

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

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January 1976

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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

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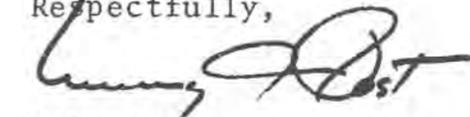
particular administration. Rather, our objective is to present and document our criticisms for constructive purpose. We trust that the adoption of recommendations will lead to substantial improvement in the organization and operation of health programs for the state.

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

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*Abstained from vote
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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,

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.

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; Medi-Cal; Mental Disability; Developmental Disability; Substance Abuse;

State Hospitals; Environmental Health; and Licensing and Certification.

- 3) Interviews following a carefully designed format adapted to different individuals and programs. Those interviewed included:
 - a. Director of the Department and his deputies, individually.
 - b. Approximately 50 key persons in the eight programs selected for intensive study.
 - c. Approximately 50 other persons in the Department, including some in administrative and other support services and some in field offices.
 - d. Approximately 50 persons elsewhere in State government, including legislators and members of their staffs, the Legislative Analyst, persons in the Department of Finance and the Office of the Auditor General, and persons in key positions in health-related programs outside the Department.
 - e. Persons in the U.S. Department of Health, Education and Welfare and in local health agencies.
- 4) Group discussions involving two or more members of the task force and usually lasting about two hours with:
 - a. The Governor.
 - b. The Agency Secretary and his staff.
 - c. Representatives of local governmental health agencies, including agency administrators, health officers, mental health directors and hospital administrators.

- 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.

The task force did not ascertain the experience and views of those served by the Department--client groups and others. This is extremely important and should be undertaken at a future time. It was not carried out as a part of this study because (a) it seemed more appropriate for the Commission, possibly jointly with the Legislature, to carry out that part of the task; and (b) the task force felt that it did not have adequate resources or time to do the job adequately. The task force recommends that ascertaining the experience with and views of the Department on the part of clients and others affected by the Department's services be undertaken systematically through (a) case-studies of individuals and families, particularly new clients such as an unemployed and single pregnant woman, a mother in a nursing home for the first time; (b) random sample surveys of persons affected by the Department's services; and (c) public hearings.

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.

Some health improvements may be noted during the past 10 years. Infant mortality, which for years had remained fairly steady and higher in California (as well as the United States) than in other developed countries, has declined sharply. In recent years, mortality from high blood pressure has fallen considerably, along with deaths due to cancer of the cervix in women and the incidence of measles and other common childhood diseases for which immunizing agents have become available.

Meanwhile, mortality from lung cancer, emphysema and other diseases due to cigarette smoking is climbing, especially now among women. Accidents continue as the fourth leading cause of death. They account for almost half of all deaths among those five to 24 years of age, while homicide and suicide are responsible for almost one-fourth of the deaths during 15-24 years. Violence is particularly important as a health problem among young men.

Although illness and death due to infectious agents have declined remarkably, and morbidity and mortality due to violence continues at a variable level among different segments of the population, only recently has the health burden associated with lifestyle been recognized. Eating regularly, and moderately, eating breakfast, exercise, using alcohol moderately or not at all, avoiding cigarettes, and sleeping 7-8 hours regularly have been identified in California* as having a very strong association with health.

The association of health and longevity with these health habits is much stronger than with income level, education, or occupation, which were previously, and rightly, regarded as major factors in health. For example, persons 55-64 years of age who follow all seven good health practices were found to have the same physical health status as persons 25-34 who followed

*Studies in Human Population Laboratory, Alameda County, by the California Department of Health.

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.

TABLE 1

A Strategy for Improvement of Health

Health Program	Personal Health Services	Environmental Measures	Educational Measures
Trauma from automobile accidents	Ambulance and first aid service Emergency medical service Definitive medical care and rehabilitation	Construction of streets and highways Design and construction of automobiles Road signs and obstacles, regular and special	Driver training in vehicle manipulation Avoidance of alcohol and other drugs before driving Avoidance of driving during adverse physiologic states, e.g. fatigue
Dental caries	Dental care	Flouridation Reduce promotion and consumption of refined carbohydrates	Prudent diet Personal oral hygiene
Myocardial infarction	Screen for risk factors Ambulance service Coronary care units	Alter food supply to reduce intake of foods that raise blood-cholesterol level	Exercise Prudent diet Stop cigarette smoking
Lung cancer	Detect and treat disease early	Reduce occupational exposures that cause lung cancer Reduce production and promotion of cigarettes	Stop cigarette smoking
Infant deaths	Routine pediatric care	Maintain hygiene in home Assure safe water supply	Good diet Proper mothering

From time to time and for different segments of the population the details of what is incorporated into the attack on disease problems will vary. The basic strategy, however, remains the same. It depends partly upon analysis of the nature and extent of the health problems facing a community. It also depends upon the nature and extent of knowledge concerning what can be done to overcome the problems, the resources available, and willingness to apply the knowledge and resources.

B. Health Resources of California

As noted above, a comprehensive approach to health improvement requires attention to environmental measures and health education as well as to personal health services.

California is fortunate in respect to all three of these components of a health strategy, compared with other parts of the United States and with other countries. The State has grown in population mostly since 1940, and that has been a significant factor in adding an advanced man-created environment to the salubrious climate of California for promoting health.

During that period of rapid growth, technology has been available and generally applied to assure decent housing, safe water supplies, and adequate waste disposal for almost all the people in the State. Also, California has been a leader in establishing new environmental health measures. The State initiated and supports innovative mosquito abatement so that, while mosquito-borne encephalitis continues to hit Mexico and the middle portion of the United States with force, the disease strikes California hardly at all. Surveillance of food-processing prevents botulism and other diseases that once threatened both health and the development of an important industry in the State. California

pioneered and enforced standards for the air and for automobile exhaust and other means of air pollution control.

In an industrialized society, however, new hazards constantly arise and the old ones must still be contained. The environment of the workplace is only beginning to get the attention it deserves for health protection. This is necessary to minimize the dangers of noise, new chemicals which are constantly being introduced, and too little physical exertion. Other features of the environment requiring attention from the health standpoint include: availability of hand guns, drugs with adverse health effects, inadequate fluoridation of public water supplies, automobiles driven by intoxicated persons, the threat of breakdown of basic sanitation in various parts of the State, the 're-use' of water, and nuclear power.

California in recent decades, has strongly supported primary, secondary, and higher education. California thus enjoys a population generally well-educated compared to people elsewhere in the country and the world. However, much remains to be done to strengthen health education at all levels and to enhance the work of voluntary health agencies.

Personal behavior and means of influencing it (education) thus constitute an important factor in health. Probably that is now the most neglected factor of all, considering its enormous potential.

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.¹

There are clear indications that we are getting too many physicians of certain kinds. For example, a recent study² reports "approximately 52,000 board-certified surgeons in the United States" and almost twice that number of total

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

²Surgery 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.

IV. EVOLUTION OF THE STATE DEPARTMENT OF HEALTH
IMPACT OF REORGANIZATION (1973 TO 1975)

A. Statutory Basis

The 1970 task force recommendations for a consolidated Department of Health were reviewed and, in general, approved by the Commission on California State Government Organization and Economy. (See Appendix B, page 360)

The Governor then prepared his Reorganization Plan #1, relating to the Department of Health, and presented it to the Commission for review and approval.

The plan went to the Legislature which has the power to veto the plan by a majority vote of either house. No veto vote was cast after hearings on the plan were conducted. The plan then became law in the Spring of 1970.

The Legislative Counsel reviewed the plan and made the necessary changes in the statutes to confer all of the legal authorities upon the new Department, which had previously been in the departments involved in the consolidation. This comprised a mechanical transfer without substantive change in the nature of the authorities.

In 1971, a bill reflecting these changes was passed by the Legislature. In both 1970 and 1971, the plan was printed as part of the statutes and amendments to the codes.

The Legislature later approved a postponement in putting the plan into effect until July 1973.

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.

- Functional isolation of nursing home care from general hospital services, from extended care, and from in-home health services.
- Isolation of service systems designed to treat those suffering from particular disorders -- mental disability, mental retardation, alcoholism, drug addition and physical disability.

In spite of the growing demand for improved services for particular segments of the population, such categorical approaches must be halted. They are too expensive, and tend to stigmatize, isolate and to socially segregate people. The eventual cost of the ultimate development of segregated services to special interest groups is beyond imagination. Even now the State loses an uncounted but substantial amount of federal dollars through shuffling legitimate Medi-Cal claims onto state categorical programs.

The poor, each ethnic minority, mothers and children, women without families, the aged, the mentally ill, the developmentally disabled, the alcoholic, the addict, those with genetic disorders, those with diseases such as hemophilia, chronic uremia, cystic fibrosis, multiple sclerosis, muscular dystrophy -- all of them, after all, are members of the family of man. The time is long overdue to begin in earnest the process of integrating services on the humane basis that those in desperate need should not have to engage in competition which is both degrading and destructive. We commend those leaders in the health community for their compassionate campaigns to alleviate human suffering, but we call upon all advocates for the interests of people in need to undertake, now, a reappraisal of the direction we have taken in all state health programs.

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.

C. Evolution of Administrative Patterns

In describing the evolution of the administrative patterns adopted in the implementation, we concentrate on two points in time -- March 1973 and November 1975. This approach is intended to reduce confusion and leave space to supply a narrative explanation of the administrative changes we wish to recommend.

We will, therefore, sketch the gross anatomy of the department as it looked immediately after the completion of the first major reorganization on March 1973. The first chart is referred to as the 'systems' organization.

The second chart, in effect, describes the present form of organization of the department at the conclusion of our study in November 1975. The discussion on impact of reorganization can be construed by the reader to apply equally to the 'systems' approach and to the present form of organization, which may seem much different, but is really similar to the 'systems' organization.

1. March 1973 "Systems" Organization

Five systems were created (see Chart #1):

Health Financing System - In effect, the administration of Medi-Cal, formerly the Department of Health Care Services.

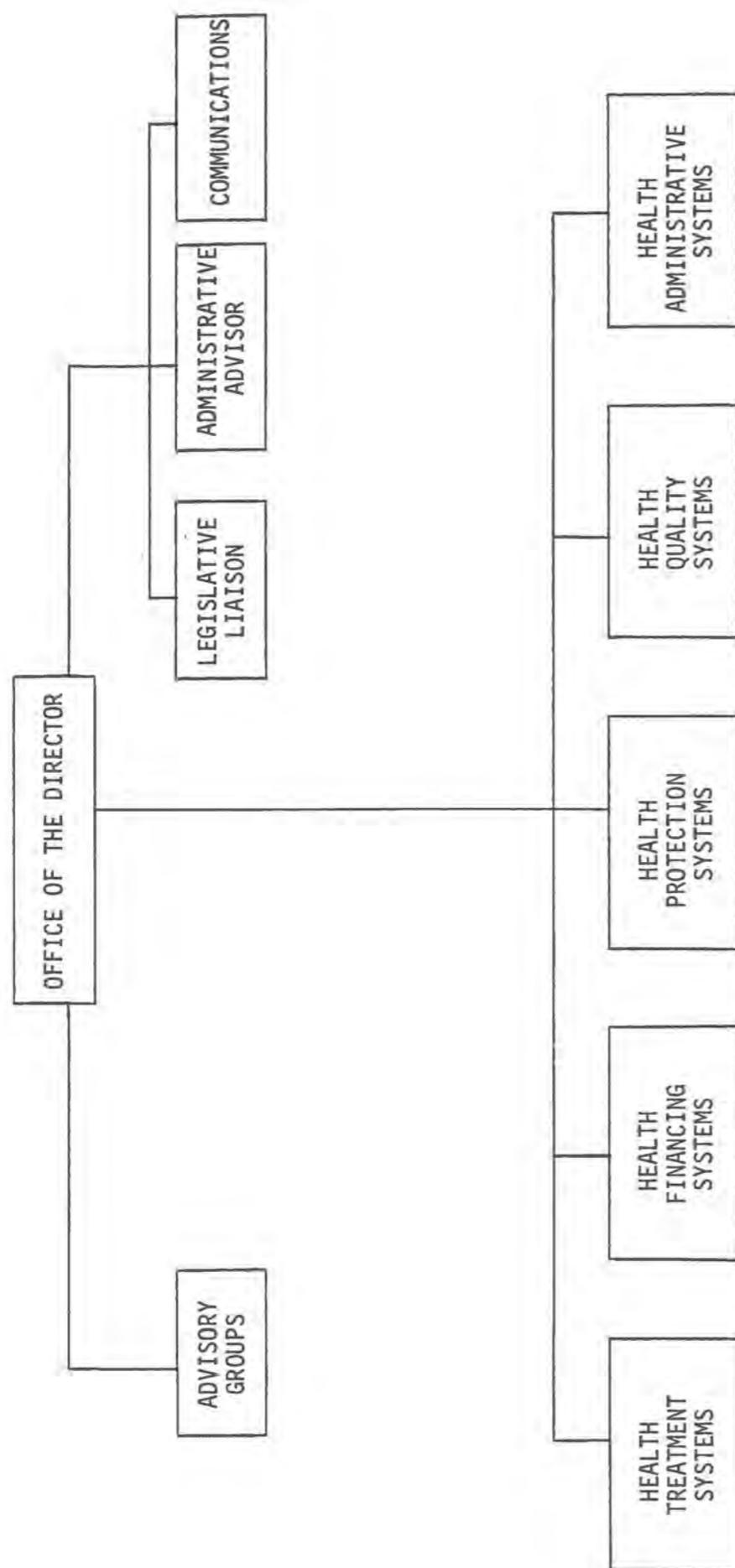
Health Treatment System - In effect, the former Department of Mental Hygiene for administration of community programs in mental and developmental disabilities, and the state hospitals.

Health Protection System - In effect, the programs of the former Department of Public Health, plus social services which were removed from the old Department of Social Welfare, but minus licensing and certification and comprehensive health planning.

Health Quality System - A new system created to combine all licensing and certification activities for hospitals, nursing homes and other health facilities as well as for care of the mentally disabled, the retarded and the alcoholic in board and care and other residential care situations. Comprehensive health planning was placed in this system along with responsibility for the quality of care evaluation for all programs in the department.

Health Administrative System - This system was newly formed to house the following support activities: budget, accounting, fiscal systems, data processing, grants, contracts, personnel transactions, vital statistics, management consultation, and audits.

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

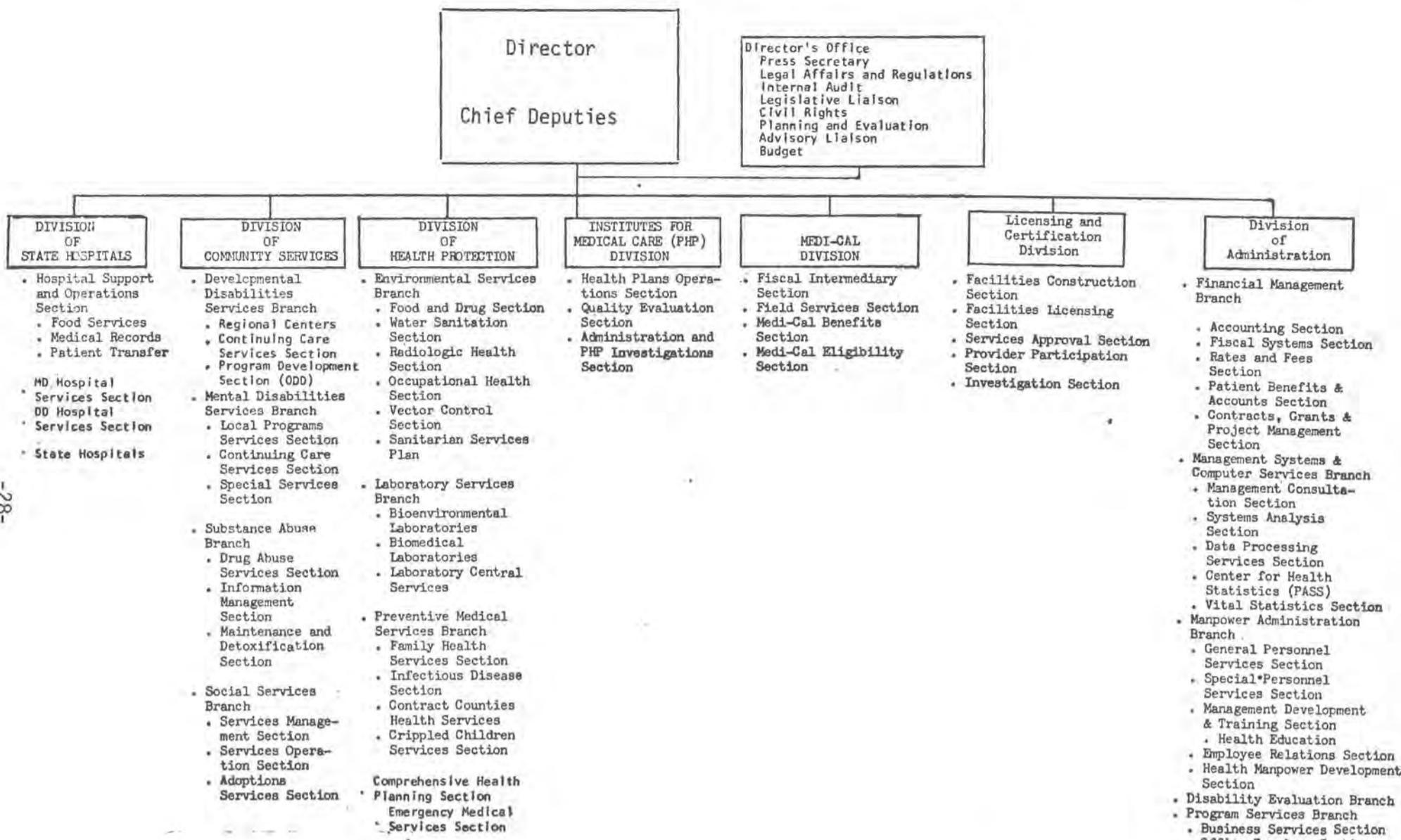
The change of administration in January 1975, brought changes in the organization shown in abbreviated fashion (see Chart #2). Out of five systems came seven divisions as follows:

- 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.



Current Organization Chart
Department of Health
Chart #2

October 1975

Accompanying the reorganization undertaken in 1973 and continuing to the present time, there has been a clearly detrimental impact on the department. The original use of the word 'system' in 1973 was confusing. Familiar terminology, long in use to identify specific programs, was abandoned and the location of program responsibility in the department became obscure. The word 'system' implied a superior and more efficient method of organization which improved management of programs. In fact, the reorganization as it was carried out was accompanied by serious and lasting disruptions.

Historically, the poor result can be traced first to the disorderly process used to implement the new plan of organization. A task force of directors of the involved departments was appointed to carry out the plan. Progress could not be made in dividing up the turf. Each director vied for expanded authority and refused to relinquish any power.

Finally, one of the directors was promoted to Secretary of the Health and Welfare Agency. He faced a deadline, twice postponed, which was drawing close. He disbanded the task force and picked a group of managers mostly from his old department, Health Care Services. With lack of both caution and planning, they concocted a new organization on paper without a narrative to explain the reasons for the placement of various functions.

The reorganization process began by moving large numbers of people into new office space without adequate planning. An era of chaos and confusion had begun. Compounding the situation, the Department of Public Health personnel faced a move from Berkeley to Sacramento, causing many defections and much unhappiness.

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.

The failure to articulate clear policy directions for the administration on major health issues has created a vacuum which is confusing to the department and to the general public. Conflict and inaction in high places has compounded uncertainty and poor morale everywhere. An atmosphere akin to anarchy causes the department to be described as a 'ship dead in the water.'

Relationships with the outside world have been adversely affected. Technical 'assistance' has become obstruction. Requests for information and decisions are not being met in a timely way. Advisory bodies are largely ignored. Promulgation of regulations does not reflect inputs into the hearing process. Responsibility for decisions is obscure.

Confidence in the department on the part of interests essential to the success of programs--local agencies, private providers, federal officials, the State Legislature and the general public--has been shattered.

The problems which reorganization have produced are legion, but they appear to have derived from factors unrelated to the logic originally used in the Commission recommendation for genuine consolidation which has not yet occurred. In place of the old departments stands a new one in shambles. Many point to the large size of the department as its major problem. Our analysis did not produce convincing evidence that this is an important factor in its dysfunction.

D. External Relationships of the State Department of Health
The State Department of Health has relationships with multiple public and private agencies, organizations and groups. In order to examine the nature

and quality of the external relationships of the Department of Health, the Task Force identified the following key organizations and met with their representatives:

Legislative Bodies

- . Standing Health and Finance committees of State Senate and Assembly
- . Select and Joint Committees on health issues
- . Legislative staff, offices of Legislative Analyst, Auditor, Research and committee staff

Executive Bodies

- . Office of Governor
- . Health and Welfare Agency
- . Department of Finance
- . Other Departments of state government
- . U. S. Department of Health, Education and Welfare

Local Government Agencies

- . County health care agencies
- . Departments of Public Health
- . Departments of Mental Health
- . County Comprehensive Health Planning Agencies
- . Supervisors Association of California
- . State Hospital directors
- . Regional Centers for Developmental Disability
- . County Welfare Agencies

Private Health Provider Organizations

- . California Medical Association
- . California Hospital Association
- . California Dental Association
- . California Pharmaceutical Association
- . California Nursing Association
- . California Podiatric Association
- . California Optometric Association
- . California Association of Health Facilities
- . Fiscal Intermediaries

State Health Planning and Regulatory Bodies

- . Post Secondary Commission for Higher Education
- . California Health Facilities Commission
- . State Health Advisory Council
- . State Health Coordinating Council ¹ (PL 93-641)
- . State Health Planning and Resources Development Agency ² (PL 93-641)
- . Healing Arts Boards
- . Comprehensive Health Planning Agencies
- . University of California Health Sciences Program

Advisory Bodies to the Department

Citizen Advocacy Groups

The following section presents a summary of findings from our discussions with selected representatives from these key organizations regarding their relationship with, and assessment of, the Department of Health. Their view of the management of the State Department of Health conformed closely to criticisms made within the Department.

1. Legislative Bodies

Those legislators interviewed made the following criticisms of the Department of Health:

- The Department does not demonstrate leadership or succeed in rational, long-term planning. Rather, they react to crises and deal with health matters in an incoherent fashion.
- Department of Health administrators do not provide comprehensive, credible, and regular reports of their programs to the Legislature and are not responsive to requests for information or documentation by the legislators.

¹ Not Yet Appointed, December 1, 1975

² Not Yet Designated, December 1, 1975

- Department of Health budget presentations lack clarity and justification, because of the deficient system of collecting and analyzing hard statistical data on the utilization of program services and costs.
- Department of Health fails to take positions on many issues of importance to health which come before the policy committees and fails to offer constructive alternatives to legislative proposals or to adequately explain opposition to program initiatives of the Legislature. There is a lack of clarity of the position of the administration as major bills are being processed.
- The promulgation of regulations for new laws has been delayed by Department of Health to an unreasonable degree. Often Department of Health regulations do not adequately reflect the legislative intent.
- The reorganization of the Department did not take place in a manner which was consistent with the intent of the Legislature and the consolidation has not produced the positive results expected. In fact, the Department is less effective, efficient and responsive now than it was prior to the reorganization.
- Reviews of programs undertaken by legislative staff seldom result in reports which are complementary to the Department. Program areas of continuing major concern to Legislators are Medi-Cal; community mental health programs; county institutions, institutes for medical

services; health manpower; regional centers; state hospitals; family planning programs; disability prevention; drug and alcohol programs; and hospital and nursing home standards and costs.

2. U.S. Department of Health, Education, and Welfare

According to HEW officials of Region IX, the relationship between the State of California and HEW leaves much to be desired. Federal financial support of state health programs is expanding rapidly, which is accompanied by federal regulations with extensive state compliance requirements. These federal regulations, at times, conflict with state policy, priorities or procedures. Thus, a strong working relationship between federal and state officials is necessary for the negotiation of differences. According to HEW officials, they have good working relationships with many middle-level program managers in the State Health Department. However, the attitude and lack of cooperation by Health and Welfare Agency and top Department of Health officials were openly criticized. They charge that contentious rhetoric aired in the news media in regard to federal health program regulations by top state officials is a poor substitute for professional discussion and adjudication of conflict.

The Task Force interviews indicate that the Health and Welfare Agency and the Department of Health should take the initiative to develop better working relationships at high levels so that federal benefits will be maximized in California's health programs without compromise in principle.

3. Local Governmental Agencies

Interviews with the professional leadership of local health programs drew a distressing picture. The counties pointed out that trends in the financing of health programs make local government increasingly dependent on state agencies. Because of the increased reliance on the state, the counties are concerned about establishing an effective partnership with the state. County officials, however, identified the following problems:

- The State Health Department is lacking in leadership, has deteriorated in terms of professional competence, and has grown callous and unresponsive to the needs of local communities.
- Recent policy directions are reinforcing a separate system of care for the poor.
- County contributions to state programs are not accompanied by a partnership of planning and implementing public programs in health services.
- Department of Health administrative red tape obstructs the smooth conduct of programs.
- Department of Health technical assistance has deteriorated into bureaucratic bungling.
- The counties share of costs is rising, especially as a result of Medi-Cal Reform.

- 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.

4. Private Health Providers

Physicians, dentists, hospitals, pharmacies, nursing homes, and other allied health professions are deeply involved in the Medi-Cal, Crippled Children, Childhood Screening and Mental Disability and Retardation programs of the Department.

From their close vantage point, the leaders of the private sector who were interviewed were unanimous in these criticisms:

- The adversary nature of their relationship to the Department, which is marked by a contentious expectation by departmental officials that the private providers are intent upon exploiting programs rather than making responsible contributions. This attitude, combined with lack of opportunity to consult and recommend, results in the displacement of negotiation by litigation. The public hearing process is frustrating in that inputs by the private sector are largely ignored. Pilot programs are launched, then discontinued without competent professional evaluation. Rates, fees, and reimbursements are at a substandard level which constitutes an invitation to poor quality of care in many settings.
- The elimination of the State Board of Health destroyed the only publicly accountable official body in the health field and left health affairs entirely in the hands of a department given to arbitrary and almost mystical ways of making decisions.

- The incompetence of highly placed administrators and their rapid rotation to different positions has made the Department a "sheltered workshop for disadvantaged managers." Competent statistical and program reporting has ceased. Those responsible for monitoring the professional performance of staffs of hospitals and nursing homes do not possess the credentials or experience to carry out their responsibilities. An appeal mechanism is needed to protect against unsubstantiated accusations of deficient performance.
- Large numbers of people unable to afford private health care are not being assisted in tax supported programs, and the Department of Health is doing nothing to document this unmet need and nothing to meet it.
- In dentistry, the paucity of public dental services places a heavy burden on the private sector to meet the dental needs of the indigent. The Denti-Cal contract has improved both access and quality, but low levels of reimbursement seriously threaten continued participation in the programs, especially in services to adults.
- Levels of reimbursement in the drug program under Medi-Cal limit services to dispensing, and they discourage consultation, patient education, improvement in records to prevent interactions, and better communications with physicians on prescribing. The department impedes peer review by not taking vigorous and timely action to eliminate abusers from the program.

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.⁷ 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

state hospitals which operate the institutional portions of the mental disabilities and developmental disabilities programs. The distribution of budget and staff among the largest programs is listed below.

Table 2
Budget and Staffing for Selected Department of Health Programs, 1975-76

<u>Program</u>	<u>Budget (millions)</u>	<u>Staff in Person Years</u>
Medi-Cal	\$2,200	838
Mental Disabilities	264	9,663
Developmental Disabilities	220	6,578
Social Services	338	187
Licensing and Certification	21	495
Substance Abuse	54	234
Preventive Medical Services	47	285
Environmental Health	10	439
Laboratory Services	9	420
Occupational Health	3	127

(Source: Governor's Budget 1975-76)

The Department is administered by the Director and four Chief Deputy Directors. The programs are grouped into seven divisions: State Hospitals, Community Services, Health Protection, Alternative Health Systems, Medi-Cal, Licensing and Certification, and Administration. The Director's Office is composed of seven units: Press Secretary, Legal Affairs and Regulations, Civil Rights, Advisory Liaison, Legislative Liaison, Internal Audit, and Planning and Evaluation. The Executive Assistant to the Director is also

⁷ Governor's Budget 1975-76

part of this office.⁸ The budget and staffing for the seven divisions is listed below.

