the City as a partner in delivering public health services, and incorporating new terms as follows:
    a. **Governance Structure:**
        i. Create, recognize, and incorporate a City of Los Angeles Public Health Liaison Office responsible for coordinating public health in times of regular business and global emergency, communicating the City's needs to Los Angeles County on a regular and ongoing basis, and improving the public process for and oversight of healthcare service delivery; and,
        ii. Create, recognize, and incorporate a new county team to focus on the City of Los Angeles and coordinate directly with the new City Public Health Liaison Office.
    b. **Contract Management:**
        i. Ensure (a) clarity and transparency in day-to-day business transactions; (b) consistency and quality of services being provided by the DPH; (c) continuous measurement and examination of the impact of services and opportunities for improvement; and, (d) a revised approach that includes a structured procedure

for negotiating services and associated fees, predicated on having established existing baseline levels of service.

ii. As the Proposed Health Services agreement proposes to charge fees for as yet unspecified services, develop a baseline of existing service levels provided by DPH to the City and its residents, and look to prioritize those that are most critical for the City, recognizing that the County DPH provides hundreds of services across multiple bureaus.

iii. Require negotiation at least ninety (90) days prior to the expiration of the fiscal year of (i) expanded services and associated fees proactively, at the beginning of each fiscal year, to ensure transparency with the County and (ii) performance measures to support trend spotting, longitudinal and holistic trend analysis to improve accountability and service provision.

c. **Provision of Services:** Ensure provision of public and related health services, particularly to persons experiencing homelessness, reflective of the percentage of the City's population receiving services from the County so that the City of Los Angeles receives adequate services and corresponding resources with respect to all matters of public health.

d. **Provision of City of Los Angeles Level Data and/or Revision of Service Planning Areas (SPAs):** Provide City level data that incorporates the City's geographic boundaries and population and that can be used to inform City officials and support decision-making and management and/or consider reorganizing SPAs to incorporate the City's geographic boundaries and population with the goal of one and no more than two City SPAs to enable greater clarity, utility, and accountability.

e. **Reimbursement Model for City Services:** Incorporate a new reimbursement model allowing the County to procure services from the City and for the City to be reimbursed for services provided at the request of the County during non-emergency periods when added staffing or other resources would be beneficial to the County and to assist in meeting public health demands (e.g., establishing testing and vaccine services to assist the County in meeting public health demands, new programs focused on emergent needs like substance abuse or homelessness).

f. **Miscellaneous Terms:**

i. Define the scope and intent of naming the County as the City's Environmental Health Department to, at a minimum, clarify its role vis-a-vis the Public Works Bureau of Sanitation;

ii. Define the mechanism by which the City would request services or support from the County and incorporate a time limit for the County to respond; and,

iii. Clarify the language requiring the City to bear the full cost of legal proceedings if a public health violation requires abatement or legal prosecution.

2. Instruct the CAO and CLA to report in 30 days on the status of negotiations.

3. Should an agreement be reached with the County on the need for proactive and cooperative governance, instruct the CAO to report with recommendations to:

a. Create a City of Los Angeles Public Health Liaison Office to be housed in the Office of the CAO with five positions (one Chief Management Analyst, three Management Analysts, and one Data Analyst) and the Health Commission to:

i. Improve the quality and quantity of services available to residents aligned to the size and scale of the City of Los Angeles;
ii. Ensure accountability structures that allow the City and County to collaborate to measure and continuously improve service delivery through data reflecting City health gaps and expectations;
iii. Respond to day-to-day and changing needs of a dynamic City population, including other areas of public health like public safety, whole person care, and other emerging areas of health; and,
iv. Respond in times of local and global emergency in a consistent and apolitical manner.

b. Reassign the City Health Commission from the Office of the City Clerk to the Office of the City Administrative Officer.

4. Instruct the CAO to report on the funding sources allocated to the County Department of Public Health to assess Angelenos' allotment of resources relative to the City's size, population, composition, and needs and alignment with the baseline City service level associated with those funding sources.
5. Authorize the CAO and CLA, with the assistance of the City Attorney, to negotiate a separate MOU or agreement that would serve as a reimbursement model for City services by enabling DPH to procure services from the City of Los Angeles and reimburse the City for those services.

SUMMARY

Public health refers to all that is done to improve health, including activities, programs, infrastructure, interventions, services, and processes that prevent disease and promote health for all people, everywhere. It is intended to be apolitical and rooted in science and longstanding codes of ethics.

While the COVID-19 pandemic highlighted the importance of public health, intergovernmental collaboration, and short-term ingenuity, in the City of Los Angeles, it also pointed to the need for a more sustainable and solid foundation that promotes collaboration with Los Angeles County during regular business and during times of local and global emergency and expanding needs.

Following the acute phase of the COVID-19 pandemic, cities in Los Angeles County began to explore the concept of creating independent city health departments to improve service delivery, increase accountability, and gain an opportunity to guide important decisions. Most cities in Los Angeles County, with one known exception, have moved away from the idea for myriad reasons, including but not limited to the significant cost of establishing a sufficient public health infrastructure. At the same time, the Los Angeles County Department of Public Health (DPH) drafted an updated Public Health Services Agreement to replace those public health contracts that individual cities have with the County. While some contracts were executed in the 1950s, the City's contract dates back to 1964 (Attachment 1), at which time the City turned over its public health operation to the County, with the provision that the County would enforce City-adopted public health codes within the City at no cost to the City (Attachment 2 outlines a timeline of public health in Los Angeles). After the County presented its initial draft public health services contract

in August 2023, it received feedback from several cities that resulted in both an updated draft contract in June 2024 (Attachment 3) and a Questions and Answers (Q&A) document (Attachment 4) addressing several concerns, including those expressed internally by the City. While the Q&A document has been helpful in clarifying the County's intent, that clarifying language has not been fully incorporated into the contract directly, leaving several questions open and raising new concerns.

DPH presented the updated proposed Public Health Services Agreement to the County Health and Mental Health Services Cluster on September 25, 2024, and planned to seek approval to enter into the proposed agreement with 85 cities before the Board of Supervisors on October 8, 2024; although the item was continued until October 22, 2024. Thereafter, cities would have the opportunity to a) accept the proposed agreement as presented or substantially similar, b) continue to rely on the current agreement in effect with the County for public health services, or c) establish a separate Public Health Department. Given significant concerns with the language as drafted in the proposed June 2024 Public Health Services Agreement, we do not recommend, at this time, that the new agreement be accepted or approved as presented. As the City's 1964 agreement does not expire, the City is under no obligation to sign the proposed June 2024 Public Health Services Agreement after the LA County Board of Supervisors approves it.

Further, this proposed Public Health Services agreement comes at a time when City of Los Angeles political leaders have continuously demonstrated an interest in assessing the arrangement between the City and County. Specifically, a 2020 motion (O'Farrell-DeLeon) instructed a review of County public and mental health departments and agencies. This motion was re-introduced in November 2021 and acknowledged that there is 'no clear method of evaluating the delivery of those [public health] services, nor a method for the City to communicate clear and concise goals to the County with respect to healthcare services for all Angelenos, especially people experiencing homelessness' (C.F. 20-0769-S2) (Attachment 5). The motion requested an evaluation of the 'contractual relationship with Los Angeles County, the delivery of health services in its existing contract, and specific recommendations on how to improve the current system.' This report now seeks to assess the most effective arrangement between the County and City with a focus on ensuring Angelenos receive the quality and volume of public health services needed to ensure a healthy and cared for City.

Accordingly, this report recommends that the City explore alternative options to obtain greater levels of 1) service delivery, 2) communication and collaboration, and 3) accountability. Specifically, this report recommends that the City negotiate a new governance structure that would 1) create and recognize a public health liaison office to be established upon agreement with the County and housed in the CAO - aligned to the County's general expectation that they will work with a City Manager or an equivalent office, such as the CAO - to oversee and manage the City's relationship with DPH, 2) realign the City's Health Commission with that office, and 3) request the County to establish a corresponding office to coordinate directly with the City. Since the governance structure would be negotiated with the County, the CAO would report separately on the resources needed to establish that office along with a more detailed scope and function. It is recommended that the office be housed in the CAO to increase the likelihood of political neutrality, central to the practice of public health while retaining direct lines of communication with

the Mayor and City Council.

This report further recommends that those negotiations create transparency in the agreement by incorporating language that addresses services and fees charged by the County, ensures the City receives a proportionate share of funding and services relative to its population, and establishes a reimbursement model for City services to enable the County to procure and pay for services from the City. In addition, it recommends incorporating clarifying language in the proposed contract to define the scope and intent of naming the County as the City's Environmental Health Department to, at a minimum, clarify its role vis-a-vis the Public Works Bureau of Sanitation, define the mechanism by which the City would request services or support from the County and incorporate a time limit for the County to respond, and clarify the language requiring the City to bear the full cost of legal proceedings if a public health violation requires abatement or legal prosecution.
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To ensure a more equitable allocation of resources, greater coordination, and alignment of governance, oversight, and management, we recommend that the CAO and CLA negotiate with the County to provide meaningful City level data that incorporates the City's geographic boundaries and population and that can be used to inform City officials and support decision-making and management and/or to reorganize SPAs to incorporate the City's geographic boundaries and population with the goal of one and no more than two City SPAs to enable greater clarity, utility and accountability. We believe now is the time to make this request to offset future challenges. Finally, in acknowledgment of the importance of the County Department of Mental Health, we propose that the CAO and CLA apply the information gained in the negotiations with DPH to subsequently pursue a separate agreement with the County for mental health services that is holistic, comprehensive, and addresses the needs of mental health services in the City of Los Angeles. We also recommend consideration of a similar approach to the Department of Health Services.

We recognize the extraordinary breadth and scope of work performed by DPH, providing hundreds of services across multiple bureaus (see Attachment 6 for a partial list). Nonetheless, the number of people experiencing homelessness in the City has created both acute and chronic public health problems in Los Angeles. According to a study by People's Health Solutions, in 2020, an estimated 66,436 people in Los Angeles County were experiencing homelessness. Of those individuals, two-thirds (41,290) resided in the City of Los Angeles. While incidents of smoking, tobacco, and diabetes affect the homeless population and have significant public health implications, recent outbreaks of communicable diseases such as Mpox, typhus, Hepatitis A and C, and tuberculosis put people experiencing homelessness, and everyone else, at risk of increasing morbidity and mortality among the population of Los Angeles.

As noted above, the County has indicated that cities have the option to create their own public health department as part of this process. While it is not impossible for the City of Los Angeles to establish a City Health Department, the attachment to this report (Attachment 7) identifies several key considerations in taking such a step, including planning for the following:

(1) **Services**: defining and establishing the basic level of service required to meet the needs of residents would necessitate a focused and intensive effort, which could encompass an extended length of time since the City does not perform those services today;
(2) **State Approval Process:** gaining approval from the State of California while State guidelines to create a City Public Health Department are being defined by the California Department of Public Health, and the timing is unclear;
(3) **Infrastructure Needs:** building and/or acquiring infrastructure (e.g., labs, service centers, office space) would require funding and time;
(4) **Staffing:** establishing positions and hiring specialized staff (e.g., medical doctors, public health analysts, service providers) would need to be a priority as such an effort would require funding and time; and,
(5) **Complex Scope:** an undertaking of this size would also be extremely complex, requiring close coordination with the County, State, and Federal governments on structure, services, accreditation, and funding.

Our recommended approach aims to (1) seek clarity in the contract terms proposed by the County and limit potential liability for the City, (2) establish a model that builds on collaborative success achieved during the COVID emergency and that will enable the City of Los Angeles to quickly obtain improved insight and input into the provision of public health services and a higher degree of coordination with the Los Angeles County Department of Public Health, and (3) achieve greater transparency, accountability, and an equitable allotment of services relative to the size, population, composition, and needs of the City. We believe this can be accomplished either as revisions to the proposed Public Health Services agreement or as a supplemental agreement. It also instructs the CAO to report on the funding sources allocated to public health to further the City's understanding of the relationship between funding sources and services that could be used to inform both the management of the proposed contract and the impact of erecting a public health infrastructure.

FISCAL IMPACT STATEMENT

As the recommendations in this report address negotiations with the County for an updated public health services agreement, adoption of the recommendations in this report will have no fiscal impact on the General Fund. The County of Los Angeles currently enforces the City's public health ordinances at no cost to the City.

FINANCIAL POLICIES STATEMENT

The recommendations in this report will have no impact on the General Fund and, thus, comply with the City's Financial Policies.

DEBT IMPACT STATEMENT

There is no debt impact on the General Fund as a result of the recommendations in this report, as no new debt issuance authorizations are recommended.

FINDINGS

BACKGROUND

Basis for Report

On April 1, 2022, the City Council adopted a motion (O'Farrell-DeLeon) instructing the City Administrative Officer and Chief Legislative Analyst to report on the findings in C.F. 20-0769-S2 (Attachment 5), including a review of the LA City contractual relationship with LA County for the delivery of healthcare services, detailed in Contract C-32683 (as amended), with specific recommendations for the City to improve the delivery of healthcare services to all Angelenos, starting first with people experiencing homelessness, including but not limited to:

- Models and options for a City position or office to monitor and evaluate County health programs, especially as it relates to people experiencing homelessness
- Recommendations to improve the public process for healthcare service delivery, including public oversight of the functions described in the body of this motion, focusing first on the delivery of all healthcare services to and for people experiencing homelessness, including shelter and housing, nutrition, health, substance abuse and assistance, and mental health services
- Recommendations to renegotiate contract C-32683 to better represent the City's residents, focusing on people experiencing homelessness, including citywide current and ongoing health needs
- A clear and concise method for the City to organize, prioritize, evaluate and then communicate those needs on a regular basis to LA County health departments or any future agencies tasked with enforcing the public health code

Subsequently, starting in August 2023, the Los Angeles County Department of Public Health (DPH) held meetings with constituent cities to present a new proposed agreement for public health services. DPH indicated it would take the proposed agreement to the Board of Supervisors, at which time cities would have the opportunity to accept the agreement as presented, continue to rely on the current agreement in effect with the County for public health services, or establish a separate Public Health Department. After receiving feedback from several cities and input from County Counsel, DPH transmitted a revised draft contract in late June 2024 (Attachment 3) with a corresponding Questions and Answers (Q&A) document (Attachment 4) to clarify language in the draft agreement. The updated proposed draft agreement was presented to the County's Health and Mental Health Services Cluster on September 25, 2024. The agreement was then scheduled for consideration by the Board of Supervisors on October 8, 2024, and continued until October 22, 2024. The contract has a presumed effective date of July 1, 2024.

In response to the County's new draft Public Health Services Agreement, the City can:

1) Accept the proposed agreement as-is or substantially similar;
2) Not accept (effectively reject) the proposed agreement and retain services under the current 1964 agreement (Contract No. C-32683, as amended), which doesn't expire unless terminated or replaced;
3) Establish its own Public Health Department; or,

4) Recommend an alternative approach that achieves City objectives, which are outlined in the 'Proposed Model' section of this report.

Public Health Services

Public health is a multidisciplinary field concerned with protecting and improving the health of an entire population, such as all residents within a city or county, instead of solely treating particular individuals, as in many clinical professions. Given the scope and the purpose of public health work, it is important to communicate and coordinate across a large regional area.

Public health departments work to provide at minimum the 10 essential public health services, updated in 2020 through a collaborative effort by Public Health Accreditation Board Center for Innovation, the de Beaumont Foundation, and a task force of public health experts (under the umbrella of the Centers for Disease Control). This list is intended to provide a broad service-delivery framework for all state and local public health agencies. The 10 essential public health services are as follows:

(1) Assess and monitor population health status, factors that influence health, and community needs and assets;
(2) Investigate, diagnose, and address health problems and hazards affecting the population;
(3) Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it;
(4) Strengthen, support, and mobilize communities and partnerships to improve health;
(5) Create, champion, and implement policies, plans, and laws that impact health;
(6) Utilize legal and regulatory actions designed to improve and protect the public's health;
(7) Assure an effective system that enables equitable access to the individual services and care needed to be healthy;
(8) Build and support a diverse and skilled public health workforce;
(9) Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement; and,
(10) Build and maintain a strong organizational infrastructure for public health.

Actual, specific public health service mandates, such as those provided in the California Health and Safety Code and various regulations, are lengthier and more detailed. The County, as well as any applicable local health officer, has some discretion in meeting these mandates by providing public health services directly or through contracts and has the ability to transfer some services by a county from the local health department to a comprehensive environmental health agency.

Los Angeles County Department of Public Health (DPH)

The County encompasses 88 cities, including three cities that have been operating their own public health departments for over 100 years: Pasadena (1892), Long Beach (1906), and Vernon (1908). Each of the three cities has a relationship with the County through memoranda of understanding (MOUs), contracts, and agreements to help administer public health services to their respective residents. Although they have their own departments and provide services within the scope of services required by the State's health officer regulations, it is important to note that Long Beach and Pasadena still coordinate with the County closely, and the County provides a

high level of support on matters outside of the health officer guidelines. In addition, the County contracts with those cities to provide services when needed. In Vernon, the health department addresses environmental quality matters while the County handles many public health matters.

