

## COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

11th & L BUILDING, SUITE 550, (916) 445-2125  
SACRAMENTO 95814



Chairman  
MANNING J. POST  
Beverly Hills

Vice-Chairman  
H. HERBERT JACKSON  
Sacramento

ALFRED E. ALQUIST  
Senator, San Jose

HARRY FARB  
San Diego

JACK R. FENTON  
Assemblyman, Montebello

HAROLD C. HENRY  
Rosemead

DONALD G. LIVINGSTON  
Los Angeles

MILTON MARKS  
Senator, San Francisco

ERNEST N. MOBLEY  
Assemblyman, Fresno

VERNE ORR  
Pasadena

LLOYD RIGLER  
Burbank

NATHAN SHAPELL  
Beverly Hills

LOUIS WARSCHAW  
Los Angeles

L. H. HALCOMB  
Executive Officer

January 1976

Honorable Edmund G. Brown Jr.  
Governor, State of California

Honorable James R. Mills  
President pro Tempore, and to Members of the Senate

Honorable Leo T. McCarthy  
Speaker, and to Members of the Assembly

Gentlemen:

The Commission on California State Government Organization and Economy has completed its review of the organization and functioning of the State Department of Health. The study emanated from the Commission's concern that the Department--comprising more than one quarter of the State's annual budget--was not fulfilling the goals set forth in the Governor's Reorganization Plan No. 1 of 1970 nor was it contributing to the health needs of the people of California in an effective and efficient fashion. Dr. Jerome Lackner, Director of Health, shared this concern; consequently, he requested the Commission, within three months of his appointment, to make a thorough study of the Department.

The Commission's interest in the health functions of the State Government dates back to 1967 when it suggested that there might be merit in grouping State health functions into a single state department. Although the Commission and the Legislature approved such a merger in 1970, we question the effectiveness of the organization and operation of the department as presently organized. The objective of the study therefore was to conduct an in-depth analysis and make recommendations which hopefully will permit the State to meet its health goals more effectively and with greater efficiency and economy.

The explosive growth of state health programs has spanned the past ten years. The complex problems described in this report relate to rapid growth and have accumulated over the same span of time. Our findings are not intended to fix responsibility for conditions which prevail on any

January 1976

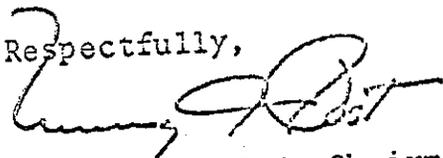
particular administration. Rather, our objective is to present and document our criticisms for constructive purpose. We trust that the adoption of recommendations will lead to substantial improvement in the organization and operation of health programs for the state.

The scope of the study was determined by a Commission Subcommittee comprised of Messrs. Verne Orr and Donald G. Livingston and was set forth in an exchange of correspondence between the Subcommittee and the task force appointed by the Chairman to conduct the study. (See Appendix A.)

The task force, chaired by Lester Breslow, M.D., M.P.H., Dean of the School of Public Health, Center for Health Sciences, University of California at Los Angeles consisted of Paul O'Rourke, M.D., M.P.H., Health Advisor to the State Senate; Charlene Harrington, R.N., Ph.D., State Department of Health; and James Miller from the State Department of Finance. Position papers and specialized assistance were received from Henrik L. Blum, M.D., Professor of Community Health Planning, University of California, School of Public Health, Berkeley; Paul Press, Assembly Office of Research; Verne Gleason; and Bert Cohen; as well as others from within the State Government. The members of the Task Force take full responsibility for all findings of fact of the study. The report, presented in two parts, was prepared under the supervision of the Commission's Executive Officer.

At all times excellent cooperation and assistance was received from Mario Obledo, Secretary of Health and Welfare Agency, Jerome Lackner, M.D., Director of Health, and employees of the Agency and the Department.

Respectfully,



MANNING J. POST, Chairman

	<u>Page</u>
D. Operations	103
E. Offices of the Agency	105
1. State Office of Narcotics and Drug Abuse	105
2. Office of Alcohol Program Management	106
3. State Office of Educational Liaison	107
4. Office on Aging	107

#### ORGANIZATION CHARTS

Chart #1	Department as Reorganized in July 1973	26
Chart #2	Current Organization	28
Chart #3	Phase I, Proposed Organization	54
Chart #4	Phase I, Program Planning and Evaluation Office	57
Chart #5	Phase I, Proposed Advisory Bodies Structure	63
Chart #6	Phase I, External Affairs Office	65
Chart #7	Phase I, Prevention and Protective Services Division	66
Chart #8	Phase I, Mental and Developmental Disabilities Division	75
Chart #9	Phase I, Licensing and Certification Division	76
Chart #10	Phase I, Medi-Cal Branch	78
Chart #11	Phase I, Program Support Services Branch (Administration)	80
Chart #12	Phase II, Proposed Organization	83
Chart #13	Phase III, Proposed Organization	87
Chart #14	Health and Welfare Agency - Original Organization	100
Chart #15	Human Relations Agency - 1968	100
Chart #16	Health and Welfare Agency - Current Organization	102

## Table of Contents

### Part II

	<u>Page</u>
B. Agriculture and Services Agency	348
1. California Occupational Safety and Health Program	348
2. Pesticide Control Program	349
C. Department of Consumer Affairs - Healing Arts Boards	350
D. Migrant Programs	351
1. Migrant Housing Inspection	351
2. Public Migrant Temporary Housing	351
E. California Health Facilities Commission	352
F. Advisory Bodies	353
1. Advisory Health Council	353
2. Citizens Advisory Group	354

### APPENDICES

A. Scope of Study	355
B. Summary of 1970 Task Force Report	360
C. Personnel Questionnaire	367
D. List of Interviewees	370
E. History of Consolidation	389
F. Bibliography	401

## Part I

### I. SUMMARY OF FINDINGS AND RECOMMENDATIONS

Throughout the course of the study, a positive change in the attitude of the Agency, the Department, and their staffs was discerned. Constructive criticism was actively solicited and candor and reflection began to appear. As Dr. Jerome Lackner expressed, when requesting the study, a new spirit is emerging which is beginning to elicit a cautious revival of expectation in the health community that real progress is possible. Although the findings of this study are critical in many instances, our recommendations are constructive and made in the hope that they will enhance this spirit of progress.

#### Findings

1. In the creation of a single Department of Health for California, in 1973, the Departments of Public Health, Mental Hygiene, Health Care Services, and elements of the Departments of Social Welfare and Rehabilitation were brought together, but the reorganization did not lead to genuine consolidation of related programs.
2. The form of organization established did not fulfill the expectations listed in a 1970 Task Force Report which was reviewed and approved by the Commission on California State Government Organization and Economy and accepted by the Legislature (See Appendix B, page 360).
3. The outcome has been a serious deterioration in planning, operation and evaluation of health programs and a failure to achieve their functional integration; inaccurate claims to the Department of Finance,

2

the Legislative Analyst and fiscal committees of the Legislature of fiscal savings which obscured budgetary overexpenditure; decline in the availability of reliable statistical information; loss of accountability; and decrease in attention to the pressing need to guide the development of health manpower and the construction of health facilities in California. Although significant improvements are in the process of being implemented these conditions continue to exist.

4. The following deficiencies exist in the structure and function of the Department:

a. Its present structure embraces a loose federation of independent programs, without substantial coordination at the state level and with little integration of services in the community.

b. Over-centralization of administrative support functions has disrupted health programs by depriving program administrators of effective participation in budget presentation, personnel management, data systems design, and contract processing. The consolidation that was implemented did not help program managers in the performance of their duties.

c. Superfluous layers of bureaucracy have encouraged unproductive procedures and driven the cost of administration beyond acceptable limits. Decisions are delayed and often made arbitrarily at a distance from those with the greatest knowledge of the health programs. Field offices are widely dispersed and poorly organized and thereby impede integration of state functions in support of local programs. Technical assistance tends to obstruct rather than facilitate.

- d. The state personnel system has been utilized improperly to place in key positions persons without training or experience in health programs sufficient to fulfill their responsibilities with competence. Rotation of personnel occurs with such frequency that responsibility and accountability have been obscured. Retention and recruitment of qualified individuals has been seriously impaired. The potential of qualified staff is not put to good use.
- e. Information essential to measurement of the performance of programs is lost in a morass of data collected and handled in a fashion which makes assessment of problems and accomplishments extremely difficult. Program managers, budget analysts and agencies outside the Department cannot obtain basic information required to fulfill their responsibilities.
- f. Confusion of authority and function between the Health and Welfare Agency and the Department creates friction and erodes the authority and effectiveness of the Director of the Department. Legislators, local health agencies and private professional groups report that they are unable to identify those in charge of programs in the Department or to obtain answers to questions. Clear and consistent decisions on policy are not forthcoming.
- g. A vacuum in leadership due in part to excessive turnover of executive and professional personnel has a paralytic effect on the Department and nurtures a crisis approach to administration which is both unsettling and demoralizing.
- h. Meaningful participation in health policy decisions by local governmental officials, advisory bodies, consumers and providers has practically disappeared. Neglect of hearing and advisory

processes aimed at soliciting the views of all concerned has fanned distrust and disrupted constructive negotiation. Arbitrary adoption of regulations causes dismay and spawns litigation.

5. These deficiencies have caused internal and external loss of confidence in the Department.

a. Within the Department, program administrators report that they do not command the authority or support necessary to operate programs and thus to be held accountable for results. Decisions are passed 'up the line' and made without sufficient consultation by those with greatest experience in a particular program. Yet, they must live with repercussions and try to defend policies they disapprove. Their integrity is challenged and professional pride is degraded.

b. Loss of confidence is prevalent amongst individuals and organizations outside of the Department who are indispensable to the successful operation of state health programs. Distrust in the capacity of the Department to bring order to its programs is impeding the placement of new health programs in the Department even when it is logical to do so.

6. Conditions which now prevail cannot be fairly attributed to a failure in the logic of consolidation of state health programs, but rather to the methods employed in carrying out the merger. Those initially charged with responsibility for implementation of the consolidation were, in fact, not in support of such a merger.

## Recommendations

1. The Governor should enunciate clear health goals and policy initiatives for California and commit the administration to build competence and confidence in the Department. His continuous leadership is essential to the restoration of the Department to a position where it can function effectively for the citizens of the State and resume national leadership in health affairs.
2. A Board of Health, chaired by the Director of Health, should be established with statutory responsibility as a publicly accountable body to review major health policies; to serve as the designated final authority for statewide health planning; to establish hearing and advisory mechanisms that will assure an open process of public participation in the formulation of regulations; and to adopt health regulations. The establishment of such a statutory Board vested with the responsibility for directing and coordinating all technical departmental structures would permit the abolition of some boards and advisory committees presently participating in the programs of the Department. The first task of the Board should be to study the advisory bodies and outline how they should be streamlined.
3. The Governor, Agency and Department should:
  - a. Undertake a phased and deliberate approach to administrative change, addressing first only those functions which require immediate modification to achieve adequate program performance, with particular emphasis on creation of a strong planning and evaluation structure within the Department;

- b. Establish clear channels of communication and delegated levels of authority and responsibility from the Governor to the Agency and the Department and its staff;
  - c. Restore to program managers effective participation in administrative processes essential to fulfilling their responsibilities;
  - d. Divest the Health and Welfare Agency of all operating units and charge the Department of Health with responsibility for operation of health programs.
  - e. Develop a regional pattern of field operations that will link effectively services provided to people by public and private providers in preventive medical programs, Medi-Cal, Short-Doyle, Regional Centers for developmental disability and the State Hospitals.
4. The system of job classification and promotion in the Department should be revised with outside professional personnel consultation, in order to place in positions of major responsibility persons who are professionally qualified and otherwise capable of performing their duties with competence for a period of time long enough to do a constructive job. This personnel study should also include an analysis of the need for additional positions that are exempt from state civil service.
5. The Department should re-establish the historic partnership between the State and counties in the provision of health services and rebuild a constructive relationship with federal officials, the State Legislature, the private health community and consumer groups. Competent reporting of departmental activities will accelerate the recovery of trust and confidence.

(6) Recopied from transmittal letter

## II. METHOD OF STUDY

The task force's approach to the report was based on a conviction that (1) a study confined only to administrative structures is insufficient, and (2) that professional expertise and management capability exert, by far, the strongest influence on the character and performance of the Department. Changes in administrative structure cannot compensate for lack of competence, but irrational and unwieldy administrative relationships can seriously impede the work of well qualified administrators.

The work plan outlined by the task force and approved by the Commission entailed:

- 1) Assembly, review and analysis of pertinent documents, including health statutes, proposals, and plans of the Department, budgets, program statements, organization charts, special studies and reports of various kinds (a bibliography of these materials is included in Appendix F.)
- 2) Selection of eight major programs for intensive study, along with other elements of the Department, and certain health related activities located in the Health and Welfare Agency and elsewhere in state government. The following criteria were used to select programs for intensive study: size of budget, number of staff, population affected, current relevance and controversy, type of activity, other evaluations in progress, and potential for influencing health. Based on these criteria, these programs were selected for intensive study: Preventive Medical Services and Social Services; Medical; Mental Disability; Developmental Disability; Substance Abuse;

- d. Representatives of health professional groups.
  - e. Representatives of private providers of health services.
  - f. Representatives of State health planning and facility-regulating bodies.
  - g. Representatives of higher education related to health manpower planning.
- 5) Distribution and analysis of returns from a questionnaire to 132 persons in key positions of responsibility throughout the Department concerning their professional and managerial backgrounds and their careers in State government, including the Department.
  - 6) Visits to a few field operations of the Department (severely limited by time constraints).
  - 7) Commissioning position papers on selected aspects of the Department's work, particularly external advisory bodies, social services and data systems.
  - 8) Preparation of working papers as the study progressed.
  - 9) Preparation of a proposal for a sample survey of the experience of people making use of the service programs of the Department to assess barriers to access and reactions to the care received.
  - 10) Formulation of findings and recommendations.
  - 11) Adoption of Subcommittee and Task Force recommendations by the full Commission.

### III. CALIFORNIA'S HEALTH NEEDS AND RESOURCES

#### A. A Strategy for Improvement

Since the turn of the century, the nature of health problems in California, as in the United States, has changed dramatically. In 1900, the epidemic and endemic communicable diseases that especially affected young people constituted the major health problems. Now, the chronic diseases that strike people insidiously in their middle and later years have become the major causes of illness and death.

Those born in 1900 among the 1,485,000 persons then living in California were likely to die either in infancy or of tuberculosis or intestinal infection before the age of 45 years. An infant born in the state in 1975, with its population of 21,030,000, could expect a life span of more than 70 years with illness and death from heart disease, cancer, or stroke. Substantial differences in health status and outlook are still associated with ethnic origin and extreme differences in socio-economic conditions.

The current health situation has arisen largely as a result of social and economic changes, improved sanitation, advances in medical science and their application, and trends in use of tobacco, alcohol, food and exercise.

Compared with that of people in the United States generally, the health of Californians is better. Infant mortality and deaths from heart disease, cancer and stroke are lower in the state, so that life expectancy is about one year longer. Blacks and Chicanos in California, as elsewhere in the

United States, still suffer a substantially higher infant mortality and higher death rates in the middle years of life than white-anglos. Native Americans fare even worse.

only two or fewer good health habits. At age 45 men who followed six or seven of the good health habits had a longevity of 78 years, compared with 72 years for those with four or five of the habits, and only 67 years for those who followed three or fewer.

Thus, the main health problems of California are the chronic diseases, particularly heart disease, cancer and stroke. The latter affect especially persons in middle and later life and together account for more than two-thirds of all deaths. They also cause a substantial amount of disability. Violence, including accidents, homicide and suicide, is another considerable adversity which strikes younger people with relatively greater force. The health of people in the State is also affected increasingly by alcoholism and drug abuse. While dealing with all these problems, those guiding public health for California cannot relax vigilance against communicable diseases which from time to time get out of control, as gonorrhoea is at the present time.

A strategy for coping with these health problems involves three major components: (1) environmental control measures, such as adequate highways and safety features in automobiles, air pollution control, chlorination and fluoridation of public water supplies, and control of materials for destruction of self or others; (2) health education, for example, in regard to use of cigarettes and alcohol, and how to use personal health services; and (3) personal health services, that is, the preventive, diagnostic, therapeutic and rehabilitative services that are derived from medical sciences for combatting disease. Table 1 (following) illustrates this strategy in tabular form.

More than any state, California has been quite generous in building the resources for personal health services. The nation now spends about eight percent of its gross national product for such services. This has produced hospital facilities second to none in the world and health manpower of high quality. California is very well off in resources for personal health care, compared with the United States in general. It should be noted, however, that the typical American works one month of the year just to support such resources and their operation.

In recent years California has had 25-30% more physicians per capita in general practice as well as in medical, surgical and other specialties than the nation as a whole. On the other hand, the State has fewer employed registered nurses per capita than does the United States and is particularly low in nursing schools.<sup>1</sup>

There are clear indications that we are getting too many physicians of certain kinds. For example, a recent study<sup>2</sup> reports "approximately 52,000 board-certified surgeons in the United States" and almost twice that number of total

<sup>1</sup>Health Resources Statistics, National Center for Health Statistics. DHEW-PUB (HRA) 75-1509, 1974.

<sup>2</sup>Surgery in the United States. Summary Report of the study sponsored jointly by the American College of Surgeons and the American Surgical Association 1975.

surgical practitioners . . . . . "between 50,000 and 60,000 board-certified surgeons, together with 10,000 to 12,000 interns and residents, would prove sufficient for surgical care in the United States for the next 40 to 50 years." Further, "the number of surgical residency positions offered in this country, approximately 16,000, is excessive by any standard. The number of persons now entering and completing surgical residency each year (2500 to 3000) is larger than that required by population needs. A conservative manpower goal involves the reduction of residency output and board certification rates to 1600 to 2000 persons per year in the next decade."