Table 3
Department of Health Budget and Staffing By Division, 1975-76

<u>Division</u>	<u>Budget (millions)</u>	<u>Staffing in Person Years</u>
State Hospitals	\$ 254	15,540
Community Services	652	1,082
Health Protection	82	1,046
Alternative Health Systems	82	112
Medi-Cal	2,118	634
Licensing and Certification	24	502
Administration	57	2,553

(Source: Governor's Budget 1975-76)

State Hospitals Division: The Hospitals Division includes the developmental Disabilities Hospital Services Section, the Mental Disabilities Hospital Services Section, and the Hospital Support and Operations Section. This division is responsible for the operation of the eleven state hospitals: Agnews, Atascadero, Camarillo, Fairview, Metropolitan, Napa, Pacific, Patton, Porterville, Sonoma, and Stockton. The division administers the institutional portions of the mental and developmental disabilities programs.

Community Services Division: The Community Services Division administers four programs: (1) Developmental Disabilities Services Branch; (2) Mental Disabilities Services Branch; (3) Substance Abuse Branch; and (4) the Social Services Branch. The division's programs provide services for the

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

⁸Department of Health, Organization Chart, May 1975.

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.

Geographical Organization: Over the years, health and related programs have been developed on a categorical basis at different periods in time. As these programs were implemented, independent organization structures were developed to meet the unique needs of each program. The result is a series of vertical program structures, each extending down to the level of service delivery to individuals, with little or no program crossover. Each program has organized its field operations into field offices, districts, catchment areas or regions, none of which are coterminous with another. Many of these operations deal with the same service agencies, providers and client population. Planning boundaries are not contiguous with operation boundaries. As a result, the evaluation of program operations in relation to planning is next to impossible.

A survey of field operations as of July 1973, showed that the Department had 23,000 persons employed in 165 program units at 99 locations in 53 cities in addition to the State Hospital System. Each unit has been a separate entity dependent upon its own operating resources, with little relation to the rest of the department. As a consequence, integration of programs at the service delivery level has not been accomplished.

In compliance with the National Health Planning and Resources Development Act of 1974 (Public Law 93-641), California established Health Systems Area boundaries in September 1975. The fourteen health systems areas designated by the state are regional planning areas replacing the Comprehensive Health Planning Areas. Each regional area will have a health system agency designated by the state for the statutory purpose of: (1) improving the health of residents, (2) increasing the accessibility, acceptability, continuity, and quality of health services, (3) restraining increases in the costs of health services,

and (4) preventing unnecessary duplication of health resources. Each agency will have responsibility for the health planning and resource development in its area. Department of Health field offices and service areas are not presently related to the Health Systems Areas established for planning purposes.

B. PROPOSED ADMINISTRATIVE CHANGES

The present form of organization is displayed in Chart #2. The Commission review of these arrangements forces the conclusion that changes are necessary to make the programs more functional. We emphasize our opposition to the shuffling of organization charts like a deck of cards. Our suggestions for administrative change are intended as guideposts, not as fixed, inflexible dictates. Administrative change is innately disruptive and ought to be undertaken with caution and deliberation. The reasons for change should be stated explicitly and in detail. The implications must be as carefully anticipated as is humanly possible, with an eye to the impact on both program and administrative support structure. Many factors must be considered, including effects on budgeting, accounting, data, personnel requirements, and space. These are as important as the administrative placement of the programs.

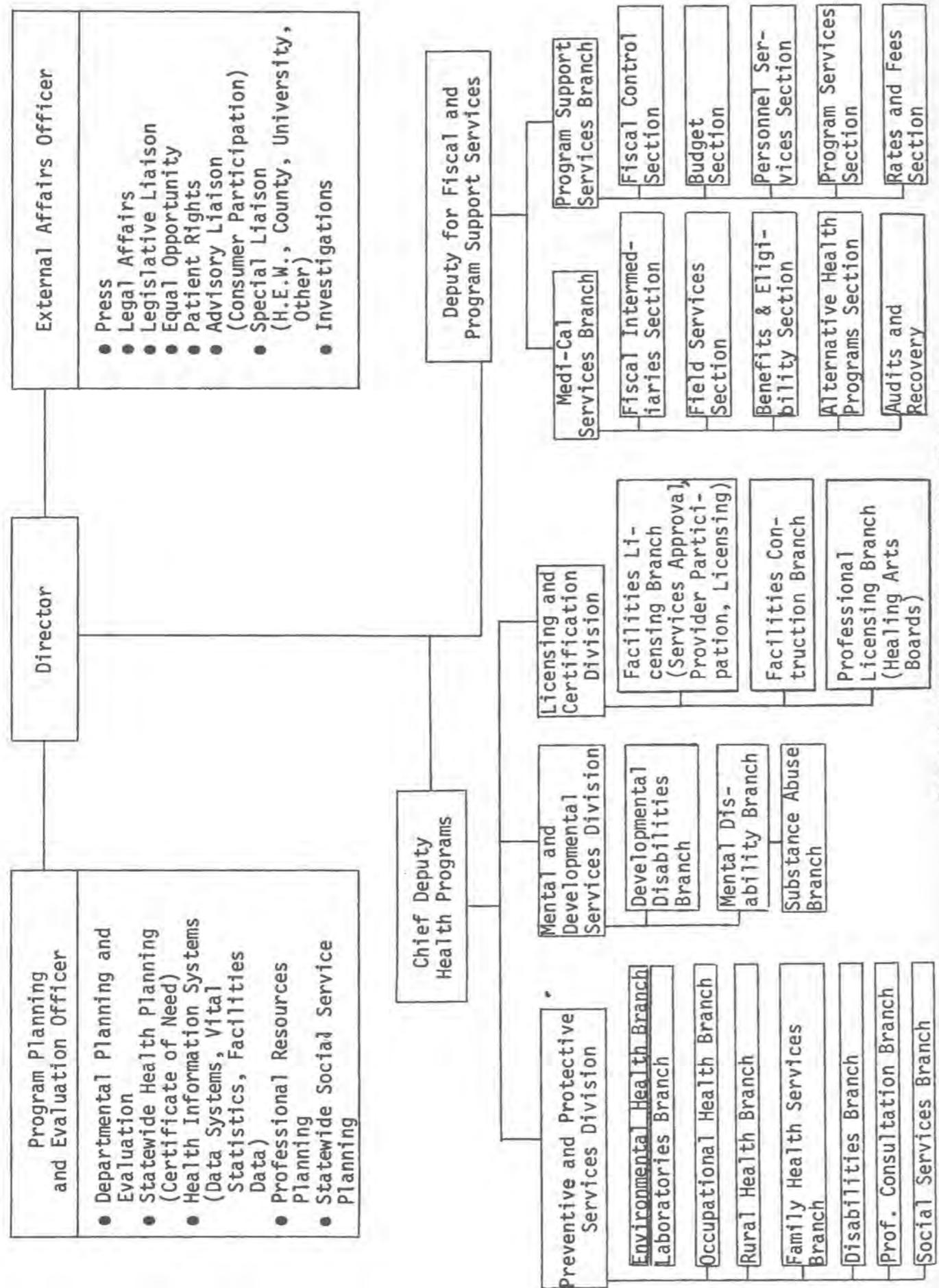
We therefore recommend an incremental approach to change rather than another massive reorganization.

Our proposal for administrative change consists of three phases:

Phase I - Changes to be given consideration immediately.

Phase II - Changes to be undertaken only after programs are judged to be working reasonably well.

Phase III - Changes to be considered as a reflection of a long-term goal and treated as desirable but, for the moment, impractical.



Phase I, Proposed Organization Chart
Department of Health
Chart #1

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

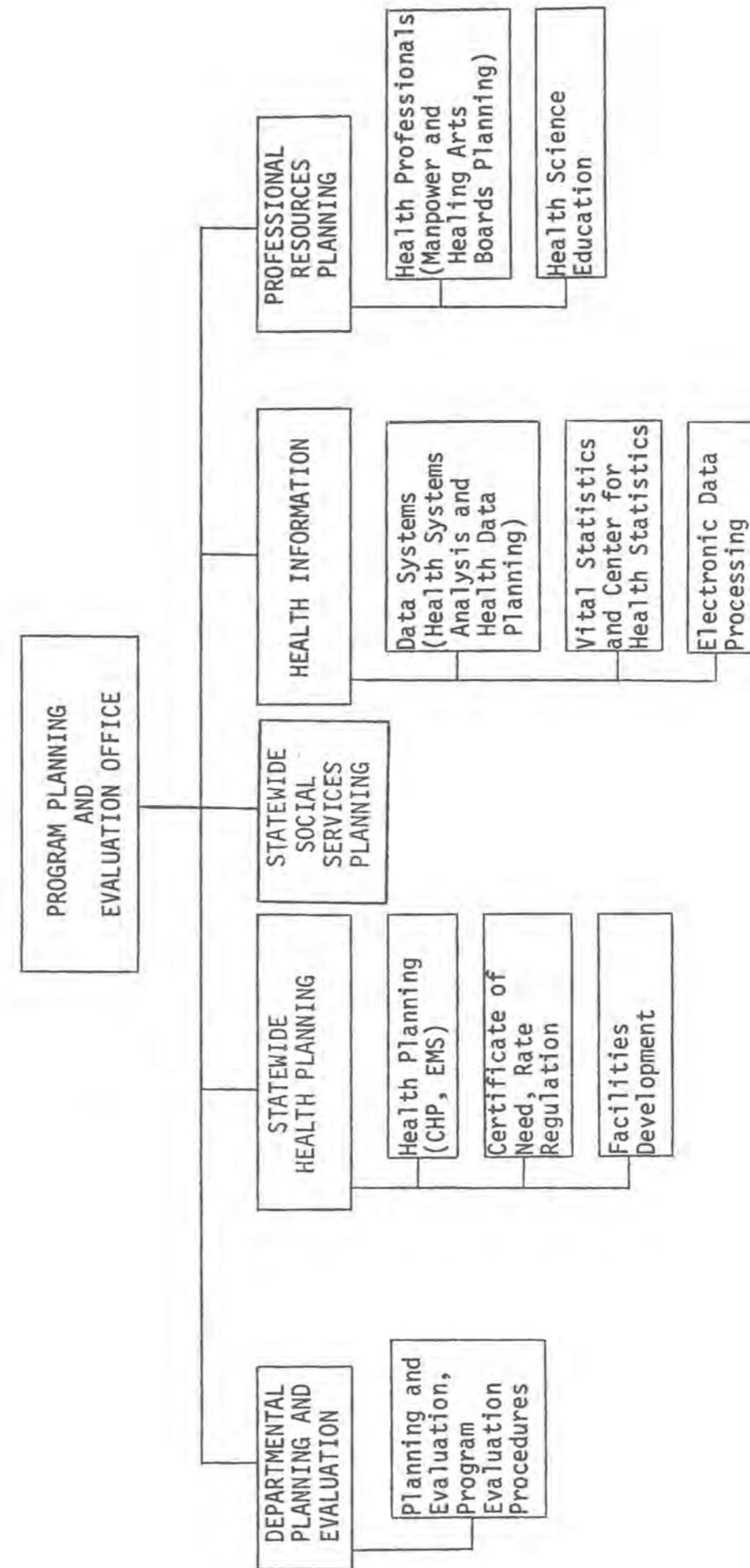
Council. After merger, the function was moved to the Quality Health System, and downgraded in status and staff support, a reflection of the lack of importance attached to this function at that time by the Health and Welfare Agency.

The disruption which accompanied reorganization coincided with passage of major comprehensive health planning legislation in the National Congress, PL 93-641, the National Health Planning and Resources Development Act. The implementation of this law in California has coincided with a change in state administration.

At this juncture, the staff of the Comprehensive Health Planning Unit is waiting in the wings--waiting for the return of stability in the administration of statewide health planning in California.

Our recommendations for administrative placement of the statewide health planning staff within the Department of Health are based on the following reasoning:

- a) Statewide health planning must command a high position in the department, because of the national move toward comprehensive health services and a desire to create the skeleton for administration of a national health insurance plan;
- b) The size and importance of California and the move to attain better integration of its publicly funded health program is coupled



Phase I
Chart #4

with a struggle to meet the needs of the poor and disadvantaged in a system of delivery of services which is not either segregated or duplicative;

- c) The attainment of such goals demands a planning process for the programs of the Department which is compatible with the planning of statewide services for all of the citizens of the State.

As government encroachment grows in the financing of health services, a confluence of effort in the public and private sectors becomes crucial. Destructive competition, segregation, categorical approaches to the health problems of people and unnecessary duplication of services may otherwise become the products of a skeptical, pessimistic view of the planning process.

We therefore recommend that departmental and statewide health planning be combined in an administrative unit which reports directly to the Office of the Director of the department, and provides staff support to the Council which is eventually to be given responsibility for statewide health planning and coordination.

Such an office need not be physically located in space adjacent to the Director, but it must be functionally close--for administrative access, participation and reporting. An important reason for this change in organization is to assure that programs of the department reflect the priorities and strategies of a statewide health plan for California.

The focus of statewide health planning will be on both public and private services and responsive to the regionalized planning agencies (health systems agencies), and to the state entity designated under PL 93-641. Functions would include comprehensive health planning, emergency medical services, certificates of need, rate regulation and facilities development.

Department planning and evaluation staff will focus on departmental programs in support of the operating programs and provide them with both program planning and evaluation expertise. Operational planning would remain the clear responsibility of program managers, but the direction of their planning would be influenced by departmental planning. A unit for the latter would be responsible to assure coordination within the department and compatibility with both a departmental and statewide plan. Independent program evaluations within the department would also emanate from this unit.

Since ordering of relevant information is central to effective planning, and is a data gathering function, it should be contained in a health information unit as a central repository of vital statistics, facilities and manpower information, and data emanating from the health systems agencies. A coordinated health information system is a massive undertaking, but absolutely essential to a rational planning process. Generous investment in data processing is also essential to program and budget control. Programs must be afforded more authority than at present in design of data systems and easier access to processing.

Because of its present condition of neglect, a social services planning unit is afforded status with health planning. The articulation of social casework

with public medical programs may be highly productive. Medical care is an important but limited aspect of effective social services. People need help with information and referral, housing, employment, social security, food purchase, family budgeting, protective services, legal service, home-maker care and many others. An attempt must be made to get away from exclusively medical models when other models are more useful.

Better articulation of health professional resources development with facilities planning is also needed. The two are interdependent. Leadership of the department is necessary to bring the consortia now involved in manpower planning together with the health systems agencies--a marriage which is perhaps overdue in many places in the State. Planning for production of professionals in the University of California Health Science Education System must be closely related to this activity of the department.

b. Advisory Bodies to the Department: The elimination of the State Board of Health in 1973 appears now to have been a serious mistake. The existence of a statutory, publicly accountable body is necessary to oversee broad policy, adopt regulations and prevent the department from taking capricious or arbitrary action in major policy areas. The machinery which presently exists at state level to guide public policy is confused, conflicting, and largely ineffective.

The Health Advisory Council is still responsible for the approval of the statewide health plan. It possesses an advisory role to the department with statutory authority limited to the certificate of need for new health facilities construction and the adoption of a statewide health plan.

The Health Facilities Commission, created by statute in 1972, possesses power to create a mandatory reporting system for disclosure of the operating cost of hospitals. The commission is presently seeking expansion of its responsibilities to include the certification of need authority and rate regulation for hospitals and other health facilities. Public Law 93-641 calls for the Governor to appoint a State Health Coordinating Council to replace the Advisory Health Council and to designate a single state agency, the State Health Planning and Development Agency, to assume responsibility for comprehensive statewide health planning, certification of need for new health facilities construction, and policy direction relating to all federally supported health programs operating in California.

The authority vested in state government under PL 93-641 is, in our judgment, potentially vulnerable to overcontrol by the Department of Health, Education, and Welfare.

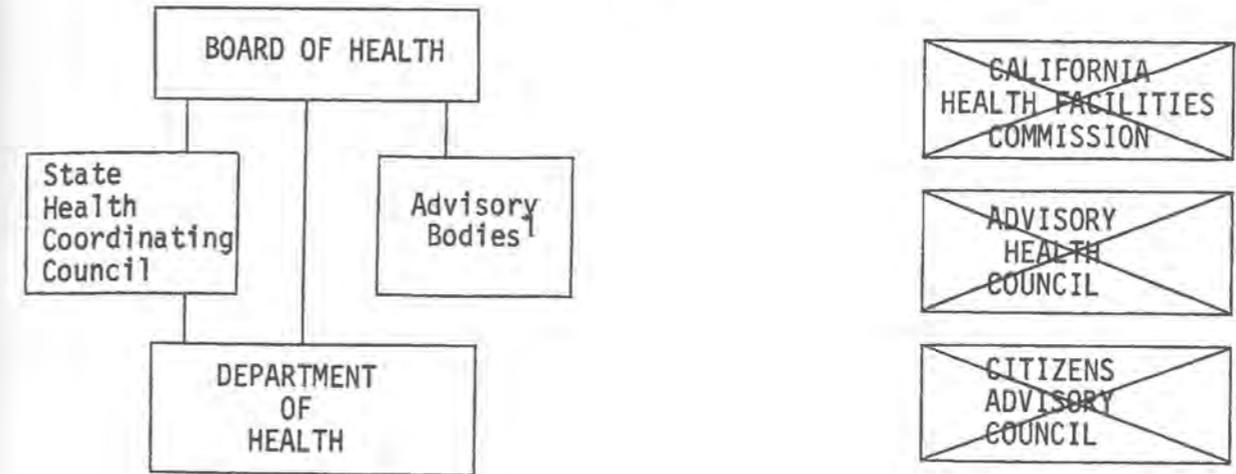
We therefore urge that the Governor ask the Legislature to re-establish a State Board of Health structured by the Legislature to be responsive to all citizens of the State. Once created, the State Board of Health jurisdiction should include all the responsibilities relating to comprehensive health planning in California. A publicly accountable body can best guide the future development of health resources and a healthy environment.

We also recommend that the Governor designate the State Department of Health as the agency for implementation of the statewide health plan, under the direction of the State Board of Health.

Chart #5

With support from the Governor, the State Board of Health should seek federal recognition to assume the authority vested by PL 93-641 in a State Health Coordinating Council. Because of the extensive authority intended for a State Board of Health, a State Health Coordinating Council should be appointed to work intensively on planning, under the direction of the State Board of Health.

We also recommend that the Health Advisory Council, the Citizen's Advisory Council, and the California Health Facilities Commission be eliminated and their functions assumed by the State Board of Health.



The State Department of Health currently has 41 statutory and 24 non-statutory advisory groups, with a total membership of 765 persons.

We recommend that the extensive list of technical advisory bodies also fall under the authority of the State Board of Health and be reorganized to eliminate duplication of effort and obsolete, inactive boards. Chart 5 depicts the recommended organization for advisory bodies.

Advisory Bodies:

I. POLICY

- * Air Quality
- * Conference of Local Health Officers
- * Conference of Mental Health Directors
- * Cancer Advisory Council
- Crippled Children Services
- Dental Health
- Seasonal Agricultural Workers
- * Technical Advisory Committee on Narcotics and Drug Abuse

II. REGULATION

- * Atascadero Hospital
- Alcohol Determination
- * Building Safety Board
- * Cannery Inspection Board
- * Child Health Board
- * Community Care Facilities
- * Emergency Medical Services
- * Hazardous Waste Technical
- Hemophilia Advisory Committee
- * Medical Therapeutics and Drug Advisory
- * Radiologic Technology Certification
- * Regional Renal Dialysis
- * Renal Dialysis and Hemo Transplantation
- * State Hospitals (14)
- * Water Treatment Facility Licensing

III. TECHNICAL

- Animal Importation
- Blood and Blood Derivatives
- * Clinical Laboratory Technology
- * Credentials Committee
- * Drug Manufacturing
- Fisheries Technical
- Genetic Disorder Advisory
- Genetic Disorder Liaison
- * Health Facilities Board
- Health Standards for Day Care
- Home Health Agency
- * Immunization
- * Pet Birds
- * Regional Rabies (6)
- Sanitarians Standards
- Sanitary Engineering
- Tumor Registry
- Vector Control
- Venereal Disease
- Visual Screening

* Statutory - 25
● Non-statutory - 18

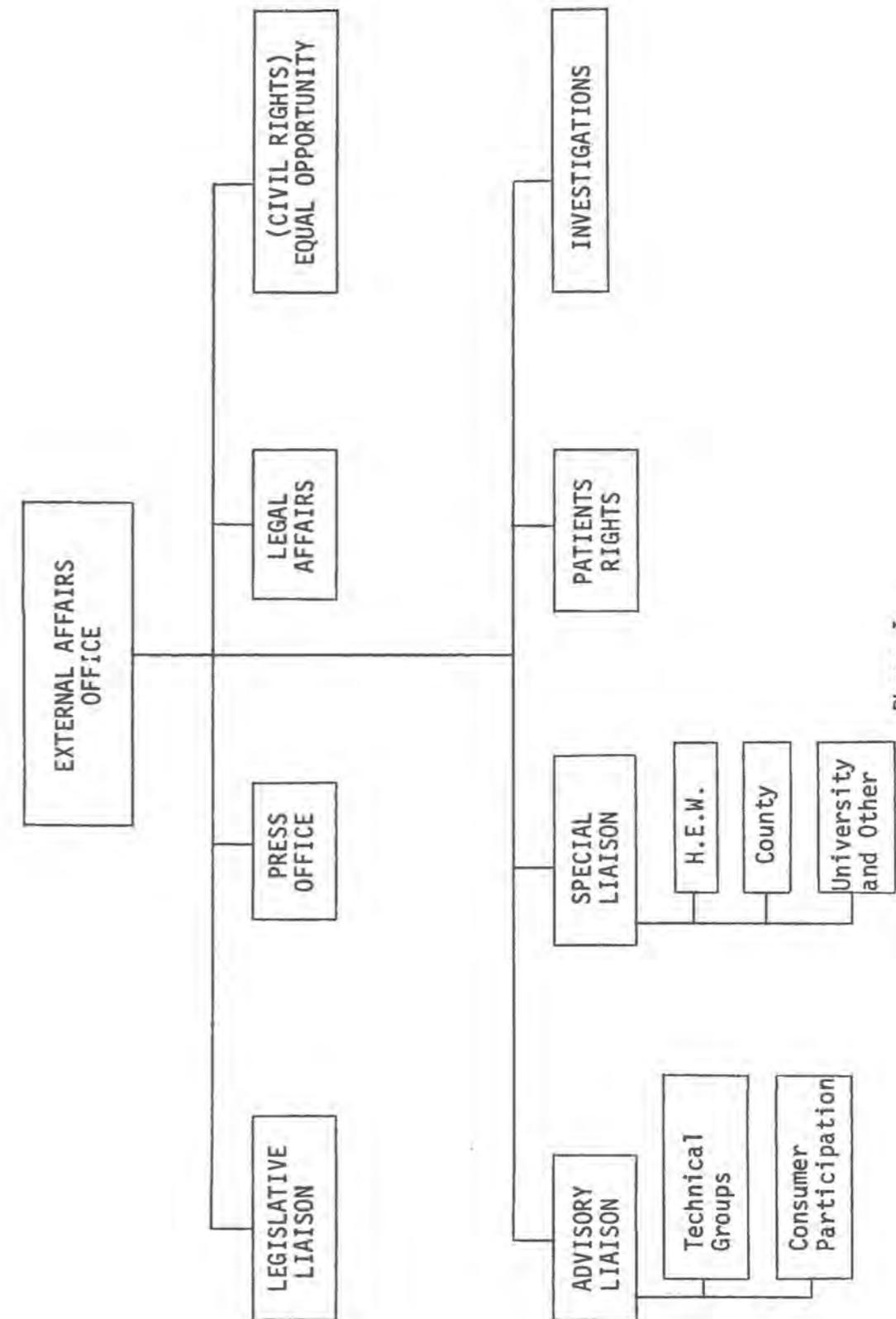
We urge immediate action by the Governor to create a more rational, orderly and open process to guide the future of health affairs in California. At present, administrative disorder threatens to impair the State's ability even to respond intelligently to further national health initiatives, for example,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

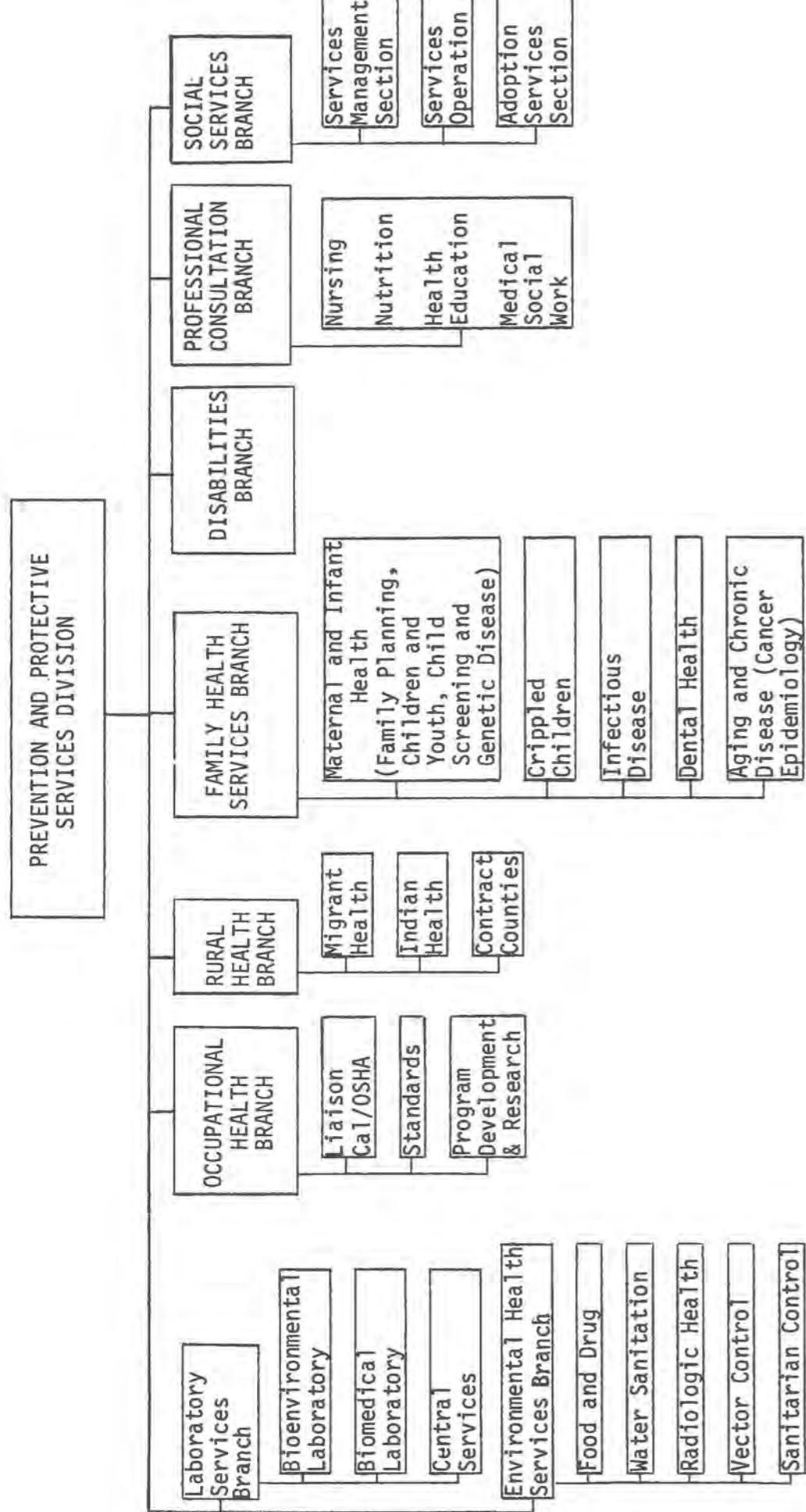
We propose creation of a consumer liaison function to be added to the advisory liaison to local professionals and programs. This is to assure access to the director by persons using programs at the local level who have reason to complain or suggest action to improve local programs.