In 1964, the City of Los Angeles entered into Contract No. C-32683 with the County for the provision of public health services as authorized by State law and at no cost to the City. Since then, DPH has expanded services provided throughout the County to address community needs as they have arisen, and the agreement, which does not expire, has been amended accordingly. DPH activities currently range from direct medical services for select communicable diseases to policy analysis and advocacy. With slightly more than 5,600 budgeted positions and a 2024-25 gross budget of slightly more than $1.6 billion, DPH directly serves a County population of approximately 9.41 million in a large geographic service area spanning 4,300 square miles. Although Pasadena and Long Beach operate their own Public Health Departments, the County DPH continues to coordinate closely and support their efforts as needed or requested. The County is divided into eight geographic regions called Service Planning Areas (SPAs) to provide targeted services. Generally, DPH reports on public health data and outcomes by SPA.

According to DPH, for a local public health department to qualify for state funding, it must offer the following basic services:

(1) Collection, tabulation, and analysis of all public health statistics, including population data, natality, mortality, and morbidity records.
(2) Communicable disease control, including availability of adequate isolation facilities, the control of the acute communicable diseases, and the control of tuberculosis and venereal diseases, based on provision of diagnostic consultative services, epidemiologic investigation, and appropriate preventive measures.
(3) Medical, nursing, educational, and other services to promote maternal and child health, planned to provide a comprehensive program to meet community needs in these fields.
(4) Environmental health and sanitation services and programs.
(5) Laboratory services, provided by an approved public health laboratory.
(6) Services in nutrition, including appropriate activities in education and consultation for the promotion of positive health, the prevention of ill health, and the dietary control of disease.
(7) Services in chronic disease, which may include case finding, community education, consultation, or rehabilitation, for the prevention or mitigation of any chronic disease.

DPH provides countywide clinical and field services through its 14 public health centers and one rehabilitation center. These facilities provide free and low-cost services for those without health insurance or a regular health care provider. Specific services include immunizations, triage for communicable diseases, Tuberculosis (TB) screening and treatment, and Sexually Transmitted Disease (STD) testing and treatment. Five of the public health centers are physically located within the City (Central, Hollywood Wilshire, North Hollywood, Pacoima, and Ruth Temple); however, services are also open to adjoining areas. The County previously estimated that City residents account for 46 percent of all visits to the 14 public health centers. Of the more than 40 programs within DPH, some of the services are contracted with community organizations.

Given the regional scope of the services being provided and the legally mandated anonymity

required of certain health services, the breakdown of the County services provided to City residents is difficult to identify.

PROPOSED NEW COUNTY PUBLIC HEALTH SERVICES AGREEMENT

The Los Angeles County Department of Public Health has drafted an updated Public Health Services Agreement that it began circulating to constituent cities during the summer of 2023. According to the County, the 85 LA County public health agreements date back to the 1950s, with most executed in the 1960s, such as the one with the City of Los Angeles. The proposed 2023 agreement incorporated updated sections of the California Health and Safety Code while some elements remain the same: DPH would continue to provide the same level of services to cities at no cost (with the one stated exception that the County would begin charging for its statutory responsibility of inspecting detention facilities). Specifically, the County agrees to continue to perform for the City such public health services as authorized or mandated by provisions of Title 11 of the Los Angeles County Code, and any amendments or additions thereto, that the City has adopted via ordinance or resolution. Additionally, contracts can continue in perpetuity. The Termination Clause would change from a date of March 1, with termination effective July 1, to 185 calendar days prior to July 1, so as to assure no lapse in public health and local health officer services to City residents. Termination can occur with or without cause.

After receiving feedback from several cities, the County transmitted an updated draft contract in June 2024 (Attachment 3) accompanied by a corresponding Questions and Answers (Q&A) document (Attachment 4). Notably, significant elements are missing from the proposed draft contract: (1) measures of accountability, such as service levels, responsiveness, and performance metrics, and (2) a mechanism to request support from the County, such as a key contact, or someone who is accountable to the City. While the Q&A document addresses some concerns raised by the City internally and has helped clarify the County's intent, that clarifying language has not been fully incorporated into the June 2024 Agreement, leaving open several questions and concerns. For example, the updated agreement would enable the City to request additional public health services but allows the County to charge the City at undefined rates for undefined additional services. Specifically, the proposed June 2024 Agreement states that the City may 'request in writing additional public health services of the County, that are not required by statute, regulation or CDPH Order, or as provided in Title 11 of the Los Angeles County Code,' and that 'the County may charge the City, at rates approved by the Board of Supervisors, an hourly rate that will reimburse the County for the costs for the provision of those specific public health services.' In contrast, the Q&A document states, 'in these instances, and subject to prior agreement with the requesting City, the County could provide such services to the City at the rate provided in LA County Code section 8.04.728 or other cost reimbursement rate for Public Health employees, yet this level of specificity is not incorporated in the updated draft agreement. Further, the baseline services are undefined. Notably, under the proposed June 2024 Agreement, the County, which has a statutory obligation to investigate health and sanitary conditions in detention facilities, would now bill and receive payment for detention facility inspections and reporting services.

Additionally, if the City elects to pursue a public health violation that requires abatement or legal prosecution, the City shall bear the full cost of such proceedings and be charged by the County for the assistance of County employees. It is unclear why the agreement anticipates that the City may be forced to enforce the Health Code, which would seem to be a clear obligation of the County. Finally, the County names itself the City's "Environmental Health Department," yet the scope and intent are undefined and should be clarified given that the City Public Works Department currently operates a Bureau of Sanitation, known as LA Sanitation and Environment (LASAN). Further, the City has previously had an Environmental Affairs Department and may again in the future. For at least these reasons, it is recommended that the City not accept the proposed June 2024 Agreement as written but instead negotiate a new agreement with the terms outlined below.

The County has indicated that the City can (1) approve the updated agreement after it has been approved by the Board of Supervisors, (2) continue to rely on the 1964 agreement, which does not expire unless terminated or replaced by a new agreement, or (3) create its own Public Health Department. Instead, we recommend alternative options that would enable the City to achieve greater accountability, transparency, and improved services from the Los Angeles County Department of Public Health.

ALTERNATIVE MODELS AND OPTIONS

Public health services are not "off the shelf" products that can be delivered without highly specialized staff with a public health orientation. The breadth and scope of services needed and the design of a system to deliver them require careful and detailed planning and consideration by a multitude of experts, which makes such an undertaking one that requires a significant commitment and thoughtful planning. Attachment 7 to this report identifies several factors to be considered in establishing a City of Los Angeles Public Health Department. Given the complexities associated with this path and the opportunity provided by the County's desire to update its public health contracts, we recommend an alternative option that would enable the City to achieve greater accountability, communication, and improved services from the Department of Public Health.

Proposed Approach

As directed by motion (O'Farrell-DeLeon), this report identifies several models and options for a City office to monitor and evaluate County health programs, including as it relates to people experiencing homelessness, and a clear and concise method for the City to organize, prioritize, evaluate and then communicate those needs on a regular basis to LA County health departments or any future agencies tasked with enforcing the public health code. Prior to the COVID-19 pandemic, the City relied on the County for public health services and made no consistent effort to evaluate these services. Following the pandemic, the City has become acutely aware of the need to further engage with DPH to ensure that Angelenos get the services they need and deserve, particularly as the largest city in the County and as the second largest city in America, as highlighted in Attachment 8. As the City of Los Angeles considers how to best meet the public health needs of residents, a future approach must address the following:

- Clear, and potentially new, roles and responsibilities for the City and County in providing services to residents
- Improved quality and number of services available to residents aligned to the size and scale of the City of Los Angeles
- Accountability structures that allow the City and County to collaborate to measure and continuously improve service delivery
- Ability to respond to day-to-day and changing needs of a dynamic city population, including other areas of public health like public safety, whole person care, and other emerging areas of health
- Ability to respond in times of local and global emergency in a consistent and apolitical manner and with science and ethics at the forefront

Accordingly, this report recommends that the City explore the following options to obtain greater levels of 1) service provision, 2) communication and coordination, and 3) transparency and accountability:

- **Governance Structure:** Creation of a new governance model to include (a) a new City of Los Angeles team with a manager and four support staff responsible for overseeing the City-County public health contract and coordinating public health with the County in times of regular business and global emergency; (b) the City of Los Angeles Health Commission aligned to the new City team to concentrate capacity and provide the highest levels of support to the City infrastructure on public health issues; and, (c) a new Los Angeles County team with a focus on collaborating and coordinating with the aforementioned City of Los Angeles team to ensure an improved response to City of Los Angeles needs and better public health outcomes for Angelenos, for example coordinating on day-to-day activities as well as special projects like convening a quarterly working group between City leaders encountering matters of public health and County experts. Such a roundtable could also include other cities in the County to broaden collaboration and positively affect public health outcomes in the region. Given the unique size and scope of Los Angeles, improved coordination between the City and County is critical and desperately needed to support improved service delivery and associated outcomes for Angelenos.

- **Contract Management:** Improved contract management of the public health agreement between DPH and the City with a focus on ensuring (a) clarity and transparency in day-to-day business transactions; (b) consistency and quality of services being provided by the DPH; (c) continuous measurement and examination of the impact of services and opportunities for improvement; and, (d) revised approach to contract management include a structured procedure for negotiating services and associated fees, predicated on having established existing baseline levels of service. We recognize DPH provides hundreds of services across multiple bureaus, and we would look to prioritize those that are most critical for the City accordingly. Importantly, creating a baseline of existing services provided by DPH to the City will allow for this prioritization as well as added transparency and clarity around service provision and associated costs.

- **Provision of Services:** Given the size of the City of Los Angeles, the City must ensure that Angelenos receive an adequate allotment of resources relative to the size, population, and composition of the City. (See Attachment 8 for population data regarding cities within Los Angeles County.) Ultimately, this report seeks to request the provision of public and related health services, particularly to persons experiencing homelessness, reflecting the percentage of the City's population receiving services from the County so that the City of Los Angeles receives adequate resources with respect to all matters of public health. Additionally, this report seeks to request greater clarity from the County with respect to service provision to Angelenos.

- **Reimbursement Model for City Services:** This report recommends that the City and County negotiate a reimbursement model and associated contracting approach that would allow Los Angeles County to procure services from the City of Los Angeles that would be beneficial to the County and assist in meeting public health demands. The City and County have informally achieved this arrangement at times, particularly in the last several years. Whether it was during the COVID-19 emergency, during which time the City provided extensive financial and staffing support to establish and provide testing and vaccine services to assist the County in meeting public health demands, or during times when there are emergent programs needed in the community but for which there is not ample County staff support available, the City has stepped in to assist. It is our understanding that a model is in practice in Los Angeles County, particularly with the Cities of Pasadena and Long Beach. While the City of Los Angeles does not have a health department, given our size, scale, and scope, the City does have specialized staff who have been used in this way in the past. For this reason, the City believes this model can be mutually beneficial.

  Using this framework, DPH, and potentially other County agencies, would be eligible to procure services from the City. In such instances, the City and County would agree to a scope of services, payment, and other related terms and add an addendum to the standing MOU. Conceptually, this new approach would allow the County to source important services from the City for an agreed-upon fee. Fortunately, in certain circumstances, the City has the capacity to establish and scale programs more quickly, and potentially more efficiently, creating a win/win for both the City and County. Such services could include special projects that the City is uniquely qualified to provide or surge support during local or global emergencies (e.g., establishing and operating special operations like testing or vaccination infrastructure or mobilizing outreach workers). Previous specific examples include the City of Los Angeles establishing COVID-19 testing and vaccination programs, and while there is precedent for this, pricing, skilled staffing, and negotiation structures didn't exist previously and could bolster the quality, capacity, efficiency, and accountability.

- **Provision of City of Los Angeles Level Data and/or SPA Boundary Realignment:** While the SPA's serve many purposes that are advantageous to County service provision, that they are not organized in a manner that considers the geographic boundaries of the City of Los Angeles continues to be challenging for myriad reasons. One important reason is that it continues to be difficult and, at times, impossible to receive data that is organized

in a manner that allows City officials to understand trends, issues, and important opportunities to address community needs as a City and in collaboration with the County. The City needs to receive data in a way that can both inform and drive decision-making. Alternatively, as the current County SPA structure does not meet the needs of the City and its residents, an update to, and ultimately change in, the boundaries of the County's Service Planning Areas to incorporate the City's geographic boundaries would ensure improved data provision as well as a more equitable allocation of resources, greater coordination, and alignment of governance, oversight, and management**.**

Additionally, as part of any negotiation with the County to address provisions in the proposed Public Health Services Agreement, the City should strive for clarification of miscellaneous provisions, including (a) definition of the scope and intent of naming the County as the City's Environmental Health Department particularly to clarify its role vis-a-vis the Public Works Bureau of Sanitation; (b) development of a baseline of existing public health services that would be the starting point for determining when the City would be expected to pay for expanded services; (c) specificity as to the mechanism by which the City would request those services or support from the County and a time limit for the County to respond; and (d) clarification of the language requiring the City to bear the full cost of legal proceedings if a public health violation requires abatement or legal prosecution.

PROPOSED GOVERNANCE STRUCTURE

Los Angeles City Public Health Liaison Office

With agreement between the City and County on improved program governance, a new City of Los Angeles Public Health Liaison Office would be established within an existing department that is ideally mission driven to work across departments and best able to be politically agnostic, particularly during times of public health crisis. The new office would need to address ongoing contract management matters and work closely with the Mayor, Council, City Attorney, and others to ensure that the goals and needs of the City are advocated for and best met by the County Department of Public Health. While this function currently does not exist in the City of Los Angeles, during the COVID-19 emergency, a centralized unit was established within the Mayor's Office to support all entities working on the COVID-19 response and act as a liaison to the County. This model is consistently cited by City and County employees as having worked well and having helped the County and City coordinate for the best possible outcomes during that extremely challenging time. Further, during the COVID-19 emergency, the Emergency Management Department (EMD) was also assigned an administrative liaison with the financial support of the County and other external funding who assisted in coordinating EMD's response.

Moving beyond the COVID-19 response and needing to address current concerns, it will be imperative that the City learn from these models and the attributes that made them successful and look to establish a small Office that can oversee contracts and related public health activities on behalf of the City while keeping both the Mayor and City Council informed. More recently, for example, the City has experienced ongoing frustration with substance abuse services, currently provided through a program within DPH. More effective liaisoning, collaboration, and results-

oriented data from DPH is critical to addressing questions about beds, access, and referrals.

With the above in mind, this report recommends that the City of Los Angeles Public Health Liaison Office be housed within the CAO and, subject to finalizing an agreement with the County, consist of the following staff:

- **Executive Director:** One senior-level position, such as a Chief Management Analyst, with a public health administration background. Oversees the Health Commission, liaises with County and City officials to manage public health contracts and performance and quality of services. Nestled in a department and reports to Mayor and Council, convenes City and County leadership as needed to meet public health needs. In times of emergency, the Executive Director would act as the central point of contact for the County, Mayor's Office, and City Council to ensure coordination of political bodies. The Executive Director would retain an apolitical stance to public health.

- **County Liaisons:** Up to four County liaisons, assigned the topics of general public health focused on coordinating with the county on the 800+ services and general emergencies (2), people experiencing homelessness (1), and data analysis (1). While Management Analysts would serve as liaisons and coordinate closely with the County, non-profits, community-based organizations, and applicable City departments and elected offices on a day-to-day basis, a Data Analyst would be critically needed to analyze health data at the City level, which could be by zip code or census tract, to provide needed performance insights and recommendations on matters of public health and for people experiencing homelessness. The data analyst would provide ongoing analysis and develop insights about trends and suggested actions presented by the data to ensure quality of services. The Management Analysts would not only partner with county staff to continuously improve services in response to data and insights but would also be pivotal in communicating and working with City and other County department staff to understand areas of concern and assist public health staff. As identified in the motion (O'Farrell-DeLeon), these positions will establish a clear and concise method for the City to organize, prioritize, evaluate, and then communicate its needs on a regular basis to City leadership as well as LA County health departments. The Data Analyst is critically needed to ensure meaningful City data is available to decision makers.

City Health Commission: Realign the City Health Commission to the CAO's Office so public health related policy efforts are consolidated into a single Department within the City.

In making the recommendation to house the City's Public Health Liaison Office in the CAO, we evaluated whether other City Departments could assume this role. While various Departments, such as Emergency Management, Community Investment for Families, Personnel, and City Planning have specific roles that touch on some aspects of public health areas, we believe the focus of the proposed Office encompasses the full spectrum of public health services. Further, the CAO is uniquely positioned to provide political neutrality, which is central to the practice of public health, while retaining direct lines of communication with the Mayor, City Council, and City departments. Finally, the updated draft of the proposed agreement assumes the City Manager or

equivalent office (such as the CAO) will serve as the contract liaison to DPH.