Moreover, California already has relatively more surgeons than the nation as a whole. For example, in 1972 the United States had 6.99 board-certified general surgeons per 100,000 population whereas California had 8.63. California has 48 surgeons of all types per 100,000, compared with 37 per 100,000 in the rest of the country. Still the State continues to license many hundreds of surgeons each year.

The number of operations performed by surgeons in the Pacific area of the country (predominantly California) were fewer than 150 per year compared with more than 170 in the country as a whole. Yet, the median annual net income of surgeons in the Pacific area was the same as that in the nation, approximately \$46,000.

California also has too many general hospital and nursing care facility beds, according to the California State Plan for Hospitals and Related Health Facilities, July 1, 1972-June 30, 1974, published by the State Department

of Health. There is an excess of more than 20,000 general hospital beds in California, approximately one-third more than needed based on 85% occupancy and 1972 data projected to 1979. And construction is still under way. The excess of nursing home beds was estimated at about 5 percent.

The excess of general hospital beds in California (the most expensive to build and use) is particularly ironic in view of the recommendation by the Report of the Governor's Committee on Medical Aid and Health in 1960 that the State reduce the then-existing 3.5 beds per 1,000 population to 3.0 beds per 1,000 by 1975. The construction trend, however, did not turn downward; it increased.

In addition to numbers of personnel and facilities, organization is very important in resources for personal health services. The Pacific region of the United States, predominantly California, has twice as high a ratio of physicians to population organized in multi-specialty group practice than does the country as a whole. While still a small minority of physicians, their influence on patterns of practice have been considerable. For example, the existence of the Kaiser Health Plan -- a prepaid, group-practice plan serving mainly the major metropolitan areas of the State -- stimulated formation of the Foundation Plan for Medical Care in counties with smaller population density to compete with the prepaid, group-practice approach to community services.

California has thus been a leader in medical care organization as well as in environmental measures and education for health.

Nonetheless, it pays far too high a price for an excess of specialists, general hospitals, and specialty services, which are concentrated in affluent settings, at the same time that serious scarcity of resources persists in the inner city and in rural communities.

## B. Guiding Principles to Effective Consolidation of State Health Programs

Attempts to improve the administration of state health programs have failed due to diverse and conflicting forces.

A brief appraisal of these forces can serve as a useful introduction to the evolution of the Department.

One force is the categorical approach to health programs which is deeply ingrained in our legislative tradition. Competition for attention to particular problems creates compartments of effort, and results in earmarking of funds and isolation of both administrative and service systems. Both professional specialization and citizen advocacy groups contribute to a fragmented and duplicative system of services.

The pattern of administration in the Department of Health reflects the disorganizing influence of these categorical forces and makes the integration of closely related services difficult to achieve in the community. The legislative budgeting process must be somehow revised to attain new ways to integrate sources of funding so that fragmentation and administrative isolation is overcome without loss of accountability. Integration of services is unlikely to occur without this reform.

The fragmentation of services includes these prominent examples:

- Separation of preventive medical services from treatment.
- Separation of primary mental health care from general medical care.

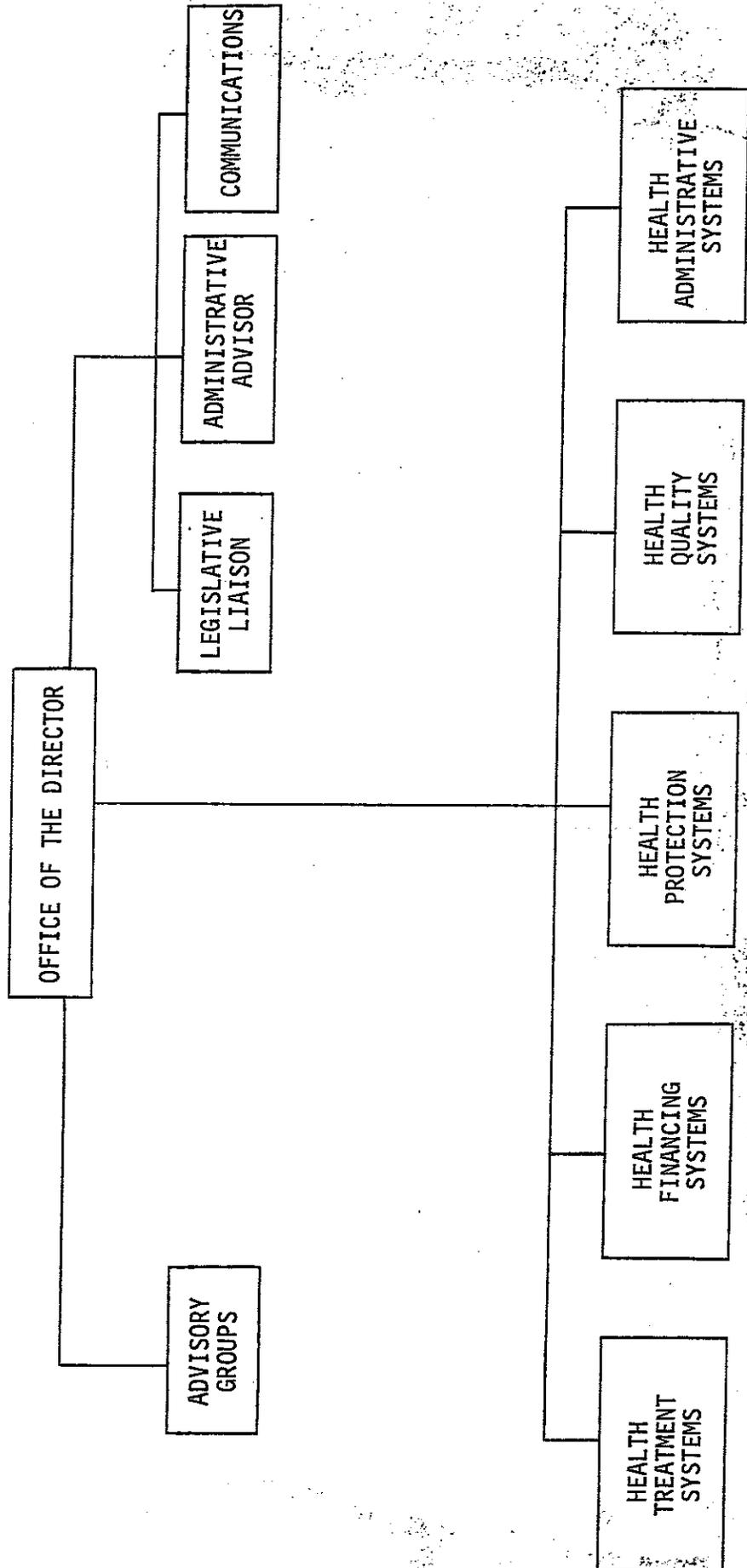
Another major set of forces which must be considered openly is represented in the struggle for tax dollars between publicly operated services and the private sector. The central issues emerge in this struggle--the goal of desegregation of the poor in the delivery of health services--a goal first stated in the implementation of Title XIX in California, and the quality of care provided. Desegregation has not been accomplished, nor has quality of care been assured.

The overriding issue is the provision of quality of care at a reasonable cost, without regard to sponsorship--public or private. The public system of direct services must not be sacrificed to a poorly organized and uncontrolled private sector. Accountability to the taxpayer comes first, and must be based on standards of performance, not the nature of the sponsorship.

A third force has been the trend in national and state thinking to attribute responsibility for health improvement to the medical care system. While that system can contribute much, the Department of Health must also give substantial attention to other means of improving health, in particular to the environmental and personal behavior aspects of health.

These guiding principles -- (1) functional integration of services, (2) quality of services at reasonable cost in tax-supported programs, and (3) the importance of non-medical approaches to health improvements -- have heavily influenced the recommendations made for phased administrative change and reform of operating programs of the Department of Health.

DEPARTMENT OF HEALTH  
As Reorganized in July 1973  
Chart #1



The Director's Office was supported with legal affairs, legislative liaison, public information, and liaison with local agencies and advisory bodies.

## 2. 1975 Reorganization

The change of administration in January 1975, brought changes in the organization shown in abbreviated fashion (see Chart #2). Out of five systems came seven divisions as follows:

- 1) Medi-Cal Division
- 2) Alternative Health Systems (Medi-Cal, Prepaid Health Plans)
- 3) Community Services (Regional Centers, Community Mental Health, and Social Services)
- 4) State Hospitals for mental disability and developmental disability
- 5) Health Protection Division (most programs of the Health Protection System)
- 6) Licensing and Certification
- 7) Division of Administration

The details of this reorganization as they were organized in November 1975, at the time of this study, are elaborated upon in the next section.

For the moment we wish to stress that only two substantial changes occurred in 1975, (1) the separation of PHP's from Medi-Cal thus establishing a new PHP Division, and (2) the separation of state hospitals from community programs in mental and developmental disability. Both new divisions are, in our opinion, ill advised, because it separates two vitally related program elements in each instance. (See sections on Medi-Cal, Developmental Disability, and Mental Disability.)

The description of the negative impact which follows applies equally to the systems form of reorganization adopted in 1973 and to the current form of organization within the department.

The new organization, instead of creating greater cohesion and functional integration produced resentment and rivalry. A loose federation of autonomous programs continued to operate independently with little evidence of increased cooperation. The situation which was created still prevails in the department.

Centralization of administrative authority has been accompanied by ascendancy to positions of influence of persons with little or no experience or credentials in health programs. (See section on Division of Administration.)

Support functions in the Division of Administration are far removed from program managers, who have lost authority and control over budgeting, personnel, data processing, contracts, and can therefore no longer run their programs.

The new breed of 'managers' have placed superfluous levels of bureaucracy, devoid of authority, between programs and top management. Response time to program requests is elongated. Decisions are made 'up the line' with inadequate consultation and too often in an ill considered fashion and after long delays. Attempts to cut budgets arbitrarily hold a higher priority than evaluation of program needs or performance and elimination of wasteful program practices. 'Managers' are rotated rapidly from one post to another through manipulation of job classifications and career executive assignments. The operating premise is that 'managers' can handle programs they know little about. Responsibility is lost and havoc takes its place.

No discernable basis for promotions exist; they are made before solid evidence of constructive accomplishment can be shown as justification. Recruitment

of new talent and retention of capable people has been impaired and the potential of qualified staff is not put to use.

The centralized data system has failed to function from the beginning. Reams of information are collected without prior study of value or a plan for analysis. The most basic types of information, essential to program evaluation and reporting, are buried in a pile of computer tapes which are seldom used.

Budget requests and projections are presented with little dependable data to support them. Inability to perform meaningful analyses obstructs evaluation of program performance and turns back all attempts at intelligent planning. Public relations techniques have been used as a substitute for solid, reliable statistical reports on the major programs.

Cost reductions are claimed but not documented. Mindless administrative procedures eat heavily into the service dollar.

The style of administration is hectic and crisis oriented. Troubled programs are subjected to expensive, serial reviews following which little corrective action is taken. Marathon staff meetings are held at all levels with loosely drawn agendas. Task forces are appointed almost daily as a problem solving device and consume large blocks of time. The total number of these task forces is unknown. Many are convened with little clarity as to their charge and only a handful seem to produce reports with definite conclusions or recommendations for specific administrative action.

The equivalent to internal task forces are off-site staff seminars, retreats, and conferences, which generate descriptions of program difficulties, position papers, 'action' memoranda and conference reports, but little substantial change results.

All of these activities are conducted in an atmosphere of great urgency and give the appearance of productive activity but, in fact, they represent the administrative equivalent of cardiac fibrillation--a condition in which the heart beats fast and irregularly but does not effectively pump the blood.

Confusion is compounded by competition for operational authority between the department and the agency. Certain program managers in the department report directly to the agency without clearance with the director of the department. The agency, in turn, assumes operational control in the department by issuing directives (without knowledge of the director) to division managers and section chiefs. Liaison staff in the agency also convene their own task forces and work groups around operational problems in the programs of the department.

Offices have been created at the agency level for both planning and operation of the same categorical programs and activities also being conducted in the department.

The character of the agency has changed significantly from that intended by the Legislature. Originally, agencies were created to supervise, delineate major policy, respond to public inquiry, keep the Governor informed, coordinate between operating departments, and review total budgets. Now the proclivity of the Health and Welfare Agency to get into operational programs has created confusion of authority and function which, in turn, causes widespread friction and tension.

- A growing amount of both professional time and program expenditures is devoted to compliance with poorly conceived administrative reporting requirements. Much of the information mandated is never used either for program analysis or improved management.
- Decisions by the state are delayed beyond reason and are often contradictory because of a breakdown in communications within the Department.
- The rapid rotation of high officials in the Department erodes both responsibility and accountability.
- Lower echelon officials carry responsibilities without concomitant authority to make decisions.
- Professional competence has been displaced by technocrats whose decisions display gross ignorance of the content of programs in their control.
- Abandonment of the State Board of Health was a serious mistake.
- Input from expert advisory bodies is ignored and the status of these advisory bodies has been downgraded.

In summary, local authorities resent the destruction of the partnership between local and state health departments, the decline in professional leadership, competence and technical assistance, and the fact that the State Department of Health now obstructs rather than facilitates the successful operation of local health programs.

## 5. State Health Planning and Regulatory Bodies

Comprehensive Health Planning: In the process of reorganization of the Department of Health, the State Board of Health was eliminated. The Board had enjoyed a long history of public confidence as a publicly accountable body charged with the responsibility of guiding the health affairs of the State through the adoption of health regulations developed by the staff of the Department of Public Health. This Board was an appointive statutory body made up of prestigious professionals and public members.

Since its demise, all elements of the health community have complained that, in its absence, the Department of Health has failed to give adequate weight to the opinions and observations of professional and consumer experts outside of the department. Several new entities have since been created but confusion of responsibility has developed between them and destructive competition for power now prevails.

The Health Advisory Council still retains responsibility for comprehensive health planning but is destined for replacement by a State Health Coordinating Council under PL 93-641, 1974. This latter council would then become the advisory body to a single state agency designated as the State Health Planning and Development Agency. At the time of this report, the Governor has not appointed this council or designated a single state agency for comprehensive health planning as called for in PL 93-641 to develop and adopt a statewide health plan.

The California Health Facilities Commission was created by statute in 1972 to develop a uniform system of reporting by hospitals and other health facilities of their costs. This Commission sponsored legislation in the

last legislative session to expand its authority to include certification of need for health facilities construction (authority to be assumed by the yet to be appointed State Health Coordinating Council) and to regulate rates for health facilities.

Over fifty other technical advisory bodies exist, some in the statutes, to provide assistance to the many programs and activities of the State Department of Health.

The difficulty in presenting a coherent description of advisory bodies to the Department results from the confused situation which now actually exists. The situation in which we find the apparatus of state government is at once unworkable and untenable.

V. PRESENT FORM OF ORGANIZATION OF STATE DEPARTMENT OF HEALTH  
AND PROPOSED ADMINISTRATIVE CHANGES

A. Present Form of Organization of Department of Health

The Department of Health employs 21,000 individuals, operates eleven institutions and 180 field offices, and will spend \$3.3 billion in 1975-76. Its budget is larger than the combined budgets of the Agriculture and Services, Business and Transportation, and Resources Agencies. It has more employees than the Agriculture and Services and Resources Agencies. Its budget represents 27 percent of the entire state budget and its employees account for 20 percent of the personnel in the four agencies and 10 percent of the total number of employees in state service.<sup>7</sup> The following chart shows the size of the Department of Health in relationship to other state agencies.

Table 1  
Department of Health and State Agencies  
State of California, 1975-76

<u>Organization</u>	<u>Budget (billions)</u>	<u>Staff in Person Years (thousands)</u>
Department of Health	\$3.3	21.0
Health and Welfare Agency (without Health)	5.5	26.0
Agriculture and Services Agency	.3	15.5
Business and Transportation Agency	1.3	34.5
Resources Agency	.5	11.7

(Source: Governor's Budget 1975-76)

Two-thirds of the Department of Health budget is allocated to the Medi-Cal program, while two-thirds of the staff is allocated to the eleven

<sup>7</sup>Governor's Budget 1975-76

mentally disabled, developmentally disabled, alcoholics, and drug abusers in a variety of public and private facilities coordinated by regional centers and local mental health programs. The regional centers and local mental health programs screen, evaluate, diagnose, and refer persons for inpatient care in the community or at a state hospital, or other appropriate outpatient care facilities. In addition, a continuing care services section includes case management and social services for the mentally and developmentally disabled.

The Social Services Branch program consists of homemaker and chore services, adoption services, services for the blind, employment services, family planning services, day care, and child care services. Social services is the second largest element of expenditure within the department, next to Medi-Cal. It serves over two million Californians and is designed to reduce dependence on financial and medical assistance programs.

Health Protection Division: The Health Protection Division consists of the Environmental Health Services Branch, the Laboratory Services Branch, the Preventive Medical Services Branch, the Comprehensive Health Planning Section, and the Emergency Medical Services Section. Through its elements the Health Protection Division identifies new or changing health problems; develops and applies improved techniques for prevention or control of disease and environmental health problems; and promotes full public participation and shared responsibility in implementing programs to reach the highest level of environmental, community, and personal health for California's citizens.

The Environmental Health Branch consists of the Food and Drug, Water Sanitation, Radiologic Health, Occupational Health, Vector Control, and Sanitarian

Services Sections. The Laboratory Services program provides administrative direction and coordinates activities of eight laboratories in the Bioenvironmental Laboratories Section, the Biomedical Laboratories Section, and the Laboratory Central Services Section. In the Preventive Medical Services Branch, the Family Health Services Section and the Infectious Disease Section aim to prevent, control, and minimize the incidence, causes, and effects of disease, illness, and death. The Contract Counties Health Services Section performs direct public health services for the smallest counties in the state. The Crippled Children Services Section maintains continuing early casefinding of children with congenital deformities and other handicapping conditions and assures that those eligible are provided high quality comprehensive medical and related services to correct, ameliorate, or eliminate their handicap. The Comprehensive Health Planning Section conducts both long and short range planning, develops a state health plan, and provides coordination and support to the 12 areawide health planning agencies in the state. In cooperation with local jurisdictions, the Emergency Medical Services Section plans, coordinates, and evaluates statewide emergency medical services.