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



Phase I
Chart #7

complementary to social work programs, including transitional residential care, day activity centers, occupational training activity, program management by patients, community organization and advocacy.

We have, for similar reasons, proposed a professional consultation branch to give visibility and status to the neglected potential of multi-disciplinary team consultation by health educators, nutritionists, and public health nurses. We see this, however, as a point to convene professional expertise, not a place to isolate them from operating programs. Division managers should make assignments to specific programs in order to build into programs these extremely important and much neglected skills. Fully funded positions in the programs themselves should be the ultimate goal to push the spectrum of care toward prevention and promotion of health.

Environmental Health and Laboratories Services are functioning well, and no changes are recommended. These two programs, however, should function as separate branches as shown on Chart #1 (Phase 1) for administrative efficiency.

Family Health Services Branch is created to move away from the tendency to deal with children's needs in the context only of mothers and children. Although we recognize the apparent neatness of combining administration of all programs involving children, we are more impressed with the fact that male adults, and the aged, are parts of families and we recommend the administrative combination of all direct preventive medical service in one branch, oriented toward the needs of all individuals within the family.

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

desire of families in comprehensive children and youth projects to expand the service capacity to accommodate adults living in the homes of children served by the projects.

Chronic Disease Control and concerns in the aging population are closely related. Prevention of unnecessary and recurring hospitalization amongst the aging population suffering chronic disease could be accomplished by forging an alliance between the Chronic Disease Unit and the Medi-Cal program. An organized program of prevention, applied to Medi-Cal, could thereby reduce costs.

The creation of a Rural Health Branch is recommended to highlight the importance of diversion of a greater share of departmental resources into rural communities. This branch, we feel, should give priority to the funding of professional positions in rural areas, and limit state staff to a small but effective unit with special experience in the rural health scene, and in the problems of the contract counties and the general citizenry of rural communities. All of them suffer from a scarcity of both manpower and budget. The special problems of agricultural workers, Indians, and even tourists can be met not by the development of services confined only to these groups, but by a unified effort to provide rural areas with resources available to all who need them. It is in the rural setting where rivalry and competition amongst various special interests is potentially the most destructive, since the rural community is short of resources for everybody and can least afford a policy of segregation or exclusion.

The Disabilities Evaluation Branch should be transferred to this division. The evaluation of disability is done for two reasons--to determine eligibility

for cash grant assistance, and to develop a connector to medical, protective, and social services support to the disabled. Hundreds of thousands are screened in this fashion, but examination of records and statistics force a conclusion that the referral to medical and social services is haphazard and disorderly. If this evaluation process, predominantly for adults, is viewed not only as an eligibility process, but as potential for creation of systematic referral to services and the development of a record system to track completion of referral, then the perennial confusion as to the appropriate placement of this function is solved.

Social Services Branch: We recommend placement of the Social Services Branch into the Prevention and Protective Services Division.

Since reorganization in 1973, Social Services has been neglected and downgraded. This function clearly needs a higher level of authority and visibility in the department. Social Services at the community level involve far more than support to medical programs and protective placements. New models of services organization dealing with employment, vocational rehabilitation, housing, social security, and criminal justice need development.

Title XX changes in financial services presents a great challenge for progress which could be seriously marred unless the State shows more talent and commitment in leading the way. Mandated services which cannot be budgeted

represent a threat to county programs which must be removed. A new birth must occur in leadership in social services planning and development.

Occupational Health Branch (Cal-OSHA): The leadership in occupational health programs was disrupted when its chief elected not to move from Berkeley to Sacramento. This unit traditionally supplied consultation to both labor and management and to the Division of Industrial Safety, Department of Industrial Relations. Consultation involved education in the prevention of occupational health hazards in the development of organized programs of worker education and prevention.

Passage of the National Occupational Safety and Health Law occurred in 1973 - Cal-OSHA was implemented the same year. This program created two independent boards - the Occupational Health and Safety Standards Board and an Appeals Board. The former sets standards; the latter hears employer appeals related to disciplinary action.

An interagency agreement with the Agriculture and Service Agency enables the Division of Industrial Safety to draw on the health expertise of the Department of Health for consultation on occupational hazards and their correction. In addition, the Department of Health supplies training to safety engineers involved in compliance inspection and enforcement. This training is aimed at increasing the ability to recognize occupational health hazards during inspection as well as mechanical safety hazards.

The Department of Health also carries out special studies of occupational health and disease.

The Cal-OSHA emphasis on enforcement and its dependence on the Department of Health for supportive health data to present in the appeals process is time-consuming for State Health Department staff and hampers their efforts to develop more comprehensive and balanced approaches to occupational health problems.

The tensions which appear to accompany the Cal-OSHA program implementation derive from differences in orientation and emphasis between public health physicians with a specialty in occupational health and industrial safety engineers.

Physicians tend to be primarily concerned with people; engineers, with the safety of the environment.

Thus, the interest of the Department of Health is oriented toward people, behavior, epidemiological study and preventive programs; the Division of Industrial Safety is oriented toward mechanics, environmental hazards, dangerous mechanical devices, and enforcement. Both are essential to occupational health and safety.

In fact, at the working level of both departments good working relations exist and mutual respect is paid to each other by people with different specialties able to work together successfully.

The present organization of Cal-OSHA should not be altered, since it is inevitable that the two departments must both be involved in the program.

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.

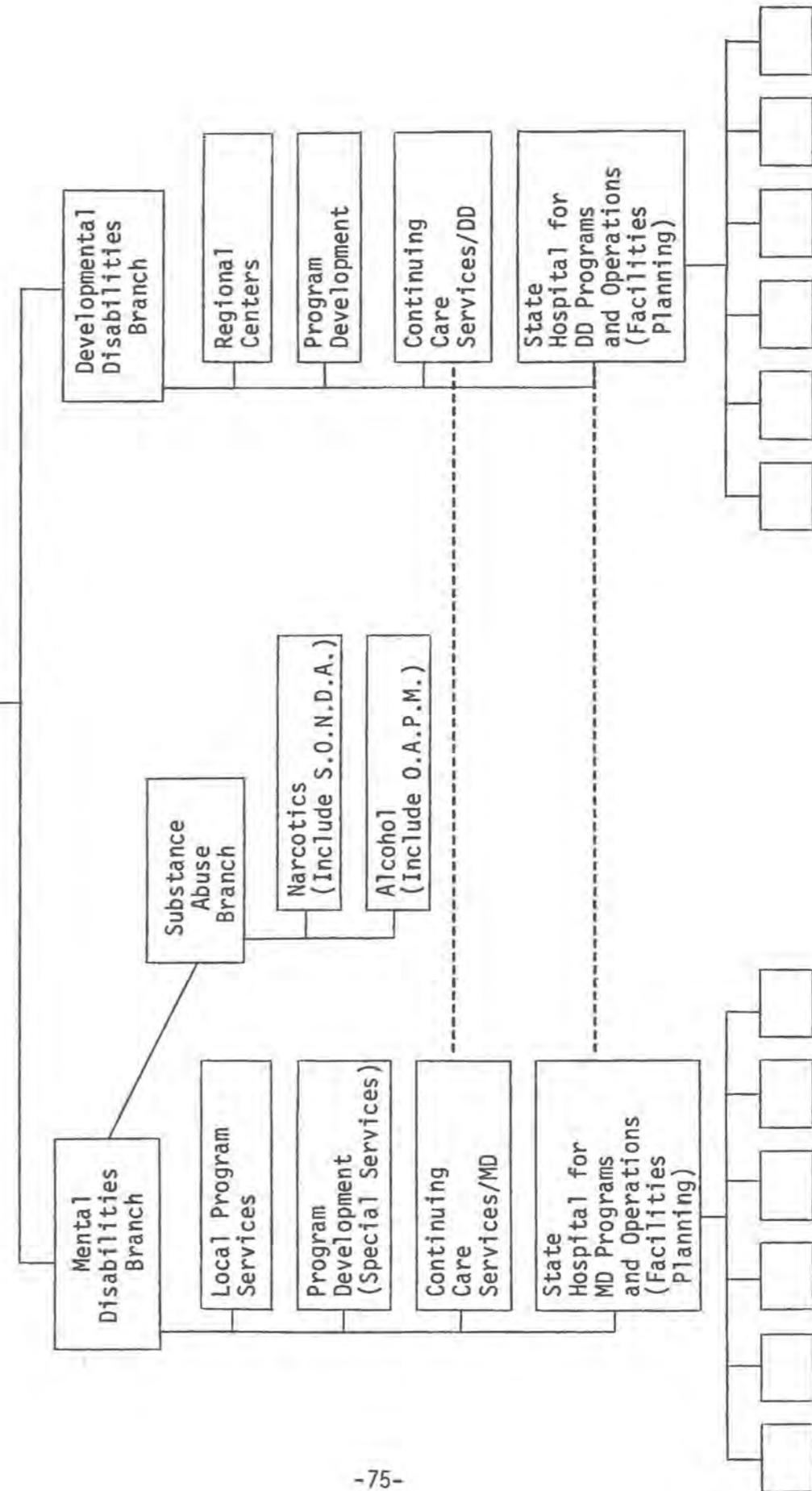
Pesticide safety standards are formulated by the Board of Agriculture and enforced by the Department. For years, complaints have been made that enforcement is lax. With a new administration interested in farm labor, enforcement will probably improve. If workers complain - (an event made more likely by 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

strengthen enforcement under a uniform set of standards. We do not advocate the transfer of enforcement of pesticide safety standards into the Department of Health.

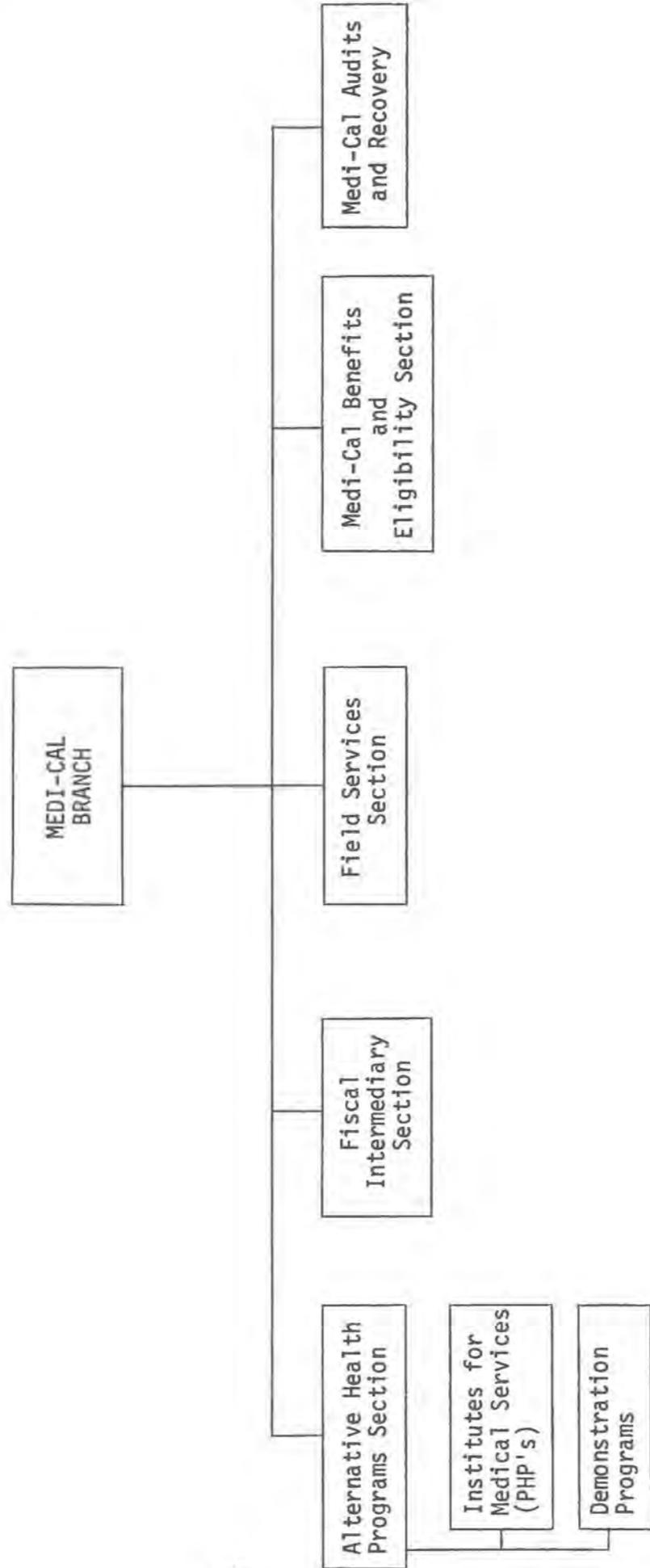
e. Mental and Developmental Disabilities Division: The most urgent administrative change is to merge the state hospitals and community services divisions together, as they were prior to May 1975. The separation of these two programs has created multiple problems for the Department as a whole, as well as all the developmental and mental disability programs, detailed in Part II. We further suggest that two major branches should be maintained within this division: (1) Mental Disabilities and (2) Developmental Disabilities, with the integration of the community and hospital programs within each section. This division could be more accurately titled Mental and Developmental Services Division because the majority of the programs fall under this label. The Substance Abuse Branch should be integrated as a section into the Mental Disabilities Branch.

f. Licensing and Certification Division: The Licensing and Certification Division should remain intact in Phase I, with some of its separate sections consolidated at the headquarters and the regional level, as described in the program review in Part II. The numerous field offices of the division should be brought together both geographically and administratively. The Investigation Section in this Division, however, should be moved to the External Affairs Office where all investigation activity of the Department should be consolidated. This program needs autonomy outside the Health Program Section, which it sometimes investigates, which will be documented in Part II. All licensing activities now located in the Community Services Division and the

MENTAL AND DEVELOPMENTAL DISABILITIES DIVISION



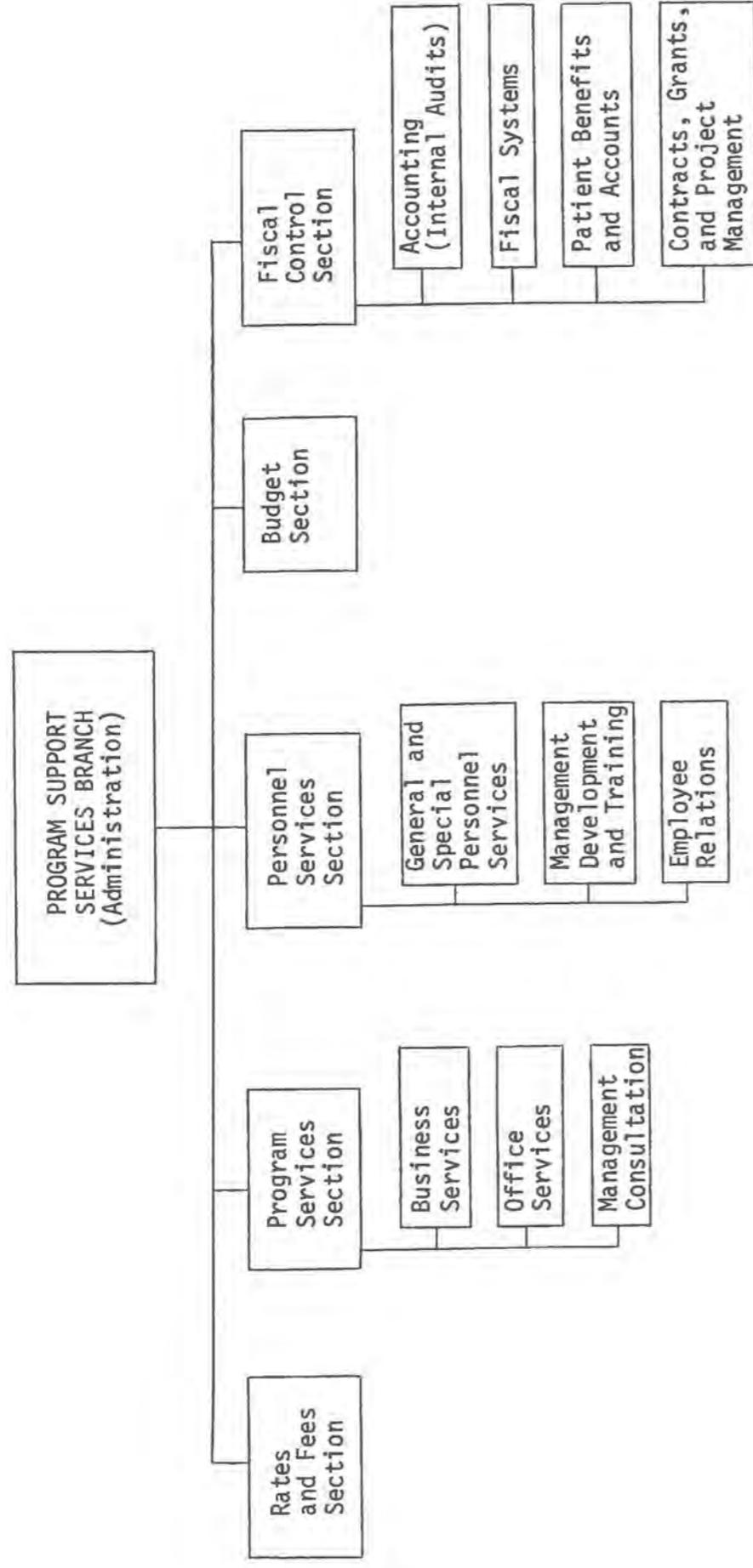
Phase I
Chart #8



Phase I
Chart #10

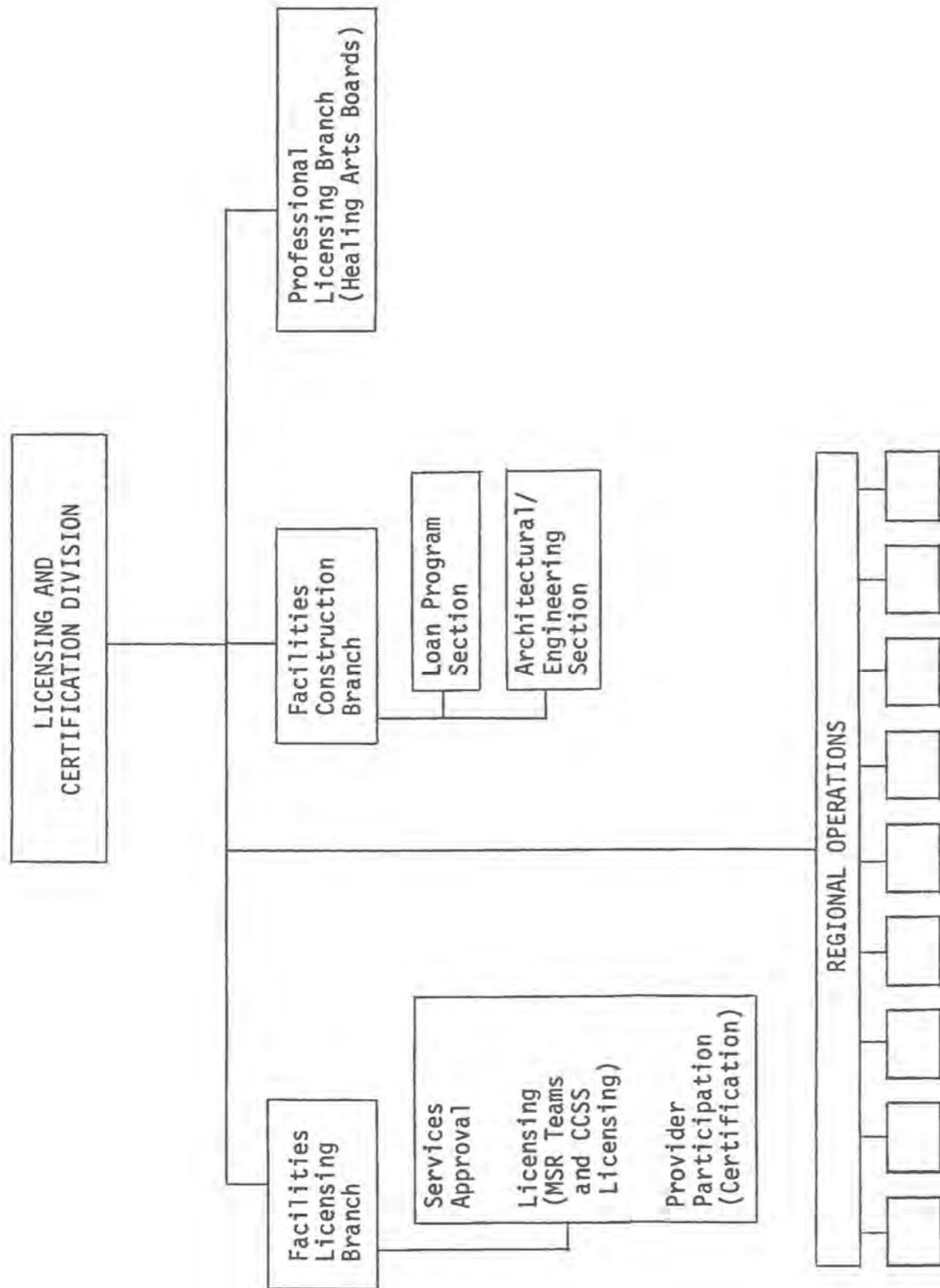
The Alternative Health Systems Division (previously called Prepaid Health Plans and Institutes for Medical Service) does not, in our opinion, warrant separate division status and should be placed back in its parent division--the Medi-Cal program. Because of its multiple management problems, described in Part II, and its inherent ties to the entire Medi-Cal program, we suggest that it should be re-merged with the Medi-Cal program immediately.

h. Program Support Services: The Program Support Services Branch (Administrative Division) should include the components which it currently has, including Personnel, Program Services, and Fiscal Operations. The fiscal operations could be divided into two separate operations; one of which is the Fiscal Control (Management) operation including Accounting and Auditing; and the other the Budget Section concerned with budgetary disbursement for the Department. The Rates and Fee setting component should be elevated to branch status in keeping with the importance of its activities. Other activities currently in the Administrative Branch of the Department should be transferred to other sections: The Health Manpower Development, the Data Systems Development activities, the Center for Health Statistics, Vital Statistics, and Evaluation Procedures, should all be transferred to the Program Planning and Evaluation Office. The Management Consultation Section should be merged with a portion of the Internal Audit Section, formerly in the Director's office, and placed with the Program Services activities. The Systems Analysis Section and Data Processing should merge and remain in the Program Services Section. The unit which coordinates departmental research activities in the Division should be transferred to the Planning and Evaluation Office.



Phase I
Chart #11

Reporting Relationships: In keeping with our recommendations for a more flat organization, with clearly defined roles for the deputies, we are suggesting the Director should have four major administrators reporting directly to him: The Program Planning and Evaluation Officer, the External Affairs Officer, the Chief Deputy for Health Programs, and the Deputy for Fiscal and Program Support Services. We are recommending that each deputy be given clearly defined roles and specific responsibilities for which they can be held accountable. Because the Program Planning and Evaluation Office and the External Affairs Office do not hold the magnitude of responsibility, and are considered vital program support units, we are recommending that administrators of these units be entitled officers with less than deputy status. This connotes that they do not hold as great a responsibility as do the Chief Deputy and the Deputy for Fiscal and Program Support Services. The Chief Deputy for Health Programs should be assigned full responsibility and authority for the divisions designated in the organization chart. The Chief Deputy should have direct line authority for health programs of the Department. The Deputy for Fiscal and Program Support services should report directly to the Director of the Department, with responsibility to the Director for providing support services to the Health Programs.



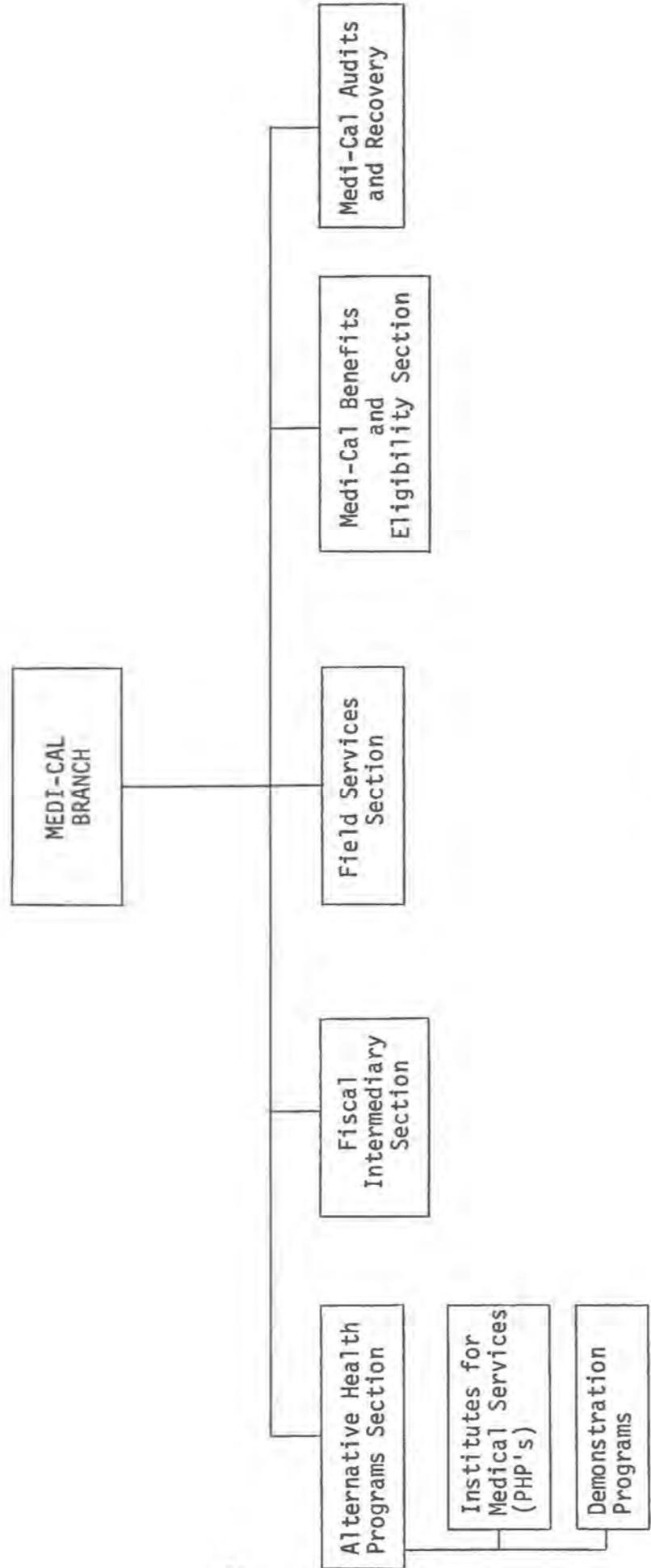
Phase I
Chart #9

Medi-Cal Division should be transferred to this Division and integrated into the over-all program. The facilities data gathering and analysis activities should be transferred to the Planning and Evaluation Office.

Healing Arts Boards: When the Healing Arts Boards move to the Department of Health in 1977, they should be positioned in the Licensing and Certification Division for administration of their responsibilities. Any activity relative to the planning of professional resources should be placed in the Professional Resources Planning Unit in the Program Planning and Evaluation Office, as previously discussed.

In summary, the three divisions described above are the primary program activities of the Department, with the exception of Medi-Cal, and thus are placed under the management of the Chief Deputy for Health Programs, who Reports to the Director.