Proposed New Los Angeles County Public Health Liaison Team
In addition to the City team, this report recommends that a County team be established to ensure that adequate management and resources are afforded to the City of Los Angeles. While we recognize that the City does not make decisions for the County, establishing a liaison office or team with public health expertise within DPH will be crucial to ensuring that services to the City of Los Angeles are adequately managed and performed. While the County's intergovernmental relations team serves an important function, this report recommends that individuals in the new Los Angeles County Liaison team have public health expertise. Ideally, the City and County organizations would mirror one another and create a corpus of talent and knowledge focused on managing the mutual needs of the County and the second largest city in America.

- **Director:** One senior-level official with specialized public health administration background. Liaises with City officials to oversee the public health contract, and performance and quality of services. Reports to Public Health Officer and Public Health Director, convenes City and County leadership as needed to meet public health needs. In times of emergency, act as the central point of contact for the City, County, Mayor's Office, and City Council to ensure coordination of the political body.

- **City Liaisons:** Up to four City liaisons with specialization in general public health (2), people experiencing homelessness (1), and data and performance (1). Provide ongoing analysis to ensure quality of services. Partner with City staff to continuously improve services in response to data and insights. Work with applicable City and County staff to ensure needs are met.

City Health Commission
The City of Los Angeles established a Health Commission in 2014, in response to an initiative ordinance (C.F. 14-0596). This Commission is comprised of 15 members, each one appointed by a member of the City Council and serving without compensation for one year. As described in the ordinance, the duties of the Commission include:

- attending all County health-related meetings, hearings, working sessions or other events;
- publishing an annual health services plan for the City;
- reporting twice yearly with an evaluation of the progress toward meeting the health goals contained in that health services plan;
- reviewing annually a sample of health services contracts executed by the County;
- evaluating annually whether the health needs of City residents are best served by continuing to contract with the County; and,
- reporting on the feasibility of establishing an independent City Health Department.

This report recommends re-aligning the Commission to the new City of Los Angeles Public Health Liaison Office to provide centralized public health policy oversight and to ensure the City speaks with one voice in this area.

LOS ANGELES COUNTY SERVICE PLANNING AREAS (SPAs)

The County Board of Supervisors adopted eight Service Planning Areas (SPAs), or regions, in 1993, and DPH services are delivered based on those SPAs: 1) Antelope Valley, 2) San Fernando Valley, 3) San Gabriel Valley, 4) Metro LA, 5) West, 6) South, 7) East, and 8) South Bay. Attached is a map of the SPA areas (see Attachment 9). According to DPH, these distinct regions allow their department to develop and provide more relevant public health and clinical services targeted to the specific health needs of the residents in these different areas. The 15 City Council Districts fall within five of the eight SPAs, but none of the boundaries align. While data regarding specific issues or public health indicators is, at times, made publicly available, that data is often extremely focused and doesn't allow for greater insights into how the City and County could better deliver services or trends across general public health. Providing extensive, high-quality data that aligns with City of Los Angeles boundaries would assist City officials as they aim to understand trends, issues, and important opportunities to address community needs as a City and in collaboration with the County. The City needs to receive data in a way that can both inform and drive decision-making while ensuring the best services are provided to City residents. Alternatively, revising the SPA boundaries would be favored by the City to not only create more accountability for services provided to City residents but also ensure more equitable resource allocation and service delivery.

NEXT STEPS

Upon approval by the Mayor and Council of the negotiation strategy and direction to move ahead, the CAO and CLA, with the assistance of the City Attorney, will reach out to the County immediately and advise the Mayor and Council on the status of negotiations no later than 30 days after discussions begin.

With the County's agreement on the need for better public health governance, the CAO will request positions and funding for the new City of Los Angeles Public Health Liaison Office, which could be established within six months. Key time drivers would include establishing positions, hiring a manager to lead the office, and enabling that person to hire qualified liaison staff. Additional time drivers would include the time it takes to re-align the Health Commission to the new office once the manager is on board.

Further informed by the negotiations with the Department of Public Health, next steps could also include pursuing similar negotiations with the County for mental health services, as the Department of Mental Health is a separate County entity.

Mental Health Services

The Los Angeles County Department of Public Health oversees the public health services provision for City residents while the Los Angeles County Department of Mental Health oversees mental health services (see County Organization Chart Attachment 10 and Department of Public Health 2018-2023 Strategic Plan Attachment 11). Mental health services are essential to the well-being of all Angelenos, especially those who are experiencing homelessness. While it is essential that mental health service delivery be improved and coordinated more successfully, the CAO and

CLA, with the assistance of the City Attorney, could be charged with negotiating a separate agreement with the County for mental health services. This report suggests that the CAO and CLA explore a similar approach to the one laid out here and align a future mental health services and public health services office such that governance, oversight, and management of both contracts is coordinated and aligned within the City of Los Angeles. In this way, the City would be able to partner effectively with the County and ensure coordination between the two large County agencies while also acting as coordinating units within the City. In addition, the new City Public Health Office could include a mental health liaison, recognizing the intersection of public and mental health and the need to address mental health. Application of this approach should also be considered for the Department of Health Services.

COSTS

A five-position City of Los Angeles Public Health Liaison Office represents the best and most effective option for successful liaison, communication, coordination, and accountability between the City and County. Recognizing that a new governance structure would be negotiated as part of the proposed Public Health Services agreement, the final number and duties of the positions, along with funding options and timing, would be contingent on those negotiations. Accordingly, costs would be provided when agreement is reached with the County on the need for proactive and cooperative governance.

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CONCLUSION

Angelenos rely on DPH for protection from various threats that could lead to regional crises, whether due to disease, bioterrorism, or tainted food. While City leaders have expressed ongoing interest in providing these services at greater levels in the future, this report identifies an alternative to creating a City of Los Angeles Public Health Department. The breadth and scope of services needed and the design of a system to deliver them requires careful and detailed planning and consideration by a multitude of experts, which makes such an undertaking one that must be considered carefully.

Public health services are not “off the shelf” products that can be delivered without highly specialized staff with a public health orientation. The slightest failure in enforcing all existing codes related to public health could unnecessarily put the residents of Los Angeles and surrounding communities at risk. Thus, this report acknowledges the need for better service delivery, communication and coordination, and greater accountability between the City and County to ensure the most effective delivery of these critical services to City residents, businesses, and visitors.

The first step in ensuring effective public health services in the City of Los Angeles is reaching agreement with the County on key contract terms and on the need for better governance, contract management, and provision of services. To achieve these critical milestones, we will need transparency and accountability, including improved data at the City level and/or new SPA

boundaries. A new reimbursement model would create a better partnership and acknowledge services the City is uniquely situated to provide to the County, particularly in times of public health emergencies. An effective governance structure that would include a City team tasked with overseeing the DPH contract and collaborating and coordinating with a corresponding County team to assess opportunities and improve the delivery of services is key to ensuring that public health services are better coordinated and the City has a say. In the absence of such agreement, the City must be prepared to consider all alternative options.

We recognize the extraordinary breadth and scope of work performed by DPH, encompassing hundreds of services across multiple bureaus and locations. Nonetheless, the number of people experiencing homelessness in the City has created both acute and chronic public health problems in Los Angeles. According to a study by People's Health Solutions, an estimated 66,436 people in Los Angeles County in 2020 were experiencing homelessness, and of those individuals, two-thirds (41,290) resided in the City of Los Angeles. While incidents of smoking, tobacco, and diabetes affect the homeless population and have significant public health implications, recent outbreaks of communicable diseases such as Mpox, typhus, Hepatitis A and C, and tuberculosis put people experiencing homelessness, and everyone else, at risk of increasing morbidity and mortality among the population of Los Angeles.

LIST OF ATTACHMENTS

Attachment 1 – 1964 Public Health Contract
Attachment 2 – Timeline of Major Events in Public Health in Los Angeles
Attachment 3 – 2024 Proposed Revised Los Angeles County Public Health Contract
Attachment 4 – Q&A Provided by County in Support of 2024 Proposed Revised Los Angeles County Public Health Contract
Attachment 5 – Motion O'Farrell-DeLeon (C.F. 20-07629-S2)
Attachment 6 – Partial List of DPH Services
Attachment 7 – Assessment of Needs for Establishing Los Angeles City Department of Public Health
Attachment 8 – Cities in Los Angeles County by Population
Attachment 9 – Service Planning Area Map (SPAs)
Attachment 10 – County Organization Chart
Attachment 11 – Department of Public Health 2018-2023 Strategic Plan

MWS:PJH:JAY

FILE
No. 42

AGREEMENT NO. 32683

AN AGREEMENT ESTABLISHING TERMS
FOR THE ENFORCEMENT BY THE
COUNTY IN THE CITY OF LOS ANGELES
OF THE COUNTY PUBLIC HEALTH CODE

An Agreement made and entered into this 18th day of JUNE, 1964, by and between the County of Los Angeles, State of California, hereinafter called the "County" and the City of Los Angeles, State of California, a municipal corporation, hereinafter called the "City."

WITNESSETH:

WHEREAS, Sections 480, 481 and 482 of the State Health and Safety Code authorize the Board of Supervisors of the County to contract with the City for the performance by the Health Officer and other employees of the County of any and all functions relating to the enforcement in the City of all ordinances thereof relating to public health and sanitation and the making of all inspections and the performance of all functions in connection therewith at cost;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, it is hereby agreed as follows:

1. In the event the City, by ordinance, adopts the provisions of the County Public Health Code (County Ordinance No. 7583), the County Health Officer shall perform the services to enforce said ordinance in the City to the

same extent as the County Public Health Code is enforced in unincorporated territory, and shall issue the permits and collect the fees provided for in Section 750 of said County Public Health Code.

Said fees, and any other or additional fees provided for by the County by ordinance adopted pursuant to the provisions of Section 510 of the State Health and Safety Code, shall be retained by the County Health Officer for the benefit of the County as full compensation for the services performed by said Health Officer in the enforcement of said ordinance, except that any court time spent by County employees for the enforcement thereof shall be compensated for in accordance with the provisions below. In the event, and whenever said County Public Health Code is amended to change the amount or amounts of any of the aforesaid permit fees, the City shall amend its adopting ordinance to provide permit fees in the exact amount as those designated in the County ordinance as amended. The County shall notify the City in writing of any such amendment.

2. The City agrees to compensate the County for court time in the enforcement of such ordinances on the basis of the cost of performing said work as defined in Paragraph 5 hereof, reduced by the amount recovered by witness fees.

3. The County agrees to submit to the City during the life of this agreement periodic statements in duplicate for the services described in Paragraph 2 and rendered during the period covered, and the City agrees to pay the cost thereof within thirty (30) days after receipt of such billing. If the City desires monthly billing, it shall notify the County in writing, otherwise billing periods shall be fixed by the County.

4. Performance hereunder shall commence on the effective date of the City's adoption of the County Public Health Code, and shall remain in full force and effect to July 1, 1965. If this contract is not then terminated, it shall be deemed renewed without further action of the contracting parties from year to year. Either party hereto shall have the right to terminate this Agreement at the end of any fiscal year by giving written notice of such intention to so do, such notice to be given not less than thirty (30) days prior to the end of any fiscal year.

5. Costs shall include salaries of employees engaged in performing the services described in Paragraph 2, a prorate of vacation and sick leave, supervision of such employees while so employed, the County Retirement Contribution and Workmen's Compensation Insurance Premiums on salaries, travelling expenses, supplies, plus a prorate of all indirect expenses. If the cost of providing such services changes, the City shall be notified of each such change in writing.

6. For the purpose of performing the functions provided for herein, the County shall furnish and supply all necessary labor, supervision, equipment, communication facilities and supplies necessary to maintain a level of service sufficient to adequately enforce the ordinances described herein and to protect the public health, safety and welfare.

7. Notwithstanding anything hereinbefore contained, it is agreed that in all instances where special supplies, stationery, notices, forms, and the like, which are different from those used by the County and must be issued in the name of said City, the same shall be supplied by the City at its own cost and expense.

8. The City shall not be called upon to assume any liability for the payment of any salaries, wages, or other compensation to any County personnel performing services hereunder for the City, or any liability of any kind other than that provided for in this Agreement. Nor shall the City be liable for compensation or indemnity to any County employee for injury or sickness arising out of his employment.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first above written.

Attest:

WALTER C. PETERSON
City Clerk

By _____
Deputy

CITY OF LOS ANGELES

By _____
Mayor

Approved as to Form

ROGER ARNEBERGH, City Attorney

By _____
Assistant

Attest:

GORDON T. NESVIG
Clerk of the Board
of Supervisors

By _____
Deputy

COUNTY OF LOS ANGELES

By _____
Chairman
Board of Supervisors

Approved as to Form

HAROLD W. KENNEDY, County Counsel

By _____
Assistant

APPROVED BY BOARD OF SUPERVISORS

JUN 1 - 1954

AMENDMENT TO AGREEMENT NO. 8225

SUPPLEMENT 1

FILE
No. 42

Aug 11 10 12 AM '69
ROY E. DAYTON
CITY CLERK
Deputy

MODIFICATION OF AGREEMENT NO. 32683 OF CONTRACTS OF THE CITY OF LOS ANGELES FOR THE ENFORCEMENT BY THE COUNTY IN THE CITY OF LOS ANGELES OF THE COUNTY PUBLIC HEALTH CODE

This Modification Agreement is entered into by and between the CITY OF LOS ANGELES, a municipal corporation, and the COUNTY OF LOS ANGELES, STATE OF CALIFORNIA;

W I T N E S S E T H :

WHEREAS, the CITY OF LOS ANGELES, a municipal corporation, hereinafter referred to as the City, and the COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, hereinafter referred to as the County, entered into an agreement for the County to enforce the County Health Code within the City, on the 18th day of June, 1964, said agreement being designated as Agreement No. 32683 of Contracts of the City of Los Angeles, and

WHEREAS, pursuant to its terms, said agreement is renewable from year to year, and

WHEREAS, said agreement has been renewed and is now in full force and effect, and

WHEREAS, it is now deemed advisable, expedient and necessary that the County perform services in the matter of inspecting mobile home parks situate in the City, pursuant to the provisions of Division 13, Part 2 of the Health and Safety Code of the State of California;

NOW, THEREFORE, the parties hereby agree that

FILED
Aug 11 10 12 AM '69
REX E. LAYTON
CITY CLERK
BY Ketchum DEPUTY

Agreement No. 32683 of Contracts of the City of Los Angeles shall be and it hereby is modified by the addition of Articles 9 through 13 inclusive, set forth below, and that each and every other term of said agreement shall remain in full force and effect as stated in the original agreement:

9. The County agrees to enforce the provisions of Division 13, Part 2 of the Health and Safety Code of the State of California, relating to the sanitation, maintenance, use and occupancy of mobile homes and mobile home parks, within the City. Said services shall be requested by the City in writing, directed to the County Health Officer, specifically designating the services to be required.

10. The County shall not make more than four (4) inspections per year of any one mobile home park without express consent of City.

11. County shall notify City not later than December 10 of any violations not corrected by December 1 of any year.

12. The City shall pay County costs for services rendered pursuant to this modification, said costs to be computed in the same manner as for the services rendered pursuant to Article 2 as set forth in Article 5, both of the Agreement. Said payment shall be made as provided in Article 3 of the Agreement.

13. The provisions and obligations of this modification are effective as of January 1, 1968; the execution of this

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AUG 11 10 12 AM '69

REX E. LAYTON
CITY CLERK
BY Kitchen DEPUTY

modification by the duly authorized officers of the parties shall constitute ratification of the retroactive application thereof.

IN WITNESS WHEREOF, the parties hereto have caused this instrument to be duly executed.

CITY OF LOS ANGELES

DATED: JUL 11 1969

By _____
Mayor

ATTEST:

REX E. LAYTON
City Clerk

By _____
Deputy

APPROVED AS TO FORM
ROGER ARNEBERGH,
City Attorney

MAY 12 1969

By _____
Deputy

COUNTY OF LOS ANGELES

DATED: AUG 5 1969

_____
Chairman
Board of Supervisors

ATTEST:
WILLIAM G. SHARP,
County Clerk

By _____
Deputy

ATTEST: JAMES S. MIZE
EXECUTIVE OFFICER AND
CLERK OF THE BOARD OF SUPERVISORS
By _____ Deputy

APPROVED AS TO FORM
JOHN D. MAHARG, County Counsel

By _____
Deputy

APPROVED BY
BOARD OF SUPERVISORS
AUG 5 1969
JAMES S. MIZE
EXECUTIVE OFFICER

Background and Context

1964 — County Public Health Contract Begins
The City merges its Public Health Department with the County Department of Health Services and executes a contract resulting in adoption of the County Public Health Code and County enforcement of the Public Health Code in the City limits.