Alternative Health Systems Division: The Alternative Health Systems Division, designated as the Institutes for Medical Services in July 1975, contracts with groups of medical providers to supply services on a prepaid basis to Medi-Cal beneficiaries. Prepaid health plans provide or arrange for health care services for voluntarily enrolled public assistance recipients within a geographically defined area on a fixed per capita basis. The Division is composed of three sections: Health Plans Operations; Quality Evaluation; and Administration and Investigation.

Medi-Cal Division: The Medi-Cal Division has responsibility for the over-all administration of the California Medical Assistance Program (Medi-Cal), especially the fee-for-service portion. The division works to assure that health care is made available to those California residents unable, either wholly or in part, to pay for their medical services under proper controls, at a reasonable cost.

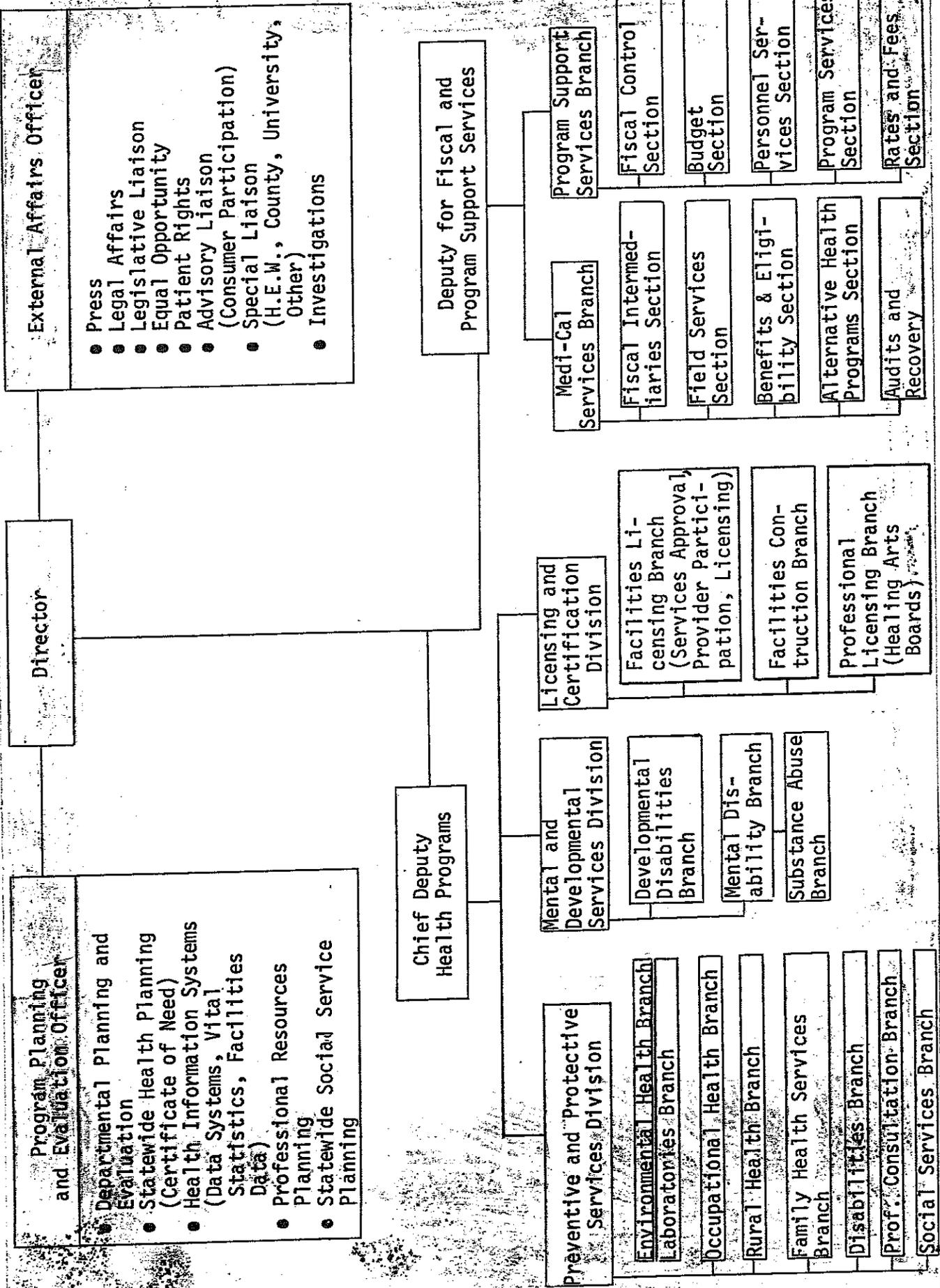
Three categories of residents may obtain Medi-Cal benefits: public assistance recipients, medically needy persons and families, and the medically indigent. All eligibles can choose public or private physicians, hospitals, or other health care providers on a fee-for-service basis or services under a prepaid health plan. Eligibility is determined by each county and coordinated with the Medi-Cal Eligibility Section. The application of program benefits is reviewed by the Medi-Cal Benefits Section. The prior authorization process is administered by the Field Services Section. Claims processing is administered through contract with a privately owned fiscal intermediary. The Fiscal Intermediary Section coordinates their operations with program management.

Licensing and Certification Division: This division regulates approximately 42,000 hospitals, nursing homes, clinics, group homes, halfway houses, day care centers and homes, and other similar public and private, medical and non-medical, out-of-home care facilities. It attempts to assure the public that all facilities in California meet established care standards. The Facilities Licensing, Facilities Construction, and Services Approval sections evaluate and report on services and conditions of facilities; cite deficiencies; help develop plans for correction; levy fines; issue, deny, or revoke licenses; certify facilities for eligibility in Medicare and Medi-Cal programs; investigate complaints; maintain a physical inventory of health facilities;

approve construction plans; manage a variety of construction grants and loans; and control performance of other public agencies under contract for these activities.

The Provider Participation Section seeks to ensure that services purchased from a health facility for Medi-Cal patients meet standards for Medi-Cal licensure and regulation. This section prepares and certifies Medi-Cal contracts and takes disciplinary action when standards are not met. The Investigation Section identifies fraud and brings violators to prosecution through law enforcement agencies. The section provides field investigators and special auditors to evaluate all complaints alleging Medi-Cal abuse.

Administration Division: The Administration Division provides support services for the management of the department's programs. Its responsibilities include personnel management and training, budgetary and accounting systems support, the collection and dissemination of statistical data, the provision of management consulting services to programs, systems analysis and data processing facilities support services, general business services and office services. In addition, the division is responsible for certain more specialized functions such as disability evaluation, facilities planning, health manpower planning, employee relations, contract management, rate setting, and the maintenance of patient accounts. The division is divided into five branches and has 20 sections: Financial Management Branch; Management Systems and Computer Services Branch; Manpower Administration Branch; Program Services Branch; and Disability Evaluation Branch.



Phase I, Proposed Organization Chart  
 Department of Health  
 Chart #3

In the implementation of these proposals, we recommend full participation in the planning process by program administrators involved in change, and use of selective outside consultation in such a way that such help does not become a substitute for strong internal management. The basic principle which should guide change should be the welfare of consumers of departmental services, not the preferences of administrators of particular programs. Isolation of related functions should not be permitted to persist.

1. Phase I

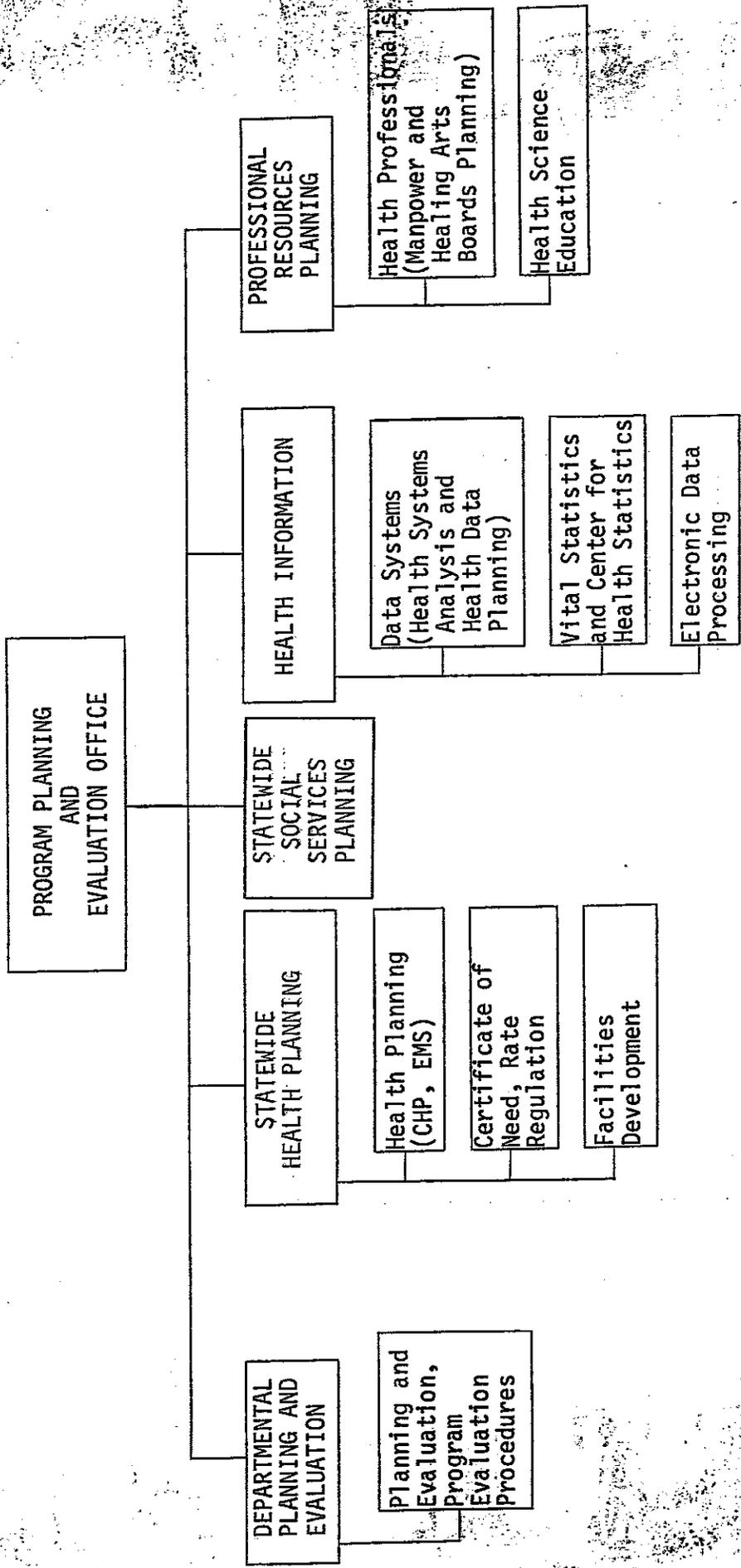
a. Program Planning and Evaluation Office: The importance of comprehensive health planning warrants special emphasis in this report.

The cost of health services provided by the department is so far out of control that the immediate need is less for a plan for the next decade than it is for defensive program control now.

The idea of statewide health planning is greeted by skepticism in many places. Those of conservative bent are convinced that planning consists of a plot to throttle free enterprise; liberals complain that the voluntary health planning process has been captured by special interests to preserve the status quo while the interest and influence of consumers is given only lip service.

The truth lies somewhere in between. The rate of increase in health facilities construction has been slowed, but excess beds remain an uncontrolled factor in pushing up costs. The redundant capacity of facilities and services, and occupancy rates seriously below optimum, increase the cost of both the public and private health care.

Prior to its merger in 1973, the Department of Public Health had responsibility for comprehensive health planning, working in concert with the Health Advisory



Phase I  
Chart #4

We urge immediate action by the Governor to create a more rational, orderly and open process to guide the future of health affairs in California. At present, administrative disorder threatens to impair the State's ability even to respond intelligently to further national health initiatives, for example, a national health insurance law.

c. External Affairs Office: This office houses a staff whose functions must be close to the Director in the day-to-day management of departmental affairs. These functions should be coordinated by a staff director, labeled an External Affairs Officer without rank of deputy director. The Department, in our judgment, has too many officials with the rank of Deputy Director. This causes confusion of authority.

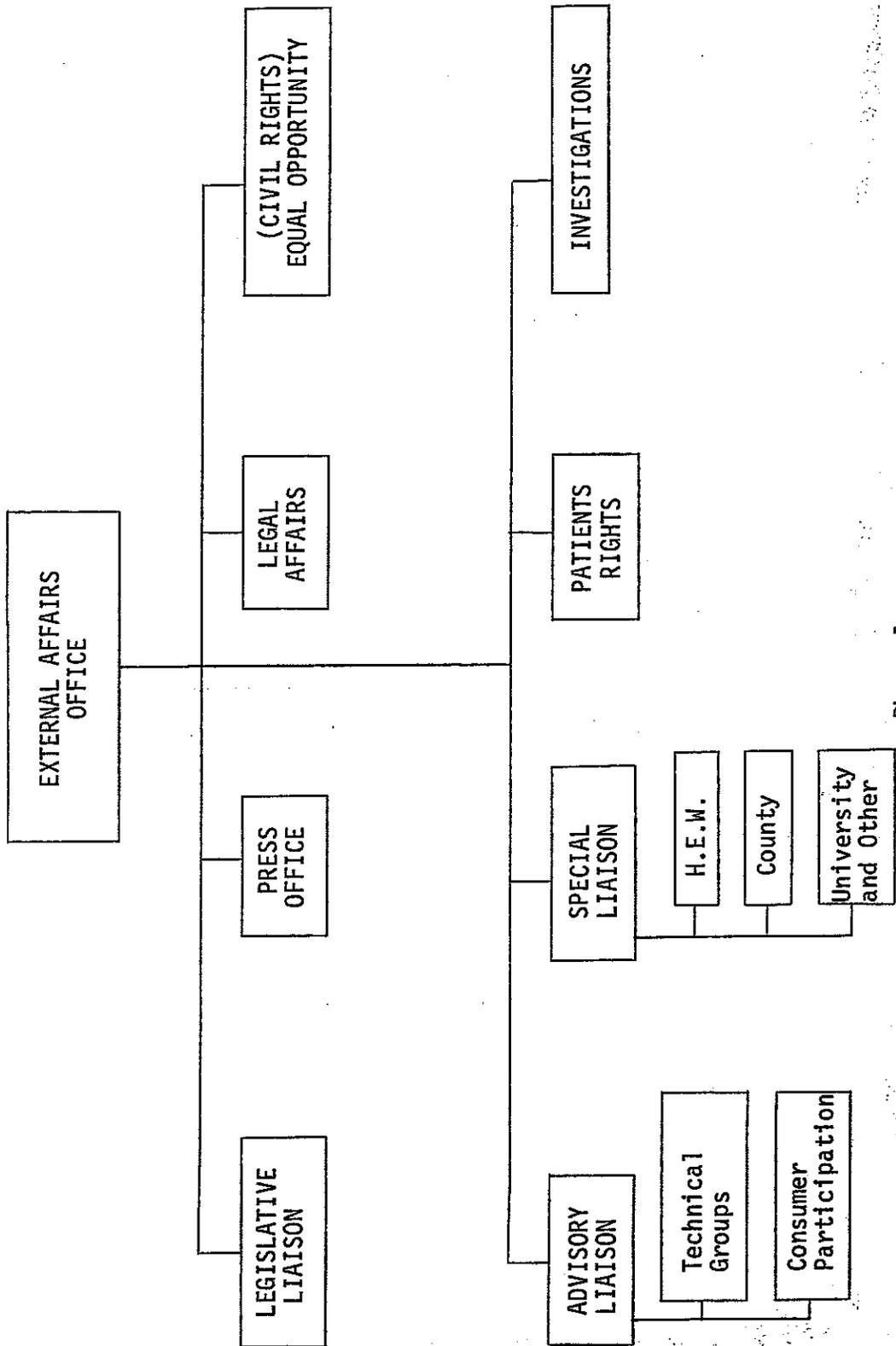
We propose creation of a consumer liaison function to be added to the advisory liaison to local professionals and programs. This is to assure access to the director by persons using programs at the local level who have reason to complain or suggest action to improve local programs.

---

Because of the serious nature of findings by the Investigations Unit, located in the Licensing and Certification Division, we recommend elevation of this Unit to the Director's Office. When serious abuses are discovered by the Investigations Unit, such reports should be made to the Director. This Unit should work closely with the Legal Affairs Office in preparing criminal cases.

---

d. Preventive and Protective Services Division: We view this division as the best placement at present for programs which emphasize prevention and social protection. Social services traditions are closest to this division and better understood by its staff. We believe that much is to be gained in the preventive medical programs by developing a strong medical social work component and conversely that medical components are



Phase I  
Chart #6



This will be an important step in the integration process, moving Crippled Children Services into the branch for closer articulation of the many concerns shared with Maternal and Child Health. Later, as we will indicate, services to developmentally disabled children and those with a need for mental health services should be brought together for similar reasons.

The Childhood Disability Prevention Program will serve, once it is fully operating, as an organized screening activity which will generate referrals to maternal and child health programs, Continuing Care Services, public and private facilities and providers, Medi-Cal, Regional Centers for the Developmentally Disabled, and children's services within Short-Doyle.

As discussed later, any attempt to move children's services presently in Medi-Cal or Short-Doyle into a family health branch would be premature until problems in both of these programs are addressed first.

Dental Health has been seriously neglected in the department. A larger staff including dental professionals--dentists and dental hygienists--is clearly required to enable the department to carry out a statewide dental prevention program.