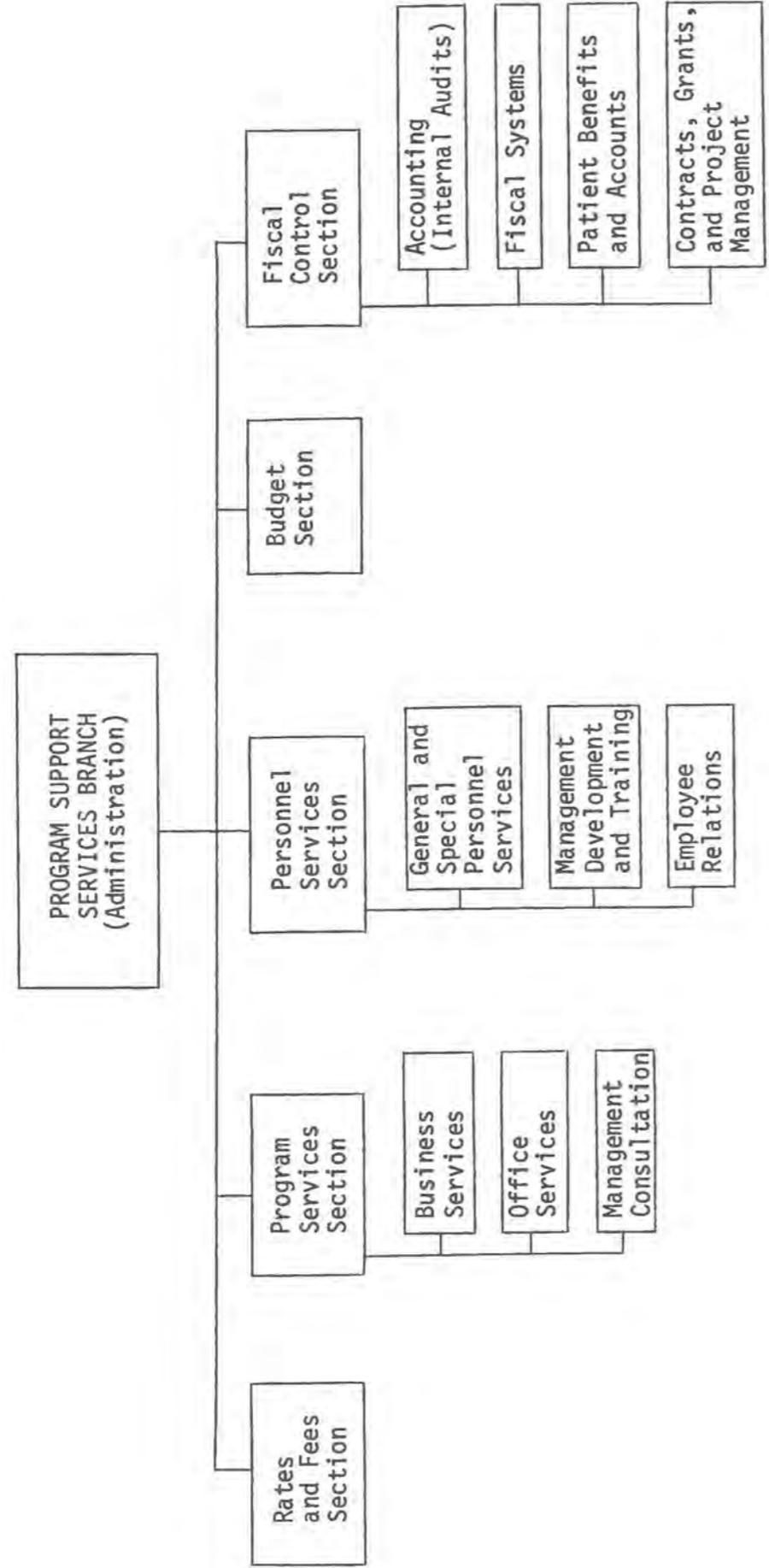
Medi-Cal Services Branch: The Medi-Cal program, discussed in detail in Part II, has so many current administrative problems that it should be kept intact until program controls can be attained. To avoid disruption, we suggest that the Medi-Cal services program be supervised further by the Deputy for Fiscal and Program Services. This branch should eventually be divided so that the fiscal control components are transferred to the Program Support Services Section and the professional program components and resource allocation activities be transferred to the Health Program and finally merged with the Preventive and Protective Services Division, in Phase III. During Phase I, we suggest that the Medi-Cal Services program maintain its current branches and activities until major reforms are made in the basic premises of the program as outlined in Part II, Section I.



Phase I
Chart #10

The Alternative Health Systems Division (previously called Prepaid Health Plans and Institutes for Medical Service) does not, in our opinion, warrant separate division status and should be placed back in its parent division--the Medi-Cal program. Because of its multiple management problems, described in Part II, and its inherent ties to the entire Medi-Cal program, we suggest that it should be re-merged with the Medi-Cal program immediately.

h. Program Support Services: The Program Support Services Branch (Administrative Division) should include the components which it currently has, including Personnel, Program Services, and Fiscal Operations. The fiscal operations could be divided into two separate operations; one of which is the Fiscal Control (Management) operation including Accounting and Auditing; and the other the Budget Section concerned with budgetary disbursement for the Department. The Rates and Fee setting component should be elevated to branch status in keeping with the importance of its activities. Other activities currently in the Administrative Branch of the Department should be transferred to other sections: The Health Manpower Development, the Data Systems Development activities, the Center for Health Statistics, Vital Statistics, and Evaluation Procedures, should all be transferred to the Program Planning and Evaluation Office. The Management Consultation Section should be merged with a portion of the Internal Audit Section, formerly in the Director's office, and placed with the Program Services activities. The Systems Analysis Section and Data Processing should merge and remain in the Program Services Section. The unit which coordinates departmental research activities in the Division should be transferred to the Planning and Evaluation Office.



Phase I
Chart #11

Reporting Relationships: In keeping with our recommendations for a more flat organization, with clearly defined roles for the deputies, we are suggesting the Director should have four major administrators reporting directly to him: The Program Planning and Evaluation Officer, the External Affairs Officer, the Chief Deputy for Health Programs, and the Deputy for Fiscal and Program Support Services. We are recommending that each deputy be given clearly defined roles and specific responsibilities for which they can be held accountable. Because the Program Planning and Evaluation Office and the External Affairs Office do not hold the magnitude of responsibility, and are considered vital program support units, we are recommending that administrators of these units be entitled officers with less than deputy status. This connotes that they do not hold as great a responsibility as do the Chief Deputy and the Deputy for Fiscal and Program Support Services. The Chief Deputy for Health Programs should be assigned full responsibility and authority for the divisions designated in the organization chart. The Chief Deputy should have direct line authority for health programs of the Department. The Deputy for Fiscal and Program Support services should report directly to the Director of the Department, with responsibility to the Director for providing support services to the Health Programs.

2. Phase II

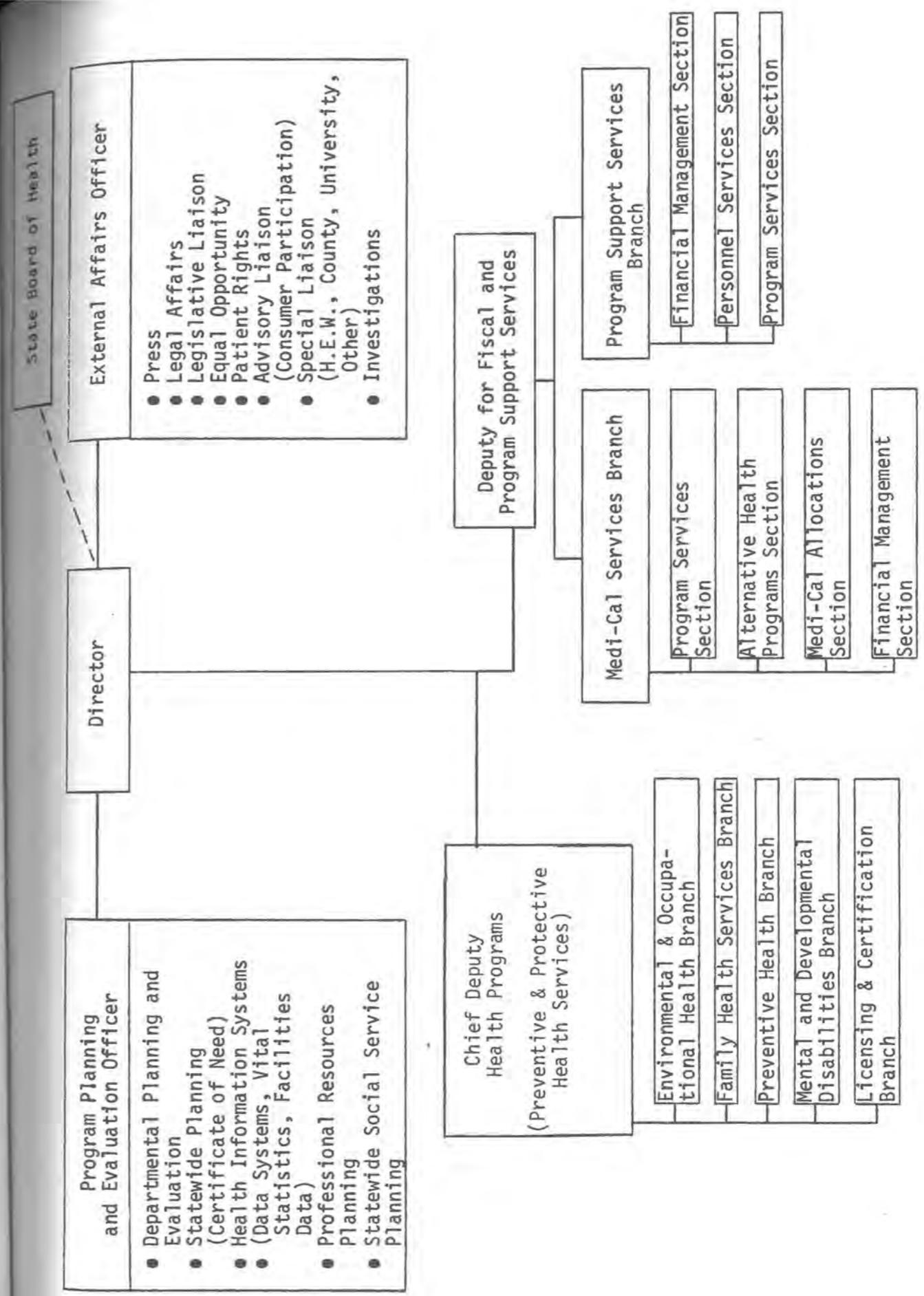
This chart depicts a second generation of change, and is based on the presumption that the service programs have been brought under a reasonable degree of administrative control.

A State Board of Health would now bear an important relationship to the operations of the Department in the review and approval of regulations.

The Program Planning and Evaluation Office and the External Affairs Office would remain unchanged.

The Preventive and Protective Health Services Division would accept transfer of the administration of mental and developmental disabilities as a new branch, to continue the work of integrating these services into an emerging system of comprehensive family-oriented community services.

Licensing and Certification, once its house is in order, would also move, with branch status, to this same division. This move is intended to tie the process of licensing and certification as a function which is supportive to the service programs. Programs and the facilities in which they are carried out bear an obvious relationship to each other, and cannot operate effectively if the licensing authority is separated from program concerns. The expectation in making this articulation is that any facility which does not meet a Department standard should not be permitted to provide services in any of the programs funded by the Department of Health. The location of the administration of the Healing Arts Boards in this branch carries the same reasoning.



Phase II, Proposed Organization Chart
Department of Health
Chart #12

Within this division, the Family Health Services Branch would absorb the Rural Health Branch and the Social Services Branch.

The social services involved in this transfer would be limited to those which bear directly on health services programs.

Independent social services, funded in Title XX, IV.A., B., C., and D., would continue to operate in a branch of the Preventive and Protective Health Services Division, not depicted in the chart.

The Disabilities Evaluation function would be incorporated in the Mental and Developmental Disabilities Branch and would continue to function both as a screening process for eligibility for income maintenance and a source of referral to appropriate social and health programs of the Department.

Occupational Health would become an activity within the Environmental and Occupational Health Branch, which continues to carry its responsibilities for environmental health and laboratory services.

A Preventive Health Branch would be newly created to begin to expand activities related to organization and promotion of preventive health programs.

This branch would absorb the Professional Consultation Branch (preventive medicine, public health nursing, nurse practitioners, nutrition, health education, epidemiology, infectious disease, chronic disease control, dental health, genetic disease control) all skills and activities which need to impact on programs which deliver services directly to people.

This constellation of activities is created not as an isolated set of functions and concerns, but as a branch clearly committed to involvement with all direct service programs in the Department, for the purpose of the development of a preventive component in each of the service programs.

Medi-Cal would remain in a separate position in the Department as a Branch under the direction of the Deputy for Fiscal and Program Support Services. We anticipate that many changes will be occurring in this program and that its basic premises will be in the process of major revision. Medi-Cal, for these reasons, and because of its large size, will not be ready for the process of integration. However, in this branch, a Program Services Section is created, to give to the Medi-Cal program a much heavier emphasis on program planning and health delivery systems development. At present, Medi-Cal is treated only as a financing mechanism, except for the Institutes for Medical Services in the Alternative Health Programs Section.

Continued attention must be paid in Medi-Cal to methods of reimbursing providers of services. A Medi-Cal Allocations Section is organized to carry a much reduced fiscal intermediary function, and to develop new systems of prospective budgeting, contracting, and composite rate reimbursements to providers other than prepaid health plans, who do not use a fee for service approach to reimbursement.

Financial management in Medi-Cal would be the responsibility of a separate section, which would deal with budgeting, accounting, audits, recovery, etc.

The Program Support Services Branch would fulfill similar functions for other programs of the Department.

3. Phase III

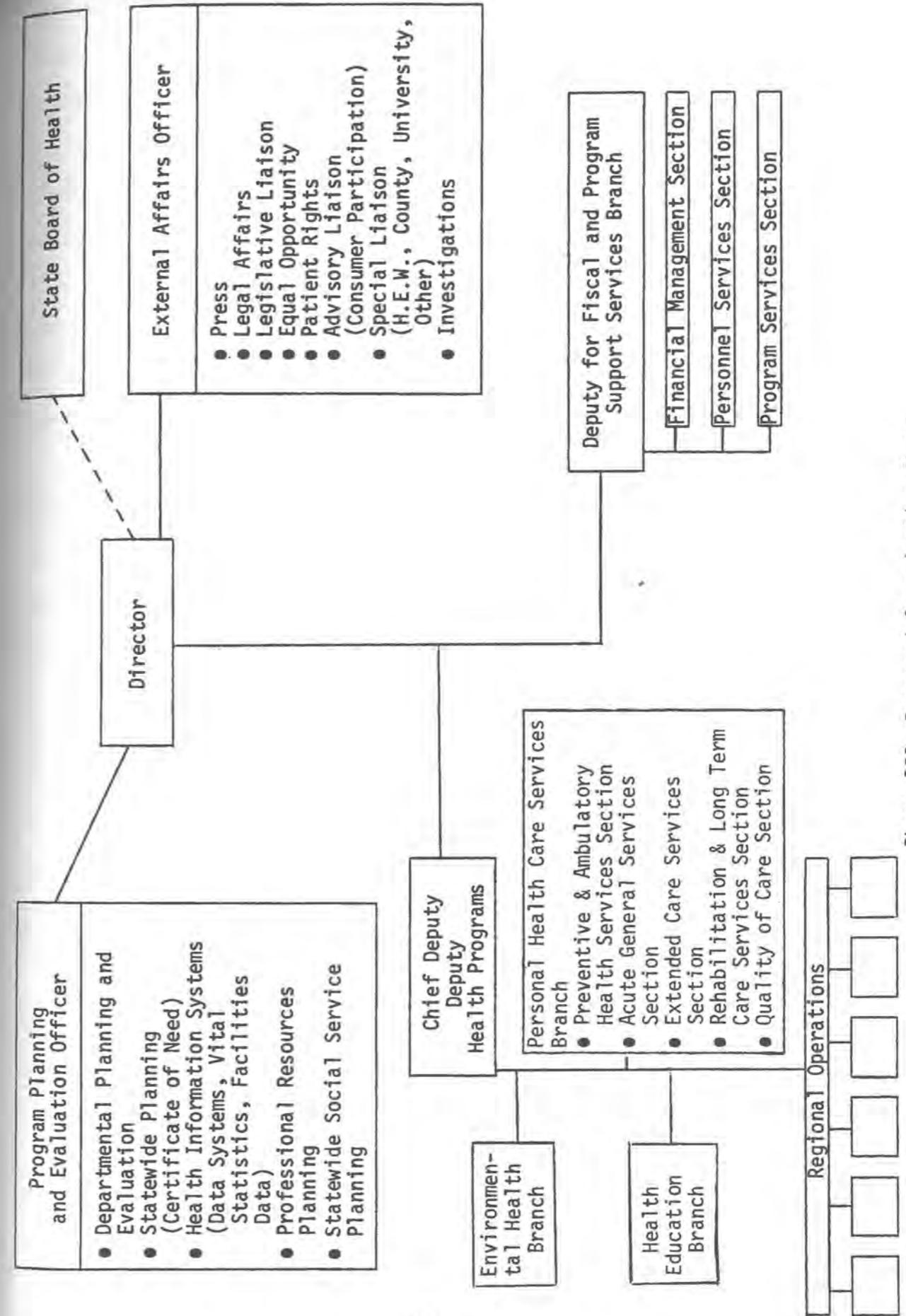
Phase III depicts the eventual goal of services integration within the Department.

Phase III chart displays three activities on the program side of the department: an integrated approach to all direct personal health services, a branch of environmental health, and branch for health education. The future of health care in California requires that a balance be struck between the treatment of disease, the improvement of public education in the avoidance of illness and the continuing attempt to control the deterioration of the environment which results in health hazards to the people of the State.

Environmental Health Branch: This branch will house all professional activities related to control of the environment and elimination of noxious influences which represent a health hazard to the general public. Occupational health programs would also be administered within this branch.

Health Education Branch: This branch would address itself to the task of increasing public awareness of the importance of development of personal health habits conducive to good health. Personal responsibility for maintenance of health through modification of life style is clearly in need of greater attention and emphasis.

Personal Health Care Services Branch: The final form of organization for personal health services in that branch depicts the completion of an attempt to integrate the delivery of health services of all kinds in the community setting.



Phase III, Proposed Organization Chart
Department of Health
Chart #13

Program concerns would be organized around the concept of a comprehensive, integrated services delivery system, supported by an equally integrated management system to address fiscal and administrative processes which are necessary to support the delivery of services.

Here, the branches on the service side would be organized by definitive, distinctive service settings, each of which is an integral component of a comprehensive system of delivery of services to all people, diseases, and problems. All prevention and organized ambulatory health services would become the concern of a single branch.

An Acute Care Services Section would deal with hospitalization and emergency health care services.

An Extended Care Services Section would be created to stimulate the development of alternatives to hospitalization--extended care, transitional residential treatment programs, day treatment and activity centers, in-home health services, etc.--and to coordinate such alternatives with patients being discharged from the acute hospital setting.

A Rehabilitation and Long-Term Care Services Section would be charged with the responsibility for making more rational the care provided to people in nursing homes, board and care homes, residential care, and other community care facilities. Such care needs to be based on uniform licensing standards, a more efficient system of inspection and monitoring, and a method of reimbursement more closely related to levels of care provided rather than to the particular designation given to the long-term care facility.

The reason for organizing rehabilitation in the same branch as long-term care is to try to organize a system of discharge planning which is oriented toward rehabilitation and does not permit an inappropriate admission to any long-term care facility. Too many patients are literally being dumped into long-term care without a careful consideration of alternatives, such as extended care, transitional care, and in-home health services.

The Quality of Care Section would house the supportive licensing and certification processes for both individual professional care and for institutional care.

To succeed in the integration of personal health services delivery, fiscal and administrative support functions must similarly be integrated. The deputy for fiscal and program support services controls the major administrative support functions to assist an integrated system of delivery of services.

Three sections are shown to accomplish this goal--financial management--wherein is placed an integrated fiscal support system, personnel services for personnel in the department, and a program services support for such functions as management consultation, data processing, and budgeting.

The final major organizational change which we recommend is that of establishing a consolidated health program at the regional level during Phase III. To mirror departmental consolidation in headquarters, we recommend that the health program activities of the department be organized and administered within regional operations.

The department should establish six to 10 geographic regions, that would incorporate the existing 14 geographic regions designated as Health Services Areas (as mandated by Federal Public Law 93-641), which were designed for regional planning and resource allocation activities. Thus, planning and health service programs for the Department of Health would be consolidated for the purpose of health planning, resource development, health service delivery system, and resource allocation in its area. Regionalization of services and planning would integrate the Department of Health's activities at the local level as well as within headquarters.

The regional operations, during Phase III, should consolidate all health program activities for administrative purposes. To the greatest extent possible, the regional operations should consolidate field office services. Regional operations should be given their own fiscal and program support services and regional administrators should report directly to the Chief Deputy.

4. Implementation of Reorganization

The Three-Phased Reorganization Plan which we have suggested needs careful evaluation as to its feasibility before specific implementation plan can be made. The department should study this general plan in great detail and develop a strategy for implementation. The department should learn from the experiences of the 1973 reorganization, that without careful systematic plans even the most rational plan can be poorly implemented.

Full-time assignment of knowledgeable staff should be made to implement these changes. To facilitate the reorganization process and plan each phase and the details we suggest that a special unit within the department should be given

continuous and complete authority to plan and implement the reorganization changes until the changes are completed. The Planning and Evaluation Office of the department could establish a special unit with the assignment and authority for reorganization. Utilization of task forces for reorganization problems were not successful with the past reorganization of the Department of Health. Because of the over-utilization and ineffectiveness of task forces in the department, we suggest that this would not be the most effective method of achieving an orderly reorganization. In addition, we consider that while outside consultant groups, such as those utilized in the 1973 reorganization, provide useful services, they are no substitute for the department developing staff with specific responsibility assigned for such activities. Members of the Commission Task Force which produced this report are available to assist the department upon request.

We realize this plan is a massive consolidation requiring systematic development efforts by the Department of Health over an extended period of time. Such a scheme is idealistic and based in part on a desire to create a comprehensive health care system. Although this plan requires a vision of future health care problems and needs and how these can best be approached, we would be remiss in not outlining such a plan to the State. Although some will say it is impractical or impossible, we believe that only such a scheme as this can solve the general health care crisis as well as the Department of Health organizational and operational crisis.

VI. POLICY INITIATIVES FOR A PROGRESSIVE STATE DEPARTMENT OF HEALTH

A. National Health Insurance

In the last Congress, serious consideration was again given to various proposals for National Health Insurance. The eventual enactment of such a law seems certain, with widespread impact on state government and its health programs. In every instance, a precise definition of the role and responsibility of the states is lacking in laws under consideration.

There is an urgent need to create a forum in California to respond in a systematic fashion to proposals for National Health Insurance in order to assure an appropriate level of responsibility at the state level. In addition, positions on major policy issues must be developed: methods of financing; the nature of administrative structures; methods employed to assure equitable access through redistribution of resources; cost, quality and utilization controls; and the impact on both public and private delivery systems.

B. Health Planning and Resource Allocation

A closely related issue is the response made so far by California to PL 93-641, The National Health Planning and Resources Act. Lack of leadership has created a vacuum and led to widespread confusion and dissension.

Experienced health planners view this law and the health systems agencies it creates as the embryonic administrative structure for National Health Insurance. They predict that these agencies will not only be given responsibility for certification of the need for new health facilities of all kinds,

but may also be vested later with additional official responsibilities, such as manpower planning, resources development, rate and fee regulations, and monitoring the quality of care of both individual and institutional providers.

If such a prediction is remotely possible, a high priority must be placed on giving consistent and expert guidance in the formulation of the geographic boundaries of Health Systems Agencies and in conferring them with authority. Of special importance is the creation of effective machinery at state level, which is responsive and accountable to the general public.

C. Health Personnel Resources

The 1970 task force report which led to consolidation of the Department stressed the need to strengthen statewide health manpower planning. Availability of health personnel resources is the most critical issue in the assurance of access to care to all citizens. Technological advance has vastly expanded the pool of health skills but has also resulted in an emphasis on specialization which has eroded the production of primary health care practitioners and exacerbated problems in geographical distribution of manpower. These developments have precipitated an urgent need to reassess the production, functions, and distribution of health personnel, especially in tax-supported health science institutions.

The State Health Department in 1977 will accept transfer to its jurisdiction the healing arts boards. In preparation for this transfer, the Department needs to expand its attention and commitment to health resources planning. It must develop the capacity to forecast personnel needs, to curtail overproduction of certain specialties, to increase the supply and improve the distribution of primary care practitioners and to maximize the use and

function of paraprofessionals such as nurse practitioners, physicians assistants and community health workers. Success in this effort implies significant changes in established institutions and in the law. Revisions must be made in the licensing process, in the professional practice acts, and in the priorities of health science education in California.

D. Innovative Health Programs

Large sums of tax money are being expended in health programs with little innovation in the delivery of service. The State Health Department has the explicit authority to innovate in all its major service programs. To date, innovation is largely limited to methods of financing services. Isolated, but important innovations have occurred; seldom has the state initiated imaginative departures from tradition. Neighborhood health centers are demonstrating the possibility of integrating preventive services and primary mental health with general ambulatory care. They have also refined the use of important supportive services such as the use of outreach workers, translators, and transportation. The surgicenter is an innovation created by private anaesthesiologists. They have proven that a large number of diagnostic and treatment procedures can be accomplished under general anaesthesia without admission to the hospital, at considerable savings and with actual improvement in safety.

Well-planned extended care facilities have shown the advantages of planned recovery and rehabilitation of patients suffering major medical and surgical illness. The length of stay in the hospital is reduced, active rehabilitation is instituted, and return to home is carefully planned. The end result of an intermediate level of care oriented toward rehabilitation is a

significant reduction in hospital cost and the avoidance of long-term institutional care.

A closely related innovation is the organized in-home health service, capable of supplying nursing and homemaker services on a temporary basis. The availability of such a service permits primary treatment in the home for conditions which otherwise require institutional care and secondary care following return home after either acute hospitalization or extended care.

Section 222 of PL 92-603 specifically authorizes the state to undertake experimental projects incorporating innovations in use of manpower in eligibility coverage and in delivery settings. Considering the enormous amount of money flowing into tax-supported programs, a sizable demonstration project seems long overdue to test, in an organized system, a variety of new approaches to delivery--the comprehensive ambulatory neighborhood center, the surgicenter, the extended care facility, transitional residential treatment centers, day treatment centers, and organized in-home health services.

Such innovations could result in sizable savings and increased continuity of care and convenience for patients.

E. Long Term Care

A subject of growing concern is the provision of long term care in the community for the aged, the mentally disabled, the retarded, the county probationer or prisoner, and for those suffering from abuse of alcohol or drugs. Activities and programs for such people are plagued with the tendency to isolate, segregate and stigmatize.

Procedures relating to licensure of facilities, their standards, inspections, and level of reimbursement can only be described as chaotic and irrational. Rigidities in rules and regulations sometimes reward the profiteer and penalize the compassionate. Our system of surveillance is costly, duplicative, and largely ineffective. (See section on Licensing and Certification.)

Many people identified as being in need of services are lost entirely to the system and are not accounted for. Patients totally reliant on state and county services are relegated to inferior nursing homes, deficient board and care homes, "intermediate" care placements, locked facilities, and slum hotels. But these problems don't go away -- they periodically produce tragedy and scandal and represent continued default of social responsibility.

The State Health Department needs to undertake a fresh look at our long term care system, albeit an extremely difficult task, in order to invent more humane and normalizing solutions.

F. Ethnic Minorities

The needs of ethnic minorities must be given priority attention in the budgeting process and in program priorities. The lag in health status of Native Americans, Chicanos, Blacks, some Asians and migrant workers speaks of neglect and inferior access to services. Related to their problems is the persistent deficiency of resources in the urban ghettos and in rural counties of the state. Special efforts must be continuously made to correct inequities and build responsive networks of service to minority groups.

G. Prevention

The need to expand budgetary and program commitments in prevention in the Department of Health is obvious. Increased education of the public in

nutrition, avoidance of smoking, excess drinking, and use of addictive drugs, curtailment of reliance on medication rather than modification of behavior, and prevention of accidents -- all of these problems require intensive and sustained efforts in prevention.

H. Program Evaluation and Planning

Finally, in order to address the issues outlined here, the Health and Welfare Agency and the Department of Health need to develop a much more effective system of program evaluation and long term planning so that a reasonable set of priorities is reflected in the ongoing activities of the Department and so that the general public can be made aware of the policy positions of the administration in this complex field.