2014 — Health Commission Established
In response to an initiative ordinance, City of Los Angeles Health Commission established to provide recommendations to city political officials in lieu of a city public health department.

2016 — Homelessness Increases
People experiencing homelessness begins to increase rapidly and the city and county infrastructure look for ways to address the growing challenge.

2020 — COVID-19 Emergency
COVID-19 worldwide emergency begins placing public health at the center of Angeleno's lives. Gaps in the City-County contract arrangement laid bare as COVID exposes existing and new challenges in public health governance structure and quality of contracted services.

2021 — City Leaders Seek Evaluation
City political leaders call for a better understanding of the need for improved service provision, a revised county contract, alternative governance structure and other key areas with a focus on improving overall public health services in the city.

2023 — County Proposes New Public Health Contract
County asks for all cities to sign standard agreement. Los Angeles and other cities begin to explore options. County updates proposed agreement in 2024.

**The County has reorganized DMH, DHS and DPH numerous times.*

Contract No._____

DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH SERVICES CONTRACT

THIS CONTRACT “Contract” is made and entered into on _____,
by and between COUNTY OF LOS ANGELES (hereafter
"County") and _____ (hereafter "City")

THIS PUBLIC HEALTH SERVICES CONTRACT ("Contract"), dated for purposes of reference only, July 1, 2024, is made by and between the County of Los Angeles, hereinafter referred to as the "County", and the City of City Name hereinafter referred to as "City."

RECITALS:

(a) The City desires to continue to contract with the County for the performance of public health services by the County’s Department of Public Health (“Public Health”), for the County’s Health Officer to act as the City’s Health Officer, and for the County's Department of Public Health to serve as the City's Environmental Health Department.
(b) The County agrees to continue performing such services on the terms and conditions set forth in this Contract.
(c) This Contract is authorized by California Health and Safety Code Sections 101400 and 101405.
(d) To effectuate public health services for the City, the County and its duly appointed Health Officer shall exercise the powers and duties that are conferred upon local health officers by law.
(e) The County Health Officer shall fulfill the obligations and exercise the authority conferred by California Health and Safety Code Sections 101470 and 101475 within the territorial jurisdiction of the City in the performance of this Contract.

THEREFORE, THE PARTIES MUTUALLY AGREE AS FOLLOWS:

1. **TERM:** This Contract shall become effective on July 1, 2024, and replace all prior contracts for public health services between the City and County. This

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contract shall continue in full force and effect until June 30, 2029. Subject to Section 7 below, this Contract shall thereafter be automatically renewed for consecutive five (5) year terms, for an indefinite period, without further action by either City or County, unless City or County terminates the Contract in the manner set forth in Section 7.

2. **PUBLIC HEALTH SERVICES**: The County and the County's Health Officer shall observe and enforce within the territorial jurisdiction of the City all of the following:
    a. Orders, quarantine, and other regulations, concerning public health, prescribed by the California Department of Public Health ("CDPH").
    b. Statutes relating to public health.
    c. Provisions of Los Angeles County Code, Title 11, and any amendments thereto, as adopted by City by ordinance or resolution, to the same extent as they are enforced in the unincorporated area of the County.

3. **DESCRIPTION OF PUBLIC HEALTH FUNCTIONS**:
    a. The performance of all public health services, the standard of performance and other matters incidental to the performance of public health services and observation and enforcement of public health statutes, regulations, ordinances and CDPH orders and guidance shall be determined solely at the discretion of the County Health Officer and/or Director of County Public Health. The control of County personnel under this Contract shall remain exclusively with the County.
    b. The County agrees to continue to perform for the City such public health services as are authorized or mandated by state laws or regulations related to public health, to be performed by the local health officer or local enforcement agency.
        i. Pursuant to California Health and Safety Code section 101045, the County shall investigate health and sanitary conditions in detention facilities operated by the City, if any. County may bill and receive

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payment from City for inspection and reporting services in the manner provided by Paragraph 4, subsections (g) and (h) of this Contract.

ii. For future enactments of state law or regulation, County agrees to perform public health services that impose a specific duty or obligation on the local health officer to observe or enforce. Should future state law statutory or regulatory enactment related to public health not impose a duty or obligation on the local health officer, City may request in writing that the County to perform that public health service. Should County elect to perform that discretionary public health service for City, pursuant to such City request, then County may bill and receive payment from City for inspection and reporting services in the manner provided by Section 4, subsections (g) and (h) of this Contract.

c. The County agrees to continue to perform for the City such public health services as authorized or mandated by provisions of Title 11 of the Los Angeles County Code, and any amendments or additions thereto, that the City has adopted via ordinance or resolution.

i. Should the County Board of Supervisors enact future provisions to or amend existing provisions of Title 11 of the Los Angeles County Code, County will inform the City of the newly enacted provision or amendment via email to the City's Manager, and describe the enacted new provision or amendment and the impact to the services performed under this Contract, if any.

ii. For future ordinances that may be enacted by the Board of Supervisors into Title 11 of the Los Angeles County Code, in order for the County to observe and enforce that enacted ordinance within the City, the City must approve the incorporation of the identical version of that new Title 11 provision into its municipal code via ordinance or by resolution of the City Council.

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iii. Any future amendments to provisions of Title 11 of the Los Angeles County Code that exist in the City's Municipal Code at the date of the execution of this Contract, shall be incorporated by the City into its municipal code.

d. The County shall issue public health permits and licenses to permittees located within the City and collect the fees as provided for in Los Angeles County Code, Title 8, Chapter 8.04. Such fees shall be retained by County Public Health for the benefit of County as full compensation for the services performed by the Public Health Director and County Health Officer on behalf of the City.

i. County may, from time to time, amend or alter the public health permit or license fees charged to those individuals or entities required to obtain a public health permit or license pursuant to either state statute or Los Angeles County Code, Title 8, Chapter 8.04.

ii. City may not set, collect, or retain public health permit or license fees for any public health service performed by County under this Contract.

e. For the purpose of performing said functions, County shall furnish and supply all necessary labor, supervision, equipment, and supplies necessary to provide the public health services described in this Contract and as necessary to protect the public health, safety, and welfare as determined by Public Health in its sole discretion.

All persons employed in the performance of public health services and functions under this Contract shall be County personnel.

4. **GENERAL TERMS**:

a. To facilitate the performance of public health services, City and County will cooperate and assist each other to fulfill the purpose and intent of this Contract.

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b. Exhibit A of this Contract, which is attached hereto and incorporated herein, shall provide the language of the City's Municipal Code, as amended, that reflects the City's specific adoption of Division 1 of Title 11 of the Los Angeles County Code as of the effective date of this Contract. Exhibit A may be revised to reflect any changes to the City's Municipal Code regarding Title 11 of the Los Angeles County Code.

c. All persons employed in the performance of such public health duties, functions and services for City shall be County employees or personnel and no City employee shall be supplanted by County, and no person employed by County under this Contract shall have any City pension, civil service, or any status or right.

d. The City shall not be called upon to assume any liability for the direct payment of any salary, wages or other compensation to any County personnel performing services hereunder for the City, or be liable for compensation to or required to indemnify any County employee for injury or sickness arising out of his or her employment.

e. The parties have executed an Assumption of Liability Contract approved by the Board of Supervisors on December 27, 1977, and/or a Joint Indemnity Contract approved by the Board of Supervisors on October 8, 1991. Whichever of these documents the City has signed later in time is currently in effect and hereby made a part of and incorporated into this Contract by reference. In the event that the Board of Supervisors later approves a revised Joint Indemnity Contract, and the City executes the revised contract, the subsequent contract as of its effective date shall supersede the agreement previously in effect between the parties hereto.

f. City is not required to separately reimburse County for the performance or enforcement of any City ordinance or resolution which adopts identical provisions of Los Angeles County Code, Title 11, and its amendments.

g. Should City request in writing additional public health services of the County, that are not required by statute, regulation or CDPH Order, or as provided in Title 11 of the Los Angeles County Code, the County may

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charge the City, at rates approved by the Board of Supervisors, an hourly rate that will reimburse the County for the costs for the provision of those specific public health services.

h. County, through its Director of Public Health, must render to City within twenty (20) calendar days after the close of each calendar month an itemized invoice which covers all extra services performed for City if such services were requested by the City in writing, during said month, and City must pay County within thirty (30) days after date of such invoice.

i. If a violation of public health statutes, regulations or ordinances results in a public health hazard within the City, County will notify the City Manager in writing. If the City elects to pursue legal prosecution or abatement, City shall provide to County contact information for counsel that will represent the City or the People in any legal proceeding to abate or mitigate the public health hazard. City shall bear the full cost of such proceedings. County may bill City on an hourly basis for time spent by County employees participating in such legal proceedings.

5. **NOTICES**: Notices hereunder must be in writing and may either be delivered personally or sent by registered or certified mail, return receipt requested, postage prepaid, attention to the parties at the addresses listed below. Public Health Director, or the Director's designee, is authorized to execute all notices or demands which are required or permitted by County under this Agreement. Addresses and parties to be notified may be changed by providing at least ten (10) working days prior written notice to the other party.

A. Notices to County must be addressed as follows:

(1) Department of Public Health
Environmental Health – Administrative Headquarters
5050 Commerce Drive
Baldwin Park, California 91706
Attention: Director, Environmental Health
E-mail: LFrias@ph.lacounty.gov

(2) Department of Public Health

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Contracts and Grants Division
Attention: Division Director
Email: contracts-grants@ph.lacounty.gov

B. Notices to City must be addressed as follows:
City of:
Attention: City Manager
Email:

6. **GOVERNING LAW, JURISDICTION, AND VENUE**: This Contract will be governed by, and will be construed in accordance with, the laws of the State of California. City agrees and consents to the exclusive jurisdiction of the courts of the State of California or the United Stated Courthouse, Central District, Western Division, for all purposes regarding this Contract and further agrees and consents that venue of any action brought under this Contract shall be exclusively in the County of Los Angeles.

7. **TERMINATION FOR CONVENIENCE**: The performance of services under this Contract may be terminated, with or without cause, in whole or in part, from time to time when such action is deemed by County or City to be in their own best interest. Termination of services hereunder shall be effectuated by the delivery of an advance written Notice of Termination of the entire Contract by one party to the other at least one hundred and eighty (180) calendar days prior to July 1 of the following calendar year. The termination of services may only be effective on July 1 of the calendar year, so as to assure no lapse in public health and local health officer services to the residents of City.

8. **ALTERATION OF TERMS/AMENDMENTS**: The body of this Contract and any Exhibits attached hereto, and documents incorporated by reference, fully expresses all understandings of the parties concerning all matters covered and shall constitute the total Contract. No addition to, or alteration of, the terms of this Contract, whether by written or verbal understanding of the parties, their officers, employees or agents, shall be valid and effective unless made in the

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form of a written amendment to this Contract which is formally approved and executed by the parties in the same manner as this Contract.

9. **INDEPENDENT CONTRACTOR STATUS**: This Contract is by and between the County and City and is not intended, and shall not be construed, to create the relationship of agent, servant, employee, partnership, joint venture, or association, as between the County and City. The employees and agents of one party shall not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

10. **NO INTENT TO CREATE A THIRD-PARTY BENEFICIARY CONTRACT**: Notwithstanding any other provision of this Contract, the parties do not in any way intend that any person shall acquire any rights as a third-party beneficiary under this Contract.

11. **VALIDITY**: If any provision of this Contract or the application thereof to any person or circumstance is held invalid, the remainder of this Contract and the application of such provision to other persons or circumstances shall not be affected thereby.

12. **WAIVER**: No waiver by the County of any breach of any provision of this Contract shall constitute a waiver of any other breach or of such provision. Failure of the County to enforce at any time, or from time to time, any provision of this Contract shall not be construed as a waiver thereof. The rights and remedies set forth in this paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

IN WITNESS WHEREOF, City by order of its City Council, caused this Contract to be signed by its duly authorized officer and attested by the City Clerk. The Board of Supervisors of the County of Los Angeles has caused this Contract to be subscribed

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by its Chair and the seal of said Board to be affixed and attested by the Executive Officer.

COUNTY OF LOS ANGELES

By _____
Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

_____
Contractor

By _____
Signature

_____
Printed Name

Title_____

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL
DAWYN HARRISON
County Counsel

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Public Health

By_____
Contracts and Grants Division Management

#07642:xx

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Follow-up Questions

Public Health City Contracts Update

Overview

The County of Los Angeles has existing contracts with 85 cities across Los Angeles County to serve as the health officer and perform public health services within those cities. State law authorizes these contractual arrangements, and the County performs these services through its Department of Public Health. Many of these contracts were made during the 1960s, and Public Health believes the language and terms of the agreements is outdated given the changes in law and public health practice over the course of the past sixty years.

Public Health has updated the language of these agreements and shared the proposed updated with contracted cities through a series of outreach webinars and workgroup meetings to gather feedback and ensure that they receive proper notification and have a forum to ask questions and share any concerns.

It is important to note that the services provided by Public Health do not change with this updated contract. The contracts will be evergreen and Public Health will continue to provide the same level of services to cities at no cost. Public Health would like to finalize an updated uniform agreement to replace the existing outdated City-County Public Health agreements.

Below is a list of follow-up questions received from the workgroup meetings with the cities with answers from County Public Health.

1. Can you explain under what authority can the County Public Health Department enforce general public health orders and regulations from the California Department of Public Health (CDPH)?

The Governor appoints a State Health Officer. The State Health Officer has authority to issue orders and regulations to local public health officers in each county. Under Health and Safety Code section 101030, the local health officer is required to enforce and observe orders, including quarantine and other regulations, prescribed by the California Department of Public Health (CDPH), and statutes relating to public health. During the COVID-19 pandemic, the State Health Officer issued statewide health officer orders regarding COVID-19 protections that local health officials were obligated to follow. In addition, Title 17 of the California Code of Regulations, provides specific instructions for local health departments regarding communicable disease case reporting and investigation.

2. Can you provide an example of what a city-requested discretionary Public Health service could be under section 3.b.ii of the proposed agreement?

Infrequently, the County receives requests from cities to provide additional inspection services of businesses or venues that do not require a public health permit to operate or that are needed to augment a city code enforcement effort. In these instances, and subject to prior agreement with the requesting City, the County could provide such services to the City at the rate provided in LA County Code section 8.04.728 or other cost reimbursement rate for Public Health employees.

Public Health City Contracts Update

3. Will County Public Health provide the services listed in Title 17 of the California Code of Regulations?

Yes. For a local public health department to qualify for state funding, it must offer the following basic services:

- Collection, tabulation, and analysis of all public health statistics, including population data, natality, mortality, and morbidity records.
- Communicable disease control, including availability of adequate isolation facilities, the control of the acute communicable diseases, and the control of tuberculosis and the venereal diseases, based on provision of diagnostic consultative services, epidemiologic investigation, and appropriate preventive measures.
- Medical, nursing, educational, and other services to promote maternal and child health, planned to provide a comprehensive program to meet community needs in these fields.
- Environmental health and sanitation services and programs.
- Laboratory services, provided by an approved public health laboratory.
- Services in nutrition, including appropriate activities in education and consultation for the promotion of positive health, the prevention of ill health, and the dietary control of disease.
- Services in chronic disease, which may include case finding, community education, consultation, or rehabilitation, for the prevention or mitigation of any chronic disease.

4. Section 4.a is requiring cities to provide enforcement resources to the County, when the City has by ordinance or resolution transferred those duties to the County under H&S 101375. What if the City does not have the funding or staff to do so?

We have made a change to this section to reflect that County Public Health is looking for a statement of cooperation that cities will assist and may be requested by Public Health, as feasible, to resolve a nuisance and other public health issues. Health and Safety Code section 120175.5 is an authority conferred by the legislature to the local health officers and does not need to be referred to in the Agreement.

5. What is Exhibit A as referred to in the proposed agreement?

Exhibit A to the proposed agreement will contain the current City Municipal Code language of a City's adoption of the County's Title 11 into its municipal code. Exhibit A can be updated to reflect any future revisions made by the City.

6. How would Public Health seek reimbursement from cities for inspections of detention facilities, as that is a statutory requirement?

Under the Agreement, for annual inspections of detention facilities owned and operated by the City, the County may bill the City according to Section 4.g and Section h. Although the County is required by the Health and Safety Code section 101045 to investigate detention facilities, the County is permitted to bill the operator for this service. Health and Safety Code section 101325 allows for reimbursement and provides: *Whenever the governing body of any county determines that the expenses of the local health officer in the enforcement of any statute relating to public health, requires or authorizes its health officer or*

other officers or employees to perform specified acts that are not met by fees prescribed by the state, the governing body may adopt an ordinance or resolution prescribing fees to pay the reasonable expenses of the health officer incurred in the enforcement. The LA County Board of Supervisors has approved an hourly rate for County Environmental Health inspection personnel, which will be applied for this service.