Finally, adult services can begin to articulate with children's services. An example of the desirability of attempting to do so is the often expressed

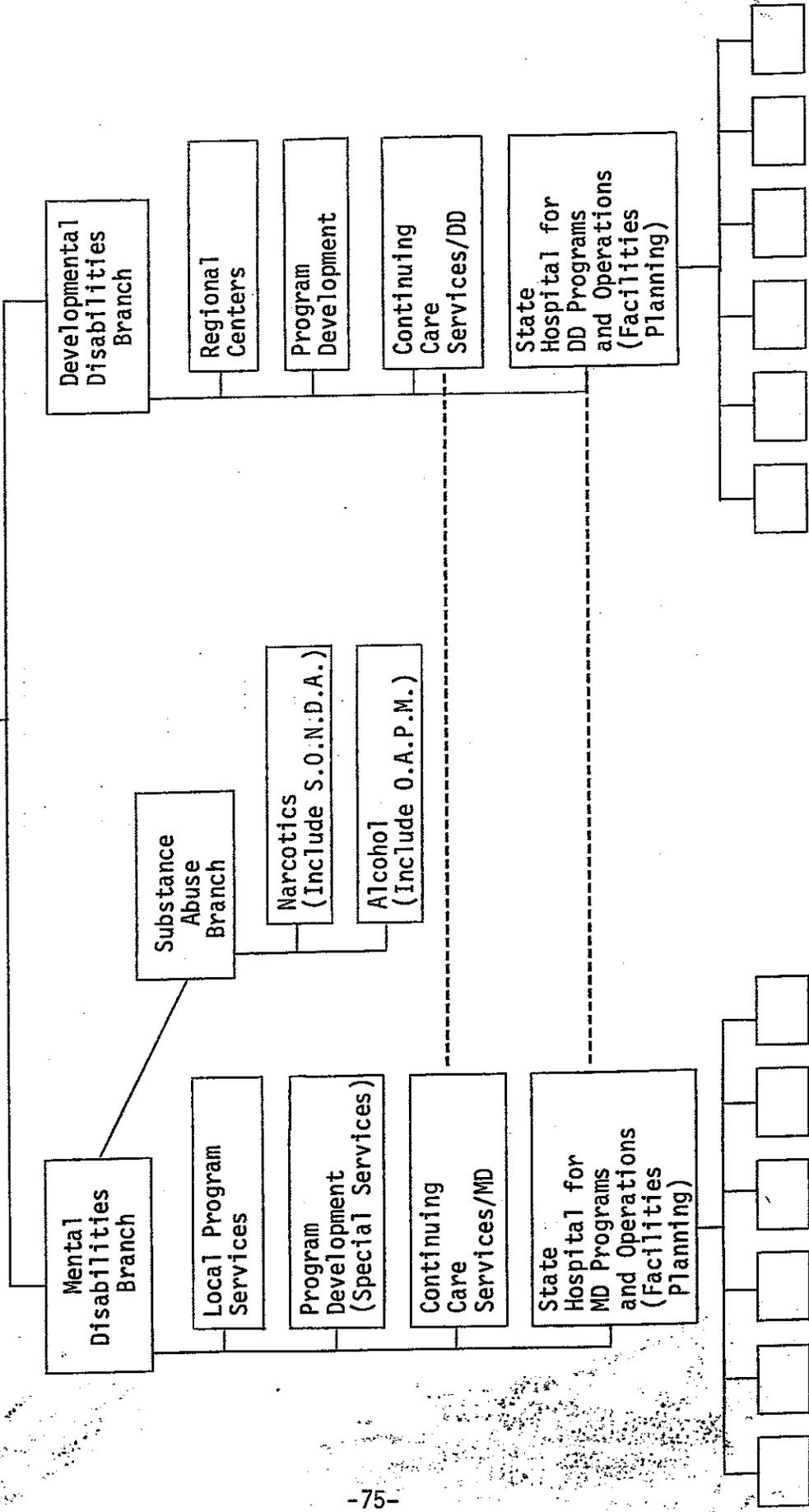
In the Department of Health, for Cal-OSHA, more medical expertise is clearly required and, consequently, a larger staff. A better balance can then be struck in the deployment of staff time in activities of five distinctive categories:

- 1) Back up technical assistance to Division of Industrial Safety in the enforcement process.
- 2) Response to worker complaints of hazards to health at work.
- 3) Consultation to labor and management on development of programs of prevention which deal with people in the work environment and include worker education.
- 4) Data systems development and collection.
- 5) Epidemiological studies to identify occupational hazards in the use of lead, asbestos, pulmonary sensitizers, cadmium, coal tar, industrial dermatitis, chemical hepatitis, etc. Accident prevention must deal successfully with both environmental hazards and the education of people.

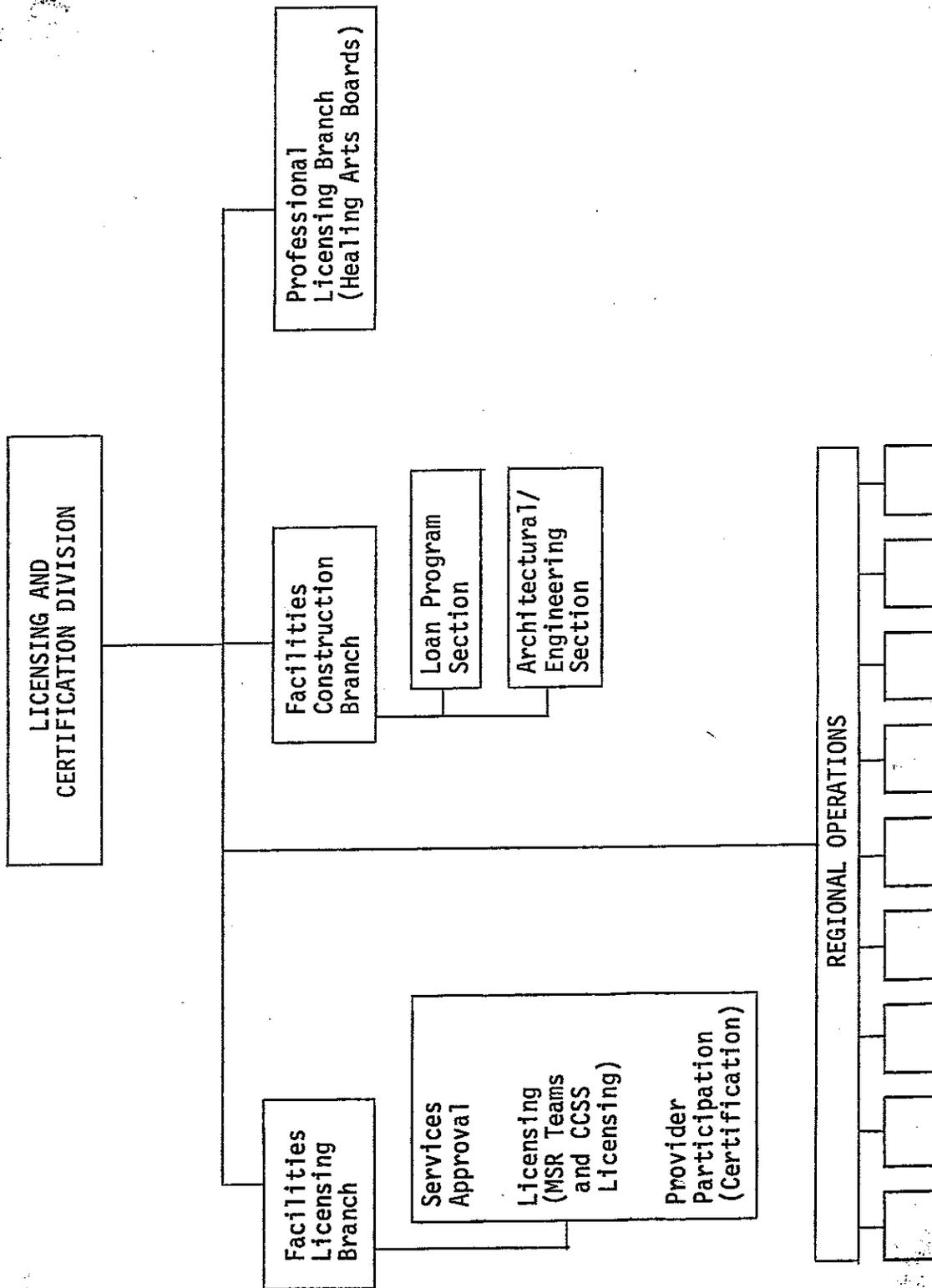
In the field of agricultural labor, there is a serious deficit of attention to the development of organized occupational health programs.

Pesticide safety standards are formulated by the Board of Agriculture and enforced by the Department. For years, complaints have been made that enforcement is lax. With a new administration interested in farm labor, enforcement will probably improve. If workers complain - (an event made more likely by unionization of the work force) - the Department of Industrial Safety may intervene. It would thus seem advisable to encourage the Industrial Safety and Health Board to adopt the same regulations in the Agricultural Code which protect the health of workers exposed to pesticides. This will

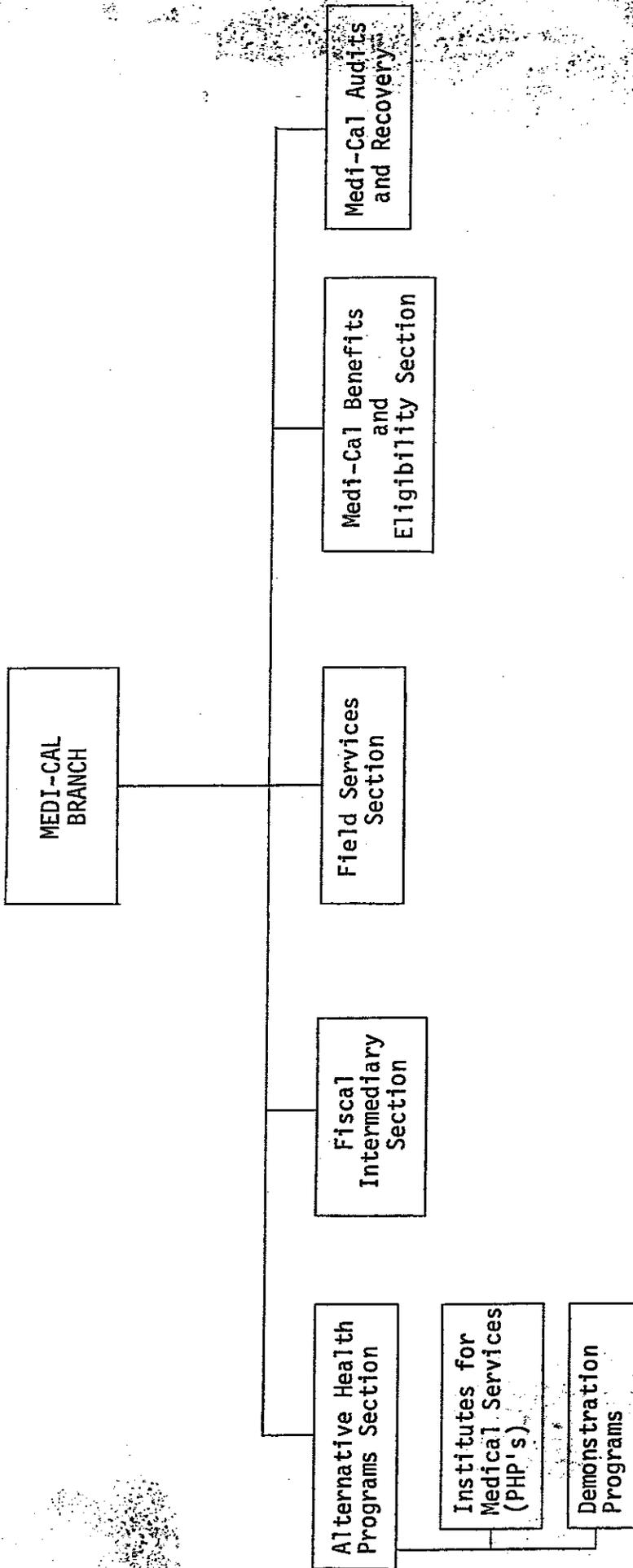
**MENTAL AND  
DEVELOPMENTAL DISABILITIES  
DIVISION**



Phase I  
Chart #8

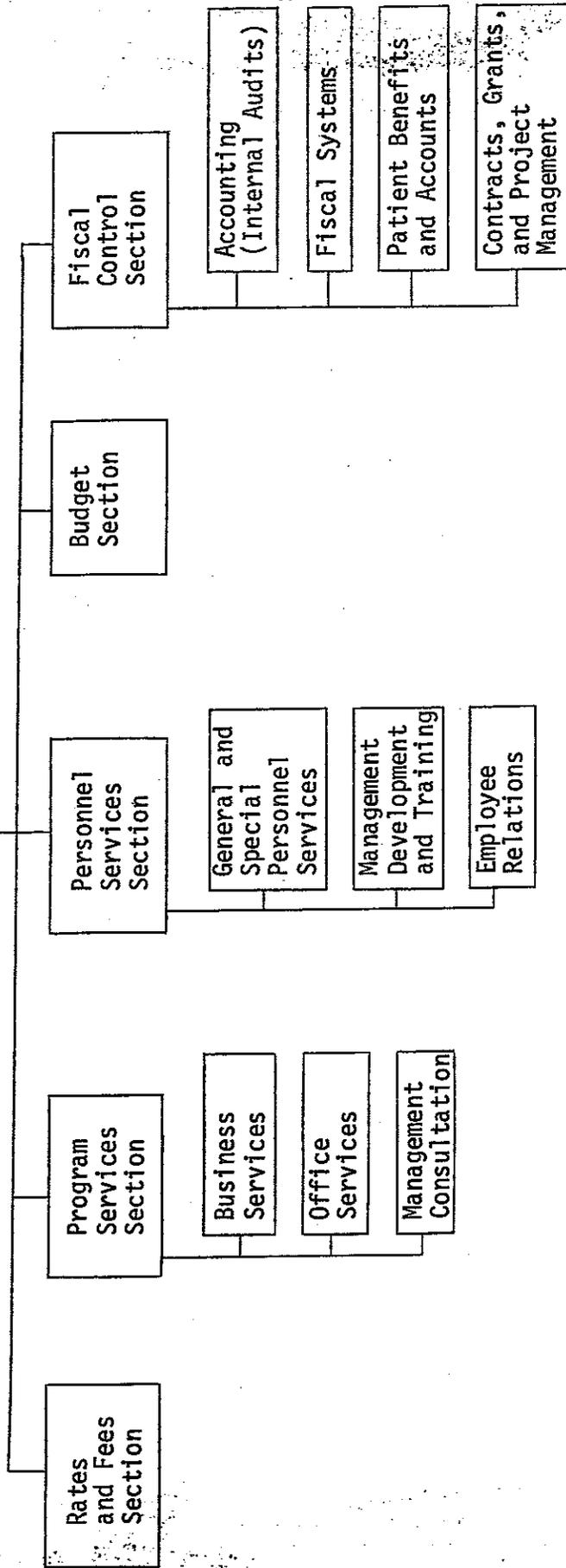


Phase I  
Chart #9



Phase I  
Chart #10

PROGRAM SUPPORT SERVICES BRANCH (Administration)

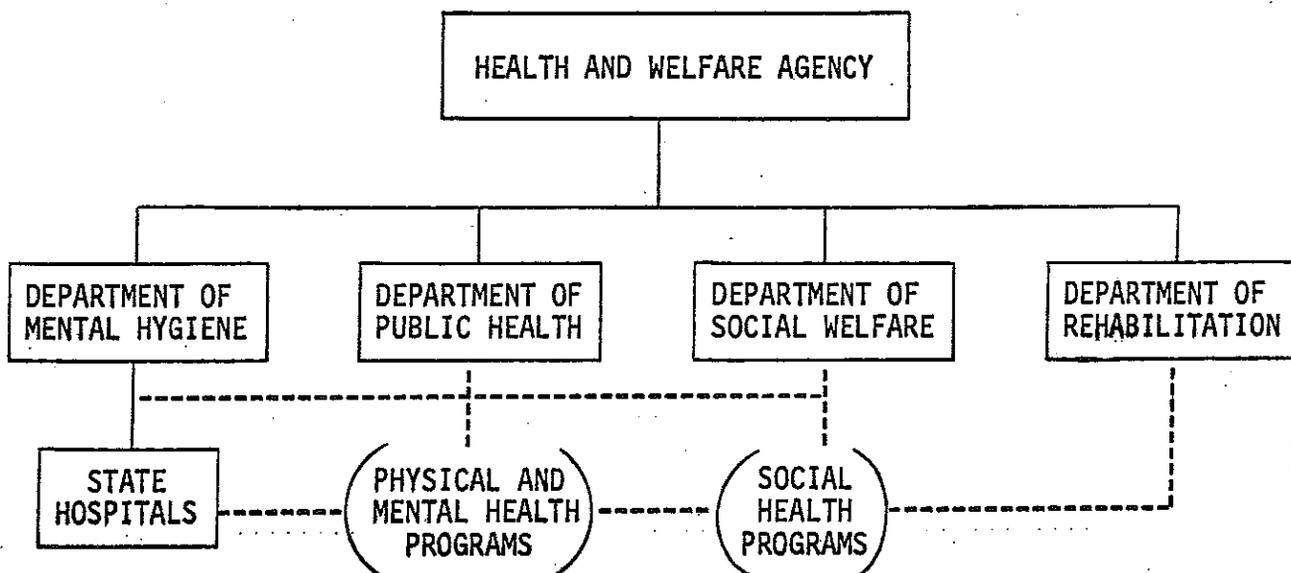


Phase I  
Chart #11

B. History

The first Health and Welfare Agency was organized in this way:

Chart #14



In 1968, these relationships were changed:

Chart #15

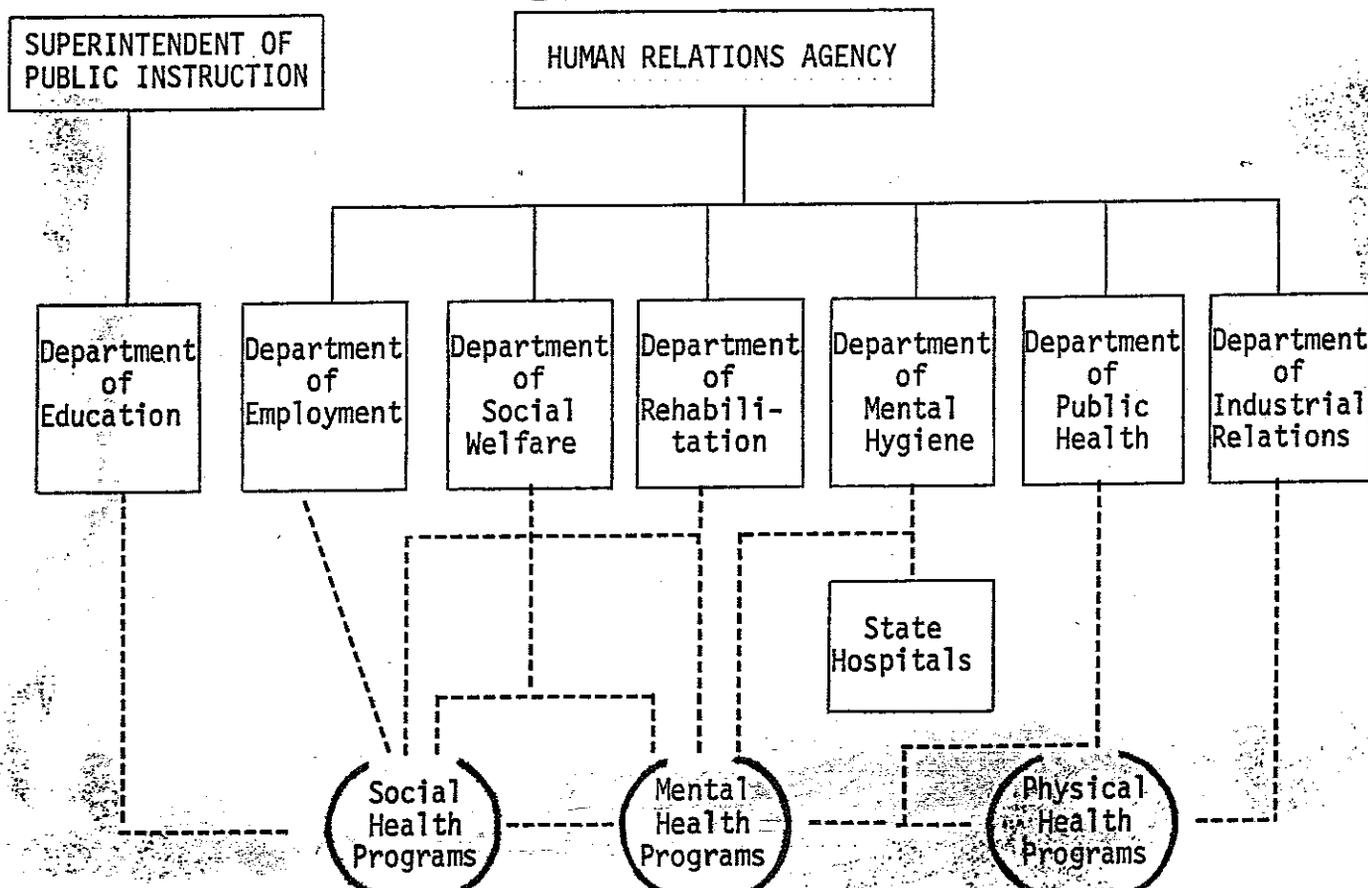


Table 1  
Budget and Staff Size of Agencies  
State of California, 1975-76

<u>Agency</u>	<u>Budget (billions)</u>	<u>Staff in Person Years (thousands)</u>
Health and Welfare	\$8.8	47.0
Agriculture and Services	.3	15.5
Business and Transportation	1.3	34.5
Resources	.5	11.7

(Source: Governor's Budget 1975-76)

In exercising its coordinative and control functions, the Secretary's office is organized along programmatic lines. There are seven assistants to the Secretary, three with liaison responsibilities to departments and one with liaison responsibility to the offices attached to the Agency. One of these assistants also have over-all budgetary responsibility. These assistants function in a staff capacity to the Secretary.<sup>3</sup> The agency has six departments plus the new Department of Aging. In addition, it has five offices with program responsibility.

#### D. Operations

The Health and Welfare Agency was established at a time when public support began to mount for health and health-related programs. Three new state hospitals were built between 1953 and 1969, the Short-Doyle program was enacted in 1957, and Medicare and Medi-Cal were implemented during 1964-65. Categorical

<sup>3</sup> Health and Welfare Agency, Organization Chart, 1975.

During the last several years, the Legislative Analyst has been critical of agency operations because of increasing confusion on two major issues: failure to show in the agency budget activities and personnel budgeted to departments which are transferred into the agency, and the increasing assumption of operational authority through offices located in the agency and through interference with day-to-day operations in the department. The Analyst has recommended that agency offices be transferred to an appropriate operating department. We strongly concur.

#### E. Offices of the Agency

The Task Force studied the organization and activities of the four offices located within the Health and Welfare Agency, because of their close relationship to the over-all health programs in the state. This review included the following offices: the Office on Aging; the Office of Alcohol Program Management (OAPM); the Office of Narcotics and Drug Abuse (SONDA); and the Office of Educational Liaison. The following is a summary of our recommendations, discussed in greater detail in Part II.

#### 1. State Office of Narcotics and Drug Abuse (SONDA)

This Office, located in the Health and Welfare Agency, was established in 1970 by the Health and Safety Code to give public visibility to the growing drug abuse problem. SONDA is responsible for administering all drug abuse programs, as well as for planning, policy direction, program implementation, program evaluation, and administration of federal funds. In 1974-75, this program administered 40 million dollars of which 25 percent went directly to the Substance Abuse Program in the Department of Health and the remainder went to county programs. All of the programs of this office relate directly to and overlap with those of the Department--the Substance Abuse Program and the Mental Disabilities Program, which are responsible for providing comprehensive mental health and drug programs at the county level. The activities of this

Office fragment and confuse the delivery of comprehensive health care services and should be merged with those programs with the same responsibility in the Department of Health.

Recommendations

1. Transfer the SONDA program immediately to the Department of Health.
2. Place the SONDA program with the Substance Abuse Program and the Mental Disabilities Program in the Division of Community Services.

2. Office of Alcohol Program Management (OAPM)

The Office of Alcohol Program Management was established in 1973 as a planning and coordinating body of statewide alcohol related programs and to disburse state and federal funds to state and local programs. In 1974-75, the budget was for 27 million with 49 positions. The greatest portion of OAPM's budget goes to fund local alcoholism programs, in conjunction with the Short-Doyle mental health programs administered by the Department of Health. In fact, this program overlaps the substance abuse program of the Department of Health as well as the mental disabilities program, creating confusion and fragmentation of such services. There is no rationale for continuing to operate these health programs outside of the Department.

Recommendation

1. Transfer the OAPM program immediately to the Department of Health.
2. Integrate the OAPM program with the SONDA program in the Substance Abuse Branch of the Community Services Division.

### 3. State Office of Educational Liaison (OEL)

The Office of Educational Liaison, established by the Child Development Act of 1972, is responsible for the planning, development, and coordination of child development activities. The office coordinates child-oriented programs between the Departments of Education, Health, and Youth Authority; develops programs for expanding child care services; and administers the health manpower training programs for family practitioners. The programs which related directly to health manpower, originally placed in this office, should more properly have been placed within the State Department of Health. This office is scheduled for expiration in December 1975, and there is little reason to believe that it should be continued at this time. If the office were not allowed to expire, however, its activities should be transferred to the Department of Health.

#### Recommendation

1. Allow the Office of Educational Liaison to expire at the end of the legislative period on December 31, 1975.

### 4. Office on Aging

The Office on Aging has departmental status within the Health and Welfare Agency. This Office was created in late 1973 under the State Welfare and Institutions Code, Sections 18300-18356, with the responsibility for administering about \$20 million in federal funds for the aged, under the Older American Act of 1965. The Office provides consultative services for development and implementation of Community Service Planning and Nutrition Programs at the state and local level, disburses grants to local projects for nutritionally sound meals at low cost to elderly individuals, serves as a center for information on aging, and cooperates with federal, state, and local bodies

to promulgate effective programs for the elderly. This Office's programs for nutrition and aging are health and social services programs which duplicate and overlap activities in the Department of Health.

Recommendation

Because of the multi-faceted nature of this program it should be retained for the present as a direct responsibility of the Agency.

We recognize that the staff requirements of each Agency Secretary will vary. We also recognize that the Secretary must be granted a great deal of latitude in determining the relationship between the Agency and the operating departments. We therefore make the following observation about the Health and Welfare Agency:

1. The role of the Agency in relation to the Department of Health is not clear.
2. There is great confusion as to who has the responsibility for speaking out on health and related issues.
3. The Agency is far too deeply involved in operational problems of the Department.
4. The attachment of Offices and the designation of the Agency as a 'single State Agency' tend to divert the Agency from its original purpose.
5. Agency staff designated as liaison figures are functioning in such a way as to erode the authority of the Director in a number of programs located within the Department.

county institution must offer services superior to those available in the private sector for Medi-Cal recipients. This lesson has been learned in the State's only county prepaid plan--Contra Costa County.

- Care in county institutions is organized imperfectly, but dispersion of elements of comprehensive medical care is much less of a problem than in the fee for service sector.
- Integration of preventive services of county health departments and of community mental health programs is more feasible in a county prepaid plan than in a private plan in behalf of its enrollees, because these services are traditionally in control of county government.
- Decentralization of integrated ambulatory services can be planned and located in neighborhoods where the poor concentrate.
- As centralized county hospitals become obsolete, use of tax-supported district hospitals on a decentralized basis can be substituted, eliminating segregation of the poor in county hospitals. Common use of hospitals by the poor and other groups is no longer socially unacceptable.
- Inclusion of non-dependent enrollees from unions and the ranks of government employees can assure eventual integration of the poor and others in a prepaid health plan, especially if ambulatory services are also located close to the neighborhoods of these enrollees as well as those of the poor.

Under present circumstances, many problems persist for county institutions and many potential improvements are frustrated. The major problems which persist are, in summary:

The continued insistence by the Department that counties conform to regulations which, though appropriate to private providers, are either unnecessary or discriminatory when applied to the tax-supported institutions. These include overly complex eligibility processing,

Director's Office, because this function was viewed simplistically as a public relations and information service in the reorganization.

The openly stated administrative policy in the reorganized Department was that physicians and other health professionals are, in general, poor managers of programs, and that persons with management training and experience from other fields have to be positioned in the Department where they can exert control over the activities of health professionals.

The leadership believed that managers could succeed in operating complex programs without substantive technical knowledge in the health field.

Day-to-day management of programs is encountering a variety of obstructions which center in the Division of Administration.

Budget presentations are no longer made in person by Program Chiefs. Denials are made by memo and indicate fundamental ignorance of the purposes and conduct of programs; arbitrary, fixed reductions or limitations expressed in percentages are imposed, on all programs, with no consideration given for level of efficiency or performance; unreasonable delays in filling vacant positions occur because of an ineffective, centralized personnel processing system and recurrent freezes on hiring; the data processing function has deteriorated and mandated program reports are seriously delayed. The negotiation of contracts has become an exasperating experience, often forcing local programs to risk audit exceptions for expenditures made beyond contract expiration dates to avoid disruption of services. Requests for management consultation often go unheeded.

Several dentists are employed in the Medi-Cal program for case review, but no organized program of prevention exists in this entire program.

The intent of the Legislature in reviving the dental health unit is clearly not being fulfilled by operation of a unit far too small to cover state-wide need.

A task force report for the Secretary of the Health and Welfare Agency is in preparation. We trust that it contains a plan for providing the Dental Health Unit with the size of staff, including dental professionals, commensurate with the responsibilities vested in the department to consult and promote a much needed program of prevention and treatments, especially to disadvantaged populations.

The Contract Counties and Rural Health Unit play complimentary roles in attempting to address the needs of rural communities in the State. No matter how one views the distribution of resources of the state health department, the rural counties of the State are not being treated equitably. Distance, terrain and technological advancement combine to make effective services in the rural setting very difficult to accomplish. Scarcity of resources compound the problem of bringing services to rural Indians, agricultural workers, and migrants--whether they are seeking work or recreation.

Both contract services and the rural health unit need an expanded staff and program capacity, with assurance that staffing assistance for service in the counties is given the first priority. We urge an evaluation by the department of the percent of total effort expended in service to rural counties, and an expansion of effort commensurate with the urgent and strategically difficult task of improving access to health services in the rural setting.

regional centers have not contracted for these program services, choosing to "opt out" and provide their own social services.

State Hospitals: The State Hospital Division serves those individuals who are severely retarded and for whom community facilities and programs are unavailable. The programs include education, training for independent living, specialized medical and rehabilitative services, and other treatment programs. In 1974-75, approximately 10,200 patients in nine state hospitals participated in this program.

#### 4. Client Population and Eligibility

A generally accepted definition of developmental disabilities are those disabilities attributed to mental retardation, cerebral palsy, epilepsy, autism, or other neurological conditions closely related to mental retardation. Mental retardation describes those individuals with sub-average general intellectual functioning which originates in the individual's developmental period and is associated with impairment in adaptive behavior. These impairments are considered to be of life-long nature and may frequently be associated with multiple handicaps including blindness, deafness, and physical deformities. Estimates of incidence in the population range from one to three percent. There are so many agencies involved in serving this population that no accurate assessment has been made as to how many clients are currently being served nor how many are in the population unserved.

#### 14. Regional Center Operations

The regional centers have serious management problems--misuse of funds, mismanagement of contract services, conflict of interest in contract services, fraud by vendors, abuse of patient rights by vendors, excessively high salaries, financial exploitation by physicians, and unfair hiring practices.

Regional centers receive line-item budgets and are expected to make expenditures in accordance with their budget allocations. A recent audit in one regional center found \$44,000 in audit exceptions for fiscal year 1973/74; another had exceptions of over \$100,000. Other centers are currently being audited by the Department of Benefit Payments. One cited multiple misuse of funds--false and fraudulent travel claims had been submitted, kickbacks of travel claims made to a center director, misappropriation of building funds, fraudulent use of building rental monies, misuse of consultant funds, hiring of relatives at high salaries, and misuse of funds to pay an attorney representing an employee charged with fraud and abuse of funds. These audit reports are to be found in the files of the Department of Benefit Payments.

A recent audit of another regional center found discrepancies in the accounting system and funding allocations between the regional center and its parent corporation. For example, the parent corporation utilized the regional center staff for its own activities and failed to keep accurate records which would distinguish expenses of the center from those of the parent corporation.

There are many instances of conflict of interest in contract services between regional centers and vendors and the parent corporation. One regional center under contract to a parent corporation (which contracts with the state for

private practice while salaried as full-time employees. In one case, a regional center director (employed as a full-time physician/director) conducted a private practice at the regional center for ten percent of his salaried time. He made use of regional center staff and facilities, and then billed the state Medi-Cal program for the private services provided. Although the state was unaware of this arrangement, the director stated that he was hired on this condition. He continues to function in this manner even though Department of Health officials are now aware of the situation. Other fulltime professionals make large incomes from Medi-Cal practices-- a departmental violation. Another regional center audit recently revealed that the director, his secretary, the accountant, and other employees who were hired as full-time staff were devoting portions of their time to other programs administered by the parent corporation without reporting this activity. Again, this represented a fraudulent use of regional center funds. Other professionals self-refer regional center patients to their own private practices.

Regional center operations, because of their private agency status, have not been subjected to state civil service requirements of fair hiring practices and policies, such as open advertising and open competition for employment. In contrast, some regional centers flagrantly hire relatives and friends. The absence of minority staff also suggests that active affirmative action programs do not exist, that discriminatory practices may be in effect. Even though staff have requested comprehensive studies of all personnel hiring and promotion practices and salary structures, the administration of the Community Services Division has refused.

The misuse of funds, decline of services, runaway costs, and management problems are a direct result of ineffective administration of the regional centers. State officials have demonstrated little desire to

placement. Placement in state hospitals is paid by Medi-Cal and the State General Fund, so does not require regional centers to contribute contract money. Other regional centers have established policies to only spend a certain portion of their funds on residential care, and thus, they may send patients to state hospitals when funds for placement are low.

The financial impact of the state paying for state hospital services in instances where clients could be maintained at home or in less costly community care facilities is, of course, great. For example, the base cost for maintaining a client in a family care home may be as little as \$600 per year, in addition to the funds received by the individual from Social Security, while the cost in the state hospital is \$40-\$50 per day, of which Medi-Cal pays \$19.85 per day, and the remainder comes from the State General Fund. Thus, alternatives to state hospitalization must be developed to control state medical costs and a system of incentives developed for regional centers which will encourage them to avoid placement of clients in state hospitals when other appropriate resources are available.

#### 18. Recommendations

##### Administrative Organization

1. Immediately re-integrate state hospital services for the developmentally disabled with developmental disabilities services in the community.
2. Rename the Community Services Division to more accurately describe its activities, Mental and Developmental Services Division.

This program, in operation since 1946, is provided through contract arrangements with local mental health programs of counties. The program is carried out by a staff of about 500 individuals including psychiatric social workers, nurses, therapists, and other professionals serving 13,000 mentally disabled clients. The program is oriented toward welfare-linked clients since it is supported by Title XX funds from the Social Security Act. Fourteen counties have opted out of this program, and have established their own social services program.

**Special Services:** This section is designed to assist and advise the local program field staff in developing coordinated services and establishing and approving local program funds selected specialty areas. This section was initially created to provide special consultation on service aspects which are not a routine part of the programs offered by community mental health services. The fifteen professional staff specialists in this section include the areas of social rehabilitation, aging, vocational rehabilitation, children and youth, Indian health, patients' right, and prepaid mental health systems. This staff administers the 314(d) grant funds, holds seminars, and assists in applications for acquisition of special federal monies. They also review local mental health programs.

**State Hospital Program:** The State Hospital Program, now located in the State Hospital Division, includes state treatment programs for 6,600 mentally disabled patients located in six hospitals throughout the State. This program for mentally ill patients had decreased to 6,300 patients in December 1973, but has gradually increased in numbers since that time. The program includes

special treatment programs for children and adolescents, drug abusers, alcoholics, aged, adult mentally ill, and penal code commitments.