VII. HEALTH AND WELFARE AGENCY

A. Guiding Principles

In February 1959, Governor Edmund G. Brown appointed a special Committee on Organization of State Government. The Committee was instructed to study the existing structure of the executive branch of the State government and to make recommendations for necessary improvements. At that time, approximately 100 separate components of State government reported directly to the Governor.

As a result of their study, the Committee suggested the Agency Plan, based upon the cabinet system of the Federal government, to achieve more orderly reporting. The 1961 Legislature took the initial steps with the adoption of statutes creating the Highway Transportation, Health and Welfare, Youth and Adult Corrections, and the Resources Agencies. Subsequently, the Governor created four additional agencies on a less formal basis by executive order: Public Safety, Employment Relations, Business and Commerce, and Revenue and Management. Full-time agency administrators were appointed to the Health and Welfare and Youth and Adult Corrections posts, while the other agencies were administered by persons also holding departmental directorships. Later, Reorganization Plan No. 1 of 1968 established the present agency structure.

After the Agency Plan had been in effect for 15 months, it was reviewed by the Commission on California State Government Organization and Economy.¹ The Commission noted that "communications to and from the Governor's office,

¹ 12/62

broad-scale planning, program development, and policy execution were improved." The Commission concluded that agencies were not "providing just another level of government, but rather a missing level."

The Commission report pointed out that if the "missing level of government was to be filled, the agency administrator must be concerned with overall policy planning, execution and evaluation, and not with the minutiae of day-to-day administration." The report pointed out that the "advantage of this arrangement was the creation of a level of policy leadership and control--on behalf of the Governor--a step removed from the professional and clientele ties and pressures which inevitably confront many of the department heads." "It is not contemplated that staff at the agency level will duplicate or replace existing departmental staff services. Indeed, a large staff at the agency level would appear to serve as a deterrent to the successful implementation and operation of the agency concept of organization."

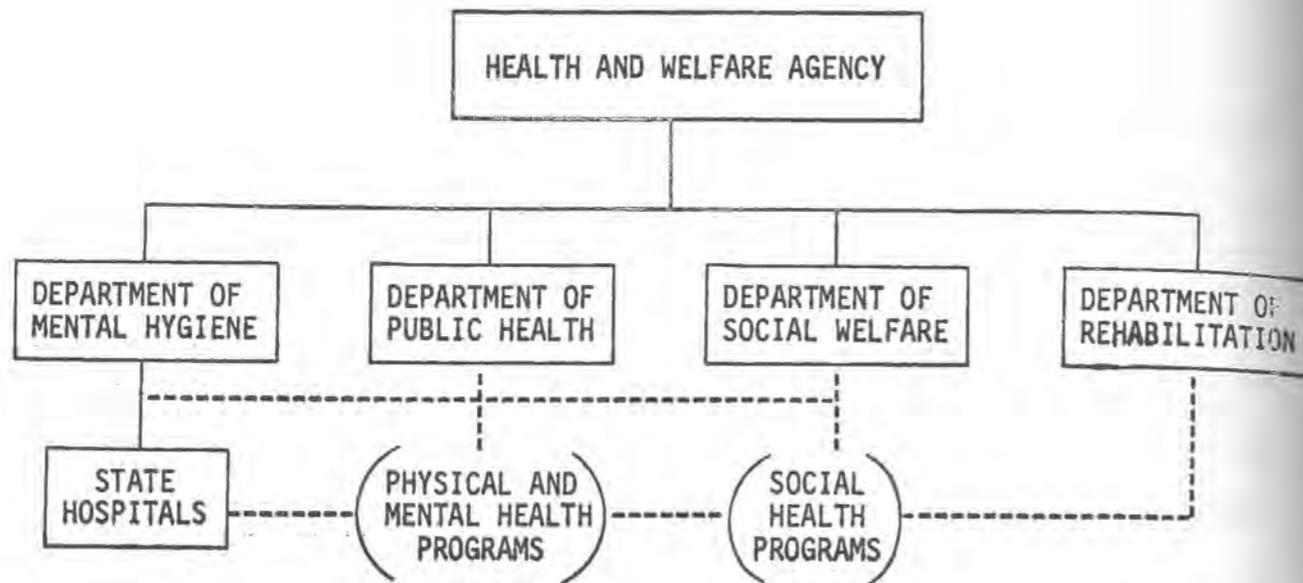
In their testimony before the Commission, agency administrators were consistent in their belief that staff requirements would be minimal, perhaps four to six professional positions. These officials would deal primarily with such matters as budget, planning and program evaluation, top-level management analysis and coordination of related activities between operating departments.

Finally, the Commission noted that if agency administrators were to become fully effective, they must devote full time to their agency assignments and not assume direct responsibility for line operations of the departments.

B. History

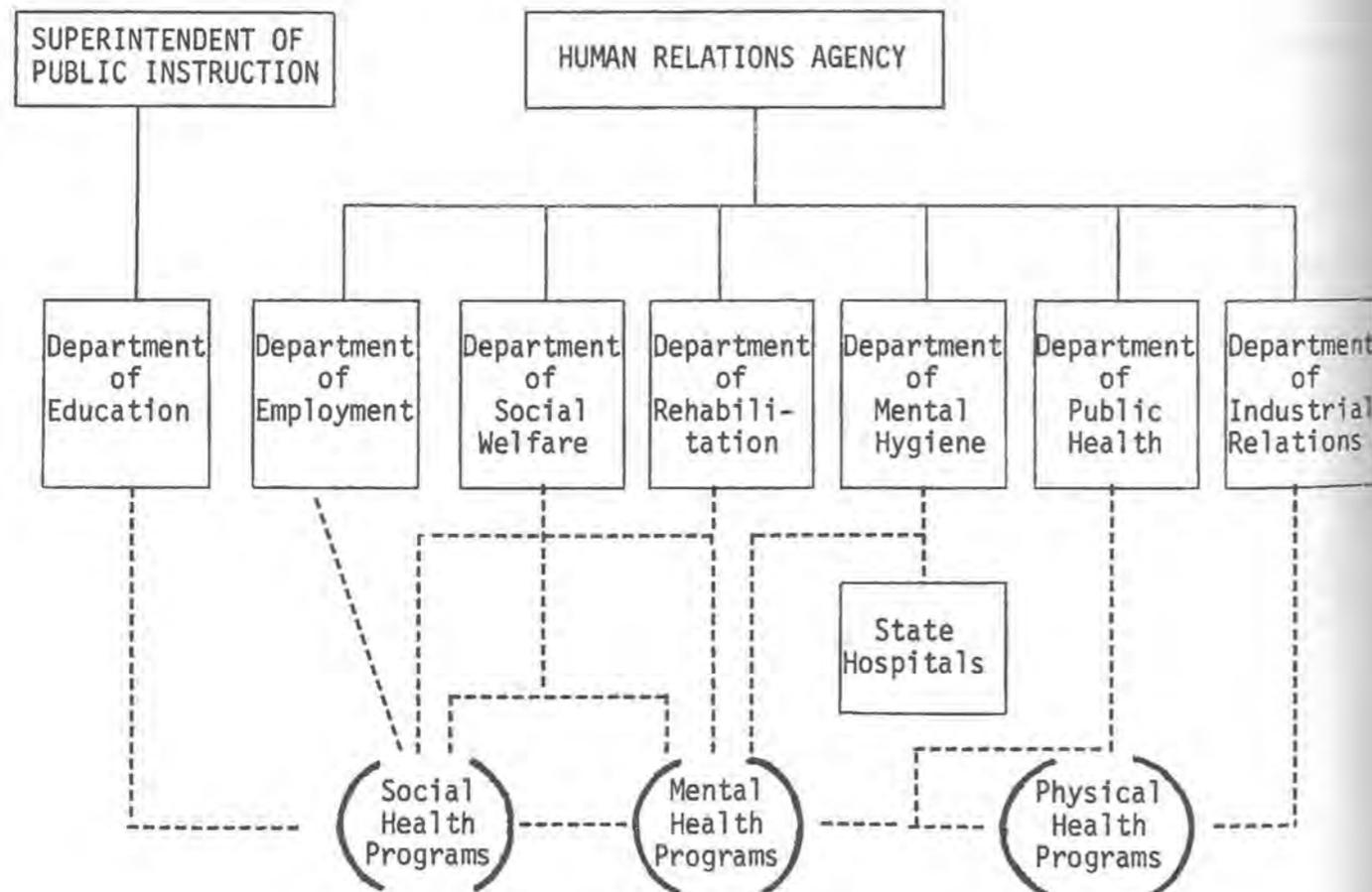
The first Health and Welfare Agency was organized in this way:

Chart #14



In 1968, these relationships were changed:

Chart #15



C. Present Form of Organization

The Health and Welfare Agency is responsible for the areas of health, employment, corrections, and welfare and administers the human service programs of the state (Chart #16.) These services have an impact upon every individual in California, either directly or indirectly, and represent an expenditure of almost \$9 billion in combined state, federal, and county funds during the 1975-76 fiscal year.

The growth of social programs that occurred nationally during the last decade has been accompanied by an increase in both the size and complexity of Health and Welfare Agency responsibilities in California. In 1968, the Agency consisted of the Secretary's Office, the Office of Special Services, and the Departments of Human Resources Development, Rehabilitation, Social Welfare, Health Care Services, Public Health, and Mental Hygiene.¹ Altogether these offices and departments spent just over \$3 billion and accounted for almost 33,000 man years of effort.

Today, the Health and Welfare Agency is the largest of the four agencies. Its budget is more than four times greater than the combined budgets of the other three agencies, and accounts for more than half of the entire state budget. It has far more employees than any other agency, operates more institutions, and manages more field offices. It employs 44 percent of the personnel in the four agencies and 24 percent of the entire state personnel including higher education faculty.² Table 1 shows the budget and staff for the Health and Welfare Agency in relation to the three other state agencies.

¹ State of California, Governor's Budget 1967-68

² State of California, Governor's Budget 1975-76

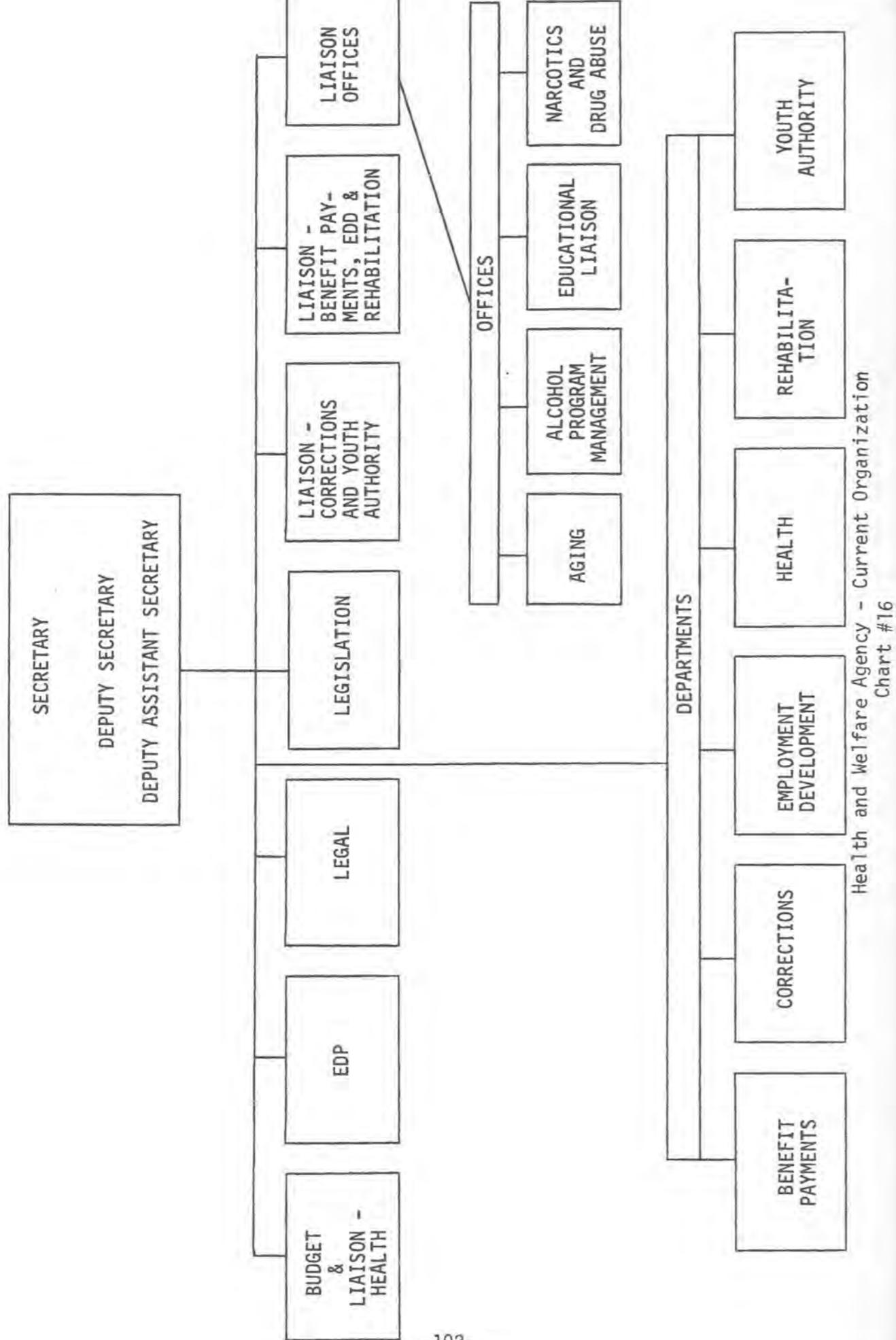


Table 1
Budget and Staff Size of Agencies
State of California, 1975-76

Agency	Budget (billions)	Staff in Person Years (thousands)
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.³ 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

³ Health and Welfare Agency, Organization Chart, 1975.

programs were being developed to meet special needs, some of which required coordination with the Federal government, local communities, other State agencies, or several departments.

For some of these new programs, the Agency asked to be designated by the Federal Government as the single state agency for coordination and receipt of federal funds. This gave rise to the organization of offices within the agency structure itself for a number of categorical programs related to alcohol and drug abuse, mental retardation, education and aging. Liaison positions in the agency were created to coordinate legislation, develop public information, deal with operational departments and other agencies, handle budgets, etc.

As a number of programs were added to the agency, its staff grew and increasingly became involved in departmental line operations, often subsuming program decisions. Many functions traditionally performed by the Department of Finance were taken over by agency staff. Consumer and professional groups began to bypass the departments and to appeal directly to the agency for decisions affecting departmental programs.

To carry out a broadening spectrum of staff work, the agency began to borrow both funds and staff from the operating departments. These transactions did not appear in the budget of the agency.

Thus, the agency is now functioning as a full extension of its operating departments, rather than an extension of the office of the Governor, as originally intended when the agency structure was created. Departmental Directors have been reduced in status.

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.

Part II

State Health Programs

I. PROGRAMS OF THE DEPARTMENT

A. Medi-Cal and Institutes for Medical Services

From its inception in 1965, the Medi-Cal Program has suffered unrelenting, but justifiable, criticism. Its growth has consistently exceeded estimates by a large margin and now threatens to encroach upon other essential state services.

Without question, access to medical care has been assured for millions who otherwise would have been denied. But the conviction grows that too large a proportion of the Medi-Cal budget is wasted and that reappraisal of basic premises is overdue.

The downturn in the economy has increased the number of people dependent on public medical assistance and an inordinate rate of inflation has been aggravated by a sudden jolting increase in malpractice insurance premiums. A crisis of major proportion looms in the Medi-Cal Program.

This evaluation attempts to deal with fundamentals and to overlook the facile and superficial assumptions which led to Medi-Cal reform. We try to discern the roots of intractable problems which continue to afflict this program. The Medi-Cal population is very large. Two and one-half million recipients represent about half of the five million people in California who receive some form of public assistance to obtain medical services.

The benefits provided in Medi-Cal are necessarily comprehensive because the standards of eligibility leave almost no margin for out-of-pocket payments. Critics who charge that benefits are too generous are hard put to identify "elective" services which are, in any way, a disposable luxury.

All private providers are, theoretically, available to participate in the program, but growing numbers are being dissuaded by low fees and excessive red tape. The recent stark increase in malpractice insurance costs could deal a final blow to "mainstream" medicine--access by the poor to private providers.

In this review, we will deal with all facets of the program. We will discuss the problems involved in forecasting budgets. We will also examine the complex dynamics of cost sharing and its impact on county institutions and university medical centers.

We will comment upon the percent of costs consumed by administration and on the incredible complexity of an eligibility system which generates indefensible costs and service inequities.

In our discussion, we will attempt to emphasize the persistence of a severe scarcity of resources in low income urban and rural communities in spite of the staggering expenditures made in the Medi-Cal Program over the past ten years.

A description of various approaches to the provision of care is undertaken, and an analysis is made of the experiences of consumers with each distinctive system of delivery of care.

In this regard, we discuss the impact of different methods of reimbursement and sponsorship on various aspects of importance to consumers in each system:

location, scope and pattern of service; service settings; control of quality and utilization; uses of manpower; flow of information; coverage after hours and in emergency; availability of preventive services and primary supervision; continuity of care; consumer relations and services; and cost of care.

We will report on problems encountered by the state in the acquisition of data and its inability to provide meaningful analyses and reports on Medi-Cal.

We will discuss the failure to integrate Medi-Cal with other service programs in the Department and the bewildering world of eligibility and financial "cross-overs" with these other programs.

A state of chronic frenzy has seized the administration of Medi-Cal at all levels of government. The sheer volume of recipients and providers in the program exerts a paralytic effect. Administrators are overwhelmed by a series of recurrent crises. They are kept constantly off balance and do not have the time to study the validity of the basic premises of the Medi-Cal Program or to suggest lasting remedies.

We intend to try to show that basic premises of this program are untenable and that failure to control it derives from the fact that Medi-Cal is simply unmanageable by anyone in its present form.

1. Financial Resources - Cost Sharing Dynamics - Budget Forecasting

Medi-Cal was implemented in California in 1966 to take advantage of substantial federal assistance in the provision of medical care to the poor made available under Title 19 of the Social Security Amendments of 1965. State implementation opened access for the poor to the private sector and enabled county institutions to expand benefits and services to a growing population of medical indigents. Under a provision of the state law implementing Title 19, counties were offered an "option" to freeze their costs in county medical institutions at the 1965 level and to be reimbursed thereafter by Medi-Cal for additional costs incurred in the care of indigents. The Medi-Cal Program thus afforded significant tax relief to county taxpayers and initiated a trend toward increased state and federal assistance to counties in the cost of provision of comprehensive services to the poor. County institutions took advantage of new funding resources and lower caseloads to improve their staffs, equipment, and services. The quality of care improved significantly in urban and suburban county hospitals. At the same time, significant numbers of indigents entered the "mainstream" of private medical care.

In 1971, this cost sharing trend was abruptly reversed. Medi-Cal reform shifted back to the counties a substantial burden in the cost of care for indigents. County share of cost was determined on the basis of historical records of county expenditures for indigent medical care, adjusted by gross population change and changes in assessed property valuations. This formula gave no consideration either to the percent of total population of each county which is indigent (this varies widely) or to the differences in financial standards used by counties to determine eligibility for medical assistance. Liberal standards were employed in some counties; in others, the standard was very stringent. This system of allocating county contributions remains inequitable

in that it penalizes progressive counties and those with disproportionate needs and rewards those counties which have followed a tradition of harsh policies of exclusion or which enjoy low rates of medical indigency.

In addition, the "option" was terminated and a statewide eligibility standard was imposed for the first time. This standard was substantially lower than that in use in most populous counties. Many counties elected not to lower their eligibility standard, thereby shifting the cost of care to the county for those above the state standard.

At the same time, complex administrative controls on reimbursement to county institutions were imposed which increased administrative costs and reduced collections for county residents who did qualify under the state standard. (See discussion under County Institutions)

The stress created by Medi-Cal on county budgets was accompanied by large increases in the state budget as well. The spectacular rate of inflation in the cost of provision of medical services was increasing the numbers of individuals and families unable to afford private medical care and also increasing the cost of county services. Realization grew that medical indigency was taxing both county and state government beyond their capacity.

Pressure for expanded financial assistance from the federal government took the form of a variety of proposals for a national health insurance plan, none of which has yet been passed.

Pending passage of such legislation, the present challenge for state Medi-Cal administrators is to attack grossly excessive administrative costs, to exert more effective controls over the abuse of the program by various providers,

and to maximize federal participation in the cost of services eligible for coverage.

The curtailment of either benefits or eligibility must be avoided at all costs for people who have no alternative to public medical assistance.

Problems of Forecasting Budgets: The department has had perennial problems in projecting budgets accurately for the Medi-Cal Program. The reasons are several: poor information on utilization and on expenditures by category of recipients and of service; difficulty in forecasting economic trends which impact the size of the welfare population; difficulty in predicting the rate of inflation in cost of covered services; inability to predict the cost of administration of regulations imposed by changes in both state and federal law; difficulty in predicting the full impact of federalization of adult categories of assistance; difficulty in assessment of the impact of changes in Medicare (Title 18) coverage on Medi-Cal crossover beneficiaries. But the major deficiency in forecasting and controlling budget is the very limited capacity of the department to evaluate the characteristics of the program and its abuses in order to propose meaningful corrections in wasteful administrative practices and in curbing excesses of providers.

2. Administrative versus Service Costs

The percentage of cost of service versus cost of administration deserves special comment. The manner of computing administrative overhead for Medi-Cal is deceptive and incomplete. Administrative cost centers are identified here and a suggestion made that an objective outside evaluation of true administrative

cost be undertaken. The evaluation should consider the costs of these procedures:

- Monthly review of eligibility of cash grant recipients by both county and state, under federal mandate;
- Review of medically needy and medically indigent eligibles by counties, and of county eligibles not qualified for Medi-Cal reimbursement;
- State certification of eligibility and the distribution of cards and labels (without validation of current eligibility status);
- The cost of state administration, especially the cost of implementing sticky labels, treatment authorizations, and review of hospital and nursing home care and the cost of continuous revision and notification of changes in benefits and regulations by the Department;
- The cost of data acquisition and processing which will increase if the Department attempts a Professional Standards Review Organization type of review of all providers.
- The cost of payment for services which are not scientifically justified due to failure to adequately review claims;
- The cost of appeals, audits, contracts, and third party recovery;
- The cost of collection of patient liabilities by county providers;
- The cost of administration to public and private providers to comply with Medi-Cal procedures; the start up costs for PHP (now Institutes for Medical Services);
- The cost of public hearings;

- The cost of litigation;
- The cost of advisory review of the program.

This list is not exhaustive, but is offered with the suggestion that one of the major unsolved problems of Medi-Cal is an unconscionably high administrative cost, which may approach forty percent of total expenditures--dollars which are sorely needed to pay for the care of people who cannot qualify for Medi-Cal. Thus a stringent review of all administrative procedures is urgently needed in order to eliminate those which are either unnecessary or unproductive. Waivers from federal government and legislative changes will be required to bring administrative order to Medi-Cal.

3. Eligibility Standards and Processes

At least four separate standards for eligibility for public assistance exist, which require a different process for each: 1) Cash grant recipients (Aid to Families with Dependent Children, Old Age Security, Aid to the Totally Disabled, Aid to the Needy Blind); 2) Medically needy; 3) Medically indigent; and 4) county indigent ineligible for Medi-Cal.

The fourth category varies by county; some counties have adopted the state-wide standard set by Medi-Cal "reform" and will not assist families just above the standard. Others continue to use a more liberal standard and provide care without state or federal assistance. Obvious inequities result for the large number of families unable to afford private care but unable to meet a Medi-Cal standard. An Attorney General's opinion has been written which states that the statewide Medi-Cal standard set under Medi-Cal reform does not fulfill county responsibility under Welfare and Institutions Code, 17,000, relating to medical indigency. This statute sets forth county responsibility

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

are: Short-Doyle mental health services and those for the developmentally disabled in both community programs and state hospitals; crippled childrens services; childhood disability prevention program; family planning and therapeutic abortion; prepaid health plans; drug and alcohol programs; services in skilled nursing and intermediate care facilities; community social services; and homemaker-chore services.

This extensive crossover creates complex problems in administration, budgeting and differences in standards which are bewildering and irrational.

The division of responsibility for processing eligibilities, the multiplicity of standards, and the complexity of keeping files current all contribute to a chaotic situation in which, at a given point in time, no one really knows who is eligible for Medi-Cal.

As a result, patients who are eligible are, at times, provided care without reimbursement to the provider. Others presumed to be eligible are sometimes provided services and reimbursement is retroactively denied due to lack of validation of eligibility at time of service.

The largest component of cost to county government in Medi-Cal is the result of administration of the eligibility process for a variety of categories; losses incurred when services are provided to eligibles who are not identified for many reasons; and the cost of care provided to those who cannot qualify for Medi-Cal because their income and resources are slightly above the standard.

In spite of all of this expensive processing and data accumulation, none of the following questions about the eligible population can be answered by

the Department:

- The exact size of the eligible population?
- The demographic characteristics of the population served? Patterns of residence? Patterns in use of services by specifically identified eligibles?
- Periods of time recipients remain eligible?
- The pattern of transfers from one eligibility category to another?
- Standards of eligibility for county services currently in use? Those counties using the statewide standard? Those using a higher standard?
- The numbers of persons who have qualified under medical needy and medical indigent standards under Medi-Cal reform?
- The size of the indigent population served without Medi-Cal participation?

These are difficult but essential questions. Their answers are buried in a pile of computer tapes. The central reason for attempting to answer them is to determine the size of the population which remains continuously eligible for public assistance in one or another form. If the enormous administrative burden and cost of processing all of these eligibility standards merely results in shuffling ninety percent of the population between categories, then we should stop doing it and use the money saved to increase the level of service to meet needs instead of wasting it on an unproductive search for a small percent of people who are only marginally ineligible for public medical assistance.

The cost and inequity of eligibility for public medical assistance is in need of a massive overhaul. Before true reform is attempted we badly need some

sophisticated study of the dynamics of eligibility and the savings to be gained by installing a much more simple and equitable approach to those in need. Even if the needs exceeds the fiscal capacity of state and local government, which is probable, it nevertheless seems clear that our existing resources can be put to much wiser use before resorting to draconian cutbacks in services to needy people.

4. Benefit Structure - Rates and Fees

Medi-Cal benefits are extremely comprehensive, since the eligible population, by definition, cannot afford out-of-pocket medical expenses. In fact, at the upper levels of eligibility (in Medical Needy and Medical Indigent categories), some patients are assigned a liability to pay part of the cost of care. Eligibility workers consider the amount of this liability to be unreasonably high when spread over several months of income, and point to the low rate of collection of patient liability to support this contention. (Failure to pay liabilities becomes a burden to providers).

Under Medi-Cal reform, small co-payments were tried as an experiment in an attempt to reduce utilization of outpatient services for certain non-cash grant recipients. But the evidence that this approach was effective is open to serious question. (The experiment has been dropped.)

A selective review of paid claims raises a much larger question. Does the very comprehensive benefit structure induce over-provision of care by various providers, influenced by knowledge that payment is practically guaranteed? A recipient can, indeed, initiate more than one visit to a provider for the same problem, but the two-visit limitation has impeded him from doing so-- rather, this visit limitation has caused some people to stay away from providers even when they should be seen, for fear of running out of stickers.

The patient, in the last analysis, can only initiate a visit to the provider. From that point on, the utilization of services is under control of the provider, who orders tests, administers treatment, performs surgery, etc. The extent of abuse of Medi-Cal by providers of marginal competence or integrity is not entirely known. The so called "up front" controls of visit limitations, treatment authorizations, etc., do not appear to have controlled excessive provision of services if growth of the budget is any indication. Post-facto controls of abuse in the claims review processing system by fiscal intermediaries are primitive and unimpressive. Paid claims information is largely in the control of the fiscal intermediaries whose proclivity to crack down on abusers is influenced by the fact that their governance is in the hands of providers who are not inclined to root out professionals who abuse the program or to develop detailed analyses of patterns of provision of services which might prove to be embarrassing.

Because of the separation of the eligibility files from paid claims files, the Department is not able to analyze patterns of provision of services by specific providers. Thus, it has great difficulty in developing profiles of the pattern of provision of services by specific beneficiaries.