7. What are considered *Future Enactments* as mentioned in Section 3.c.i-iii of the proposed agreement?

Each contracted city, at some point in time, has previously adopted the provisions of Division 1 (Health Code) of Title 11 (Health and Safety) the Los Angeles County Code into the City's Municipal Code.

As illustrative examples:

- City of Agoura Hills adopted Title 11 as amended and in effect on December 1, 2018.
- City of Carson adopted Title 11 as amended and in effect on July 1, 1998
- City of Industry adopted Title 11 *"as such code may be amended from time to time, except as hereafter amended by this chapter…"*
- City of Los Angeles adopted Title 11, except for Chapter 11.19 and Section 11.20.310.

For future public health ordinances that are enacted by the LA County Board of Supervisors, (i.e., children's camp registration and public pool lifeguard requirements) each City may elect to incorporate the identical version of that Title 11 provision into its municipal code via ordinance. Cities may elect not to incorporate future provisions. County Public Health will notify cities when future public health ordinances are passed by the Board of Supervisors and incorporated into Title 11. If a City does not include that into its municipal code, then the County will not enforce that County ordinance within the City.

8. Can you explain Section 4.1 in the proposed agreement that mentions court proceedings for prosecution or abatement?

Section 4.i is included in the Agreement because Public Health has found it difficult to make a connection with a City Attorney, as the issue is within the City's jurisdiction, and Public Health cannot independently institute legal proceedings for enforcement. In this scenario, Public Health would look to the City to decide whether to institute legal proceedings by the City Attorney of that City in conjunction with Public Health. If litigation is initiated, County would want the City to reimburse County for time spent by County Public Health employees assisting with the prosecution. If County believes that a legal proceeding is warranted because of a nuisance or lack of compliance with a health order, usually in the housing context, Public Health will notify the City's contacts.

ARTS, PARKS, HEALTH, EDUCATION, & NEIGHBORHOOD

MOTION

According to the most recent Los Angeles Homeless Services Authority (LAHSA) "point-in-time" homeless count (2020), Los Angeles County is home to over 66,000 people experiencing homelessness (PEH). The City of Los Angeles accounts for the majority of that, with over 41,000 people living within the city limits, 62% or nearly two-thirds of the accounted for population. Earlier this year, Los Angeles County's Department of Public Health released a comprehensive report titled: "Trends in Mortality Rates and Causes-of-Death Among People Experiencing Homelessness, January 2021", showing that death caused by drug overdose continues to rise, and is the leading cause of death year over year, among people experiencing homelessness. The report details that in the combined years of 2017-2019, people experiencing homelessness were *36 times more likely* to die of a drug overdose than people in the general LA County population.

The reality is alarming. The report notes that between January - July 2020, 273 people died as a result of an overdose; in the same month to month period for 2019, there were 205 deaths - a 33% increase. In addition, the increased dependent use of opioids, and methamphetamines often laced with fentanyl, has added to the mental health crisis. In fact, the first set of recommendations in the 2021 Los Angeles County Public Health report is very clear, "Enhance the reach, depth and quality of multidisciplinary team services for PEH...establishing trust, offering interim housing, with an explicit focus on reaching Black and Latinx PEH...and extending harm reduction approaches to substance use disorder (SUD) and mental health treatment". The City should play a greater role due to the magnitude of the crisis.

Homelessness is the number one issue in the city; what is our collective, and municipal government's role? For nearly 60 years, all health service delivery has been administered by Los Angeles County. Contract C-32683 (1964), as amended, is the principle document outlining the delivery of public health and mental health services for all residents within the City of Los Angeles, operated and staffed by the County of LA. As of today, this 57-year old contract governs the delivery of all health services to LA City residents, minus Medicare and Medicaid. The City has amended the agreement twice before, and can do so again.

Motion CF: 20-0769-S2 was adopted in October of 2020, instructing a review of county public and mental health departments and agencies. The motion resulted in a partnership with the United Way of Los Angeles and People's Health Solutions, where an analysis of the functions, delivery methods and systems in place for public health and mental health was done from the perspective of the City's residents. The results confirmed the present day situation: since 1964, the city has had a contract for health services with the County of LA, but no clear method of evaluating the delivery of those services, nor a method for the city to communicate clear and concise goals to the County with respect to healthcare services for all Angelenos, especially people experiencing homelessness. In fact, this arrangement already has shown some deficiencies, as evident by the 1990s lawsuit against LA County by the City which resulted in the creation of the Los Angeles Homeless Services Authority (LAHSA). Updating this contractual agreement is the right policy move and is the next logical step after the city and its residents invested so clearly and thoroughly by adopting ballot initiatives H and HHH.

NOV 2 4 2021

The need is clear throughout Los Angeles. Services, help and offering a path to wellness for people are priorities for Angelenos. Today, the delivery of health services is visibly insufficient, especially in relation to the neglect of people experiencing homelessness. Now is the time for Council to amend the original instruction in CF: 20-0769-S2, and zero in on mental health and substance abuse issues that go untreated in encampments across the city.

I THEREFORE MOVE that the Council INSTRUCT the City Administrative Officer and the Chief Legislative Analyst to report on the findings in CF: 20-0769-S2, including a review of the LA City contractual relationship with LA County for the delivery of healthcare services, detailed in contract C-32683 (as amended), with specific recommendations for the City to improve the delivery of healthcare services to all Angelenos, starting first with people experiencing homelessness, including but not limited to:

- Models and options for a City position or office to monitor and evaluate County health programs, especially as it relates to people experiencing homelessness
- Recommendations to improve the public process for healthcare service delivery, including public oversight of the functions described in the body of this motion, focusing first on the delivery of all healthcare services to and for people experiencing homelessness, including shelter and housing, nutrition, health, substance abuse and assistance, and mental health services
- Recommendations to renegotiate contract C-32683 to better represent the City's residents, focusing on people experiencing homelessness, including citywide current and ongoing health needs
- A clear and concise method for the City to organize, prioritize, evaluate and then communicate those needs on a regular basis to LA County health departments or any future agencies tasked with enforcing the public health code

Presented By: _____
MITCH O'FARRELL
Councilmember, 13th District

Seconded By: _____

Program Directory

Web Sites

- Acute Communicable Disease Control
- Cardiovascular Health Program
- Center for Health Impact Evaluation
- Children's Medical Services
- Chronic Disease and Injury Prevention
- Communicable Disease Control and Prevention
- Communications & Public Affairs
- Community Health Assessment Unit
- Community Health Services
- Contracts and Grants Division
- Custodian of Records
- Data Collection & Analysis Unit
- Department of Public Health
- Division of HIV and STD Programs
- Domestic Violence Council
- Emergency Preparedness and Response Division
- Environmental Health
- Epidemiology Unit
- Health & Aging Services
- Health Education Administration
- Health Facilities Division
- Human Resources
- Injury Prevention Program
- Institutional Review Board
- JUMPP - Joint Shared Use Moving People to Play Task Force
- Lead Program
- Maternal, Child, and Adolescent Health
- Medical Affairs Program
- Medical Marijuana Identification Program
- Nutrition Program
- Office of Health Assessment and Epidemiology
- Office of Planning
- Office of Planning, Integration, and Engagement
- Office of Senior Health
- OFFICE OF VIOLENCE PREVENTION
- Office of Women's Health
- Oral Health Program
- Organizational Development & Training
- Policies for Livable, Active Communities and Environments (PLACE)
- Public Health Education for Physicians
- Public Health Investigation Administration
- Public Health Laboratory
- Public Health Library
- Public Health Nursing
- Quality Improvement & Accreditation Program
- Substance Abuse Prevention and Control
- Tobacco Control and Prevention Program
- Toxics Epidemiology
- Tuberculosis Control Program
- Vaccine Preventable Disease Control Program
- Veterinary Public Health

Public Health has made reasonable efforts to provide accurate translation. However, no computerized translation is perfect and is not intended to replace traditional translation methods. If questions arise concerning the accuracy of the information, please refer to the English edition of the website, which is the official version.

Enriching lives through effective and caring service

Get tested for HIV or STDs

Report a Food Illness

Public Health Services

- Order death certificates
- Restaurant and Food Truck grades
- Housing inspections
- Tuberculosis (TB) screenings
- Emergency preparation resources
- Health care provider for Child Health & Disability Program
- Health information for individuals and families
- Healthy eating & injury prevention tips
- Stop smoking resources

I want to:

...vaccinate my child

Free or low cost vaccination clinics

...vaccinate my pet

Find low cost veterinary care

...learn about Zika

Zika FAQs, travel warnings & more

Referral Services

LA County Departments:

- Health Services
- Mental Health
- Public Social Services
- Children and Family Services
- Animal Care & Control
- Coroner

Women's Infants & Children (WIC) Services

Medicare

Medicaid

Medi-Cal

Look Up Physician Licenses

Register to Vote

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Enriching lives through effective and caring service

ATTACHMENT 7: Assessment of Needs for Establishing a Public Health Department

One option for the City to consider in meeting its public health needs would be the creation of a City Public Health Department. While it is not impossible for the City of Los Angeles to establish a City Health Department, such an undertaking would require thoughtful consideration, careful and detailed planning, and a significant commitment by all levels of City government.

Assumptions

Creating any new City department requires identification of the scope and services of the department. Once that information is known, the magnitude of services being offered, the number and type of staff needed, and facilities and equipment required can be determined and budgeted. For Public Health Departments, specifically, in the State of California, the California Health and Safety Code along with the California Code of Regulations require that health departments have a certified health officer and, in addition to that requirement, a specific and wide range of services that are expected and required of a health department.

In the case of a new City Public Health Department, estimating basic costs, timelines, and funding sources must be based initially on the services provided by the County. Because public health provides population-based services, those services cannot be arbitrarily terminated for a period of time while people depend on them and a new department is being created.

Importantly, the first step required to create a City Public Health Department is approval by the California Department of Public Health (CDPH). Until the City of West Covina contacted CDPH about creating its own Public Health Department in 2021, it had been about 100 years since a public health department was created in California. As a result of this 'first in a century application,' there was no modern process for a city to apply or receive approval from CDPH. CDPH has been drafting guidelines for consideration of West Covina's request since 2021 and expects to circulate those before the end of the 2024 calendar year, although this date has yet to be confirmed by the City of West Covina or CDPH. Those guidelines would need to be in place before the City of Los Angeles would be able to create a Public Health Department. Assuming the guidelines are circulated when expected, the waiting time has been shortened as a result of West Covina's application. It is important to note, however, that those guidelines could add requirements and steps that could increase both the time and complexity of implementation.

Costs

The establishment of a new City Public Health Department would incur both start-up and ongoing costs. A commitment from all levels of City government would be required as existing City staff would be needed to lay the foundation that would enable the department to be created. Following is a sample of anticipated impacts to existing City Departments:

- Personnel Department would be required to conduct Charter-required classification, recruitment, and examining functions. Based upon the required services, Personnel would first need to establish all the necessary classifications so that the Executive Employee Relations Committee, based upon recommendations provided by the CAO,

could establish salaries. Once that effort is complete, Personnel Department assistance would be needed to recruit and hire thousands of additional specialized and medically qualified staff, some of whom could potentially be hired from the County.

- Public Works-Bureau of Engineering would need to determine space needs and potentially acquire land and oversee construction of a lab(s) and other buildings key to the delivery of public health to the public.

- GSD would need to find space and procure supplies and equipment for administrative buildings, buildings for the provision of public health services, a lab(s), and other medical buildings, potentially in concert with, or from the County

- ITA would need to provide telephone and internet access for the staff at any new office and laboratory space, which may include installation of new network infrastructure to accommodate the additional usage. Additionally, ITA would assist with the procurement of computer equipment and necessary software, as well as the design and implementation of any specialized information technology systems necessary to support the operations of a Public Health Department and comply with data security needs associated with HIPAA (Health Insurance Portability and Accountability Act), the Affordable Care Act (ACA), and any other applicable State and federal legislative mandates.

- The City Attorney would need to prepare several ordinances to establish and empower the Department and create the necessary positions, as well as provide legal advice and guidance throughout the process.

- The City Attorney and CAO would need to prepare contracts to administer new public health and medical services.

In addition to facilities and personnel resources, start-up costs would include acquisition of cars for inspectors and other field personnel; acquisition of both mobile labs and the equipment for those labs; acquisition or development of integrated information technology systems, including electronic health records; and development of electronic or physical capacity to contain and manage birth and death certificates. For comparison, the County's annual cost for total capital assets equipment includes medical equipment; non-medical lab/testing equipment; telecommunications, data handling, electronic, and other information technology equipment; as well as office furniture and fixtures, and transportation. For reference, in FY 2022-23, the County spent $4.6 million on these types of expenses. The City would also need to be prepared to develop training and certification required under HIPAA as well as a program to ensure clinical staff are appropriately and currently licensed and credentialed.

Once the department is created, the largest single operating cost would be salaries and benefits. We assume that the City would be obligated to provide every service currently offered by DPH, and 40 percent of the County's health services and DPH budget would represent the amount to be expended in the City. Consequently, a City Public Health Department would be 40 percent of the size of the LA County DPH with an estimated annual operating budget of roughly

$640 million, of which salaries would be about $369 million. City salaries could be higher, in part because the City would be required to virtually duplicate the executive and management structure of the County department. Thus, the estimated annual salary cost of $369 million for 2,200 positions is expected to be low. Related costs could add an estimated $124 million to the annual budget. Some of these costs could be partially offset by federal and State grants and license and permit fees as noted below.

Supply and equipment costs would be based on the City's procurement process. It is reasonable to expect that the City's supply costs may be higher than the County's, due to economies of scale. Since the City would be buying smaller quantities of specialized items, the City may not get bulk pricing available to the County. Nonetheless, the City may be able to purchase at a discount surplus equipment from the County that the County may no longer require.

Additional ongoing resources may be required in several City departments. The Controller may require additional resources to set up and process accounting documents, along with the need to provide accounting guidance for the new Department because it will potentially have a significant number of restricted funding sources. GSD, Personnel, ITA, CAO, and the City Attorney may also have ongoing staffing needs.

Looking at the County's liability experience, the City can also expect to incur liability and risk costs. In fiscal year 2022-23, the County had 192 new claims and paid close to $9.9 million, which includes indemnity and legal fees and expenses for worker's compensation, vehicle liability, general liability, and medical malpractice. Of those claims, seven were from medical malpractice and 139 were from worker's compensation.

Funding

The County DPH 2024-25 Adopted Budget is almost $1.6 billion, which includes intra-fund transfers of $113 million to other County agencies that provide public health related activities (e.g. public health nurses in the Children and Families Department). Of the $1.5 billion net total, $1.245 billion (83 percent) is derived from direct revenues including various fees, state and federal funding allocations, and grants, leaving roughly 17 percent, or $253 million to be covered by the County. The County DPH currently has at least 400 fees established for public health services, and receives fee revenue totaling approximately $100 million per year. These fees range from charges for copies of birth ($32) and death certificates ($24) to permit fees for body art establishments ($2,254 for initial inspection and $213 for annual renewal) to restaurant inspection fees ($118 to more than $3,000). The City would not be entitled to any fee revenue currently received by the County. As the City currently does not have any fees established for public health, fee studies would need to be completed to determine the cost for the City to provide these services. The Council would then need to establish fees through ordinance. Fees can only recover the costs associated with the provision of the specific service being provided, and could not supplement any other public health services provided. The County may currently be achieving a reduced fee structure due to the economy of scale associated with serving such a large population. Therefore, if the City were to achieve full cost recovery for the services provided, it is possible that the City's fees may exceed the current County fees for the same

services.

Further, the County receives additional State and federal funding, including direct allocations and grants, for public health. While the City may be entitled to formula grant funding that is awarded simply based on population estimates, the City would need to identify each grant and submit applications. Additional grants have previously consistently been allocated to the County, as the County is currently the only eligible service provider, but may be available to the City if a Public Health Department is established. However, a greater analysis would need to be completed on each individual funding source to determine whether the City could receive additional funding. Additionally, the County has indicated that some federal and State funds are allocated to the County, and then the County subsequently provides a portion to the Long Beach and Pasadena Public Health Departments based on population. Without knowing the formula by which funds are allocated to Long Beach and Pasadena, it is difficult to estimate an amount from those grants that may be received by the City.

The County also receives grant funds through competitive awards, which would likely not be immediately available to the City, as they were awarded in response to grant applications submitted by the County. However, the City may be able to compete for such grants in future funding cycles, although it is unknown how competitive the City's applications would be due to the lower population service area and the City's initial lack of experience and expertise in providing these services. Additionally, competition between the City and County for the same grants may result in lower funding being allocated to the region overall.

Other funding sources include direct State allocations pursuant to various State legislation, including AB109 revenue, also referred to as 2011 State Realignment Funding, and AB8 revenue, also referred to as 1991 State Realignment Revenue. However, the County is often specifically named in the State legislation as a funding recipient for these types of funds, and therefore State and/or federal legislation change would be required for the City to receive any of these funds. At this time, it is unknown how much, if any, additional funding would be provided to the City associated with any legislation change.