#### 4. Client Population and Eligibility

The clients in the mentally ill program include about 1.5 million individuals, who receive services ranging from counseling, hospital care, to acute medical and emergency care. The programs include every category of the mentally ill and emotionally disturbed, as well as substance abusers. Most clients are adults and many are substance abusers, while children and youth and elderly clients comprise smaller percentages of the total clients.

It is the policy of the Department of Health that mental health services supplied by the Department of Health and Community Mental Health Programs shall be charged for in accordance with the Uniform Method of Determining Ability to Pay (UMDAP).<sup>1</sup> (This policy was developed in accordance with provisions of Sections 5717 and 5718 of the Welfare and Institutions Code.) It is also departmental policy that no person shall be denied service because of ability or inability to pay, and that the amount paid shall not exceed the cost of services received. Charges are based on family size, income assets and allowable deductions, and average expenditures by family size and geo-economic area. The intent of UMDAP is to maximize third party payments and reduce State General Fund money. The CCSS program requires eligibility guidelines in line with Title XX, designed primarily for disabled clients.

---

<sup>1</sup> State of California, Department of Health "Uniform Method of Determining Ability to Pay for Community Mental Health Services," June 1, 1973

## 5. Financial Resources

The total budget for the mental disability program, including that of the state hospital program for 1975-76, is about \$289 million. This includes 182 million for local programs, 10.6 million for continuing care services, .9 million for administrative and special services, and 86.5 million for state hospital services. Income for the continuing care program is primarily from Title XX. Local programs are funded primarily by the State General Fund with 10 percent matching money from the counties. Revenues are generated to pay for about 43 percent of the local program cost, and come from patient fees (3%), insurance (3%), grants (7%), Medi-Cal and Medicare (22%), federal funds (4%), and other (4%). Funds for the state hospital program come from the State General Fund and the Medi-Cal and Medicare program, as well as patient fees.

## 6. Providers of Service

A community mental health service may contract for services and facilities with any public or private hospital, clinic, laboratory, agency or facility. Each county program compiles a list of contract providers and the services provided for the Department on an annual basis. The list of direct treatment facilities and indirect service providers includes all types of agencies and facilities which provide the inpatient services, outpatient services, residential care, day treatment and rehabilitation, crisis intervention, suicide prevention, vocational training, counseling, screening and diagnostic services, education, emergency care. Facilities include hospitals, clinics, group homes, nurseries, rehabilitation centers, day care homes, workshops, recovery houses and half-way houses.

for short term care are estimated to cost state hospitals about \$110-\$115 a day, or as much as short-term admissions in acute general hospitals. If the state hospitals were utilized only for longer term care patients, and had a policy of not admitting the 72-hour patients, the state hospital costs would be reduced considerably. This would facilitate the early release of patients who do not need hospital care, probably reduce the over-all utilization of inpatient services.

Alameda and Los Angeles utilize Napa and Metropolitan State Hospitals, respectively, for short-term acute care patients. Since these counties do not have a shortage of hospital beds for patients, they should be required to use local hospital beds for short-term admissions. Counties such as San Francisco which over-utilized state hospitals, should develop adequate intermediate care facilities. Measures are needed to reduce state hospital utilization and over-all costs even though pressure to use them inappropriately still comes from some counties.

Another potential for reduction in state hospital admissions is the creation of incentives to families to keep certain patients in the home. In-home health services and homemaker care hold the promise of assisting families with successful home based treatment.

In general, the State has not shown either initiative or imagination in the creation of humane alternatives to various environments now in use, which plans have a suffocating impact on patient potentials for rehabilitation and self-care.

Resolution of these issues is highly dependent upon the personal relationship between the hospital administrator and the medical director. As a result, the division chief at headquarters is often the lowest level of decision making on issues that can not be resolved between the two managers.

In some cases, dual administrators have worked out fairly well, while in others either the medical director or the hospital administrator has assumed a dominant role.

Those who work with the hospitals at both the state and local level were in general agreement that dual administrator concept is both confusing and difficult to work with. With no single person having over-all responsibility it is often necessary that both administrators be contacted on particular issues.

There is a general opinion on the part of department managers that there are a few hospital administrators and medical directors who are very effective and could do a good job of managing both administrative and treatment functions. They point out that professional training alone does not insure that a person will be an effective hospital manager.

#### Recommendations

1. Propose legislation to establish a single person as director of each state hospital.
2. Establish as the primary qualification knowledge and professional experience in the field of mental disability or developmental disability.

#### 4. Quality of Care Standards

Living conditions and standards of patient care in state hospitals are too frequently below minimum licensing standards. Licensure reports show numerous violations of fire, life safety, and seismic standards as well as staffing standards, and patient care standards.

According to licensing survey reports of state hospitals, physical plant deficiencies include those for emergency electrical power systems, equipment to maintain fire detection, alarm and extinguishing systems and life safety support systems. In addition, some facilities have locked rooms, exit doors, corridors, yards, and areas not approved by the Department which conflict with safety and fire standards. Most facilities lack a signal system for visible and audible communication between the nursing personnel and patients.

Many wards have large numbers of patients' beds that exceed the units' rated capacity for patients. And the patients' rooms do not provide adequate floor space required by regulations. In addition, there are no provisions for isolation of patients as necessary with private toilets and handwashing facilities when necessary for treating infectious diseases. The ventilating systems in some housing units are inadequate to maintain a comfortable inter- for temperature, especially during the summer. Other units lack handrails and special equipment for handicapped persons. Visual privacy for patients is not provided in patient rooms, tubs, showers, or toilet facilities. These are only a few of the essential requirements with which the State has not yet complied.

licenses at that time. During the summer and fall of 1975, the Licensing and Certification Division conducted surveys of the state hospitals, except for Metropolitan which was surveyed by the Los Angeles County Department of Health by agreement with the State Department of Health.

Again, all of the state hospitals except for Porterville were found to have substantial deficiencies with state licensure laws. Because of the pressure to have the hospitals certified for Medi-Cal purposes, the State Licensing and Certification Division, with approval of the H.E.W.'s Region IX Office, have granted waivers for some areas of non-compliance and a provisional agreement was granted because the hospitals established plans of corrections for the violations.

The State Department of Health is definitely in a conflict-of-interest situation in granting licensure and certification to its own state hospitals.

The pressures for licensure are substantial because federal Medi-Cal funds (estimated to be at least \$35 million) are in jeopardy. It is questionable that the state hospitals would receive licensure and certification if they were in the private sector rather than owned by the State. A double standard has been applied; standards for the state hospitals are less stringently enforced than those licensure and certification standards applied to the private sector. There can be little justification for the State Department of Health approving licensure and certifications for its own hospitals. Instead, licensure and certification should have been conducted by the federal government's H.E.W. Region IX Office, under an agreement by the State.

## Recommendations

1. Ensure that the State Department of Health enter into an agreement with the federal H.E.W. Office to independently conduct licensing and certification reviews of the state hospitals.
2. Apply licensure and certification standards for state hospitals in the same manner as for the private sector's facilities.

## 6. Treatment Modalities

State hospitals utilize a variety of "behavioral modification" techniques for increasing and decreasing the frequency of behavior, including procedures such as "time out". Time-out is utilized "to arrange the environment so that as many or all positive reinforcers are withheld" and this may be achieved by a variety of methods and devices, including: <sup>1</sup>

- (a) ignoring patient's behavior
- (b) removal of reinforcing objects such as toys, tokens, etc.
- (c) turning patient to face away from the group
- (d) removal from the group. This is accomplished in a highly impersonal manner with no eye contact, no speech, and minimal physical contact
- (e) removal from room to another area
- (f) a bib, pillow case or blanket, loosely placed over the patient's head to eliminate a visual reinforcement, sometimes called "sheeting"
- (g) temporary removal of food tray when patient is disruptive during meals

The hospital policy and procedure manual states that time-out should not be utilized for more than a one-hour time period. Time-out was designed

---

"Policy and Operations Manual." Fairview State Hospital, Costa Mesa, California, June, 1975, #5, 1, 9, 8..

as a behavioral modification technique for use by trained staff members, who must be in constant attendance of the patient during use of the procedure, according to the manual.

Another technique used for behavioral modification is that of restricting the client's use of facility grounds. For example, patients whose behavior is disruptive in certain locations, such as the canteen, may have that location placed as "off limits" for certain time periods. Or patients may be restricted to the ward area.

Adversive conditioning is a behavior modification technique designed for use in cases where other techniques are not effective; for example, in some instances of severe self-abuse or aggression toward others. According to the manual, this approach may involve:<sup>1</sup>

the use of a mild, battery-generated electric stimulation to the client's skin at the onset of the behavior or immediately following. This mild shock is usually aversive to the client but causes no damage. Very special controls are to be observed when these techniques are used.

The manual states that the use of aversive therapy must be a very carefully controlled, non-rewarding event designed to eliminate a selected behavior. Another technique of aversive conditioning approved for use by some hospitals is that of splashing water on the client at the onset of the unwanted behavior.

Our review of treatment modalities utilized by state hospitals certainly raises questions as to the legitimacy of many behavioral modification

---

<sup>1</sup> "Policy and Procedure Manual." op.cit., p. 5.1.9.8.3.6.

treatments as well as the actual practices of treatment modalities in the hospitals. First we find that while behavioral modification is a common treatment, the hospitals each have their own policies and procedures. No standard policy has been developed for the state hospital system as a whole which ensures minimum standards. Although the Division is establishing a policy which will ensure minimum standards and minimum protection of patient's rights in requiring written consent by parents or guardians, these standards will only be minimal and no enforcement of such a policy is mandated. We support the Division's efforts to establish policies and their concern for patient's rights.

The Commission expresses concern, when informed by task force members, about the use of "sheeting" and aversive conditioning. Professional nursing consultants in the licensing division of the Department of Health stated that their observations are that behavioral modification techniques on patients are utilized by unskilled staff and that such treatments are sometimes inappropriately utilized. At one hospital, the consultants found that care plans for use of such techniques are not available, that staff appeared to utilize techniques as sheeting frequently without established plans. Qualified nurses and psychologists or other professionals are not available or in charge of such treatment programs. Some indicated that the "treatment" experience is extremely threatening to patients under certain conditions, in that if materials for covering the client's head are placed tightly over the head, the patient may have the sensation of suffocation, strangulation, or dizziness. In other cases, staff noted that patients are restrained with leather cuffs which may be attached to benches or chairs, and this may occur at the same time that "sheeting" is utilized. Certainly, the use of leather restraints, considered an inhumane practice, should be examined as well as practices of "sheeting".

These are some of the violations of patients' rights which still occur in the state hospitals. All such violations must be eliminated in order to protect patient rights, comply with state and federal licensure regulations, and protect the institution from lawsuits by patients.

The State Department of Health has been preparing regulations for protection of patient rights, and preliminary regulations were approved by the Conference of Local Mental Health Directors in June 1975. These regulations are currently in the hearing process and will probably be approved in the near future. We commend the Department for its efforts to develop procedures which will eliminate the violations of patients' rights and for efforts to establish patients' rights advocates at each state hospital. Such activities should be more vigorously pursued in the future. Once regulations are adopted, independent reviews should be made on a periodic basis of all policies and practices regarding patients' rights at each state hospital to ensure full compliance with regulations and to revise and improve upon such regulations. We suggest that an additional mechanism be established to ensure that patients have the right to discuss their concerns and grievances with a representative of their choice and/or an ombudsman outside the state hospitals and the State Department of Health.

#### Recommendations

1. Adopt written statements of the policies and procedures which protect the rights of patients.
2. Establish training programs for patients and employees in regard to these rights.
3. Hire special staff to carry out such training.

4. Establish a system for periodic review of patients' rights and procedures, utilizing the special teams from the Licensing and Certification Division, to monitor the implementation of patients' rights and procedures in the state hospitals.
5. Study the feasibility of establishing a special ombudsman outside of the Department of Health and the state hospitals so that patients can obtain counsel and support in adjudicating grievances against a state hospital.

#### 9. Community Placement

State hospitals are charged with the responsibility for working with local and state agencies for an early discharge of patients, appropriate placement of patients in the community, and continuity of care from the hospital to the community. Each hospital has an office for community liaison and for coordination of admissions and releases. The effectiveness of such services varies from institution to institution. We received complaints about the ineffectiveness of hospital services for community liaison and coordination in some instances.

The low discharge rate of patients at some state hospitals is of concern. For example, Sonoma State Hospital for the developmentally disabled, with a patient population of 1,965 in 1974-75, placed only 113 patients in the community. Of this number, many were re-admitted to the hospital. Thus, the hospital is reporting a discharge rate of about six percent of their patients during a year, and a high return rate. Staff indicated that they do not vigorously pursue placement of patients even when the latter appear

ready for discharge. The policy in one program is to let the patients initiate efforts for their own return to the community. However, these efforts are not adequately supported by community service staff.

Administrators in the state hospital program admit that their placement efforts are not as effective as they could be. Some staff have a tendency to want to keep patients rather than to have a large patient turnover. For example, because some hospitals have no waiting lists for patients to be admitted, staff are concerned about keeping beds full in order to maintain full employment. The low rate of discharge is due to a variety of factors, some of which can not be controlled. However, there does not appear to be adequate justification for the very low rate of discharge and successful community placement.

#### Recommendations

1. Re-evaluate the system for discharge of patients and develop policies which will maximize patient discharge and community placement.
2. Develop a more effective system for the review of each individual patient's progress which includes plans and goals for the discharge and community placement of each patient.
3. Review the discharge and community placement records and evaluate the effectiveness of each hospital, taking steps to correct barriers to placement.

The investigation activities for Prepaid Health Programs (Alternative Health Programs) were placed in the PHP section and removed from the Investigations Section in the Spring of 1975. This gives the investigation section of PHP the role of investigating its own providers and no autonomy from the program. There seems to be little justification for splitting investigation activities between divisions, and it only adds to the program and organizational confusion.

The Investigations Section is currently burdened with administrative duties in relation to beneficiary overpayments. This activity is apparently of a routine clerical nature which could be assigned to the county welfare departments who now complete the eligibility screening and are identifying cases of overpayment due to ineligibility. There appears no reason that routine cases of overpayment should be handled by the Investigations unit. The unit should be assigned only responsibility for special investigative work related to fraud and abuse.

#### Recommendations

1. Centralize all investigation activities involving providers in the Investigations Section.
2. Handle only cases of fraud and abuse in the unit and not cases of routine overpayments of beneficiaries.
3. Transfer the Investigations Section to the Director's Office where it can relate directly to the legal office and have program autonomy.

d. Construction: The Facilities Construction Section has functions which overlap with other programs in the Division and the Department.

offices are all involved with licensing activities: the Licensing Section Office, Berkeley; Services Approval Office, Berkeley; Investigations Office, South San Francisco; Medical Social Review Team Office, Oakland; and CCSS offices in San Francisco and Oakland. Such offices could easily be combined within one geographic location to facilitate coordination, cooperation, and communications, as well as to be more accessible to the public.

Second, District offices are operated with separate administrations for each of the sections, except for provider participation which is located only in the headquarters office. The cost of having multiple administrators for different sections with overlapping functions is an obvious inefficiency. Having one administrator for a combined district operation would provide benefits in reducing administrative staff, but also could be expected to improve the coordination, communication, and cooperation of staff in the district offices. The many different district and field operations within the Division makes accountability for program functions more difficult because of confusion of responsibility for field operations.

While there is considerable resistance within the Division against consolidation of administrative activities of the Licensing Section, the Services Approval Section, and the Provider Participation Section, we could not find reasons for not merging these sections. These three sections all provide essential licensing services which are closely inter-related. Thus, we believe that efficiencies in administration as well as better coordination, cooperation, and communications would develop if these sections were combined for administrative purposes.

The administration and operation of the licensing section is divided into two groups: (1) health facilities staffed by Health Facilities Representatives (HFRs) and Registered Nurses; and (2) community care facilities staffed by Social Workers and community program analysts. The same professional divisions in licensing staff exist now as before the 1973 reorganization.

With the merger of staff from three different departments, an immediate problem arose in that the salaries of HFRs and Registered Nurses from the former Department of Public Health were somewhat lower than the salaries of social workers from the former Department of Social Welfare, while the highest salaries were given to community program analysts who were from the former Department of Mental Hygiene. All staff were assigned to do essentially the same work activities but were given different pay schedules for different background requirements. The Licensing administration has attempted to work with the Personnel Section in the Division of Administration for the past two years in an effort to correct what appears unequal pay for equal work, and yet no progress has been made.

The Health Facilities Representatives (HFRs) are not required to have professional health experience although they may have health administrative or medical corps experience. Many employees in this category are retired military inspectors or administrators. The health facilities association and health professionals within licensing complain that many of the surveyors

c. **Professional Leadership:** Poor professional leadership within the Licensing and Certification Division has lead to administrative footdragging in establishing and enforcing regulations, greater emphasis on health than community care facilities regulations, little enforcement of day care regulations, bureaucratic rigidity in the development and enforcement of regulations, and avoidance of licensing activities for special types of facilities.

As mentioned earlier, the latest licensing laws were two years old before the Division developed and implemented its regulations. Many of the staff attribute the delays to poor leadership by the top administrators within the Division who have little background knowledge and professional experience with health programs or with licensing activities. In addition, the administration did not fully utilize the talents of its professional staff in developing the regulations and attempting to implement the regulations earlier, according to most of the staff interviewed. In fact, staff without either professional or licensing expertise were recently utilized for developing regulations. Because of the delays, and what many staff consider to be weak and rigid regulations, the morale within the Division is reportedly at a low point. Field staff also complain that as the ones most knowledgeable about the program, they are not consulted and have little input into policy decisions or regulations.

The staff in licensing who work with community care facilities are deeply concerned about what they term a neglect of the community care facilities and regulations by the Division. Most community care licensing and enforcement activities are delegated to the counties, but the state licensing section has never monitored the activities of the counties to determine the extent to

g. Administrative Staff Surplus: The Division has an excess of administrators within the Licensing and Services Approval Sections located in headquarters who apparently have minimal responsibilities and authority.