Until the Department is in control of eligibility information tied into paid claims, the utilization of services and the validity of provision of care can not be measured. This crucial point will be covered in more detail in our discussion of information systems and data processing.

The Medi-Cal program is heavily skewed toward sickness and institutional care. Emphasis on preventive services is lost because these services are largely excluded from coverage (excepting under Institute for Medical Services program guidelines). The reason for exclusion is that preventive services are theoretically

available in local public health departments. In fact, the service statistics of departments of public health indicate contact with only a small fraction of Medi-Cal recipients-even if one presumes that all patients seen are Medi-Cal eligibles (local departments of health traditionally do not impose eligibility standards for most preventive care).

The articulation of preventive services with Medi-Cal has not occurred within the local delivery system. However, sophisticated program managers in preventive medical programs do avidly pursue Medi-Cal dollar reimbursements to augment their budgets and to extend dollars made available from other sources. This "crossover" of funding programs is proof that Medi-Cal recipients are to be found in large numbers in other programs of the Department and that opportunities to integrate funding do not, at present, cause integration of services.

Only the sophisticated health care specialist seems to understand that maximizing the benefits allowed under Medi-Cal by the federal government results in sparing of the state budget because of the size of federal matching of funds (about fifty percent). Several actual examples illustrate this point:

If Medi-Cal (50% match) denies coverage for orthodontial surgery for disfiguring and pathological conditions and the care is paid by CCS (10% match), the state loses money.

If coverage for ambulatory services in the drug programs is denied under Medi-Cal, then it must be paid entirely out of other funds, including state funds, thereby reducing the total pool of funds available due to loss of a 50 percent match under Medi-Cal. (See further discussion under Substance Abuse Programs.)

If Medi-Cal eligibles are not fully identified in Short-Doyle programs, then service benefits are paid entirely by state and local government (90-State, 10-local match).

These examples illustrate the importance of several observations:

- That the administrative costs of the crazy quilt financing of categorical programs must be ended to reduce administrative cost and divert savings into expanded services;
- That reduction in eligibility standards or curtailment of benefits cannot be justified in view of the wastes encountered in eligibility and benefits processing, administrative red tape, and in the uncontrolled provision of unnecessary services.
- That benefit reduction in Medi-Cal can actually increase costs to the state.

In fact, when benefits are reduced or standards are made more arduous, only two results can be predicted: People go without ambulatory care and end up as emergencies in hospitals at higher cost; or county government's financial burdens are increased for the care of people not able to qualify under a stricter state standard.

If reduction in Medi-Cal benefits is made, costs are shifted either to other state programs with lower or non-existent federal matching funds, or to county tax roles. Another reappraisal is in order.

Rates and Fees paid by Medi-Cal are said to be substandard, because they are below "usual and customary" levels. The dilemma here is that tax supported programs are confronted with hospital costs which are inflated by oversupply of beds and services and low occupancy rates. This redundancy of beds drives rates up for all purchasers of care, including the government.

Fees are substandard for Medi-Cal providers of integrity and competence but they apparently are not considered substandard by that segment of the provider community which has learned that a large volume more than compensates for substandard fees. Only a reliable study of patterns of provision of services by specific individual and institutional providers can identify the statistical extent of overprovision of care. If selected review of claims is an indication, the elimination of high volume, low quality, low integrity providers entirely from Medi-Cal would be beneficial for all concerned. Patients would be spared the danger of being exposed to care they do not need. The savings incurred may be sufficient to raise fees to honest and disciplined providers and keep them from abandoning Medi-Cal patients.¹

The malpractice rate increase is a reflection of a closely related issue. The amount of malpractice insurance costs passed through to consumers and to Medi-Cal, CCS and other publicly funded programs would be substantially less if physicians, other professional providers, and hospitals would cull out of the pool of risk those providers unable or unwilling to meet high standards of professional performance and review. Although we lack precise and complete data, there are strong indications that a major portion of malpractice suits emanate from providers of substandard quality and that their behavior is contributing significantly to both the Medi-Cal and malpractice crises. Capricious law suits and poor results from high risk procedures performed with competence are clearly part of this problem, but unlikely to prove to be the major factor in the exorbitant malpractice rate increases.

¹ Henry Anderson Report

5. Influence of Method of Reimbursement on Provision of Care Types of Providers

Medi-Cal uses several methods of reimbursement. These are:

- Fee for services provided;
- "Reasonable" rate of reimbursement to institutional providers.
(This method does not reimburse for professional services.)
- Composite rate reimbursements for institutional care, when professional services are provided by employed or teaching staff. This method is used when the Director determines that total cost of care is lower than it would be under fee for service reimbursement for provision of professional services in an institutional setting. Examples of this method are payments to county institutions and to university medical centers.
- Capitation payments made under contract with prepaid health plans. In this instance, Medi-Cal recipients are enrolled in such a plan and all of their services used are prepaid on the basis of a negotiated capitation rate per enrollee, made monthly.
- A unique mixture of methods is used when a Foundation for Medical Care, usually comprising most of the membership of a local medical society, enters into a contract as a prepaid health plan provider. In this instance, the Foundation administers the plan, receives the capitation payments, and then pays participating providers on a fee for service basis. Claims are reviewed for their charges and the validity of case management to enhance the quality of care provided. Controlled hospital admissions and length of stay is built into these plans to reduce the cost of unnecessary institutional care. This type of peer review is usually absent from private prepaid health plans not sponsored by a medical foundation.

a. Fee Providers: At present, almost eighty percent of reimbursements are made on a fee for service basis and on "reasonable" rate reimbursements to institutional providers.

The pattern of provision of this care is thus of utmost importance in evaluation of the characteristics of the Medi-Cal program.

Fifty-five thousand providers are included and the fee transactions which occur are counted in the millions. The record of these transactions is in a paid claims computer tape developed by the fiscal intermediaries and made available as a raw data base to the Department of Health. These paid claims are only potentially linked to the central identification file of eligible recipients. This separation and disarticulation of two key data bases obstruct systematic analysis of patterns of utilization of services. Only a crude analysis is made of the cost of categories of services to categories of eligibility, but this so called "budget information system" is not adequate to discern patterns of provision of services to specific eligibles by specific providers. Meaningful control of information and management analyses are thereby frustrated. The impact of fee reimbursements on the patterns of provision of services is buried in the claims tape file, obstructing the Department from answering the following questions of crucial importance:

- The statistical pattern of participation of various private providers of care? (Totals are available, but the volume of participation by particular providers is unknown.)
- The geographical distribution of Medi-Cal providers, especially those with high volumes of participation?
- Profiles of the pattern of provision of care, especially by high volume providers?

- Profiles of the provision of services to specific eligibles, especially those who use a high volume of service?
- Comparisons in the patterns of provision of services to the Medi-Cal population with those using private insurance plans?
- Comparisons, within Medi-Cal, of patterns of utilization of services by fee providers, by private institutional providers, by foundations for medical care, by county institutions, by university medical centers, and by prepaid health plans?

In a massive tax supported health program, now in its tenth year, it is deplorable that such basic information has not been developed. Without such analyses, everyone is kept in the dark in attempting to judge the performance of the program and to get it under a semblance of fiscal and quality control. Until these analyses are accomplished, the varying impressions of Medi-Cal program characteristics remain speculative.

However, this gross failure to analyze cannot be used as an excuse to refute those deficiencies which are obvious to the pragmatic, close observer of Medi-Cal. A set of hypotheses is thereby put forward, to stimulate a demand for study of Medi-Cal utilization:

- Fee for service provision of care in Medi-Cal reflects a deviant pattern of provision of excessive service by many providers and can not be justified medically or ethically.
- The cost of over provision is of major proportions.
- Participation in Medi-Cal follows a concentric pattern, with high volume of provision of services amongst private providers located

in low income neighborhoods, and a decreasing pattern of participation as one moves to middle and high income communities.

- The high volume providers in low income settings are forced to process more patients than is desirable, with erosion of the quality of care.
- The low volume providers are more likely to take more time and provide a higher quality of care.
- A significant percent of providers in middle and high income settings refuse to see Medi-Cal patients at all.
- Medi-Cal is paying for care which overconcentrates in hospitals and in other institutions at high cost and does not invest wisely in preventive services, or in stimulation of alternatives to institutional care which is better organized and potentially cheaper, more convenient, and of higher quality. (Neighborhood health centers, extended care facilities, recovery motels, transitional residential care, day treatment centers, in home health services.)
- Malpractice insurance cost increases, if not met in tax supported health service programs, will dislocate Medi-Cal patients from the private sector and suddenly overtax the service capacity of public institutions. Survey research techniques could be used to anticipate such a crisis and enable the Department to put forth a contingency plan to meet it, in order to prevent denial of necessary care to medical indigents.

The impact on provision of care under prepaid capitation, composite rate reimbursement, and in medical care foundations is discussed in subsequent

sections of this report dealing with county institutions, university medical centers, and foundation Prepaid Health Plans.

b. Foundations for Medical Care: The problems of measuring program performance by fee providers is also reflected in other approaches to provision of care. The Foundations for Medical Care first participated in Medi-Cal in several pilot demonstrations, some involving attempts only to reduce administrative costs, others experimenting with prepaid capitation combined with claims review, utilization control, and claims payment.

There is little question that foundations manage to improve the quality of care provided in the private sector, but there is considerable doubt that they have the capacity to provide care at a cost lower than other fee providers. The problems which foundations encounter are listed:

- Marketing and enrollment costs, not faced by other fee providers;
- A tendency to enroll a higher risk population, since physicians participating are in contact with patients who are seeing them and hence ill. The ability to enroll non-user eligibles is hampered by lack of contact with them.
- Start up costs are very high, especially when the foundation assumes all of the functions of fiscal intermediaries, instead of confining themselves to claims review only.
- Prepayment puts foundations at financial risk and thereby burdens them with escalating hospital costs and the malpractice rate increase--problems over which they exert little influence.

- The continuation of fee reimbursements does not effectively eliminate provision of excessive services, since the community standard of practice is not necessarily equivalent to a scientific standard. It is awkward to deny payment to colleagues and friends, especially if they are a source of referral of patients.
- Practitioners who become disenchanted with a foundation plan may withdraw and revert to straight fee practice with little loss of revenue if their patients disenroll to stay under their care.
- Dispersed, solo and small group practices are at a competitive disadvantage with large consolidated multi-specialty closed panel group practices such as Kaiser. This is because they are less efficient in terms of sharing staff, space, equipment, and overhead. Control of hospital operations is another clear advantage of Kaiser type plans.

To date, the foundation model for provision of care to Medi-Cal is floundering-- several have discontinued contracts and others are negotiating for rate increases unlikely to be met by the Department of Health unless the potential benefit of research in rates and utilization patterns warrants continued support for this reason.

The contribution of the foundations to the refinement of methodology for professional standards review organizations (PSRO's) has been significant, and may well find wide application not only in fee practice, but also in measuring the quality of care in prepaid health plans as well as county institutions.

c. Institutes for Medical Services (Formerly Prepaid Health Plans):

Medi-Cal reform much expanded the prepaid approach to Medi-Cal coverage first tested in a pilot demonstration project. The great promise of this

innovation, however, fell prey to poor planning, lack of experience and bad judgment on the part of the staff of the State Health Department.

Contracts were hurriedly negotiated and signed without the prior development of standards to assess the capability of contractors to deliver medical care of good quality. Once initiated, the plans were not properly monitored to measure their actual performance.

Rates were not based on actuarial study. An arbitrary ten percent reduction below the costs of the fee for services costs was adopted. A different rate was negotiated with each plan and additional money provided to cover the costs of marketing, enrollment and other administrative costs. In fact, many of the plans eventually exceeded the fee for service costs recorded for their area.

Problems with the plans are legion. Most of them have rapidly fallen into disrepute amongst patients as well as those with experience in prepaid health plans. The California Medical Association has taken a position in opposition based on lack of quality of care. Adverse newspaper reports were followed by extensive inquiry by a variety of authorities--state and federal legislative committees, auditors, and the Legislative Analyst.

A listing of the deficiencies, which were documented, is presented without elaboration in this review, in order to focus, not on the past, but on the present status of the new Institutes for Medical Services:

- Unethical and deceptive marketing.
- Financial inducements to join plans.
- Misrepresentation of the medical staffs available in the plans.

- Unfulfilled promises of transportation to the plans and language assistance.
- Failure to locate services within reach of the residence of those enrolled.
- Failure to provide services after hours or weekends and in cases of emergencies.
- Failure to provide either access to a primary care physician or to assure referral to competent specialists.
- Failure to improve continuity of care or to provide health supervision to families who enrolled.
- Failure to provide an adequate ratio of physicians to enrolled population.
- Failure to organize program components for prevention and patient education.
- Failure to monitor quality of care, medical records or patterns of utilization of services in the plans for their adequacy by requiring meaningful statistical reports of clinical activities.
- Failure to disclose details of corporate dealings to account properly for the flow of cash, or to describe centers of cost, or to document financial condition in the plans or of activities of subcontractors.
- Failure to identify and eliminate conflicts of interest.
- Failure to enroll or disenroll in an orderly and fair manner.
- Failure in capacity to deliver the full scope of services covered under Medi-Cal.
- Failure to provide a controlled prescription drug service.
- Failure to insist upon the use of hospitals which are accredited.
- Misuse of allied health personnel and use of staff not holding professional licenses in California.

- Failure of medical staffs to organize in such a fashion that responsibilities for the quality of medical care was accepted as a mutual responsibility and that regular internal medical audits of professional performance were carried out
- Failure to organize a formal mechanism for consumer participation, patients grievances, outreach or other patient support services including information on the use of the plan
- Failure by the Department of Health to terminate contracts except under dire circumstances
- Blanketing of service areas with plans whose total projected enrollment actually exceeded the eligible Medi-Cal population in those areas.
- Failure to prohibit contractors to continue to be reimbursed on a fee basis for patients eligible for enrollment in the plan. This invited holding out of enrollment the high risk sick patient who, in theory, should be included in the risk pool as prepaid enrollees.

With the change in administration in January 1975, a new advisory committee was appointed to address these deficiencies and to recommend a course of action. Subcommittees were then appointed to deal with organization and financing, quality of care, county institutions, and the consumer role. Reports of recommendations have been made and are available from the Department of Health.

A new approach to prepayment was developed by the Department with guidance from the advisory committees. A report to the Governor was made, however, by the Health and Welfare Agency, which did not adequately reflect the recommendations of the advisory committee. Regulations were then developed, but hearings on the regulations have not been held at the time of this writing. The same is true of the public hearings to be held on applications from the plans for renewal of contracts.

The new regulations are obviously in need of change and refinement, but, in general, they attempt to set specific standards to overcome the operational deficiencies of the plans. The character of the new regulations are such that many existing plans will probably be terminated, making way for new contractors who are prepared to meet the new standards.

Prepayment in Medi-Cal, in spite of difficulties encountered, holds the promise of attaining fundamental improvement in access to care, in the improvement of quality of services, in the control of costs, and in strengthening the participation of consumers in Medi-Cal. Strong administrative leadership and professional competence in the Health Department are prerequisites to the attainment of such goals in the prepaid plans. The reader of this report is referred to the Department of Health for materials which have been developed by the Prepaid Health Plan Advisory Committee and Subcommittees. These materials contain extensive analyses of the major issues in prepaid health plans and carry many key recommendations which will not be repeated here.

d. County Institutions: County institutions have always played a central role in the provision of health services to the poor and disadvantaged. They are often referred to as a place of last resort in that they provide care to people not able to afford care anywhere else. The Legislative Analyst's Office is presently engaged in a comprehensive survey of county institutions, which will provide, for the first time, a complete picture of patterns of services and variations by county.

In spite of the creation of freedom for those eligible for Medi-Cal to choose private sources of care, county institutions have remained a major source of care for both Medi-Cal patients and those just above its standard of eligibility, persons usually referred to as "county" indigents. The size of this category of patient is difficult to measure for several reasons. Some counties

now use the statewide standard of eligibility established in 1971 under Medi-Cal "reform", others use a higher standard because they are convinced that the state standard does not cover many individuals and families with a legitimate need for medical assistance.

An Attorney General's opinion leaves an important legal question unresolved: Can the state standard of eligibility be legally applied by county government as a definition of their responsibility toward the poor under Welfare and Institutions Code 17,000? His opinion is that it can not. Nevertheless, many counties have adopted the state standard. No court test of this practice has yet occurred. If it does, a ruling could result which is equivalent in health to the Serrano decision in public education, with enormous impact on state financing of medical care.

Estimates of the numbers of citizens in California without health insurance are 2.5 million--a population as large as that counted under Medi-Cal. It is reasonable to assume that this population constitutes the majority of those people just above the Medi-Cal eligibility standard who can afford neither health insurance nor the cost of medical care. When illness strikes, they become the "county" indigent and, unlike those eligible for Medi-Cal, they cannot choose to obtain care privately, but instead must rely on the county hospital. The general failure of Hill-Burton assisted private hospitals to meet their legal obligation to provide a reasonable percent of free care to the poor contributes to the heavy pressure on county institutions, which become the "dumping ground" for those unable to pay. In a real sense, county institutions are the community's catastrophic insurer.

Under Medi-Cal "reform", county institutions are treated no differently than private providers. They are forced to convert to fee for service billing systems, to conform to use of the sticky labels, and treatment authorization requests for care in excess of two visits per month, and to adhere to the

schedule of maximum allowances developed by the department.

The application of these rules is both unreasonable and inequitable. Unlike private providers, county institutions provide a very large contribution, established in law, to the Medi-Cal health care trust fund. They do not operate for profit. The majority of their services are provided by salaried professional staff. Their budget and operation are under the control of the Board of Supervisors. They clearly are not a vested interest or a competitor with private providers.

The administrative costs incurred by counties in conforming to Medi-Cal reform regulations constitute a wasteful burden which is added to losses incurred in the application of the new eligibility standard. The termination of the county option has cut off reimbursements for services previously paid for people not eligible as individuals for Medi-Cal.

A major shift of cost back to county government has occurred and has precipitated a serious trend--the sale or closure of county hospitals by supervisors in an attempt to escape escalating costs and to protect against the need to raise local taxes. A number of rural county hospitals of small or moderate size have closed.

The Legislature has reacted to this trend by holding hearings on the problem and by passing a law which requires counties to present an acceptable plan for meeting the medical care needs of the poor prior to closing any more county hospitals. (SB 2369 - Beilenson, 1974)

Only one county, Contra Costa, has attempted to contract with the Department to operate as a prepaid health plan. The success of this approach has not,

as yet, been documented in complete detail but preliminary reporting seems to indicate that income to the county for care of Medi-Cal patients has increased for those enrolled in the plan. Losses are still being recorded for Medi-Cal patients being cared for in the same delivery system, but under the fee reimbursement process. The reasons for the discrepancies in cost are of utmost importance in order to comprehend the high cost and the adverse impact on county institutions of procedures imposed as a condition of fee reimbursement. These losses occur for these reasons:

- Counties are paying the full cost of care for county indigents not eligible for Medi-Cal. Under the county option, services to this population were reimbursed. This population has increased rapidly in size.
- The severity of the state eligibility standard eliminated more persons than were newly covered under the medical indigent category (M.I.).
- The low percent of recovery of patient liabilities adds to county losses.
- Administrative costs for counties have accelerated because of the need to use four different and equally complex eligibility standards (for medically needy, Medi-Cal indigent, cash grant, county indigent).
- The failure to identify and qualify eligibles contributes heavily to county costs, and reflects the complexity of the process and reluctance of patients to submit to it.
- Conversion to fee billing has been expensive, and losses are incurred when eligibles do not bring sticky labels or when treatment authorizations are denied.

- Employed physicians in county institutions tend to ignore both labels and authorizations, since they do not affect their income and because they are generally regarded as a nuisance.
- Aliens and transients in need of hospital services rely on county institutions which bear the full brunt of cost without state or federal assistance.
- The most difficult types of patients are referred to county hospitals. Private providers show a preference for patients with routine problems and tend to avoid those which are unpleasant or very difficult to treat.

When a county operates a prepaid plan, the following advantages and potentials pertain:

- Use of labels, visit limitations, and authorizations are eliminated.
- Capitation payments are made for individuals and families who are enrolled, but who are well and not currently receiving care. (If counties know how to enroll the universe of eligibles, they avoid the enrollment only of those using services while ill, those of high risk.)
- The cost of procedural billing is eliminated.
- Eligibility is determined prior to use of service, and losses for failure to establish eligibility are thus reduced.
- Prospective budgeting encourages more orderly administrative and fiscal controls and accountability.
- Sensitivity to consumer perspectives and complaints increases, in order to retain those enrolled in the plan. To succeed, the

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,

use of labels and treatment authorizations, fee reimbursements in place of composite rates, and the use of a schedule of maximum allowances which does not give recognition to the costs of providing care to the most difficult portion of the Medi-Cal population.

A systematic departmental evaluation of the propriety of these regulations and the low participation by counties in prepaid contracts is overdue. For the reasons state above, the cultivation of county institutions by the State Health Department is one major pathway to improvement in the quality of care under Medi-Cal. Elimination of useless administrative procedures in the eligibility and reimbursement process and of the need to police an unmanageable number of private providers is essential. Investment in the improvement of county institutions holds promise for both Medi-Cal recipients and the general public in the future of medical care.

e. University Medical Centers: Universities participate in the provision of services to medical patients in two basic ways. First, in their own hospitals, in much the same way as private hospitals, with the exception that physicians involved in teaching programs as interns and residents cannot bill for their professional services. The rate of reimbursement reflects the cost of the employment of these physicians.

A second, and more complex form of participation by universities occurs when they take over either ownership or operating responsibilities for county institutions. Three large institutions so involved are located in San Diego, Sacramento, and Orange County. In such situations, a most

exasperating set of unresolved problems arise:

- Separation of the cost of teaching and clinical research from cost of services. The teaching function is funded by the university. The service function (impossible to separate clearly) is funded from state and local tax funds. Cost per unit of service is always higher in university hospitals because of teaching activities.
- Responsibility for care of indigents not eligible for reimbursement under Medi-Cal or other tax supported programs. This is, by tradition, a county responsibility, but shifts to university when direct hospital operations are assumed, unless the contract protects the university from assuming this responsibility.
- The strong proclivity of universities to develop expensive specialized services and residencies in the specialties (burn centers, trauma centers, intensive care units, special surgical services, rehabilitation, etc.) and a reluctance to organize family oriented primary health care services and residencies.
- Pressure exerted by the Regents to operate in the black--a policy which tends to force hospital administrators to refuse to accept the traditional role of provision of care of last resort to those without funds to buy private services.
- The reluctance of the State Legislature to provide funds to build new campus hospitals which are clearly superfluous to community needs.

Medi-Cal has not dealt adequately with county-university medical centers. Medi-Cal reimbursements are not conditioned by a set of standards which are designed to assure access to preventive and well-organized primary health services and to assure that county indigents are not denied care.

Thoughtful study of these problems is long overdue in an atmosphere cleansed of adversary maneuvering so that all parties fulfill their responsibilities--the university to teach, but also to organize services which are sensitive to the needs of poor families; the counties to fulfill their legal responsibilities for the payment of care of indigents; and the Legislature, to condition support to universities on maintenance of access to services to the poor. Both the Legislature and county government must retain responsibility for provision of funds for medical indigents and, at the same time, make sure that university operation of county hospitals does not, in effect, convert them to private institutions with no commitment or responsibility toward patients unable to pay for services.

6. Consumer Experience with Various Types of Providers

In the last analysis, the experience of consumers of Medi-Cal services soars in importance above all other considerations. In spite of the logic of this statement, the consumer has almost nothing to say about the workings of the program. In order to assess the impact on consumers of various approaches to care, some definitions are listed which will be used to measure the experience of consumers:

Access: The location of services in terms of proximity to the residence of consumers.

Availability: The ability to reach services after office hours, on weekends and in emergencies.

Patient Information: The description of program benefits, eligibility standards and process, and rights of patients.

Scope of Services: The range of services available: prevention, ambulatory diagnosis and treatment, primary and specialty care, hospitalization, rehabilitation, long term care, and in-home health care, mental health, drug and alcohol services.

Continuity of Care: The degree of supervision afforded in the use of services listed above and the degree of convenience encountered in the use of services. Also, the degree of integration in the organization of services.

Quality Review: The degree to which professional services provided are reviewed to judge their competence and necessity.

Utilization Control: The degree to which the inappropriate use of institutional care (hospitals, nursing homes) is controlled.

Uses of Professional Manpower: The manner in which various health professionals provide services and the degree to which they coordinate patient care. Professional manpower includes family practitioners, medical and surgical specialists, nurse practitioners and physicians assistants, various technicians, and public health specialists including nurses, nutritionists, social workers, health educators, and community health workers.

Medical Records: The manner in which clinical information is recorded and exchanged and the degree to which these records are unified.

Financial Records: The degree of disclosure of how funds are used in patient care.

Consumer Relations: The manner in which consumers are involved in planning and provision of services and the system used for processing complaints.

Outreach and Patient Support Services: The manner in which patients are assisted in the appropriate use of services through education,

transportation, language assistance, child care, and group activities.

Treatment Outcome: The system in use to measure the results achieved by services provided.

Cost of Care: The costs incurred in the provision of care by various types of providers.

In Medi-Cal, consideration for these crucial attributes of the service system has been grossly neglected and obscured by preoccupation with eligibility rules, rates and fees, fiscal intermediary transactions and treatment authorizations.

We will next describe the experience of consumers with various types of providers in terms of the characteristics of the delivery system described above.

a. Fee for Service (excluding Foundations for Medical Care): Much has been made of the importance of freedom of choice to elect private care in the "mainstream" of medicine under Medi-Cal. The goal of integration of recipients with the general population is far easier to advocate than to implement. Location of residence, social class, language and cultural differences, lack of transportation and child care, do much to narrow choice. On the other hand, private providers located away from the ghettos are often uncomfortable with the poor and reluctant to mix them in their practices. Those who are willing are disheartened by unreasonable red tape, low fees, and delay or denial in claims for payment. These aggravations, however, do not appear to discourage high volume providers who choose to compensate for low fees by providing unnecessary services to too many patients in order to maximize their income.

In the discussion of integration into the mainstream, it is important to point out that no freedom to choose private care has ever existed for families just above Medi-Cal eligibility who must use county institutions. Their number may now be larger than the Medi-Cal population.

The scarcity of all kinds of health resources persists in the inner city and in rural slums in spite of the enormous expenditures made over the years and raises a question whether the program has benefited providers disproportionately compared to recipients.

Availability. If a patient on Medi-Cal can locate a family physician in the neighborhood, availability of care is enhanced. The shortage of such physicians prevails everywhere and is growing worse in low income areas. After hours and on weekends, the county institutions are usually used because physicians are least available then.

Patient Information. Few private offices are prepared to assist patients in understanding how to find services by referral, except in referral to physician specialists.

Scope of Services. Solo or small private group practice handle a narrow scope of service confined to their clinical specialty. To reach comprehensive services, patients usually must travel to multiple locations to independent practices.

Continuity of Care. Again, unless blessed with a skillful generalist, continuity of care is lost. Preventive services are provided in health department clinics and usually organized as a group of separate services. Specialty care is sought without guidance--a very undesirable practice. Mental health services

are offered separately. Hospital care is provided at times by physicians other than those providing ambulatory care.

Quality Review. Review of quality of office care is absent amongst private fee providers. It varies widely in hospital practice, and is weakest in private hospitals with a high volume of Medi-Cal reimbursements.

Utilization Control. No self-imposed utilization controls of care in hospitals and nursing homes exist in fee practice.

Use of Professional Manpower. In fee practice, care is dominated by physicians. Little experimentation exists in controlled use of nurse practitioners. Generalists attempt procedures better left to specialists. Public health specialists in nutrition, health education, social work, etc., are not employed.

Medical Records. In fee practice, medical records are kept in individual offices, exchanged with specialists when necessary, but unification is not achievable as in organized group practice. The quality of records of fee practitioners is almost never examined by the Department of Health, as they are in prepaid health plans. The medical record is traditionally considered the keystone in the judgment of the quality of care provided.

Financial Records. There is no access to financial records of fee practitioners, except under subpoena in fraud investigations.