According to multiple studies across the nation, local government public health agencies obtain an average of 44 percent of their funding from local governmental appropriations, with the remainder derived from state government (30 percent), fee-based revenue (19 percent), and direct federal appropriations (three percent). Based on this, it is reasonable to anticipate that significant General Fund resources would be needed to support a City-operated Public Health Department and to begin planning accordingly.

Timeline

Establishing a City Public Health Department requires approval from the State of California which, as noted above, could be a three- to four-year process. It is also a particularly extensive and unprecedented plan to hire employees and acquire necessary property for programs, services, and facilities, including a laboratory as mandated for local Public Health jurisdictions by the California Health and Safety Code. To put the demands of this effort into context, a recruiting and hiring process for one specialized classification can take two or more years. This estimated timeline does not include the time it would take the City to create the new

classifications which is anticipated to be up to two years prior to when recruitment begins.

These three areas: receiving approval by CDPH, hiring the necessary personnel, and providing space for the operations, would have the most significant impact on the timeline associated with establishing a new Department, although some activities and processes can occur concurrently.

Given the anticipated time required to address all of the items required to stand up a new, specialized public health department, it is anticipated it could take seven to ten years for a new City of Los Angeles Public Health Department to be fully operational and functioning at the level of today's County Public Health Department.

State Approval for a Health Department

The State of California has a State-mandated, County-administered public health system. As a result, the State has never approved the creation of a new public health department. Long Beach and Pasadena were reportedly grandfathered in. Thus, the process for application and approval is currently being developed by CDPH. West Covina wrote and submitted a proposal to the State seeking to establish a City Health Department. Three years later, the process remains in progress and is not anticipated to conclude before, at earliest, 2025. Should the application and approval process be disseminated in late 2024 for public comment, the City would be able to see the requirements, comment as needed, and begin work to develop a proposal should the Mayor and Council decide to proceed.

Personnel/Recruiting Process

Currently, the County DPH has slightly more than 5,600 budgeted positions. Considering the City is roughly 40 percent of the County's population, the City's Personnel Department would have to follow City protocol for creating new job classes for potentially as many as 2,200 positions. For comparison purposes, in 1964 the City transferred about 1,000 positions to the County when the City and County public health functions were merged.

Because public health would be a completely new undertaking for the City at this time, several steps would need to be taken before recruiting and hiring could begin. As noted above, the first and most critical step is to define the scope and services to be provided. The Department organization would also need to be determined. Typically, department managers begin the process by defining individual jobs, duties, and requirements. In the absence of department management, that work would need to be undertaken with the help of the consultants and possibly County DPH and Human Resources personnel.

The City could potentially use County classification specifications and position descriptions to guide this process; however, care would need to be taken to ensure City requirements and needs were met. It is also unlikely that County DPH personnel could be hired at the outset. If the County were required to lay off DPH personnel, it would require a Civil Service process that would result in the employees with the least seniority being released. Those employees may not have the qualifications or experience needed in a new City Department.

Further, to compare a large-scale recruitment and staffing effort by the City, it took about five years to hire 800 police officers in the early to mid 2000's. The noted police positions did not

have as extensive technical education or experience requirements and a substantial hiring infrastructure (such as classifications and position descriptions) was already in place. A later police hiring effort in the 2017-2019 timeframe aimed to hire 400 police officers. That effort required major overhauls to the process and additional support from the Mayor's office, ITA, external contractors, and an expansive, first of its kind City-funded advertising campaign. While ultimately successful, the scale of hiring made it challenging, and the campaign was delayed in reaching its goal. To recruit and hire as many as 2,200 positions for the proposed Department without comparable existing structure and resources would be extremely challenging, thus requiring a firm commitment from the Mayor and Council throughout this process, and a focussed priority effort on the part of all impacted City departments.

Building/Property Acquisition Process

One of the minimum requirements for a public health jurisdiction is operating and maintaining a lab. It is an option to contract with a private lab, however such an alternative can be costly. The City could send certain specimens to a State lab, but for special cases, not for daily testing operations. Therefore, the City would need space to house the new Department and laboratory. Assuming that matters such as the scope of operation (including staffing levels) are first resolved, the City would need to plan for BOE to perform a space analysis, GSD to conduct a facilities assessment, and roughly four to five years for an Environmental Impact Report (if needed), land acquisition, facility design and construction, all of which are contingent on a defined operational scope.

To provide a comparison, the County opened a multi-million dollar, technologically advanced lab in March 2007 with approximately 165 staff in a 34,000-plus square feet space. The County's lab is unique among other local public health laboratories in California due to the volume of testing it performs, conducting more than 700,000 tests on 400,000-plus specimens a year. Not only would space need to be acquired for a lab, but storage space to keep vital records would be necessary as well. Providing birth and death certificates would be a function that would need to be up and running immediately for the residents of the City. The buildings themselves require planning, design, and construction, but would need to be outfitted with office and specialized lab supplies and technologies necessary to carry out the needs of the City. They also require upgrades on a regular basis to ensure modern technology and space. A recent upgrade of the DPH Downey lab, announced in 2023, is anticipated to cost $33 million and will focus on a renovation of the space to improve conditions outgrown by staff and specimens and increased specimen and testing capacity.

The City could consider the feasibility of contracting with the County for space or services, but must be prepared to recognize that County pricing may not be at market rate and other complications may arise.

Other Considerations

Contract Compliance

In accordance with the current agreement between the City and County for public health services, the services provided by the County must continue unless the City terminates them by adoption of a resolution or ordinance on or before March 1 of any subsequent year. If

termination is adopted, the services of the county health officer must end on July 1 following the service of notice. Further, the contract specifies that one party can terminate the agreement at the end of any fiscal year by giving written notice of such intention to do so not less than 30 days prior to the end of any fiscal year. The existing statute and contractual requirements appear to be intended to provide sufficient notice and time for the transition of operational, organizational, and financial requirements for all parties (City, County, and State). In relation to any action to set up a City Public Health entity, the above timeline is not sufficient to feasibly create such an organization as outlined in the preceding sections. If the City elected to move forward, negotiations with the County on an extended timeline would be required. Or, the City could continue to contract with the County until such time as the staffing and facility infrastructure were in place, if the County were amenable.

Memoranda of Understanding (MOUs)

Currently, cities that have their own public health departments have formal MOUs with the County to contract particular services, as well as more informal relationships and regular processes that support each department's own mission. For instance, under one contract the County and the City of Long Beach Diabetes Prevention and Management Program would work collaboratively to adopt and implement a team-based care approach to promote standard protocols for delivering high-impact care and clinical preventive services to low-income persons with diabetes. Another contract with the County DPH provides the City of Pasadena with storefront HIV counseling, testing, and referral services, among many other agreements.

Accreditation

In addition to the current regulatory structures facing public health jurisdictions, nationally departments are reportedly moving towards voluntary accreditation through the Public Health Accreditation Board (PHAB), a nonprofit organization founded in 2007 that aims to advance the quality and performance of public health departments. In California, 26 departments have been accredited, including CDPH, Los Angeles County, Pasadena, and Long Beach. Most public health departments take one to two years to prepare and complete the seven-step application process which requires substantial documentation. The City would need additional years to prepare for the application process in order to have sufficient experience and data necessary for application materials that demonstrate the Department is established and operating.

Accreditation through PHAB may become a new standard to identify the performance of public health jurisdictions, particularly in a budgetary environment where departments are required to provide quality services with modest financial resources. Applying for accreditation would be an ongoing responsibility with a potential impact to a department's costs. The time that the City would be without accreditation through PHAB could negatively impact applications for competitive grants, and it could easily take several years for a new public health jurisdiction to meet the application requirements. Applying for accreditation through PHAB would require at least one key staff person from the department (though PHAB recommends a team), supporting staff time, and the necessary application fee based on population size of the public health jurisdiction. There are likely several other accreditations and certifications that a new City department would also need to consider.

Coordination

The field of public health in California requires a high degree of coordination between public health agencies and the State and federal government during normal operating times and during local and global crises. A new City Public Health Department would be required to coordinate closely with the County and State to ensure that services the City provides do not conflict with services that other County departments provide and are aligned. Coordination would be required with multiple federal and State agencies to ensure compliance with State health officers and other federal requirements. A new City Public Health Department would be required to coordinate on matters of grant funding and other financial matters. As is the case in cities like Pasadena and Long Beach, staff/units within the agency are specifically tasked with intergovernmental coordination.

Impact on Public Health: Transitioning from the County to the City

A City Public Health Department may not be immediately equipped to respond to a crisis like the 2020-2022 COVID-19 emergency due to a lack of personnel resources during the early stages of operation coupled with a lack of experience in coordinating a strategic response to public health threats. Such capacity could develop once staffing needs are sufficiently met and the Department has experience deciding how to respond to challenging situations.

The County also relies on timely information sharing between hospitals and physicians in order to avoid public health disasters, and this communication could be disrupted during a transition. MOUs and relationships built over decades with hospitals, non-profits, school districts, ports of entry, and other organizations support DPH operations. If particular strains of communicable diseases occur that could impact the County, then DPH relies on its established relationships to alert its staff of the situation in order to coordinate an appropriate and timely response. With communication across various sectors, a public health department can manage an outbreak with efficiency, often detecting the issue before it becomes a widespread problem.

In addition, because it is unclear that the City could immediately recover all grant dollars or other restricted revenue streams lost in the transition, there could easily be a strain on public health services both in the City and County. In cases where one jurisdiction must serve residents of another in order to protect against a public health crisis, service levels may be inadequate.

Los Angeles City Public Health Department Conclusion

The sum of projected costs identified in this report serves as a baseline for operating a Public Health Department within the City. However, identification of the cumulative fiscal impact is contingent on many factors that are impractical to quantify prior to implementation. Potential staffing and facility needs are extensive and highly specialized and could incur significant start up costs. Obtaining these resources is also dependent on multiple points of legislative and administrative approval. Additionally, the level of coordination, formal communication processes, and work systems required between the City and County to arrive at a transition point where a new City Department can function alongside the County to ensure a safe and healthy environment throughout the region is high and thus could impose further operating costs.

The following are also worth noting:

- It is a largely uncommon practice for any public health jurisdiction in the U.S. to fully cover its operating costs through fees, and given the City's baseline cost estimates identified in this report, it is not feasible to fund the proposed Department entirely through fees.
- There are significant limitations to accessing supplemental sources of revenue, particularly grants and other streams that are currently specified for the County.
- A newly established Public Health Department in the City will take several years - possibly a decade or more - to be equipped to adequately serve all the public health needs for the City's entire population given its vast and specialized responsibilities coupled with the necessary financial resources to fully prepare for implementation.
- All residents within a public health jurisdiction rely on their department of public health for protection from various threats that could lead to crises in the region, whether it is due to bioterrorism or tainted food. The slightest failure in enforcing all existing codes related to public health would unnecessarily put the residents of Los Angeles and surrounding communities at risk.
- Looking at the County's liability experience, the City can also expect to incur legal liability and risk costs (e.g., medical malpractice and workers' compensation).

As the second largest city in the United States, Los Angeles is nearly 9 times the size of the next largest city in Los Angeles county. Public Health serves nearly 10M residents excluding three* cities that have their own public health agencies.

- **Los Angeles (3,898,747)**
- *Long Beach (466,742)*
- Santa Clarita (228,673)
- Glendale (196,543)
- Lancaster (173,516)
- Palmdale (169,450)
- Pomona (151,713)
- Torrance (147,067)
- *Pasadena (138,699)*
- Downey (114,355)
- West Covina (109,501)
- El Monte (109,450)
- Inglewood (107,762)
- Burbank (107,337)
- Norwalk (102,773)
- Compton (95,740)
- Carson (95,558)
- Santa Monica (93,076)
- South Gate (92,726)
- Hawthorne (88,083)
- Whittier (87,306)
- Alhambra (82,868)
- Lakewood (82,496)
- Bellflower (79,190)
- Baldwin Park (72,176)
- Redondo Beach (71,576)
- Lynwood (67,265)
- Montebello (62,640)
- Pico Rivera (62,088)
- Monterey Park (61,096)
- Gardena (61,027)
- Arcadia (56,681)
- Diamond Bar (55,072)
- Huntington Park (54,883)
- Paramount (53,733)
- Glendora (52,558)
- Covina (51,268)
- Rosemead (51,185)
- Azusa (50,000)
- Cerritos (49,578)
- La Mirada (48,008)
- Rancho Palos Verdes (42,287)
- Culver City (40,779)
- San Gabriel (39,568)
- Bell Gardens (39,501)
- La Puente (38,062)
- Monrovia (37,931)
- Claremont (37,266)
- Temple City (36,494)
- West Hollywood (35,757)
- Manhattan Beach (35,506)
- San Dimas (34,924)
- Bell (33,559)
- Beverly Hills (32,701)
- Lawndale (31,807)
- La Verne (31,334)
- Walnut (28,430)
- South Pasadena (26,943)
- Maywood (25,138)
- San Fernando (23,946)
- Calabasas (23,241)
- Cudahy (22,811)
- Duarte (21,727)
- Lomita (20,921)
- La Cañada Flintridge (20,573)
- Agoura Hills (20,299)
- Hermosa Beach (19,728)
- South El Monte (19,567)
- Santa Fe Springs (19,219)
- El Segundo (17,272)
- Artesia (16,395)
- Hawaiian Gardens (14,149)
- Palos Verdes Estates (13,347)
- San Marino (12,513)
- Commerce (12,378)
- Signal Hill (11,848)
- Sierra Madre (11,268)
- Malibu (10,654)
- Rolling Hills Estates (8,280)
- Westlake Village (8,029)
- La Habra Heights (5,682)
- Avalon (3,460)
- Rolling Hills (1,739)
- Hidden Hills (1,725)
- Irwindale (1,472)
- Bradbury (921)
- Industry (264)
- *Vernon (222)**

Source: 2020 US Census

**Department provides some basic services but relies on the County for significant support.*

Community Health Services

- Announcements
- About Us
- Service Planning Areas (SPAs)
- SPA 1: Antelope Valley
- SPA 2: San Fernando Valley
- SPA 3: San Gabriel Valley
- SPA 4: Metro LA
- SPA 5: West
- SPA 6: South
- SPA 7: East
- SPA 8: South Bay
- Library
- Regional Health Offices

Contact Information

Community Health Services
Los Angeles County
Department of Public Health
241 N. Figueroa Street
Los Angeles, CA 90012
(213) 240-8040
Email: chs@ph.lacounty.gov

What Is a Service Planning Area?

A Service Planning Area, or SPA, is simply a specific geographic region within Los Angeles County.

Due to the large size of LA County (4,300 square miles), it has been divided into 8 geographic areas. These distinct regions allow the Department of Public Health to develop and provide more relevant public health and clinical services targeted to the specific health needs of the residents in these different areas.