In reviewing the activities of administrative support staff in the division headquarters office, we found a number of administrators who appear to have minimal responsibilities. Licensing has 30 professionals and Services Approval has 6 professionals located in their headquarters offices. These administrators generate their own workload and seem to add to the bureaucratic confusion of the office. Some administrators state they are unhappy with their assignments in that they are given little responsibility and all decisions are made by the section chiefs. In some cases, this appears to be a situation where ineffective administrators were 'kicked upstairs' to the headquarters office, where they are given busywork with little responsibility and no authority. Some of the work within the licensing section appears to be conducted by task forces, by-passing the administrative support staff. Certainly, the responsibilities and authority of administrators within the headquarters units of Licensing and Services Approval are unclear and confusing.

#### Recommendation

1. Conduct a complete desk audit of the functions, responsibilities, authority, and the professional qualifications of all administrators located in the headquarters office of Licensing and in Services Approval.
2. Substantially reduce the administrative bureaucracy located in the headquarters office of Licensing and Services Approval, placing such individuals in field operations with specific job assignments.

6. Maximize the utilization of professional staff within the division in policy-making decisions and in developing and implementation regulations.

d. District Operations: The district managers are not given authority for their operations and the support services which would allow them to make personnel, budgetary, planning, audit, and legal decisions.

The District Managers are given responsibility for their operations but do not have staff to assist them with personnel problems. Personnel problems are handled within the Personnel Section of the Administration Division. An inadequate understanding of the licensing program needs and perhaps a lack of time allotted for assisting the Licensing Division has created many problems, such as those described earlier in this section, with unequal professional salaries, inappropriate use of personnel classifications in hiring, and difficulty in resolving personnel problems.

District managers, in fact, appeared poorly informed as to which administrators made certain decisions and how the decision-making process was conducted. During the period of time of our study, several administrative decisions, such as the decision not to transfer the MSR teams to the licensing section as previously planned, were made by headquarters. The district administrators were told, but did not have a clear understanding as to the reasons for the decision, were not involved in discussions about the decision, and did not even know which administrators made the decision. This indicates that information channels to the districts are not well established and certainly that district administrators are not involved in decisions which affect them, let alone field staff involvement.

Another problem is that the federal government is threatening to discontinue reimbursement for the social service activities of the state conducted by the counties because of poor record keeping and claims procedures, and/or time studies to justify the reimbursement rates. Such poor administrative procedures threaten 7-8 million dollars in federal income to the counties.

The fiscal staff within the licensing division report that they do not understand the current reimbursement procedures for the Federal Social Rehabilitative Services funds which are given for the surveys of community care facilities. Certainly confusion over method and amount of federal funds indicates a need for careful study and improvement of management techniques within the Division.

#### Recommendation

1. Conduct a study of federal fiscal financial procedures and methods to determine how the State can better meet requirements in order to achieve adequate reimbursement for federal licensing activities.
2. Conduct periodic time studies to determine the time requirements for federal regulations and activities for various procedures by professional staff to justify reimbursement rates.
3. Conduct a complete study of staff accounting activities to determine the most efficient method of accounting for reimbursement purposes.

for indigent medical care, but does not define that responsibility clearly, hence the confusion and inequity.

Responsibility for determination of eligibility status is now divided amongst county, state, and federal government.

Counties process cash grant applications and those for medically indigent and medically needy. The state certifies eligibility from information sent by counties, and records eligibility status in a central identification file located in the Department of Benefit Payments. This department supplies the Health Department with this eligibility file and stickers and cards are mailed monthly to recipients. However, this system is remarkable in that the Health Department issues cards without validation of current eligibility status, making the assumption that the central identification file is accurate, a questionable assumption at best.

The transfer of adult categories to Social Security under the Supplemental Security Income program (SSI) and passage of a State Supplemental Plan (SSP) has displaced an unknown number of adults from Medi-Cal eligibility by increasing their income just enough to make them ineligible.

At present, the Social Security Administration is determining eligibility in adult categories, again without state validation of eligibility status!

To add to the confusion, eligibility standards for other programs of the Department are inconsistent with Medi-Cal, in terms of income, resources and level of liability for part payment by patients for services. Therefore, other programs pursue Medi-Cal reimbursements with varying skill and success for caseloads which "cross over" into Medi-Cal eligibility. These programs

**ENVIRONMENTAL  
HEALTH SERVICES  
BRANCH**

<p style="text-align: center;"><b>Food and Drug Section</b></p> <ul style="list-style-type: none"> <li>. Food Control</li> <li>. Drug/Medical Device Control</li> <li>. Product Safety Control</li> <li>. Cannery Control</li> <li>. Health Fraud Control</li> </ul>	<p style="text-align: center;"><b>Radiologic Health Section</b></p> <ul style="list-style-type: none"> <li>. X-radiation Control</li> <li>. Radioactive Material Control</li> </ul>	<p style="text-align: center;"><b>Water Sanitation Section</b></p> <ul style="list-style-type: none"> <li>. Domestic Water</li> <li>. Domestic Sewage</li> <li>. Disposal and Safe Use of Reclaimed Water</li> <li>. Recreational Water Sanitation</li> <li>. Shellfish Sanitation</li> </ul>	<p style="text-align: center;"><b>Occupational Health Section</b></p> <ul style="list-style-type: none"> <li>. Field Studies (Compliance)</li> <li>. Standards Development</li> <li>. Training, Consultation, and Evaluation</li> </ul>
<p style="text-align: center;"><b>Vector Control Section</b></p> <ul style="list-style-type: none"> <li>. Vector Surveillance and Suppression</li> <li>. Hazardous Waste Management</li> </ul>		<p style="text-align: center;"><b>Sanitation Services Section</b></p> <ul style="list-style-type: none"> <li>. Local Environmental Health Program Development</li> <li>. Sanitarian Registration</li> <li>. State Institution Surveillance</li> <li>. Housing Health Component</li> </ul>	

The statutory base for the above activities has been built up over the years to include for the:

1. Food and Drug Section, powers to "investigate preparation, sale and adulterations of drugs and food; . . . . administer and enforce Penal Code Provisions relative to foods and drugs; . . . . enforce laws pertaining to adulteration, standards of identity, and labeling of bakery products; . . . . license and inspect cold storage businesses . . . . canneries . . . . drug and

A commitment to reestablish professionalism and vigorous leadership in attacking California's health problems within the Environmental Health Services Branch is the major need. Advancing technology is creating new health hazards in the work place, air, water, food and other aspects of the environment. State government must proceed to protect the public health against these hazards in the future as in the past. In California the environmental health guard has obviously been lowered.

While organization for environmental health is not ideal, especially in the relationships existing between the Department of Health and other units of State government, the situation is not critical. Immediate changes are not indicated.

#### Recommendations

1. Commit the Department to rigorous study of environmental health problems, those present and those emerging, and the development of programs to deal with these problems.
2. Re-establish professionalism and leadership in the Environmental Health Services Branch.
3. Examine critically the present organization of state government for protection of the public against environmental health hazards, with a view toward improving particularly the arrangements in regard to pesticide control and occupational health.

10. To provide support services relating to space, clerical support, and business support services.
11. To provide disability evaluation program services to disabled individuals.
12. To assure the dignity of the disabled individual is maintained.

### 3. Division Components

Financial Management Branch: This branch is responsible for administration of the fiscal resources and related activities in the Department. They include accounting records (both Department of Health and Patients Assets), analytical determination of provider reimbursement rates, and contract/grant management.

Management Systems and Computer Services Branch: This branch provides consultation to management for the improvement of program methods and procedures; system analysis support for the design and implementation of both manual and computer based systems; and data processing services. In addition, health statistics--both public and departmental--are provided by components of this Branch.

Manpower Administration Branch: This branch provides personnel services to departmental employees including recruitment, training, employee safety-health, employee rights and employee-employer relations. Also included is a component which deals with the health manpower development aspects of comprehensive health planning.

Program Services Branch: This Branch provides business and office support, office and laboratory space, and facilities construction and repair services to the Department.

Disability Evaluation Branch: This branch, under contract with H.E.W., makes determinations of medical disabilities under the provisions of the Social Security Act. Those claimants who demonstrate a potential for rehabilitation are referred for vocational rehabilitation services. This branch maintains six regional offices throughout the State.

Information Systems: The Department spends over \$23 million annually on automated information and processing systems, and an untold amount on manual information systems. Program managers and officials outside of the Department reported consistently that they can not obtain basic information necessary to the performance of their responsibility.

The problems of the Department are similar to those which affect other departments. Problems include lack of long-range planning at either program or the Department level; piecemeal approach to development of information; unrealistic time constraints; limited resources; unwillingness by users to participate in system design; and poorly designed systems. Information systems are often initiated unilaterally by program and staff personnel, through one of several offices: the Management Consultation Section, Systems Analysis Section, or the Center for Health Statistics without coordination.

Traditionally, the State has attempted to control the proliferation of automated program by limiting the size of the data processing budget. Typically, the programs compete for this limited resource, on a first come, first served basis. Consequently, certain programs have developed overly complex collection of data which is poorly used; others proceed without even a primitive attempt at essential collection of data.

Systems analysis and data processing personnel are required to defend the inadequacies of information systems which they take little part in designing.

On July 14, 1975, the Department adopted criteria for defining data processing project priorities. Division chiefs were asked to appoint an EDP liaison representative in each Branch to coordinate EDP activities for their Branch. These are steps in the right direction. However, it is clear that the Department will not be able to manage its information systems effectively or meet its information needs until an information system plan is developed at the program level. Ultimately, program managers must assume the primary responsibility for the design and effectiveness of information systems and EDP specialists for processing information in a timely fashion.

#### Recommendations

1. Develop a long-range plan for an integrated health information system for the Department. This plan must identify information needs so that both manual and automated systems can be developed and applied on a more logical basis.
2. Clarify the roles of management consultation, systems analysis, data processing services and the Center for Health Statistics in this effort.

parts to the administrative functions in such areas as personnel, budgeting and data processing. However, many have not recognized that under normal conditions, the workload of the support services are heavy and that the problems compounded by consolidation rendered the Administration Division nearly dysfunctional.

Most managers in Administration admit that they have become too control oriented, many times out of necessity, and are now discussing ways to bring about a better balance between service and control. In October of this year, the Division announced that both the budget and the personnel roster had finally been reconciled. A priority system has been adopted to allocate the limited resources for automated data systems. Accounting is attempting to implement a system, before the end of the year, to provide program managers with accurate expenditure reports. Even though this Division still faces many problems, it appears that it is beginning to move in a positive direction. In order to do so, management must recognize that capricious organizational changes have an untoward affect upon budgeting, personnel and accounting. These functions need to be included in the planning of such changes from the outset.

#### Recommendations

1. Shift the control of program resources from Administration to the programs.
2. Have the Administration concentrate on developing uniform administrative policies and procedures, and on increasing the level of service to programs.

3. Evaluate the need for administrative support positions at the program level and establish, if justified, particularly in the areas of budgeting, personnel, data processing and business services.
4. Ensure that future reorganizations within the Department will not be implemented until key administrative functions have been fully involved in the planning of such changes.
5. If the regional organizational structure is adopted, fully decentralize administrative functions and staff.

#### 5. Contracts

The Department of Health expends over a half a billion dollars annually in contracts with public and private agencies and with individuals. The quality of most contracts is below standard and time consumed in completion is beyond reason (median is five months).

The initiation and processing of contracts is disorderly, time consuming and diffuse. Programs do not assume the basic responsibility for assurance that contracts are drawn to require adequate measures of quantity of output or integrity of performance and are difficult to evaluate. Once designed, contracts are sent on a long journey through the departmental system: to the budget section, accounting, legal affairs, financial management, and then outside the department to the Department of Finance or to the Department of General Services. Twenty-five percent of contract proposals are rejected outside of the Department of Health and are returned for revision and repeat processing.

2. Impose clear standards on the programs for service contracts and supply them with technical assistance in the legal and technical aspects of the contract process.
3. Charge the Division of Administration with the job of developing standards applicable to fiscal and accounting reports for service contractors.
4. Make standards for accountability for program planning and evaluation equivalent for contractors as well as for direct operations within the Department of Health.

## 6. Personnel

Of all the functions in Administration, departmental employees and managers complained more about the personnel functions than any other area.

Employees complained about payroll, promotional and classification problems. Managers complained about lengthy delays in the establishment, reclassification and filling of positions. Many accuse Personnel of being an extension of the State Personnel Board and being more concerned with meeting the Board's needs than the Department's needs.

The impact of consolidation was probably felt more by Personnel than any other administrative function. When consolidation took place, the Department's

budget was reduced by 505 positions. Employees in these positions were not laid off, but merely shifted to other sources of funding. Health Care Services had approximately 400 positions paid from temporary help funds, many of which were permanent employees. In addition, there began a constant shuffling of employees within the Department.

As an example of the workload, a comparison was made between the General Personnel Services Section and the Departments of Cal Trans and Employment Development. This section performs personnel support services for headquarters and field offices except for state hospitals. The comparison shows that this section has one roster clerk for every 210 employees, compared to the statewide standard of one to every 200 employees. Even though the staffing ratios may be similar, the document workload varies significantly. The Department's transaction unit processes an annual document workload four times greater than Cal-Trans and slightly greater than EDD.

Comparative Workload Volume

	Forms					
	604	605	606	607	Total	# Employees
Health	4,152	1,308	2,400	2,376	10,236	21,117
EDD	8,872	2,248	5,188	3,256	19,564	13,768
Cal Trans	3,042	1,983	1,153	814	6,992	16,700

Included in the data shown above is the number of Forms 607 processed annually which establish, delete, or change budgeted positions. The volume

personnel changes prior to this study. This confirms the notion that the reorganization removed Social Welfare staff from top management but does not confirm the common notion that the Department is controlled by staff from the Health Care Services Department.

b. Turnover: Previous studies of top management in the Department of Health have noted that high turnover rates in top management positions, and have identified problems with the turnover rate. This study data confirm the high turnover rates. Of the 112 individuals studied, 29 percent report holding their present position for less than one year; 23 percent for 1.0-1.9 years; 23 percent for 2.0-2.9 years; 17 percent from 3-10 years; and 8 percent over 10 years. Thus, 75 percent of all top managers have held their current positions for less than three years. Those managers who have held their current positions for more than three years are almost all either in the state hospital system or in the field of public health.

c. Biographical: The top administrators in the Department of Health are primarily in the age category of 45 years or older. They reported the following age groups: 13 percent are 25-34; 30 percent are 35-44; 42 percent are 45-54; and 15 percent are 55 years or older. Generally, the age range of management shows a desirable bell-shaped curve, with almost equal numbers in the high and low group.

The top managers are predominantly male. Less than 4 percent are women. Ethnic minorities are under-represented in the top administration. Of the total administrators, 3.6 percent are Black males, 3.6 percent are Asian males, and 2.7 percent are Spanish surnamed males. There are no minority women represented in the top management. This indicates a serious need for affirmative action, particularly for women and Mexican-Americans.

assignments of management. A questionnaire (Appendix B) was sent to each of the individuals identified by the Department as holding one of the following positions considered to be top management: director, deputy director, manager, branch manager, section chief, unit chief, hospital administrator, or clinical director. Using this classification scheme to identify top managers produced a list of 112 individuals who all responded to the questionnaire that was sent to them.

The total accuracy for individuals in top management was difficult to determine. During the one-month time period when questionnaires were sent, there was some turnover of individuals in top management positions. Two deputies left, three deputies were added, several administrators within the Administration Division were changed and new titles assigned. New titles were assigned to chiefs within the Alternative Health Systems Division, some administrators and clinical directors within the state hospitals were changed, and the Health Protection Division was reorganized. With this almost constant changing of individuals, titles, and organization, general confusion exists among top management themselves, which may account for the fact that some of them did not respond correctly (according to the Department's records) to their own working title.

Aside from the difficulties in attempting to survey the top management in the Department of Health, the information obtained presented the following profile of managers. Of the 112 individuals in top management positions within the Department of Health, the following working titles were recorded: one director, three deputy directors, 7 division managers, 12 branch

The high percent of administrators considered seriously lacking in their positions reflects how poorly professional and managerial ability are presently articulated in program management.

The obvious remedy is to seek to balance these skills in the major programs, and to avoid arguments as to which is more important. Obviously both are essential to success.

The following criteria were used in the Commission Task Force's evaluation of departmental leadership:

1. Formal educational background.
2. Nature of professional experience.
3. Nature of the program and the amount of health program expertise required.
4. Level of responsibility and span of control.
5. Management experience and its relevance to specific job responsibilities.

The programs of the Department of Health are complex. They deal with highly technical issues, such as environmental protection, financing, organization, and delivery of services to people with both general and highly specialized needs. In this setting, a fundamental and indispensable part of the definition of competence is the ability to comprehend the basic nature of the program being managed.

d. Education: The top management in the Department of Health are extremely well-educated. Of the educational degrees reported, 62 percent held a master's degree or higher. The following educational degrees were reported as the highest degrees held: 8 percent had less than a bachelor's degree; 30 percent held a bachelor's degree; 35 percent held a master's degree; 3 percent held a doctoral degree; 4 percent held a law degree; and 20 percent held a medical degree.

e. Qualifications: Qualification for administrative leadership in the department depends on two basic types of skill and experience: health professional expertise and the ability to manage a program. These skills are complimentary and equally essential. Rarely are they entirely manifest in a single individual. This fact creates a dilemma - if a manager has no command of the basic nature of a health program, the manager is at a distinct disadvantage; on the other hand, if a knowledgeable professional with training and experience in the field is without talent or experience in program management, the professional, too, is at a distinct disadvantage.

In judging the qualifications of the leadership of the department, both attributes (health professional and managerial abilities) were given equal weight. If either attribute was seriously deficient, a judgment was made that an administrator was unqualified in the sense that his skills standing alone were insufficient to assure program effectiveness.