Consumer Relations. The patient-doctor relationship is the heart of consumer relations. If it is unsatisfactory, the patient goes elsewhere. The relationship of consumer satisfaction to quality of care is not necessarily direct,

in that unwary patients may be entirely pleased with questionable medical practice.

Outreach and Patient Support. This is not a feature of fee practice under most circumstances.

Treatment Outcome. This is seldom measured in office practice. It is examined only in well-controlled hospital practice, the exception in Medi-Cal.

Cost of Care. The cost of the existing system of fee practice is high. Major factors at work are, in summary: cost of unnecessary services, cost of the procedural billing system by fiscal intermediaries, cost of duplication of staff, equipment, overhead of dispersed small practice, and the cost of analyses of patterns of provision and utilization of services in the review process.

b. Institutes for Medical Services: The new regulations being promulgated under the new Institutes for Medical Services are promising, in that all of the issues of importance to consumer experience are being addressed, guided by an active and sophisticated advisory subcommittee on consumer participation. The reader is referred to those regulations, not adopted at the time of this writing, and available from the Department of Health.

c. County Institutions: Access. In general, county services are centralized and hospital based. Exceptions to this pattern are beginning to occur, in the decentralization of ambulatory services to population centers of indigent users, stimulated by the neighborhood health center programs of O.E.O. and H.E.W.

Availability. County institutions traditionally operate services for emergencies at night and on weekends, because physician house staffs are assigned

to cover emergency rooms and the wards for inpatient admissions.

Patient Information. County hospital staff tend to develop referral skills to other sources of care, but this type of referral is usually casual and poorly organized.

Scope of Services. The scope of services in larger county hospitals is very comprehensive. This results both from the impact of university teaching affiliation and the fact that county institutions are a source of care for the most difficult cases--trauma, burns, detoxification services, intensive care units, rehabilitation, communicable disease, and a broad spectrum of specialty clinics.

Continuity of Care. This is generally poor in county institutions due to a continuous rotation and flow of internes and residents in and out of various services. Family health services are being developed in some county institutions to attempt to bring continuity of care in the outpatient setting.

Articulation with preventive services, mental health care, and rehabilitation is potentially easier for county institutions which largely control these types of services.

Quality Review. The tendency of urban and suburban county hospitals to affiliate with a medical center enhances quality by providing continuous review of cases by both house and visiting staffs. No motivation exists to perform unnecessary services induced by fees. The teaching function, however, increases the use of diagnostic testing and treatment procedures.

Utilization Control. Pressure on county institutions to handle large caseloads tends to spontaneously limit both admissions and length of stay to clear beds for incoming patients. There is little motivation to keep patients any longer than is necessary except for social reasons and failure to employ skillful

social work.

Uses of Manpower. County institutions are amenable to the expansion of functions of middle level practitioners and technicians. No fee competition exists, and the willingness to rely heavily on non-physician manpower is thus enhanced.

Medical Records. The teaching affiliation increases the quality of medical recording. Failure to adopt a problem oriented medical record system is particularly significant in that rotation of physicians tends to make charts voluminous and indecipherable.

Financial Records. Public institutions keep financial records subject to full disclosure.

Consumer Relations - Outreach Services. The pressure on county institutions is such that consumer relations are generally poor and reactive. Outreach is usually limited to ambulance service.

Treatment Outcome. More attention is paid to this where teaching affiliations exist.

Cost of Care. County institutions are hardly paragons of efficiency. They do not, however, tend to excessive provision of services, are non-profit, and try to make the most of limited budgets.

d. **University Medical Centers: Access.** One must go to university medical centers for care--they are not inclined to develop community based family oriented care.

Availability. Most medical centers maintain services which are readily available nights and weekends at the hospital.

Patient Information. Medical centers usually have organized systems for conveying information to patients, but this activity is too often confined to services provided by the center.

Scope of Services. The scope of services available at university hospitals is very extensive, but poorly organized in terms of consumer convenience. The orientation is strongly clinical and highly specialized.

Continuity of Care. The continuity of care in university systems leaves a great deal to be desired. Entry care is handled in the emergency room or drop-in clinics. Outpatient services are organized around the specialties and subspecialties. Little attention is usually paid to organization of family oriented primary services as a focus for guiding patients through the maze of specialty care. Decentralized neighborhood based family care is resisted. Preventive services are not stressed.

Quality Review. The quality of care in university systems is under continuous review because of teaching activities. This review, however, is confined to individual treatment transactions and is not applied to the system of services, which cannot pass a review of quality applied to consumer convenience, which succumbs to the complexity of these centers.

Utilization Control. Control of admissions and length of stay in university medical centers revolves more around issues of teaching interest than medical care economy. The exotic nature of diseases and services in the university setting makes control of length of stay a superfluous issue compared with other types of hospitals.

Uses of Manpower. Again, specialization prevails and manpower utilization supports the priorities given to research and teaching in the specialties.

Support for development of family practice departments, undergraduate courses and residencies is weak. Community medicine is given lip service, but intense competition for status and budget overwhelms concerns for development of primary family oriented types of services. For the poor, the medical center is a good place for specialty care--a confusing place for family care.

Medical Records. In university hospitals, records are given a high priority because of their importance in teaching and clinical research and in responding to referrals for consultation.

Financial Records. This subject is beyond the scope of this study.

Consumer Relations - Outreach Services. In general, university hospitals are insensitive to consumer reactions to care and usually too complex for consumers to deal with effectively.

Treatment Outcome. A great deal of attention is paid to treatment outcome as an essential component of both teaching and research excellence.

Cost of Care. The nature of the university hospital is such that the unit cost of care is very high. For this reason, prepaid health plans and tax supported programs often question the wisdom of paying for routine care in the university setting.

7. Data Acquisition and Processing

It is not stylish to initiate a discussion of computer programs with a comment on value systems. There is no doubt that the design and use of computerized information reflects the basic value orientation of the Department of Health and tests whether it is primarily interested in objectivity or wishes instead to support preconceived notions of what constitutes correct policy.

At present, the Department of Health does not control the acquisition and processing of information which it must possess if it is to evaluate and manage the Medi-Cal program.

Before describing our view of this problem, we offer a framework to explain the criticisms we will make.

Medi-Cal is based on the presumption that health care will be provided in a timely fashion, only when necessary, and assure an appropriate treatment for a variety of problems in the most economical way possible. In order to discharge this responsibility, the Department requires timely and valid data on people eligible and on the health problems they develop which require treatment. In addition, the Department must develop normative criteria which describe legitimate intervention, the sequence of procedures used, and the appropriate pattern and setting for treatment, and the fair cost.

At present, the Department is dependent upon paid claims tapes furnished by fiscal intermediaries to perform program evaluation. But the Department is not now capable of applying tests of the claims payment process to validate the accuracy of coded claims, the basis for approving or denying claims on grounds of medical necessity, the reasonableness of charges, or the adequacy

of the qualifications of the provider. For prepaid health plans, lack of data is even more critical since there exists, at present, no way of recording the procedural details of care provided.

Edits and audits being applied to paid claims are capable only of detection of gross errors in coding or illogical entries. The services utilization review process stimulated by recent federal requirements consists of a gross utilization edit which does not test the validity of services performed.

The eligibility file is even more vulnerable in that it is now used primarily to generate a list for mailing eligibility cards and cannot be relied upon as an indicator of numbers of persons eligible at a given point in time.

The Medi-Cal Management System (MMS) was designed to integrate claims processing with eligibility and to edit in such a way so as to detect fraud and identify inappropriate utilization on the part of both providers and beneficiaries. This system, in the pilot tests, was also capable of identifying current eligibility for providers upon telephone inquiry to county information centers. Turn around time in payment of claims was shorter. Claims of all providers were machine processed in the system. Treatment authorization requests were coordinated with the system.

Most importantly, profiles of both provider and beneficiary utilization could be developed.

The decision to scrap MMS and revert to the fiscal intermediary system of Blue Cross--the Medi-Cal Information Operation system (MIO)--should be carefully evaluated since MMS appears to have been on the way to the development of a capacity to find out what is going on in the Medi-Cal program. Before more money is invested in major revision of the fiscal intermediary system, however, the heavy reliance on fee for service provision of care in Medi-Cal must be re-examined.

A closely related issue is the Department's policy on the use of outside Professional Standards Review Organizations which are controlled, in effect, by local medical societies. Experience to date with foundations for medical care on the effectiveness of their peer review casts serious doubt on whether the Department can rely entirely on outside review. Poor control of both quality and budget points to the need in the Department of Health for internal controls.

8. Program Controls (Audits - Fraud - Recovery)

The vast number of transactions involved, and the participation of so many different providers, limits the ability of the Department to audit providers adequately. A defective information system enables providers to abuse the program without detection. At present, audits are initiated in instances of suspected fraud and when gross mismanagement is suspected. The number of routine audits is not adequate. Fraud investigators are hampered by lack of information and staff.

Even when audits clearly call for legal action to recover overpayments, such action is not necessarily taken. Providers selected for review of questionable claims are permitted to continue to participate for long periods of time.

The Investigations Unit, located in the Department of Health, is disconnected from audits--their reports do not necessarily trigger action by the Audits Unit, which is administratively located in the Department of Benefit Payments as is the Recovery Unit. The Recovery Unit handles third-party payments in instances where Medi-Cal recipients are eligible for insurance which overlaps their Medi-Cal coverage.

The separation of Audits, Fraud Investigations, and Quality Control into two departments is unwise. All of these functions belong together in Medi-Cal so that proper coordination can be accomplished.

9. Program Planning and Evaluation

This report amply illustrates the need for much stronger planning and evaluation, which now is simply missing from the program. Suggestions for improved planning have already been implied in our findings. The recommendations which follow, if adopted in whole or in part, will have a profound affect on the future operation of Medi-Cal and will alter its planning requirements to an extensive degree.

10. Recommendations

To assist the reader, recommendations are made in the same sequence used in reporting findings. Some of the recommendations made can be implemented administratively. Others will require legislative action or federal waivers. The recommendations are so sweeping in their implications that they should be taken as a point of departure for further discussion and debate. Our purpose in making them so strong and sweeping derives from our conviction that major surgery is required if Medi-Cal is to survive.

Cost Sharing Dynamics

1. The Department of Health should collect, analyze and report the standards of eligibility in use in each county to the Legislature.

2. The Legislature should define and make uniform the standard of eligibility for public assistance medical care under W & I Code 17,000.

3. Formulas which determine county share on the cost of Medi-Cal be revised to reflect variations which exist in the proportion of indigents in the county population eligibility standards, the assessed valuation of the county, and growth of population.

Budget Forecasting

The Department of Finance Should Require that the Department of Health justify budget requests in the Medi-Cal program with more detailed information on the eligible population, and program data which evidences a systematic process for elimination from medical providers guilty of abusing the program. (See details under PSRO.)

Administrative vs. Service Costs

The Department of Health should commission a study of administrative costs in Medi-Cal, taking into consideration the costs generated by the administrative processes listed in the findings of this report.

Eligibility Standards and Process

1. The Department, with federal waivers, should undertake, in a large county institution, a study of the fiscal implications of elimination of prior eligibility processing for non-cash grant recipients, (MI, MN, County indigent) and the substitution of sample post treatment audits to determine eligibility status. If a relatively insignificant number of patients in such a study prove to be marginally ineligible for care in a county institution, the simplification of eligibility should be employed in all county institutions to reduce costs of processing every patient. (This experiment is consistent with the intent of Section 222 of PL 93 603.)

2. A second study should be undertaken to explore the feasibility of reducing the number of standards used in the determination of eligibility in all programs of the Department including Medi-Cal. The nature of medical indigency is such that multiple standards may be more costly to apply than a single standard at the maximum level.

Benefit Structure

1. The benefit structure in Medi-Cal should be systematically reviewed in those programs which are involved in "crossover" funding. The purpose of such a review is to study with care the dynamics of the fifty percent federal share and the losses being incurred to the state budget by failure to cover services under Medi-Cal which are therefore covered in other programs with less advantageous matching formulas or which are funded entirely by the state.

2. Preventive medical services should become a covered benefit in the provision of care by organized providers--defined as Institutes for Medical Services, federally funded comprehensive care projects, county institutions, and university-county hospitals. This recommendation is limited to organized providers in a position to build a program of prevention into their system of delivery of services.

Rates and Fees

The Department should study alternatives to its present vulnerability of paying for the excesses which prevail in the private sector. A reduction in the number of fee providers, expansion of quality prepaid plans, expanded support to county institutions, and preferential treatment to Foundations for Medical Care could substantially reduce cost and enhance quality of care.

Influence of Methods of Reimbursement on Provision of Care

1. The Department, in its dealings with organized providers, should move in the direction of prospective budgeting and reimbursements, composite rate reimbursements and prepayment, and move away from procedural billing. The cost of processing fees for every service provided is high and inherently wasteful.
2. Composite rate reimbursement to selected hospital providers could overcome the losses incurred by dealing with the universe, which has a large redundant capacity. If, as a purchaser of care, the state enabled quality providers to attain optimal bed occupancy, the cost of redundancy could be removed from services purchased by government. This strategy of provider selection could also reduce the size of the malpractice cost pass-through by elimination from the program of substandard providers.

Types of Providers. Fees for Service.

1. The principle of selection of providers should be applied to the Medi-Cal program as is now done under CCS. The installation of a Professional Standard Review Organization capacity in the Department of Health (see later recommendation) would enable the Department to identify patterns of practice which are substandard and eliminate those providers from participation. The quality review process should deal with all types of providers, individual and institutional. Reimbursements from Medi-Cal should be conditioned on a satisfactory review record. Incompetence and exploitation must be added to fraud as grounds for removal from the program.
2. To accomplish this type of review, the Department should assume direct responsibility for the fiscal intermediary function. The Medi-Cal Management System should be reinstated as a first step toward development of a standards

review capability in the Department. To accomplish this capacity, the central identification eligibility file should be tied into the paid claims file, as discussed under Data Processing.

Foundations for Medical Care

The Department should show preference to Foundations for Medical Care in the selection of private fee providers on the basis of their record of claims review and hospital utilization control, to improve the quality of care. This is consistent with the intent of federal amendments to Medi-Cal which gave rise to Professional Standard Review Organization review as a requirement of participation in the program.

Prepaid Health Plans (now Institutes for Medical Services)

1. The prepaid approach to Medi-Cal should be preserved and strengthened.
2. The charge to the Prepaid Health Plan Advisory Committee should be revised by the Director of the Department to encompass the entire Medi-Cal program.
3. The regulations for the Institutes for Medical Services should be taken to public hearing for purposes of making revisions which are justified, to strengthen this program.
4. The Alternative Health Division should be abolished and the program be moved into the Medi-Cal Division.

County Institutions

1. The traditional partnership should be restored between the State Health Department and county institutions by removal of regulations designed for private providers which are inappropriate to public institutions.

2. County institutions should be encouraged to participate in the prepaid health plan contracts on a modified risk basis, since they already carry the burden of catastrophic care in the community and, unlike private providers, are making a substantial contribution to the health care trust fund of the Medi-Cal program. Tests of enrollment of all categories of eligibility should be undertaken in county prepaid plans. Composite rate reimbursements should replace the fee reimbursement systems imposed upon county institutions for care of patients not enrolled in prepaid plans.

University Medical Centers

The State should enter into contract negotiations between University of California and county institutions for provision of care to medical indigents. Contracts should be written to assure no loss of access to care by medical indigents not eligible under Medi-Cal reimbursement. The care of such indigents is both a state and county obligation. Contracts should also demand that a system of family oriented primary care be developed and preserved to coordinate care and referrals to specialty clinics. Such family oriented clinics should be located in the neighborhoods close to recipients and not only at the hospital site.

Consumer Experience

The Medi-Cal program's power to purchase services should be utilized to begin to bring together integration of services to recipients. Dispersal of care, i.e., preventive services, ambulatory diagnosis and treatment for general medical and surgical care, mental health services and services to special groups--alcoholics, drug abusers, the retarded--poses serious problems in continuity of care. All organized providers must be made more aware of

the need to attain service integration; improve access and availability of services; improve continuity of care; control unnecessary hospitalization; avoid unnecessary admission to nursing homes; provide a plan to meet patient grievances; and provide information and assistance to patients. Requirements being developed for Institutes for Medical Services are appropriate even if care is not reimbursed on a prepaid basis.

Data Acquisition and Processing

The Department, in assuming fiscal intermediary operations, should plan to install a data system capable of performing analysis of characteristics of recipients as well as patterns of provision of services. The professional services review function is extremely important, but program evaluation in Medi-Cal extends to many other issues. The Medi-Cal Management System should be used as a first step in building a data system capable of tying together information on specific eligibles and patterns of provision of services to them by specific providers. This data base is fundamental to planning throughout the Department programs, because the population eligible for Medi-Cal is also eligible for many other programs. Knowledge of the characteristics of people and the services they use is indispensable to both evaluation and planning in the Department. Lack of control over information makes it literally impossible to control any program.

Program Controls

The auditing and recovery functions now lodged in the Department of Benefit Payments should be transferred into the Medi-Cal Division in such a position that both functions articulate with the services review operation, as described above and with investigations.

The system of collection, organization, and analysis of data in Medi-Cal should be premised in the future on these changes in policy:

- Selection, and hence reduction, of the numbers of providers in Medi-Cal.
- Selection of providers on the basis of systematic review, in all treatment settings, of compliance with a very specific statement of professional performance standards developed by the Department of Health.
- Assumption by the state of the fiscal intermediary function, in phases, on the basis of a planned reduction in the volume of procedural billings.
- Much expanded investment by the state in organized, comprehensive prepaid health delivery systems and in prospectively budgeted contracts with county institutions, Institutes for Medical Services, university-county institutions, Foundations for Medical Care, consumer-sponsored, federally assisted programs (neighborhood health centers, 314-E projects--children and youth projects, comprehensive migrant projects, Model Cities health projects, regional medical program grants, etc.), and with State Health Department-sponsored innovative demonstration programs.

The adoption of such priorities would significantly reduce information requirements, and make more feasible the successful assumption of the fiscal intermediary function by state government.

1. Preventive Medicine

Prior to consolidation, the Department of Public Health, headquartered in Berkeley, held responsibility for a number of traditional activities. The majority of its programs are mature and settled. They deal with environmental sanitation, laboratory support services, preventive health programs in maternal and child health, including Crippled Children Services (CCS), dentistry, control of infectious and chronic disease, epidemiology, occupational health, comprehensive health planning, facilities licensure, monitoring and certification, and Hill Burton construction programs. Contract counties and programs for migrants and Indians address the special problems of rural counties.

For this department, consolidation has proven to be most traumatic and disruptive. The physical removal of most elements of the Department from Berkeley to Sacramento resulted in a significant attrition of both professional and experienced clerical staff who were either unable or unwilling to make the move or to accept the new management philosophy which emerged with reorganization.

A number of changes have occurred which proved to be detrimental:

- A decision was made to centralize in the Administrative System (now the Division of Administration) program support elements such as data processing, systems analysis, budgets, fiscal system, personnel, management analysis, and evaluation, auditing, contracts and statistics.
- Licensing and certification were removed to a new Quality System, created, in theory, to assure the quality of care in all departmental programs. The Health Education capacity was removed to an Office of Communications in the

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.

Recurring crises in the Medi-Cal program have diverted experienced support staff from public health programs, which had already suffered losses relating to the move from Berkeley.

The idea of placing reliance for assurance of quality of programs in a new Quality "System" was especially offensive to public health professionals whose training does not permit them to divest themselves of this essential responsibility. They consider it foolhardy and naive to attempt to isolate this function in a division which was viewed as being devoid of budgetary control, devoid of program responsibility and devoid of professional talent to contribute to quality assurance. (The Quality System)

The status of Preventive Health Programs has decreased ominously and a low priority of attention is shown to them. Many opportunities exist to integrate preventive components into Medi-Cal, Short-Doyle Developmental Disabilities and other direct service programs but the malfunctions which accompanied the pattern of consolidation have discouraged attempts to proceed in this direction. The only progress being made in programs of prevention have resulted from legislative initiatives in the creation of new programs.

An abbreviated account of the current status of specific programs is presented below.

Maternal and Child Health: This unit is extremely large for its present level of administrative placement. Its budget is large and its programs include family planning, maternal and child health projects, childhood disability screening, infant health, nutrition consultation, supplemental food programs for women, infants and children projects, children and youth projects, genetic

disease control, hearing conservation, and rural health projects. In general, the unit is acknowledged to be very well managed. An exception is the childhood disability screening program, whose major problems will be given particular attention and analysis later in this report.

This unit expressed strong criticism of the present organization and administration of the department, which have already been described: excessive length of administrative channels, diffused responsibility, lack of delegation of authority, incompetence in high places, destructive decisions made because of lack of program knowledge, poor administrative support, especially in the areas of personnel, budgeting, data processing, contracts, and lack of leadership.

Many opportunities exist for integration and coordination, but are not undertaken. Relationships with Medi-Cal and the Department of Benefit Payments are extremely difficult. Program integration with developmental disabilities is of special importance, and has been approached constructively in recent weeks.

Opinion in this unit reflects support for preservation of departmental consolidation, but in different form. Reduction of powerless levels of authority, partial decentralization of administrative support, delegation of decisions to program professionals, improvement in relationships with H.E.W. and counties, and a different approach to program planning, evaluation, and management were stressed.

Crippled Children Services (CCS): Return of this program to Preventive Medical Services Branch has much improved morale and function. When run as a "financial" program in the health financing system, concern for quality of

care and controlled case management were eroded. This occurred because division managers did not know the CCS program and were more committed to budget reduction than maintenance of the excellent reputation enjoyed by the CCS program through the years. An example of this attitude is the attempt to deny CCS services to Medi-Cal children enrolled in PHP's on the presumption that the level of care was adequate in the plans for all diseases of childhood. Disenrollment was required before CCS eligibility was restored. Another example is the denial by Medi-Cal of care for severe orthodontic problems and for dental surgical claims for repair of cleft palate. CCS picked up the cost of the provision of these services. In doing so, a loss of revenue to the State occurred since federal financial participation in CCS is far less than in Medi-Cal.

CCS also has close functional ties with the Maternal and Child Health Unit, and with developmental disabilities. Eligibility for these programs overlap; lack of coordination can result in repeat evaluations of the same children; provision of outside care by referral to regional centers for children who are eligible for CCS; rules regarding third party payments for Medi-Cal liability which artificially deny Medi-Cal eligibility to needy families; and repayment policies which are inconsistent and contractory. There is an obvious need to pull together pediatric and maternal services of Medi-Cal, maternal and child health services, including family planning, crippled children services and services for the developmentally disabled. This dispersion of program authority is a good example of the confusion which results from categorical approaches to health programs in place of a comprehensive approach to the needs of all children. The Childhood Health and Disability Prevention Program in full gear will provide casefinding for all of the pediatric services programs of the department.

Cyclic swings in the funding of CCS causes at one end, a backlog of cases and rejection of children in need, and at the other end attempts at vigorous case finding to prevent reversion of funds. Staff support to counties is inadequate to assure the smooth processing of applications and the adequate surveillance of cases under active management. County eligibility standards vary in application, and inequities result.

CCS administrators admit a deficiency in evaluation programs results. They would like to be able to analyze the numbers of children in the CCS caseload who are cured, whose situation is ameliorated or stabilized and the results obtained in restoration of function and in lengthening of life.

Another major recommendation, now being actively reviewed, is that some kind of umbrella mechanism be created in the department to make improvements in the continuity of effort being expended in tax-supported health services to children. Such a mechanism would permit review of eligibility, overlaps, duplication, reimbursement policy, repayment, and attempt to agree on an integrated approach to the management of the full spectrum of health services received by families.

Chronic Disease: Following consolidation, activities relating to prevention, casefinding and treatment of chronic disease were all but decimated. Staff reductions and budget cuts were severe and the capacity of the department to make progress in this important field were severely curtailed. The Regional Medical Programs, with a similar point of departure, may have influenced the loss of priority in chronic disease control. The residual staff of the Chronic Disease Unit has worked closely with the Regional Medical Programs whose imminent demise illustrates the importance of maintaining a chronic

disease program in the State which is not vulnerable to federal program cutbacks.

The chronic disease unit conceives of both humanitarian and cost effective approaches to the health of older Californians, but receives little encouragement in budget allocations. Hypertension screening, home care follow-up of patients with recent admissions for congestive failure, efforts at influenza immunization--these are examples of active programs which have the potential of reduction in use of hospital based care.

The lack of data accumulated in the Medi-Cal program is a source of frustration in the chronic disease unit. A great potential exists to analyze diagnostic data and treatment patterns in chronic disease, which may lend themselves to programs of secondary prevention and innovation in case management which can at one time reduce morbidity and disability and ameliorate the cost of hospitalization for preventible complications of chronic conditions.

Failure to support and expand the capacity of the chronic disease unit is pennywise, pound foolish. A higher priority in funding this program is clearly indicated.

The Dental Health Unit is similarly in a condition of near starvation. Dental disease is almost universal; preventive measures are clearly effective; the case for fluoridated water supplies is closed -- a resounding success -- one of Public Health's more impressive accomplishments. Dental prepayment, expanded use of para-professionals, and organized programs of prevention are flourishing--yet, in face of these realities, the entire State of California is covered for public health dental program development by one lonely dentist.

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.

Infectious Diseases: The Health Task Force did not review the activities of this section, which is viewed both within the department and by local health departments as a well managed, responsive, and effective program, one of the few which draw far more praise than criticism. A concern for increased funds for ambulatory treatment of tuberculosis was expressed by local health departments.

Childhood Health and Disability Prevention Program: This program, organized in the Maternal and Child Health Unit, is illustrative of the difficulties experienced in trying to launch an ambitious new program without control over the administrative processes. We will refrain from a description of the program itself and confine our remarks to administrative problems.

The following assessment of each contact's level of cooperation, as viewed by those in the department responsible for the program and generally concurred in by those responsible for the programs at the local level, is portrayed as follows: * Good; ** Fair; *** Difficult; **** Poor.

To launch such a program, decisions had to proceed through the administrative hierarchy as follows:

Vertically	
Through Children and Youth Unit	* to
Maternal and Child Health Unit	* to
Family Health Services Section	* to
Preventive Medical Services Branch	* to
Health Protection Division	* to
Two Deputy Directors	*** to
The Director	*

Rates and Fees-----	Refusal to consider levels sufficient to accomplish provider participation
Systems Analysis-----	} Obstructed the design of a data collection and analysis program satis- factory to program managers
Data Processing-----	
Center for Health Statistics---	
Vital Statistics-----	
General Personnel-----	Up to eight months' delay in approval of positions. Further delay in processing applications

The CHDP Program has had a very slow start not because its program manager is inept or a poor manager, but because he lacks control over key administrative processes absolutely essential to new program implementation.

By contrast, the Family Planning Programs of Maternal and Child Health under SB 1176 was launched with all controls within the unit. In one year, 60,000 individuals were served, rates and fees were set, program standards and regulations adopted, forms printed and distributed, bills paid, and quarterly reports made to the Legislature. The staff support was small but effective - completely in the control of the program manager.

2. Summary of Recommendations

The activities of the Division of Health Protection deserve a much higher priority within the Department. Organized programs of prevention are relevant to all direct service programs of the Department; namely, Medi-Cal, Short-Doyle,

alcoholism, and drug abuse. Examples of the unfulfilled potential of prevention include dental education and fluoridation, nutrition education among children and adults, prevention of avoidable and recurrent hospitalization among the chronically ill, reduction in mental retardation through improved care of high risk mothers, prevention of genetic disease through counseling, organized screening of children and adults for treatable disease, and much heavier emphasis on health education and maintenance of health in the entire population. Emphasis on prevention and maintenance of health can reduce morbidity and lower the cost of medical care.

3. Social Services

The dismantlement of the Department of Social Welfare by transfer of social services into the reorganized Department of Health has caused deterioration of the status and effectiveness of social services in California.

This transfer was accomplished by an administrative emphasis on routing "cheaters" out of the welfare system. This emphasis displaced, in importance, the humane tradition of concern of the profession of social work for the majority on the welfare roles who are in need of both income maintenance and social services. This professional commitment touches many other Californians not on the welfare role.