Source: Los Angeles Department of Public Health Website, October 2024
http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm

COUNTY OF LOS ANGELES

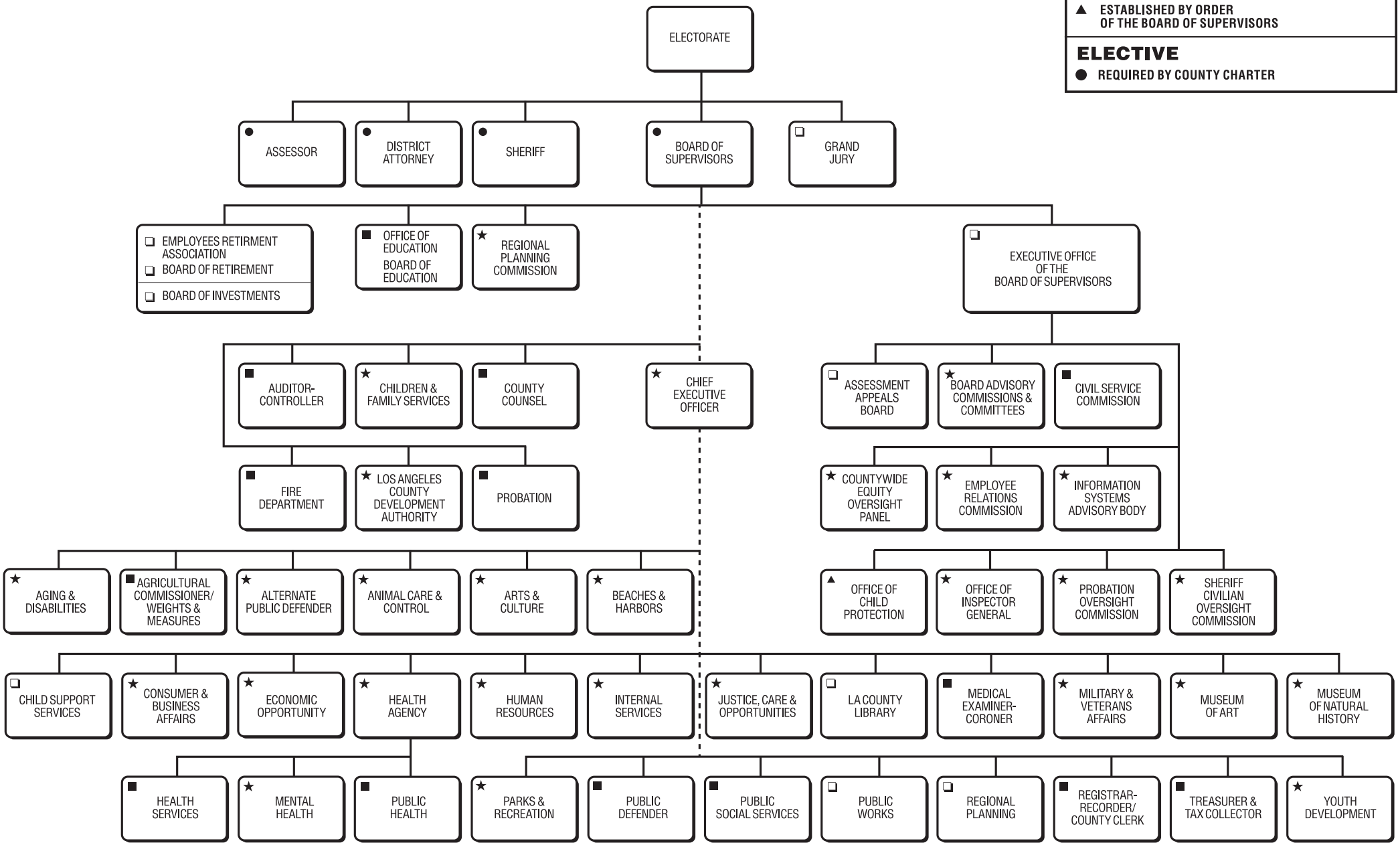
LEGEND

APPOINTIVE

- ■ REQUIRED BY COUNTY CHARTER
- ❑ REQUIRED OR AUTHORIZED BY STATE LAW
- ★ ESTABLISHED BY ORDINANCE OF THE BOARD OF SUPERVISORS
- ▲ ESTABLISHED BY ORDER OF THE BOARD OF SUPERVISORS

ELECTIVE

- ● REQUIRED BY COUNTY CHARTER



County of Los Angeles Department of Public Health

STRATEGIC PLAN

2018-2023

LOS ANGELES COUNTY HEALTH AGENCY

COUNTY OF LOS ANGELES Public Health

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Letter from the Director

Dear Colleagues,

Health equity means that everyone has the opportunities and resources needed for optimal health. Access to a quality education, full-time employment, a livable wage, social support, and community safety is linked to well-being. Specifically, these social and economic factors are associated with 40% of all death and disability.[1] Right now, many low-income residents and people of color face unfair health burdens due to the unjust distribution of these social and economic opportunities.

At the Los Angeles County Department of Public Health (DPH) we are working to fundamentally change how we think about and approach our work to systematically address the unjust policies, practices, and attitudes that consistently produce negative health outcomes for communities across our County.

I am excited to present the 2018-2023 Strategic Plan that anchors health equity as a priority for the Department, and charts a course for us to…

- Support engagement and mobilization efforts to address community concerns, amplify authentic stories, and strengthen capacity to spur policy and systems change
- Collaborate with partners to find innovative ways to protect and promote health in places where people live, learn, work, worship, and play
- Continue to use science to inform and refine our strategies
- Prepare our workforce and create a culture of learning and respect across the department

We all have a role to play in implementing this plan. By working together, we will ensure that everyone in Los Angeles County has the opportunities, resources, and protections in their communities and beyond that support optimal health and well-being.

Sincerely,

Barbara Ferrer

Dr. Barbara Ferrer, Director
LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH

1 County Health Rankings & Roadmaps. "Our Approach." http://www.countyhealthrankings.org/our-approach. Accessed 11/14/2017.

Introduction and Purpose

The Los Angeles County Department of Public Health Strategic Plan for 2018 to 2023 presents a blueprint for organizational advancement that will accelerate the Department's impact on building optimal and equitable health and well-being for the people of Los Angeles County. Based on a thorough self-examination, as well as suggestions and candid feedback from partners, the plan identifies key improvements to strengthen our ability to achieve the community conditions necessary to realize health and equity.

We know that social factors such as access to care and prevention services, safe communities, access to quality housing, education and jobs, and others – i.e., the social determinants of health – have an outsized impact on community members' health and well-being. For too long, many people of color and those living in or near poverty in Los Angeles County have suffered from systemic disadvantages, such as unequal access to healthy foods, green spaces, and quality educational opportunities, and disproportionate involvement with our criminal justice system, resulting in poorer health outcomes. To make meaningful and just improvements in population health and achieve racial, social and economic justice, we must work with our community partners to eliminate the institutional and environmental barriers that have impeded the path to wellness, and build communities that foster health for everyone.

About the Plan's Five Strategic Priorities

This plan puts in place critical measures to advance the Department's capacity to narrow these longstanding inequities. First, community health improvement efforts must start with a foundation of accurate, timely and actionable data on health and factors influencing health in the many communities of LA County, and the best available scientific information to inform decisions on how to most effectively improve community health and achieve health equity. Thus, one strategic priority focuses on **Data Accessibility, Science Excellence, and Innovation**. Second, understanding that the Department is but one player working to improve public health, the Department has a responsibility to make health information more easily accessible to community members and stakeholders to facilitate their work in their own community; accordingly, forging **Communication Channels that Inform, Educate, and Empower Los Angeles County Residents** will be critical. Third, the Department can directly influence some social determinants, such as access to high-quality, integrated health and mental health services, through **Health Agency Integration that Fosters Healthy People and Healthy Environments**. We can achieve community conditions that foster good health for all through nurturing cross-sector partnerships to promote policies that lead to equitable health outcomes, and prioritizing the importance of community voices to deepen our understanding of the causes of health inequities. This priority focuses on **Policy and Institutional Change to Ensure Equitable and Just Distribution of Resources and Opportunities**. Finally, the key to success in all these areas is an empowered, motivated and skilled Department workforce, which is why our final strategic priority will make **Investments in Our Staff**. The achievable set of goals, objectives and strategies in this plan will sharpen our skills, abilities and infrastructure in these five areas, and will augment our effectiveness in meaningfully impacting population health.

Aligning Our Strategic Plan with County, Health Agency and DPH Priorities

In crafting our new Strategic Plan, DPH considered the priorities of the Health Agency and the County of Los Angeles. By design, the plan reflects and aligns with the County's strategic goals, including supporting community wellness, driving economic development, and fostering environmental sustainability. The plan will advance Health Agency priorities by improving data systems to better coordinate consumer services across departments; improving DPH's ability to work across sectors to address social determinants of health; making upstream policy recommendations; and strengthening workforce capabilities. Improvements set out in this Strategic Plan also parallel the priorities set forth in DPH's Quality Improvement and Workforce Development Plans.

The Strategic Plan is a key tool in our efforts to narrow health inequities in collaboration with partners across sectors and will facilitate DPH's Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP). The CHA lays out the stark inequities across our diverse population in LA County, and the CHIP proposes bold strategies that multiple stakeholders in the County can employ to reduce these inequities. The Strategic Plan envisions critical institutional advancements that deepen DPH's ability to produce community health data for our CHA and achieve the health outcomes we seek in our CHIP, and in our departmental programs.

Vision, Mission, Values

Vision
Healthy People in Healthy Communities

Mission
To protect health, prevent disease and injury, and promote health and well-being for everyone in Los Angeles County

Values

- *Leadership:* We are recognized throughout the field for our innovative and effective approach to public health.
- *Service Excellence*: We provide exceptional service with professionalism and respect.
- *Quality:* We utilize state-of-the-art science, evidence-based best practices, and performance monitoring to maintain and improve program efficiency and efficacy.
- *Collaboration:* We develop, nurture, and leverage key partnerships.
- *Accountability:* We act with transparency and integrity as responsible stewards of public funds.
- *Diversity:* We respect people of all cultures, communities, ethnicities, and perspectives.
- *Professionalism:* We maintain a well-trained, high-performing workforce.
- *Compassion:* We treat each other and those we serve with kindness and empathy.

The Planning Process

DPH undertook a comprehensive planning process that involved engaging department staff at all levels ranging from leadership to line staff; interviewing community partners and public health experts; and reviewing public health literature and other health department strategic plans. Our executive leadership offered preliminary strategic priorities and suggested areas for improvement and innovation. Staff at all levels gave input by Bureau, and each Bureau's leadership chose how their staff would provide suggestions: approximately 150 Health Promotion Bureau staff participated in two facilitated, "town hall" style meetings where they rotated through stations corresponding to the different strategic priorities and offered ideas in small groups; the Health Protection Bureau and the Bureau of Disease Control conducted presentations and surveys with their staff to identify potential innovations and improvements, and then participated in facilitated meetings to discuss the ideas that emerged; and the Operations Support Bureau surveyed their staff via their internal teams, and summarized their staff's input. This process allowed hundreds of DPH staff to contribute. Once all input was gathered, a comprehensive set of ideas was presented at a Program Directors' meeting, where directors discussed them and voted on the improvement strategies they thought would best increase DPH's effectiveness.

To turn the ideas into goals, objectives, and strategies, workgroups were formed for each strategic priority area, consisting of three to five representatives from each Bureau with expertise in that strategic priority. The workgroups met four times, and began by reviewing the information collected. Once they had discussed the ideas generated from staff, they prioritized them and narrowed the list according to feasibility and impact, considered what if anything was missing, and grouped ideas into content areas. As goals emerged from the content areas, the groups crafted measurable objectives and strategies to achieve each goal. Staff from the Office of Planning and Quality Improvement & Accreditation Program reviewed goals, objectives and strategies in the five strategic priorities for overlap and merged some areas that had similar strategy ideas. To create a final draft of recommended goals, objectives and strategies to be presented to Department executive leadership, the Office of Planning collaborated with department "leads" for each strategy. The leads were selected based on their area of expertise to fine-tune the language and ensure that the goals, objectives and strategies are feasible, relevant, and likely to have the desired impact.

Strategic Priority I: Policy and Institutional Change to Ensure Equitable and Just Distribution of Resources and Opportunities

What We Intend to Accomplish

DPH recognizes the tremendous power of policy and systems change to affect community well-being, racial equity and the social determinants of health. As the Department moves towards broader involvement in the policy arena, we are aware that "policies" and "systems" take many forms, including city and county ordinances, state legislation, Health Officer orders, government procedures, regulations, and budgetary decisions.

Beyond the critical policy work that DPH programs currently conduct, this plan sets the course for DPH to deepen our involvement in local and state policy, alongside community partners.

By working closely with community partners, we can identify and prioritize local and state policies and systems changes, as well as changes to DPH that may be needed to further operationalize our commitment to racial, social and economic equity. Once we have selected priority policies and systems changes, we will build the collective capacity of DPH staff and our partners to achieve policy change, via trainings and other opportunities. Ultimately, these steps will position DPH to work jointly with the Board of Supervisors and our partners to effectively carry out policy change efforts. This might involve developing new local or state legislation, commenting on pending bills and ordinances, or providing input on the implementation of policies already adopted, to ensure that all policies maximize the benefit to public health.

Goal 1: Collaborate with Community Partners to Support Policies that Achieve Racial Equity, and Social and Economic Justice

Objective 1.1: By December 31, 2020, collaborate with community partners to identify priority DPH-wide, local, and state policy and systems changes that promote equity.

Strategies

1.1.a: By March 31, 2018, launch the Center for Health Equity to serve Health Agency efforts that build health equity across the County by addressing the root causes of disparate health outcomes; and convene five listening sessions across the County to gather input about the goals of the Center from residents and community organizations.

Lead: Center for Health Equity

1.1.b: By March 31, 2018, and annually thereafter, employ a new policy planning approach that convenes community partners and DPH staff with policy expertise to identify proposed DPH annual high-priority local and state policy opportunities.

Lead: Policy and Legislative Affairs; Office of Planning

1.1.c: By December 31, 2020, collaborate with community partners to identify priority policies and/or systems changes for inclusion in the next Community Health Improvement Plan.

Lead: Office of Planning

Goal 2: Transform Departmental Capacity, Culture, and Practice to Promote Health Equity

Objective 2.1: By June 30, 2023, implement at least three new or modified administrative practices and three new or modified DPH programmatic activities to achieve racial equity.

Strategies

2.1.a: By June 30, 2018, conduct at least one department-wide event to raise employee awareness about implicit bias; and ensure all department employees complete implicit bias and cultural competency training.

Note: Implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.

Lead: Center for Health Equity

2.1.b: By June 30, 2018, develop a framework for assessing departmental policies using an equity and "just culture" frame (see Goal 11), and initiate a process for reviewing and proposing revisions to existing policies to ensure alignment with the framework.

Lead: Chief of Staff

2.1.c: By December 31, 2019, revise policies and procedures to ensure that internal structures and practices support equal opportunity for all DPH staff.

Lead: Chief Deputy Director

2.1.d: By December 31, 2018, develop a race equity team of champions from across the Health Agency dedicated to racial equity learning, planning and practice: for example, creating safe spaces to discuss current racial justice issues and health inequalities, establishing common language and collective understanding.

Lead: Chief of Staff; Center for Health Equity

2.1.e: By March 30, 2020, secure DPH leadership approval and initiate implementation of a Race Equity Action Plan that integrates direction from community partners for new and/or modified administrative practices and DPH programmatic activities to achieve racial equity.

Lead: Chief of Staff; Center for Health Equity

Objective 2.2: By June 30, 2022, implement a minimum of four new capacity building strategies for DPH staff and community partners to achieve policy and systems change.

Strategies

2.2.a: Each year, provide capacity building opportunities, as needed, for DPH staff and collaborating partners pursuing DPH's annual high-priority policies.

Lead: Office of Planning; Policy and Legislative Affairs; DPH Programs leading policy efforts

2.2.b: By July 31, 2018, develop and offer a training for local health care providers to support DPH's policy priorities by serving as advocates for public health policies at the local and state level.

Lead: Medical Affairs Program

2.2.c: By December 31, 2018, develop and offer a training course for DPH staff to build and/or deepen their skills to engage in public health policy change efforts.

Lead: Policy and Legislative Affairs

2.2.d: By June 30, 2019, develop and offer a revised training course for DPH staff and their community partners to learn essential skills for leading multi-stakeholder collaborations.

Lead: Organizational Development and Training; Office of Planning

Goal 3: Work Jointly with Partners to Support Bold Local and State Policies that Accelerate Equity and Justice in Our Communities

Objective 3.1: Each year, collaborate with partners on policy teams to actively advance a minimum of two high priority policies on DPH's annual list and/or in the CHIP.

Strategies

3.1.a: Each year, use data-driven tools to support the policy change work led by DPH policy teams and/or CHIP collaborations, including participatory action research, health impact assessment (HIA), systems modeling, economic analysis, policy evaluation, and DPH publications/reports on relevant topics.

Lead: Center for Health Impact Evaluation; Office of Health Assessment and Epidemiology

3.1.b: Each year, develop communication tools as needed (for example, press releases, social media, etc.) to support the efforts of major DPH policy initiatives.

Lead: Office of Communications and Public Affairs

3.1.c: By June 30, 2018, and annually thereafter, form "policy teams" of DPH staff from multiple programs to collaborate with partners to advance DPH's annual prioritized local and state policy opportunities.

Lead: Policy and Legislative Affairs, with strong support from DPH Programs

3.1.d: By June 30, 2018, strengthen coordination within DPH by enhancing centralized mechanisms that track and disseminate information on DPH's policy-related activities.

Lead: Policy and Legislative Affairs

3.1.e: By June 30, 2023, participate in at least three multi-stakeholder collaborations to achieve priority CHIP strategies.

Lead: DPH program (depending on CHIP strategy selected); Office of Planning

Strategic Priority II: Health Agency Integration that Fosters Healthy People and Healthy Environments

What We Intend to Accomplish

The Los Angeles County Health Agency brings together three Los Angeles County health departments — the Departments of Health Services, Mental Health, and Public Health. The vision of the Health Agency is to provide integrated and enhanced services to Los Angeles County residents.

Aligning efforts across our sister departments is a top priority. A critical step to streamlining access to care and enhancing customer experience will entail putting referral mechanisms in place for patients who need services from more than one department or specialty area. To expand access to care beyond Health Agency programs, DPH will work with external partners to create a network of community resources, such as housing options and substance use treatment.