In some instances, professionals require management assistance; in others, managers require health professional assistance.

local bodies to promulgate effective programs for the elderly. Although this office's programs for nutrition and aging are health and social services programs, its responsibility for varied other functions outside the department supports its retention as a direct responsibility of the agency. (See Chapter V, Part I)

#### Recommendation

Because of the multi-faceted nature of this program it should be retained for the present as a direct responsibility of the Agency.

#### 4. Office of Educational Liaison

The Office of Educational Liaison (OEL), established by the Child Development Act of 1972, is responsible for the planning, development and coordination of child development activities. The office coordinates child-oriented programs between the Departments of Education, Health, and the Youth Authority; develops a program for expanding child care services; and administers the health manpower training programs for family practitioners and serves as staff to the Health Manpower Policy Commission. The programs which relate directly to health manpower should more properly have been placed within the State Department of Health. This office is scheduled for expiration on December 1975. If this were not to occur, due to new legislation, this office should be transferred to the Department of Health.

6. Limit the Cal/OSHA program to activities of coordination and support between the Department of Health and the Department of Industrial Relations programs. No administrative unit in either agency is required to attain such coordination.

5. Department of Benefit Payments

Audits and Recovery Program in Benefit Payments: The Audits and Recovery Program, located in the Office of Benefit Payments as a result of the 1973 reorganization, is assigned responsibility for the audit and recovery of funds for the Medi-Cal Program of the Department of Health. While the Department of Health is charged with the over-all administrative responsibility for the Medi-Cal program, it does not have authority over one of the most important aspects -- auditing and recovery of funds. The splitting of responsibility for the program into two departments has created confusion, frustration, and multiple administrative problems for the Department of Health. (See Part I, Chapter V, Phase I)

Recommendations

1. Transfer the Audits and Recovery Program for Medi-Cal immediately from the Department of Benefit Payments back to the Department of Health.
2. Place this program in the Fiscal Management Program of the Medi-Cal Division.

## 2. Pesticide Control Program

The Pesticide Control Program is located in the Agriculture Chemicals and Feed Unit of the Department of Food and Agriculture. Its main function is to register and regulate the use of pesticides, and to establish standards for workers in contact with pesticides. This program interfaces with the Department of Health, in establishing protective health standards. The Environmental Health Services program of the Department of Health needs a program to establish protective health standards for the health of migrant workers. The role of the Department of Health in protection of workers against pesticide poisoning is discussed in Part I, Chapter V, Phase I.

### Recommendations

1. Standards for pesticide and poison control which affect the health of people should be issued by the Department of Health.
2. The enforcement of uniform standards for pesticide and poison control should be continued and strengthened by the Department of Food and Agriculture.
3. The Department of Health should establish training programs for Department of Food and Agriculture inspectors which will ensure that minimum standards for pesticide and poison control are enforced.

4. The Industrial Safety and Health Board should adopt and enforce the same regulations in the Agriculture Code which protect the health of workers exposed to pesticides.

#### C. Department of Consumer Affairs - Healing Arts Boards

The Healing Arts Boards in the Department of Consumer Affairs perform the primary licensing and monitoring functions for physicians, dentists, nurses, and other health professionals in California. All of the Healing Arts Boards are presently scheduled to be transferred to the Department of Health in July 1977. The Healing Arts Boards at times have been criticized because of their control by their respective professional associations and their lack of responsiveness to consumers. Transferring these Boards to the Department of Health should allow the Boards to be more responsive to consumers and less dominated by professional organizations. In addition, the Healing Arts Boards activities are intricately tied to the functions of the Department of Health in establishing standards for health care, monitoring the quality of health care, and the licensing and certification activities. Consolidation with the Licensing and Certification Division program should provide a more comprehensive approach to ensuring high standards of health care in the State. (See Part I, Chapter V, Phase II)

#### Recommendations

1. Transfer the Healing Arts Boards to the Department of Health as scheduled.
2. Place the functions of establishing standards, monitoring, and enforcing standards within the Licensing and Certification Division.
3. Place the investigation activities of the Boards in the special Investigations Section, to be located in the Office of External Affairs.
4. Place professional health planning (manpower planning) activities in a special unit of the Planning and Evaluation Office.

instrument for all hospitals in California, which is scheduled for completion by mid-1977. The primary client for the data collected by the commission is the Department of Health, although other public and private agencies are expected to make use of the data. This activity overlaps with the responsibilities of the Department of Health for data collection, especially that for the facilities planning data required for the State Health Plan. (See discussion of advisory health bodies, Part I, Chapter IV)

#### Recommendations

1. Abolish the California Health Facilities Commission.
2. Place the commission's activities and responsibilities in the Information Systems Unit of a Planning and Evaluation Office in the Department of Health.

#### F. Advisory Bodies

##### 1. The Advisory Health Council

The Advisory Health Council was established in 1973 with the abolishment of the State Board of Public Health. Its purpose is to advise the Director of Health, with specific duties relative to comprehensive health planning statewide, in response to enactment of Public Law 89-749. Members are appointed by the Governor, the Chairman of the Senate Rules Committee, the Speaker of the Assembly, the Regional Medical Program, and the Veterans Administration, who represent agencies, consumers, providers of health care, and other representatives. The role of this council is eliminated with the passing of Public Law 93-641 which requires a State

Interviews by Task Force  
State and Federal Officials

Health and Welfare Agency

Obledo, Mario, Secretary of the Health and Welfare Agency  
Gnaizda, Robert, Deputy Secretary  
Brian, Earl, M.D., Former Secretary

Department of Health, Director's Office

Lackner, Jerome, M.D., Director  
Sifuentes, Ben, Deputy Director  
Prod, Jerry, Deputy Director  
Brown, Al, Deputy Director  
Snyder, Stuart, Former Chief Deputy Director

Legislative Analyst

A. Alan Post  
Thomas Dooley

State Hospitals Division

Arnold, Frances, Assistant Administrator, Sonoma State Hospital  
Bair, Peggy, Program Director, Social Rehabilitation Unit, Sonoma State Hospital  
Bowling, Donald, Chief, Developmental Disabilities Hospital Services Section  
Brannick, Ellen, Community Liaison Representative  
DeLong, Duane, Patients Rights Officer, Assistant to Medical Director  
Donoviel, Stephen, Ph.D., Program Director, Napa State Hospital  
Eiland, Murray, M.D., Program Director, Napa State Hospital  
Fossum, James, Chief, Special Projects Unit  
Friday, Richard, Hospital Administrator, Napa State Hospital  
Gallisdorfer, Jack, Chief, Mental Disabilities Hospital Services Section  
Gillions, Thomas, Hospital Administrator, Sonoma State Hospital  
Heard, Jack, Fiscal Officer, Sonoma State Hospital  
Howard, Doug, Trust Officer, Napa State Hospital  
Koford, Glenn, M.D., Medical Director, Sonoma State Hospital  
Linn, Abraham, M.D., Medical Director, Napa State Hospital  
Lucas, Richard, Assistant Director, Behavioral Modification Program, Sonoma State Hospital  
Meza, Richard, Affirmative Action Officer, Sonoma State Hospital  
Miller, Donald Z., Manager, State Hospital Division  
Nelson, Russell, Office of Program Review, Napa State Hospital  
Owen, Dorothy, Personnel Officer, Napa State Hospital  
Powers, Mary, Liaison Coordinator, Sonoma State Hospital  
Spicer, William, M.D., Program Director, Napa State Hospital  
Tremonti, Orin, Advisory Board Member, Sonoma State Hospital  
Whitsell, James W., Chief, Hospital Support and Operations Section

Community Services Division

Argys, George, Director, California Association for Mental Health, Sacramento  
Arnold, Douglas, Chief, Local Program Services Section  
Baldo, Robert, Chief, Regional Centers  
Bowen, John W., Administration Director, Golden Gate Regional Center  
Bronston, W. H., M.D., Assistant to Dr. Koch  
Calavan, Charles, Social Worker, CCSS/DD, San Francisco Office

## COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

11th & L BUILDING, SUITE 560, (916) 445-2125  
SACRAMENTO 95814.



Chairman  
MANNING J. POST  
Beverly Hills

Vice-Chairman  
H. HERBERT JACKSON  
Sacramento

ALFRED E. ALQUIST  
Senator, San Jose

HARRY FARB  
San Diego

JACK R. FENTON  
Assemblyman, Montebello

HAROLD C. HENRY  
Rosemead

DONALD G. LIVINGSTON  
Los Angeles

MILTON MARKS  
Senator, San Francisco

ERNEST N. MOBLEY  
Assemblyman, Fresno

VERNE ORR  
Pasadena

LLOYD RIGLER  
Burbank

NATHAN SHAPELL  
Beverly Hills

LOUIS WARSCHAW  
Los Angeles

L. H. HALCOMB  
Executive Officer

January 1976

Honorable Edmund G. Brown Jr.  
Governor, State of California

Honorable James R. Mills  
President pro Tempore, and to Members of the Senate

Honorable Leo T. McCarthy  
Speaker, and to Members of the Assembly

Gentlemen:

The Commission on California State Government Organization and Economy has completed its review of the organization and functioning of the State Department of Health. The study emanated from the Commission's concern that the Department--comprising more than one quarter of the State's annual budget--was not fulfilling the goals set forth in the Governor's Reorganization Plan No. 1 of 1970. nor was it contributing to the health needs of the people of California in an effective and efficient fashion. Dr. Jerome Lackner, Director of Health, shared this concern; consequently, he requested the Commission, within three months of his appointment, to make a thorough study of the Department.

The Commission's interest in the health functions of the State Government dates back to 1967 when it suggested that there might be merit in grouping State health functions into a single state department. Although the Commission and the Legislature approved such a merger in 1970, we question the effectiveness of the organization and operation of the department as presently organized. The objective of the study therefore was to conduct an in-depth analysis and make recommendations which hopefully will permit the State to meet its health goals more effectively and with greater efficiency and economy.

The explosive growth of state health programs has spanned the past ten years. The complex problems described in this report relate to rapid growth and have accumulated over the same span of time. Our findings are not intended to fix responsibility for conditions which prevail on any

January 1976

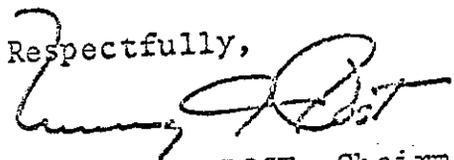
particular administration. Rather, our objective is to present and document our criticisms for constructive purpose. We trust that the adoption of recommendations will lead to substantial improvement in the organization and operation of health programs for the state.

The scope of the study was determined by a Commission Subcommittee comprised of Messrs. Verne Orr and Donald G. Livingston and was set forth in an exchange of correspondence between the Subcommittee and the task force appointed by the Chairman to conduct the study. (See Appendix A.)

The task force, chaired by Lester Breslow, M.D., M.P.H., Dean of the School of Public Health, Center for Health Sciences, University of California at Los Angeles consisted of Paul O'Rourke, M.D., M.P.H., Health Advisor to the State Senate; Charlene Harrington, R.N., Ph.D., State Department of Health; and James Miller from the State Department of Finance. Position papers and specialized assistance were received from Henrik L. Blum, M.D., Professor of Community Health Planning, University of California, School of Public Health, Berkeley; Paul Press, Assembly Office of Research; Verne Gleason; and Bert Cohen; as well as others from within the State Government. The members of the Task Force take full responsibility for all findings of fact of the study. The report, presented in two parts, was prepared under the supervision of the Commission's Executive Officer.

At all times excellent cooperation and assistance was received from Mario Obledo, Secretary of Health and Welfare Agency, Jerome Lackner, M.D., Director of Health, and employees of the Agency and the Department.

Respectfully,



MANNING J. POST, Chairman

Part I

I. SUMMARY OF FINDINGS AND RECOMMENDATIONS

Throughout the course of the study, a positive change in the attitude of the Agency, the Department, and their staffs was discerned. Constructive criticism was actively solicited and candor and reflection began to appear. As Dr. Jerome Lackner expressed, when requesting the study, a new spirit is emerging which is beginning to elicit a cautious revival of expectation in the health community that real progress is possible. Although the findings of this study are critical in many instances, our recommendations are constructive and made in the hope that they will enhance this spirit of progress.

Findings

1. In the creation of a single Department of Health for California, in 1973, the Departments of Public Health, Mental Hygiene, Health Care Services, and elements of the Departments of Social Welfare and Rehabilitation were brought together, but the reorganization did not lead to genuine consolidation of related programs.
2. The form of organization established did not fulfill the expectations listed in a 1970 Task Force Report which was reviewed and approved by the Commission on California State Government Organization and Economy and accepted by the Legislature (See Appendix B, page ).
3. The outcome has been a serious deterioration in planning, operation and evaluation of health programs and a failure to achieve their functional integration; inaccurate claims to the Department of Finance,

21

the Legislative Analyst and fiscal committees of the Legislature of fiscal savings which obscured budgetary overexpenditure; decline in the availability of reliable statistical information; loss of accountability; and decrease in attention to the pressing need to guide the development of health manpower and the construction of health facilities in California. Although significant improvements are in the process of being implemented these conditions continue to exist.

4. The following deficiencies exist in the structure and function of the Department:

a. Its present structure embraces a loose federation of independent programs, without substantial coordination at the state level and with little integration of services in the community.

b. Over-centralization of administrative support functions has disrupted health programs by depriving program administrators of effective participation in budget presentation, personnel management, data systems design, and contract processing. The consolidation that was implemented did not help program managers in the performance of their duties.

c. Superfluous layers of bureaucracy have encouraged unproductive procedures and driven the cost of administration beyond acceptable limits. Decisions are delayed and often made arbitrarily at a distance from those with the greatest knowledge of the health programs. Field offices are widely dispersed and poorly organized and thereby impede integration of state functions in support of local programs. Technical assistance tends to obstruct rather than facilitate.

- d. The state personnel system has been utilized improperly to place in key positions persons without training or experience in health programs sufficient to fulfill their responsibilities with competence. Rotation of personnel occurs with such frequency that responsibility and accountability have been obscured. Retention and recruitment of qualified individuals has been seriously impaired. The potential of qualified staff is not put to good use.
- e. Information essential to measurement of the performance of programs is lost in a morass of data collected and handled in a fashion which makes assessment of problems and accomplishments extremely difficult. Program managers, budget analysts and agencies outside the Department cannot obtain basic information required to fulfill their responsibilities.
- f. Confusion of authority and function between the Health and Welfare Agency and the Department creates friction and erodes the authority and effectiveness of the Director of the Department. Legislators, local health agencies and private professional groups report that they are unable to identify those in charge of programs in the Department or to obtain answers to questions. Clear and consistent decisions on policy are not forthcoming.
- g. A vacuum in leadership due in part to excessive turnover of executive and professional personnel has a paralytic effect on the Department and nurtures a crisis approach to administration which is both unsettling and demoralizing.
- h. Meaningful participation in health policy decisions by local governmental officials, advisory bodies, consumers and providers has practically disappeared. Neglect of hearing and advisory

1. Summary Findings and Recommendations  
(4th page)

4

processes aimed at soliciting the views of all concerned has fanned distrust and disrupted constructive negotiation. Arbitrary adoption of regulations causes dismay and spawns litigation.

5. These deficiencies have caused internal and external loss of confidence in the Department.

a. Within the Department, program administrators report that they do not command the authority or support necessary to operate programs and thus to be held accountable for results. Decisions are passed 'up the line' and made without sufficient consultation by those with greatest experience in a particular program. Yet, they must live with repercussions and try to defend policies they disapprove. Their integrity is challenged and professional pride is degraded.

b. Loss of confidence is prevalent amongst individuals and organizations outside of the Department who are indispensable to the successful operation of state health programs. Distrust in the capacity of the Department to bring order to its programs is impeding the placement of new health programs in the Department even when it is logical to do so.

6. Conditions which now prevail cannot be fairly attributed to a failure in the logic of consolidation of state health programs, but rather to the methods employed in carrying out the merger. Those initially charged with responsibility for implementation of the consolidation were, in fact, not in support of such a merger.

5

Recommendations

1. The Governor should enunciate clear health goals and policy initiatives for California and commit the administration to build competence and confidence in the Department. His continuous leadership is essential to the restoration of the Department to a position where it can function effectively for the citizens of the State and resume national leadership in health affairs.
2. A Board of Health, chaired by the Director of Health, should be established with statutory responsibility as a publicly accountable body to review major health policies; to serve as the designated final authority for statewide health planning; to establish hearing and advisory mechanisms that will assure an open process of public participation in the formulation of regulations; and to adopt health regulations. The establishment of such a statutory Board vested with the responsibility for directing and coordinating all technical departmental structures would permit the abolition of some boards and advisory committees presently participating in the programs of the Department. The first task of the Board should be to study the advisory bodies and outline how they should be streamlined.
3. The Governor, Agency and Department should:
  - a. Undertake a phased and deliberate approach to administrative change, addressing first only those functions which require immediate modification to achieve adequate program performance, with particular emphasis on creation of a strong planning and evaluation structure within the Department;

- b. Establish clear channels of communication and delegated levels of authority and responsibility from the Governor to the Agency and the Department and its staff;
  - c. Restore to program managers effective participation in administrative processes essential to fulfilling their responsibilities;
  - d. Divest the Health and Welfare Agency of all operating units and charge the Department of Health with responsibility for operation of health programs.
  - e. Develop a regional pattern of field operations that will link effectively services provided to people by public and private providers in preventive medical programs, Medi-Cal, Short-Doyle, Regional Centers for developmental disability and the State Hospitals.
4. The system of job classification and promotion in the Department should be revised with outside professional personnel consultation, in order to place in positions of major responsibility persons who are professionally qualified and otherwise capable of performing their duties with competence for a period of time long enough to do a constructive job. This personnel study should also include an analysis of the need for additional positions that are exempt from state civil service.
5. The Department should re-establish the historic partnership between the State and counties in the provision of health services and rebuild a constructive relationship with federal officials, the State Legislature, the private health community and consumer groups. Competent reporting of departmental activities will accelerate the recovery of trust and confidence.