Goal 4: Forge Robust Partnerships among Health Agency Departments and Staff

Objective 4.1: By June 30, 2020, connect Health Agency patients to the services they need by creating a mechanism for the three Health Agency Departments to refer patients: to community resources for chronic disease management and other supportive services; and from the Department of Public Health to the Department of Health Services for permanent medical homes.

Strategies

4.1.a: By March, 2018, all DPH clinic sites will use the same Electronic Health Record system as the Department of Health Services (referred to as ORCHID - Online Real-time Centralized Health Information Database).

Lead: Community Health Services

4.1.b: By June 30, 2019, create or strengthen quality referral and coordination mechanisms for connecting Health Agency patients to community-based chronic disease management and prevention services.

Lead: Chronic Disease and Injury Prevention

4.1.c: By June 30, 2019, pursue the possibility of expanding the use of the Department of Health Services' (DHS) Nurse Referral Form, to refer patients in any DPH clinic or those working with Public Health Nurses in a community setting, to DHS for a permanent medical home.

Lead: Community Health Services

Objective 4.2: By June 30, 2022, identify and address at least three gaps or needed improvements in services for the target populations served by the Whole Person Care initiative.

Note: Whole Person Care is a Health Agency initiative that provides comprehensive and coordinated services to the sickest and most marginalized people in LA County, including individuals who are homeless, justice-involved, or have serious mental illness, severe and/or persistent substance use disorder or medical issues.

Strategies

4.2.a: By January 31, 2018, coordinate monthly community engagement meetings at each Service Planning Area (SPA) Whole Person Care Regional Coordinating Center to identify and address gaps in the services provided to key target populations as part of the Whole Person Care program.

Lead: Community Health Services Area Health Officers

Goal 5: Conduct Initiatives with Health Agency Departments to Achieve the Goals of the Center for Health Equity

Objective 5.1: By December 30, 2018, at least two action plans will be developed and implemented collaboratively across the Health Agency.

Strategies

5.1.a: By December 30, 2018, collaborate with community partners and Health Agency staff to develop at least two action plans for the Health Agency that advance health equity.

Lead: Center for Health Equity

Objective 5.2: By June 30, 2018, support Health Neighborhood coalitions in 11 communities.

Strategies

5.2.a: By June 30, 2018, at least two DPH staff persons will attend each of the 11 Health Neighborhood Coalitions and contribute to coalition efforts as needed.

Lead: Center for Health Equity

Strategic Priority III: Data Accessibility, Science Excellence, and Innovation

What We Intend to Accomplish

Data and science are the cornerstone on which public health is built. To keep pace with and take advantage of technology advances while expanding our ability to rapidly address an evolving health landscape, DPH will refine and improve the way we gather, use, and communicate data and scientific information.

To streamline DPH's response to communicable disease, we will integrate surveillance data and case management systems, housing all the information needed to manage communicable disease in one data system. Because residents and a wide variety of community partners look to the Department for accurate and timely health information, DPH must harness new communication technologies and channels to reach audiences with messages that are easily understood, useful and relevant.

Goal 6: Augment the Quality, Breadth, Timeliness, and Utility of Surveillance Data

Objective 6.1: By December 31, 2022, implement an integrated communicable disease reporting, investigation, surveillance, and case management system.

Strategies

6.1.a: By December 31, 2019, make modifications to the Visual Confidential Morbidity Reporting (vCMR) System to become the integrated reporting, investigation, and surveillance (IRIS) system that includes sexually transmitted disease, tuberculosis, and other communicable disease reporting.

Lead: Division of Communicable Disease Control and Prevention

6.1.b: By December 31, 2020, enable data exchange between the integrated reporting, investigation, and surveillance system and the California Department of Public Health's California Reportable Disease Information Exchange (CalREDIE) disease reporting and surveillance system.

Lead: Division of Communicable Disease Control and Prevention

6.1.c: By December 31, 2020, incorporate case management functionality into the integrated reporting, investigation, and surveillance system that allows DPH staff to document and track all case follow-up activities and communications.

Lead: Division of Communicable Disease Control and Prevention

Objective 6.2: By December 31, 2020, utilize data from one or more healthcare systems to produce at least three analyses or reports with recommendations for lowering disease rates and reducing health inequities.

Strategies

6.2.a: By December 31, 2018, establish partnerships with one or more large healthcare systems to share priority data that will augment surveillance data on communicable disease, chronic disease, injury and violence, and other priority health outcomes and health determinants, including social determinants of health.

Lead: Office of Health Assessment and Epidemiology

Goal 7: Strengthen the Department's Collection and Dissemination of Information that Connects Determinants of Health with Health Outcomes

Objective 7.1: By December 31, 2022, produce at least ten products (publications, presentations, etc.) using infographics, videos and/or storytelling to bring data to life by connecting it to community members' experiences.

Strategies

7.1.a: By December 31, 2018, provide technical support to DPH programs to ensure that publications and presentations utilize new techniques of presenting data, for example personal vignettes, storytelling, and infographics; and connect the social determinants of health to health outcomes.

Lead: Office of Communications and Public Affairs; Office of Health Assessment and Epidemiology

7.1.b: By December 31, 2018, develop a plan to improve the quality, collection, and dissemination of social determinants of health and racial equity data.

Lead: Office of Health Assessment and Epidemiology

Objective 7.2: By June 30, 2018, create neighborhood reports for 50 communities that will comprise a key component of the next Community Health Assessment (CHA).

Strategies

7.2.a: By June 30, 2018, develop community profiles for 50 cities in the county that include information about the social determinants of relevant health outcomes.

Lead: Chief Science Officer; Office of Health Assessment and Epidemiology

Objective 7.3: By December 31, 2020, expand the public's access to user-friendly health data by making improvements to the ThinkHealthLA website (www.thinkhealthla.org), which will result in increased volume of activity from 450 average users per month to 1500 average users per month.

Strategies

7.3.a: By June 30, 2018, add key data from DPH to the ThinkHealthLA.org website to make DPH data more accessible to the public.

Lead: Office of Planning; Chief Science Officer

7.3.b: By December 31, 2019, offer tools on ThinkHealthLA.org that allow for easier display of information and creation of user-friendly reports.

Lead: Office of Planning

7.3.c: By December 31, 2020, increase promotion of the ThinkHealthLA.org website to external partners and the general public.

Lead: Office of Planning

Goal 8: Evaluate DPH Program Activities to Assess Impact and Increase Transparency

Objective 8.1: By December 2023, increase by 10% the proportion of large-scale DPH interventions that have been evaluated (baseline to be established).

Strategies

8.1.a: By December 2018, where appropriate, include a provision in DPH contracts that requires contractors to conduct baseline and follow-up measurement to evaluate the impact of program services and public health policy changes.

Lead: Contracts and Grants; Chief Science Officer

8.1.b: By December 2019, establish partnerships with local universities to provide support on evaluation methods.

Lead: Chief Science Officer

8.1.c: By January 2019, encourage grant funded programs in DPH to allocate 5-10% of their budget for evaluation, contingent on approval by the funding organization.

Lead: Chief Science Officer; Finance

8.1.d: By June 2019, establish an in-house group of evaluation specialists to lend technical assistance in evaluating large scale DPH interventions, including policy change initiatives.

Lead: Chief Science Officer; Office of Health Assessment and Epidemiology

Strategic Priority IV: Communication Channels that Inform, Educate, and Empower Los Angeles County Residents

What We Intend to Accomplish

In any organization, but especially a large one like DPH, strong communication is vital to keeping staff informed about each other's work, and ensuring that critical information reaches staff at all levels and in all locations. Further, how DPH communicates with the public is key to successfully sharing salient information that can be used to protect and promote individual health and health equity in communities. The enhancements that DPH will make internally, and when communicating with the public, capitalize on advances in technology and social media trends.

Goal 9: Revitalize and Modernize DPH's Public Communication Channels and Messaging, Including a Mix of "Bottom-up" Process and Feedback Loops

Objective 9.1: By June 30, 2022, increase DPH's capacity to raise Los Angeles County residents' awareness about community-wide health threats and promote practices for building equitable communities, by implementing at least three new communication strategies.

Strategies

9.1.a: By June 30, 2018, develop an approach and process to rapidly and systematically disseminate health information directly with Los Angeles County residents and other stakeholders.

Lead: Community Health Services; Emergency Preparedness and Response Division

9.1.b: By June 30, 2018, ensure every Bureau has a tool kit with accessible information for residents about their programs, services, and ways to get involved; program materials should identify and convey specific health equity objectives.

Lead: Office of Communications and Public Affairs; Bureau Directors

9.1.c: By June 30, 2018, develop a mechanism to request translation of key documents and to produce translated documents.

Lead: Office of Communications and Public Affairs

9.1.d: By December 31, 2020, create a platform for collecting and sharing information from community members and partners regarding health-related concerns and community health issues.

Lead: Public Health Information Systems; Office of Communications and Public Affairs

Goal 10: Expand Internal Communication and Coordination within DPH

Objective 10.1: By June 30, 2020, at least 80% of DPH Staff Satisfaction Survey respondents will agree or strongly agree that the management team at their work location effectively communicates new policies, updates and changes within DPH (baseline is 56%).

Strategies

10.1.a: By June 30, 2018, within each Bureau, ensure use of regularly scheduled communication methods to disseminate and review information; for example, standing Bureau staff meetings, Division and Program Directors' meetings, and/or regular Bureau Director visits to programs.

Lead: Bureau Directors

10.1.b: By June 30, 2018, implement at least two strategies for staff to provide suggestions to Bureau management; for example, a suggestion box in each Bureau, and a mechanism within each Bureau for Bureau management to report back to staff on the status of suggestions.

Lead: Bureau Directors

10.1.c: By December 31, 2019, redesign the intranet by implementing a new web platform that is more accessible, and ensure that all DPH Programs regularly update their information.

Lead: Public Health Information Systems; Office of Communications and Public Affairs; Bureau Directors

Objective 10.2: By December 31, 2018, in order to strengthen coordination among DPH programs, at least 90% of programs that conduct community-based activities will enter information about community-based projects into an internal database (baseline to be established).

Strategies

10.2.a: By June 30, 2018, develop and disseminate instructions for DPH programs to enter content into a shared internal database (SmartSheet) on a regular basis to strengthen internal knowledge of programmatic activities and foster coordination among DPH programs.

Lead: Office of Planning

Strategic Priority V: Investments in Our Staff

What We Intend to Accomplish

DPH conducted a Department-wide staff satisfaction survey in 2016 to understand employees' priorities relating to their work environment, advancement, and professional development. The survey gives DPH staff a crucial role in identifying how individuals, teams, and DPH as an organization can better function in order to achieve our public health mission.

Rather than create a separate action plan to capture the solutions proposed through the staff satisfaction survey, this section of DPH's Strategic plan serves that role. Additional ideas that were generated by staff in town hall meetings, workgroups, and surveys to shape the Strategic Plan are woven into the goals, objectives and strategies below.

The new approaches that DPH will institutionalize over the next five years aim to strengthen workplace safety and supervisor-employee relationships, boost professional development opportunities, and expand our internal efficiency, as we strive to make the Department the public health employer of choice.

Goal 11: Fully Integrate "Just Culture" and Create a Work Environment Valuing Safety and Physical & Emotional Wellness

Objective 11.1: By June 30, 2023, achieve department-wide success resulting from DPH's Just Culture initiative by increasing by 20% the number of DPH staff who agree or strongly agree that they can speak up about errors and mistakes without fear of retaliation (baseline to be established).

Strategies

11.1.a: By June 30, 2018, develop and implement a DPH Just Culture policy and department-wide mandatory training program to apply Just Culture principles in DPH's work environment.

Note: The Health Agency is leading an agency-wide initiative to promote a Just Culture, defined as "shared attitudes, values and practices that stand for and foster dignity, trust, fairness, and kindness."

Lead: Organizational Development and Training

Objective 11.2: By June 30, 2022, increase by 15% the number of DPH staff who agree or strongly agree that they benefit from DPH's Employee Wellness program (baseline to be established).

Strategies

11.2.a: By December 31, 2018, develop new or modify existing DPH policies and practices to create an environment accommodating parental needs, including but not limited to expanded access to lactation rooms.

Lead: Maternal, Child and Adolescent Health Programs

11.2.b: By June 30, 2019, develop a comprehensive DPH Employee Wellness Program plan that provides opportunities for staff to improve their physical and mental wellbeing.

Lead: Organizational Development and Training

Objective 11.3: By June 30, 2021, at least 80% of DPH Staff Satisfaction Survey respondents will report that they agree or strongly agree that they work in a safe environment (baseline is 68%).

Strategies

11.3.a: By June 30, 2020 (DPH-owned facilities) and June 30, 2021 (DPH-leased facilities), conduct assessments at DPH staff worksites and make necessary safety and security improvements.

Lead: Risk Management

Goal 12: Bolster Recruitment and Retention of Employees to Attract and Maintain a Talented and Diverse Workforce

Objective 12.1: By January 1, 2019, institutionalize improvements in our hiring process to effect a 15% reduction in hiring time for new County employees, and implement a minimum of three new retention strategies to encourage quality staff to remain at DPH (baseline to be established).

Strategies

12.1.a: In order to hire new staff for the most critical job openings throughout the Department, every three months, prioritize which job examinations the Bureaus would like DPH Human Resources to open.

Lead: DPH Director; Bureau Directors

12.1.b: To assist Bureaus with hiring, create a Human Resources dashboard that: 1) By June 30, 2018, annouces current open exams and eligibility hiring lists as well as target dates for upcoming examinations and release dates for eligibility lists; and 2) By June 30, 2019, analyzes key hiring data for each Bureau including racial/ethnic data on new hires and promotions, the vacancy rate, the average number of days that positions have been vacant, and the length of time to complete Personnel Action Requests (PAR) for new hires and internal transfers.

Lead: Human Resources

12.1.c: By December 31, 2018, expand the existing on-boarding practices throughout DPH to deepen the welcoming environment for new staff and standardize the off-boarding process to learn from departing employees.

Lead: Human Resources

12.1.d: By June 30, 2019, create a family-friendly workplace and an expanded set of employment options, by pursuing the possibility of allowing job sharing (one job and benefits split between two half-time employees) and part-time jobs (with prorated benefits).

Lead: Human Resources

12.1.e: By June 30, 2019, in order to increase staff retention, strategize with internal and external partners how DPH could provide financial compensation to employees who obtain academic degrees, advanced educational training, and/or certifications that are relevant, but not required, for their current job description.

Lead: Human Resources; Organizational Development and Training

Goal 13: Spur Career Growth by Offering Innovative Leadership and Professional Development Opportunities

Objective 13.1: By June 30, 2022, at least 55% of the DPH Staff Satisfaction Survey respondents will report that they have career advancement opportunities within DPH (baseline is 50%).

Strategies

13.1.a: By December 31, 2018, develop a comprehensive program (a DPH "University") that will promote continuous learning for professional growth and development.

Lead: Organizational Development and Training

Goal 14: Drive Workforce Efficiency by Modernizing and Streamlining Administrative Processes

Objective 14.1: By June 30, 2022, implement at least three new or modified administrative practices to achieve a higher level of efficiency.

Strategies

14.1.a: By June 30, 2018, increase use of modern technology in everyday business practices; for example, expanded use of videoconferencing/web-based conferencing and electronic forms.

Lead: Public Health Information Systems

14.1.b: By June 30, 2022, to facilitate and accelerate purchasing, hiring, budgeting, contracting, and various other administrative functions that DPH programs carry out, develop and disseminate to all DPH program staff, procedural manuals that detail the correct processes to follow.

Lead: Materials Management; Human Resources; Finance; Contracts and Grants

Implementation and Evaluation

The Strategic Plan is meant to be a document that sets a course for the future, but too frequently plans such as this one can get lost in the day-to-day challenges that public health departments face. We felt it was essential to develop measurable objectives and time-bound strategies in order to hold ourselves accountable for achieving specific results. To ensure the plan remains relevant, dynamic, and responsive to Department needs, DPH will coordinate a systematic implementation and evaluation framework. This plan allots six years for implementation of the strategies; the sixth year will also be used to evaluate progress and develop the next plan. Staff leads for the strategies will recruit a team of internal colleagues, as needed, to collaboratively develop yearly action plans, carry out the strategies, collect data to measure achievements, and report on progress annually. A mid-term review will be held after completion of the plan's first two years, to examine progress towards goals, identify barriers, consider mid-course adjustments due to changes in priorities, resources, or opportunities, and plan for the remaining implementation years. A final report will outline DPH achievements due to the Strategic Plan, challenges and barriers encountered, and lessons learned, to inform the development of DPH's 2024 Strategic Plan.

Acknowledgments

Key Informant Interviews

Many thanks to the following public health and community leaders who offered candid feedback to DPH and shared big picture ideas for spurring innovation and health equity in Los Angeles County.

Heidi M. Bauer, MD, MS, MPH, Chief, STD Control Branch, California Department of Public Health
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Dennis Worsham, Prevention Division Director, Public Health - Seattle & King County, Washington

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