The traditional partnership between state and counties also suffered disruption. Although it should be obvious that the point of coordination in the delivery of social services is always at the community level, the state administration has denied a meaningful role to local directors in policy formulation. State policies are independently developed and regulations are promulgated and then imposed on the local directors. They are, in turn, held responsible for administering and financing programs which they have not had a hand in developing. This lack of communication between state and local officials leads to confrontation and friction which has now become pervasive and widespread. This situation must be corrected.

The most recent example of the disturbed relationship is the recent history of the development of state regulations under Title XX created by Social Security law amendments last year.

No leadership came from the Department of Health. Local directors took the initiative and forced the Department to take the formulation of regulations

under Title XX to public hearings called for by law.

In spite of these hearings, a state plan was hastily drawn which poorly reflects both the local inputs made at hearings and the concerns of local departments.

Mandates for eleven services remain in the state plan under Title XX, but money to carry out these mandatory social services is clearly inadequate. Both the state administration and the State Legislature must be criticized for conveying on the counties legal responsibilities which cannot be fulfilled in the absence of a reasonable funding base.

The flexibility and progress which could accompany Title XX is thereby being frustrated.

Although the Title is presented as a national plan with five clear goals, counties are still under a mandate to provide eleven types of social service.

A comparison of national goals with the eleven mandates is illustrative of a basic problem. The five national goals are:

- Self support
- Self sufficiency
- Protection for adults and children
- Community and home-based care
- Institutionalization

Title XX leaves the potential for great flexibility in the pursuit of these goals, giving consideration to the wide differences in conditions which prevail in the fifty-eight counties. The infamous "revolt" in Plumas County is not entirely without justification, and is symptomatic of the degree of hostility felt toward state administration at the local level. Local elected officials are growing tired and rebellious at the tendency of the state to ignore the realities of local conditions.

The state mandated programs call for these types of services:

1. Information and referral
2. Protective services to children
3. Protective services to adults
4. Out-of-home placement of children
5. Out-of-home placement of adults
6. Child care
7. Health-related services
8. Family planning
9. Home-maker
10. Chore
11. Employment

Social services are also mandated for mentally and developmentally disabled adults and children.

Clearly, these mandates must be withdrawn if the flexibility intended by Title XX to adapt to local conditions is to be attained. Plumas and Los Angeles Counties cannot be asked to operate on the same set of premises.

To restore appropriate status and to bring order to social services in this state, several things must be accomplished without delay.

First, the administration of social services must be awarded more authority than is represented by locating this function four levels down in the State Department of Health.

Second, stronger leadership in the Department, at top levels, is urgently required, with a sufficient number of positions allotted to enable the state to carry out its responsibilities.

Third, the location of responsibility must be made clear to local directors, so that their questions are answered clearly and with authority within the Department.

Fourth, meaningful county participation must be attained if the traditional state-local partnership is to be restored and destructive hostility is to be converted to reasonable negotiation of differences in perspective. Local directors simply must be accorded the opportunity to participate in the basic design of programs they are asked to run.

Fifth, statewide planning of social services must be elevated to a level of status equal to that accorded to comprehensive health planning (discussed elsewhere in this report).

Sixth, a system of regionalized technical assistance to local departments must be constructed in a rational pattern so that knowledgeable state professionals can deal harmoniously with the needs of county directors.

At present, technical assistance consists mostly of authoritarian and irrational dictation.

4. Recommendations

1. Appoint a chief of social services at the branch level in the Preventive and Protective Health Services Division of the Department, described in Phase I charts of organization in Chapter V of this report.
2. Recruit new leadership to this position, with participation of local directors, capable of justifying the recruitment of sufficient numbers of experienced and talented professional consultants to develop a progressive system of social services in cooperation with local directors.
3. Re-establish a State Board of Social Welfare with statutory power to review regulations promulgated by the state in partnership with local directors.
4. Rescind state mandates for eleven social service functions, and substitute five national social services goals as a mandate, to allow for flexibility to meet local conditions in a rational fashion.
5. Transfer the fiscal control for social services programs from the Department of Benefit Payments into the Preventive and Protective Health Services Division of the Department of Health, with the exception of Title XIX - specifically, funds available under Title XX, IV. A, B, C, and D of the Social Security Act.

6. Locate a unit for planning for statewide social services in the Planning and Evaluation Office of the State Health Department, as indicated in the Phase I chart of administrative change described in Chapter V of this report.
7. Organize competent technical assistance to local departments to conform to the Health Systems Agency pattern of regionalization, to assist in coordination with efforts in health services planning.
8. Review state statutes relating to social services exhaustively and revise them to improve understanding of social services requirements in the fields of health, welfare, employment, education, rehabilitation and corrections. After this review, mandates which are either obsolete or inadequately financed by state and federal government should be removed.
9. Although there is, currently, a movement to create an independent Department of Social Services, the Commission does not support such action at this time.

C. Developmental Disability Program

1. History

For many years in California, the major resource for the mentally retarded was placement in state hospitals. With increasing concern for the problems of this neglected group, community services were developed, and the population of mentally retarded patients in state hospitals was reduced. In 1965, legislation created a regional center pilot program in the Department of Public Health to provide diagnostic services and a coordinated system of community based treatment. Care for the retarded in state hospitals and follow-up services after discharge remained the responsibility of the State Department of Mental Hygiene.

In 1969, the Lanterman Mental Retardation Services Act created a statewide system of regional centers for the diagnosis and referral of the mentally retarded, administered by the Department of Public Health. In 1973, legislation was passed to include services to others with severe developmental disabilities; i.e., cerebral palsy, epilepsy, and other handicapping neurological conditions. In the reorganization of the Department of Health in 1973, programs for developmental disability were brought together into the Health Treatment "system".

2. Goals and Objectives

The Developmental Disabilities Services Branch organizes, coordinates, and directs community statewide developmental disabilities programs provided, under contract, by a network of regional centers for the developmentally disabled. This includes planning and development of new services for the

developmentally disabled; providing guidance in case management and the purchase of service; providing liaison and coordination of community programs with federal and state agencies.

The three major goals of the program are normalization, prevention, and outreach.

1. Normalization: Assure that citizens with developmental disabilities are afforded the human right to their place in society in accordance with the mandate for social integration and assimilation.
2. Prevention: Reduce the incidence of developmental disabilities.
3. Outreach: Assure that all developmentally disabled citizens and their families receive the full array of services and programs.

3. Program Components

There are four major components of this program: (1) program development; (2) regional center services; (3) continuing care services; and (4) hospital services.

Program Development Section: This section was originally established as the Office of Developmental Disabilities in 1969, and was located in the Health and Welfare Agency, where it served to coordinate the services of Area Boards and the Developmental Disabilities Planning and Advisory Council (DD Council). The Area Boards were established throughout the state to plan, coordinate, and encourage the development of services in designated areas. The DD Council was established as the statewide planning and coordinating advisory body to work with the State Health Advisory Council, the comprehensive health planning

body. In addition to its staff functions, the office served as the single state agency in the disbursement of federal funds for Community Program Grants. In July 1975, as a result of budget language, the Office of Developmental Disabilities was transferred to the Department of Health and re-named the Program Development Section. In 1975-76, the section will retain its original functions and will allocate about two million dollars in federal funds and with state general matching funds for Community Program Grants.

Regional Center Section: The Regional Center Section coordinates and monitors the activities of 20 regional centers located throughout the state. Regional centers are private, non-profit community agencies under contract with the Department of Health. Designed to be fixed points of referral in the community, they serve as entry and coordinating bodies for developmentally disabled individuals, offering diagnosis, counseling, coordination, and follow-up services. In addition, the centers contract with vendors to provide special services to clients. In 1974-75, the regional centers served approximately 27,000 clients at a cost of about 36 million dollars, mostly from state general funds.

Continuing Care Services Section (CCSS): This State Health Department program provides direct services to developmentally disabled clients in local areas. Originally designed to provide follow-up for patients discharged from state hospitals, it now includes care for all developmentally disabled persons. It provides social services to clients to assure adequate living conditions, support services to reduce the need for hospitalization, specialized treatment services, and general psychological counseling. All CCSS services are funded by Title XX of the Social Security Act, and are made available by contractual arrangement with 17 regional centers. Three

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.

In 1974-75, there were approximately 10,200 clients in state hospitals, 27,000 served by regional centers, and 7,700 served directly by the CCSS program.

Eligibility for clients depends upon the source of care. In regional centers, any client may obtain diagnostic and referral services free of charge, as specified by legislation. Regional centers clients, whose disability is defined as being in the developmental category, regardless of income, may be referred for vendor services provided by outside agencies.

The state regional center program has no general guidelines on reimbursement. Some centers believe that patients should not pay for any DD services, but others have a philosophy that patients should pay part of the costs. In those centers where patients are asked to pay part of the costs, this is based upon arrangements with the individual client and family, and not based upon sliding fee formulas.

Clients who are placed in residential care homes or the state hospitals, according to the Title 17 regulations in the California Administrative Code, are asked to make a monthly parental contribution if they are able to pay. The monthly contribution goes up to \$150.00. Payment for out-of-home placement services may be covered by Medi-Cal and private health insurance. Payment to vendors is made directly by regional centers.

Eligibility for services by the CCSS program is based on guidelines for Title XX eligibility, which is designated for low income clients.

5. Financial Resources

The total budget for the developmental disabilities program for 1975-76 is 222 million dollars. The program allocations are as follows:

Amount	Program Component
\$ 2.2 million	Program Development
\$ 50.4 million	Regional Centers
\$157.8 million	State Hospitals
\$ 11.6 million	Community Care Services
\$.2 million	Administrative Costs

The sources of income for the program vary by the specific program. The administrative costs are paid by the State General Fund. The regional center program funds come from a variety of sources, including state general funds (74 percent), federal funds (20 percent), and parental contributions (6 percent). The federal funds for program development of special projects comes from the Developmental Disabilities Services and Construction Act of 1970 and the Social Rehabilitation Services Act, which are matched by the state on a 25 percent basis. The state hospitals receive funds from clients, from Medi-Cal which is fifty percent state and federal matching money, and from the State General Fund. The CCS money for social services comes from Title XX of the federal Social Security Act.

6. Providers of Services

Clients who are developmentally disabled may receive services from a variety of public and private agencies and individual providers. Regional centers serve as contractors for services with providers --labeled vendors. A variety of services may be obtained from vendors; the state lists 110

different types of vendor services. These include services from special schools, nursing homes, day care programs, boarding care facilities, family care homes, rehabilitation centers, hospitals, nurseries, workshops, prosthetic and appliance companies, summer camps, homemaker services, and specialists such as recreation therapists, physicians, pharmacists, and so on.

The public providers, in addition to State Department of Health services, may include county hospitals, university medical centers, local school districts, county welfare agencies, and local park services. The public providers usually do not receive funds for services from the state developmental disability program, but the private providers are paid on a contract basis by the regional centers. The private providers include all those physicians, specialists, facilities, and other contract agencies such as transportation companies, homemakers, home-teachers, day schools, and special centers or clinics.

7. Rates and Fees

The rates and fees established by the State Department of Health include those for the state hospitals and for residential care placement, as well as fees for private vendors paid by the regional centers. There are three general categories of rates: residential care, medical services, and all other services. The state established a flat rate for all individual providers, based on the Medi-Cal rate schedule. The state also establishes a flat rate to pay small community care facilities. Other facilities, including large residential care homes, day care programs, and special services, such as transportation and infant stimulation, etc., are paid on a cost-basis by the regional center program, with some ceiling limits for specified services.

Because of the complex rate setting system--some flat, and others on a cost basis--for the many different types of vendors paid by the state, this area is confusing and controversial. The state should not allow regional centers to establish their own rates independently; this makes the system more complex and unstandardized. The State Department of Health should study methods for standardizing and simplifying these procedures.

8. Advisory Bodies

The two major advisory bodies to this program are Area Boards and the State Developmental Disabilities Planning and Coordination Board. In addition, each state hospital has an advisory board to guide hospital programs.

The thirteen Area Boards and the State DD Council were established by the Lanterman Developmental Disabilities Act in 1969 for the purpose of planning and coordination of services. Membership is composed of parents, professionals, and the general public. The Boards and the Council have had little impact on planning and coordination of services because of a number of factors which include: the voluntary nature of the board members; the lack of financial and staff support to the boards; the poor interface between the state planning and the delivery system of services; and the state Department of Health's failure to develop an effective planning system. The activities of the boards and the Council were primarily utilized to meet minimum planning requirements for federal funding. The state hospital advisory boards have primarily served as advisors on administrative policies and have assisted in obtaining financial support for the state hospital programs.

9. Administrative Organization

The developmental disabilities program is complex in that it is administered by two different divisions. The Regional Center Program, the Program Development Section (formerly the Office of Development Disabilities), and the Continuing Care Services Section (CCSS) are administered by the Community Services Division. The State Hospital Program, administered by the State Hospital Division, offers programs for the developmentally disabled in nine state hospitals. The Community Services Division staff are located in the headquarters office, in 15 CCSS area offices, and in 36 CCSS field offices. The twenty regional centers under contract to the state are operated as private independent agencies. Thus, the state program includes direct services provided by the state hospitals and CCSS program, and indirect services provided by contract with regional centers.

The total staff for the state DD program, not including those staff in regional centers and in state hospitals, are distributed as follows: 12 staff (including four clerical) in the Program Development Section; 14 staff (including six clerical) in the Regional Center Program; and 252 staff in the CCSS Program, of which 18 are located at headquarters, and 234 in the field offices. The CCSS staff includes 162 social workers and community program analysts, 15 public health nurses, and 57 clerical staff. There are 9,844 staff in the state hospitals, including 6,327 nursing, 887 other professionals, and 2,630 administrative support staff.

The 1973 reorganization of the Department of Health combined the State Hospital Program and the Developmental Disability Program into the Health Treatment System. In May 1975, the State Hospital Program was given divisional status

and separated from the community programs, which were named the Community Services Division.

Our interviews with state program staff in the Developmental Disability Section, with regional center staff, with CCSS staff, with members of the DD Council, and with area board members, produced unanimous agreement that the separation of these two programs has created multiple problems. Staff in the regional centers and the CCSS Program consider the hospital staff to be uninterested in working together for planning discharge and after-care services for clients.

State hospital staff are not receptive to community services staff visiting patients and acting as their advocates. State hospitals staff do agree that coordination, communication, and attitudes have been disturbed by the division of these programs. Continued separation of programs will surely lead to worse fragmentation of the delivery system.

10. The Delivery System

The "regional center" system was designed to serve as the hub of a single system for developmental disabilities services. Unfortunately, the regional center concept has done little to alter the fragmented character of the delivery system itself. The "regional centers" are private agencies contracted by the State Department of Health to provide intake, counseling, and referral services. They, in turn, contract for community services with both public and private agencies and with the state CCSS Program. As private entities, the regional centers are largely contracting agencies and are not an integral part of a state health services program. The responsibility of the state

has been obscured. The regional centers have severe limitations as private agencies in coordinating a complex public and private system of services, and in assuring the development of services which are needed but unavailable.

The term "regional center" is a misnomer in that centers are not established within pre-designated regional areas of the state. Rather, regional centers are private centers founded on the basis of population needing services and upon the state's ability to find a sponsor who can establish a satisfactory operation. The size of geographic areas and populations served vary considerably among the regional centers as do the services provided. For example, in Los Angeles County, with a population of 7 million, there are six regional centers, while in the nine-county Bay Area, there are three centers. Since "regional centers" are not true regional operations, they should more accurately be referred to as DD service centers.

Boundaries for regional centers follow county lines, but jurisdictional disputes do arise. Clients are served on the basis of their county of residence, but if a client is placed in a community facility in a county located in a different regional center area, disagreement arises over which center should provide services. Misunderstandings of this nature are inevitable in a system with so many regional centers who compete for state contract dollars and which are not linked and coordinated with each other. Regional centers vary widely in their services to clients and display different priorities for the services which are provided.

The state Developmental Disabilities Program has little control over the operations and services of regional centers. The state has even less control over third party contracts which regional centers make with community agencies. Contract arrangements have failed to ensure that comprehensive

and coordinated services are provided. If the state wants a more coordinated and comprehensive delivery system for developmentally disabled clients, it will have to take more direct responsibility for developing and regulating the system.

Each geographic region of the state should have a regional operation for developmental disabilities, which would bring together the state hospital programs, the "regional centers", the CCSS Program, and the Area Board planning activities. Because of the intricate nature of DD services which cross county boundaries and include a complex network of health and educational programs, it is logical that such a system is best coordinated on a regional level rather than at a county or a statewide level. The State Department of Health attempts to develop a coordinated system at the state level have not been successful because of the complexities of the public and private system. By establishment of a genuine regional operation, both planning and delivery of services can be made more effective.

The regionalization of services must be intimately tied to program planning and development. The planning and coordination activities of the Area Boards and the DD Council have been almost a complete failure, according to all objective measures and the opinions of interviewees in this study. Area Boards are given responsibility for planning programs with voluntary membership, little staff resources, and with no regional support from the State Department of Health. Regional centers are asked to work directly with Area Boards, but neither the regional centers nor the Area Boards have authority, nor are they held accountable for area planning and development. The plans produced by these groups are primarily intended as documents to fulfill federal requirements for obtaining funds and are not used for actual planning. By establishing the Area Boards and planning activities in direct relationship

with the service delivery system within regional areas, the planning would become a more meaningful and integral part of regional services.

11. Program Interfaces

The Developmental Disability Program (DD) and the Mental Disability Program (MD) of the State Department of Health are overlapping and fragmented. The DD and the MD programs developed together under the state hospital program in the Department of Mental Hygiene, but the Developmental Disability Program, historically, received less attention and financial support. Since the 1973 reorganization of the Department of Health, the Developmental Disability Program has held equal departmental status with that of the Mental Disability Program, and have been located properly in the same division for administrative purposes.

The Mental Disability and Developmental Disability Programs are closely related and, consequently, difficult to separate. Within the state hospitals, some hospitals have only developmental disability programs, some only have mental disability programs, while others have both programs. It would be difficult to separate the programs for state hospitals, converting each hospital to one program or the other to achieve administrative separation. It is hard to assess whether this would bring administrative benefits or better program services, but there is little reason to think that such a separation would have significant benefits.

Some client advocate groups and some physicians within the Department would like to separate completely the mental and developmental disability programs in order to achieve greater administrative control and different program directions.

Client advocate groups for the developmentally disabled claim that clear separation of the developmental program would give the program more visibility and autonomy that would have benefits for clients. Specialists agree that developmental disability programs are uniquely different from those of mental health programs and that such programs need autonomy from psychiatrists who dominate the mental health field.

Individual clients and families in both the developmental and mental disabilities treatment categories have common needs for both mental and physical health care services, as well as social services, nutrition, housing, recreation, education, and adequate incomes. Both programs need state hospitals services at this time, social services, out-of-home placement services, and have similar funding sources and facility licensing problems. At times, clients in the two separate programs need services from both programs--mental and developmental services--and sometimes clients are eligible for funding from both regional centers and local community mental health programs. For example, neither the regional centers nor the local mental health programs want to assume responsibility for autistic children; thus, some clients get lost in bureaucratic disputes.

Since these programs have common problems, and provide sometimes overlapping and fragmented services, the task force members conclude that the mental and developmental disabilities programs should remain in close relationship to each other within one division, to ensure maximum coordination and communication. While each program should continue to have equal status within the Department of Health, it would be a serious mistake to separate these programs into two separate administrative divisions.

When regional operations are developed for each program--mental and developmental disabilities--then these programs can gradually achieve integration at the regional level. Ultimately, over a period of time, the two programs could be integrated with other health service programs to achieve genuine comprehensive health services.

Programs for the developmentally disabled, and sometimes the mentally disabled children, are closely related to, and overlap with, the children's program for Crippled Children, located in the Health Protection Division. Both programs include the population of handicapped children, although the Crippled Children's Program deals with a broader range of potentially handicapping conditions. Services provided by the developmental disability, the mental disability, and the Crippled Children programs, all include the purchase of diagnostic evaluations, case management, special treatment services, and health-related equipment. At present, the data systems of the Department of Health are not able to determine the number of clients who are served by more than one program at the same time. Duplication and overlap of services exists, and the areas of responsibility between these programs overlap.

12. Program Services

The state program for developmental disabilities was designed to be a single system for comprehensive services to clients. The program includes different levels of care and types of services to clients based upon need. A wide range of service is included: medical, social educational, rehabilitation, prevention, out-of-home care, homemaker services, recreation, and special programs such as transportation, legal or infant stimulation. A broad range of services is made available, tailored to individual need.

Legislation establishing regional centers specified that the centers were to provide a point of contact with clients and their families for diagnosis, counseling, evaluation, and referral to contract services for treatment and management. The precise role of each regional center was not clearly specified and, to date, remains too vague. Some regional centers are expanding services to include case management and follow-up of clients. Administrative leaders within the Developmental Disabilities Program have encouraged the regional centers to "opt out" of the Continuing Care Services Section program, to provide their own case management of social services and to contract for social services with local agencies. Other regional centers argue that regional centers should not provide social services, and should limit their role to that of diagnosis and referral to local agencies.

The conflicts and disagreements over what services should be provided have developed because of lack of clear definition of purposes, goals, activities, and standards for regional center operations by the Department of Health. Without policies and procedures for regional center operations, confusion and disagreements among centers have increased. One of the reasons for such disagreements over policies within the Department of Health appears to be the absence of careful evaluation of regional centers services. Leaders within the State Developmental Disabilities Program are strong advocates for the regional center system but have done little critical evaluation of programs to attain an objective assessment of their strengths and weaknesses. The program needs a comprehensive evaluation, by independent social scientists, to serve as a basis for guiding future policy, by establishment of clear and objective standards for this program.

The State Developmental Disability Program has not ordered its priorities to close the gaps in services for the developmentally disabled, and especially those with minority ethnic identification.

Regional centers were designed to meet the needs of clients otherwise not able to receive medical and social services and to improve the quality and quantity of services for a neglected client population. Two regional centers have been established in low income neighborhoods, serving large ethnic minority populations, but the other regional centers develop programs and services which are more likely to serve middle class white patients. Regional centers do not use eligibility requirements designed to direct services to low income clients, although some have established priorities for such groups. Other programs, according to staff reports, are not oriented toward low income groups, and favor those groups which are more likely to obtain services through community agencies without the assistance of regional centers. The Department of Health does not require regional centers to report information on the income levels nor the ethnicity of clients, so it is impossible to determine whether centers are meeting the needs of such target groups without conducting a special review of regional center clients.

The Department of Health has not requested that regional centers place a priority on closing the gaps in services for low income groups or members of ethnic minorities. The failure to articulate priorities allows regional centers to establish their own. Some Department of Health staff charge that some regional center staff prefer to serve middle class clients and openly discriminate against welfare-linked clients by shifting such clients completely to county welfare departments. Further evidence to support the lack of emphasis on serving low income and ethnic minority clients can be seen in that

the staff of small regional centers does not reflect the ethnic and income composition of the community, and that out-reach programs are not in operation to attract clients from underserved population groups.

13. Continuing Care Services

The Continuing Care Services Section (CCSS) for the mentally disabled is not clearly defined and continues to be fragmented and to duplicate other services by regional centers and local communities.

Regional centers contract with the State CCSS program for direct protective social services for DD clients including case management, placement in out-of-home facilities, continuing care follow-up, and other activities such as referral for vocational, transportation, and treatment services. The activities of the CCSS staff are often the same as those provided by regional centers, and those provided by other private and public agencies under contract agreements with regional centers. With similar services offered by multiple agencies, it is confusing to both agencies and clients as to which agencies should provide what services. Competition develops between agencies for funds and clients, and often involves adjacent regional centers.

The lines of responsibility between the CCSS program and the regional center program, in spite of contract arrangements, remain unclear and services are fragmented. CCSS field offices contract with regional centers to provide services, and may contract with more than one regional center. Each regional center may have contracts with more than one CCSS office. There is no standard contract for offices, and services differ between regional centers and offices.

The CCSS program provides some valuable social services to welfare-linked clients who, in many areas, might not otherwise obtain services. CCSS has had program experience since 1946 when it was first developed, so has developed programs and staff talents which many regional centers do not yet have. The CCSS program provides for continuous services for low income clients, whereas regional centers do not emphasize services to this population. In addition, the CCSS staff of the state provides valuable information to the state developmental disability program regarding the activities of regional centers and the local community services for clients. In interviews with CCSS social workers and staff at the local level, we were impressed with their youthful energy and dedication.

On the other hand, the CCSS program of direct services may be in conflict with the state's historical policy to reduce its emphasis on the provision of direct services. The state programs, through legislative mandates, have provided funds and adopted standards, and encouraged local communities to develop their own programs; e.g., the Short-Doyle Act which provides the counties the option to develop their own social services programs in place of the state CCSS program. While this issue has yet to be resolved by the new administration as to its policy on the provision of direct services, we would support the concept of maximizing direct services at the local level, and minimizing the state's role in direct services.

The Department of Health has been reviewing its CCSS program and some leaders in the Community Services Division have suggested that the Department should lift its current moratorium on "opt out", allowing regional centers to develop social services of their own, instead of contracting for services from the CCSS program. This has created great concern and low morale of the 242

staff in the CCSS program for developmentally disabled clients, who fear the loss of their jobs in the CCSS program. Charges have been made by the CCSS staff that regional centers do not necessarily offer services to low income clients now served by CCSS and that regional centers which offer their own social services have lower quality of services which cost considerably more than those provided by CCSS. The regional centers charge that CCSS services are, themselves, not effective and are outmoded services. Such charges can not be refuted or confirmed without a comprehensive independent program evaluation of both CCSS and regional center programs--data which currently do not exist.

While development of local social services is theoretically the best approach, the State Department of Health should not lift its present moratorium on "opt out" of the CCSS program until a comprehensive study of CCSS and regional center programs can be made. The state should study the feasibility of contracting for social services from other agencies of local government, rather than from the regional centers, because of the multiple problems of regional centers discussed later in this section. Before the state shifts its CCSS program to regional centers or to county agencies, the state developmental disabilities and social services programs should establish minimum standards for programs supporting their clients. Without the establishment of minimum standards and criteria to guide a decision to allow "opt out" of the CCSS program, the development of an "opt out" policy is a complete abrogation of state responsibility. Discontinuance of the CCSS programs now would only add to the confusion in an uncoordinated system of service for developmentally disabled clients.

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

services) in turn contracted for services from its parent corporation. This is apparently common practice. Other regional centers contract with vendor companies in which they have a financial interest. There are no requirements by the State that conflict of interest must be reported. In fact, the state regional center office does not have staff to monitor and study vendor contracts so as to avoid conflicts of interest.

Regional centers report breach of contracts when services are not provided. State and regional centers can cancel contracts but have little capacity for alternate action against vendors. In one recent case, a community care facility with developmentally disabled patients was allegedly utilizing clients to work without pay at a ranch owned by the facility. Such practices constitute a violation of patient rights, if not patient abuse and fraud. Other similar cases have been reported.

The salaries of staff in regional centers are frequently higher than salaries of state employees of similar experience and education. In a recent survey by the Department of Health, salaries paid to regional center directors were considered inordinately high. Some regional centers paid employees at higher rates, and others at lower rates, than determined by the State. Five regional center personnel earned more than the Agency Secretary (\$43,000/annually), eleven staff exceeded the salary of the Director of the Department of Health (\$40,000/annually). When high salaries were criticized, regional centers stated they wanted to pay rates competitive with the private marketplace. The obvious impact of high salaries makes the centers less economical than comparable services provided directly by the State.

In many circumstances, physicians and other professionals have not provided the services for which they have been paid. Some physicians maintain a

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

produce comprehensive analyses, clear policies, or effective control mechanisms.

15. Program Controls

Staff in the state regional center program consists of only eight professionals (six community program analysts, one fiscal officer, one staff services analyst) and six clerical staff, in addition to the program chief. The number of staff has declined as the number of regional centers and the size of operations has increased. Clearly, the small staff is inadequate to monitor the program and administration of 20 large and complex regional centers. It is no wonder that abuse and mismanagement occur. The state needs to expand both the professional and administrative support staff.

With only one fiscal staff officer for a 36 million dollar program (which includes multiple small-vendor contracts), it is impossible to review center expenditures and determine if centers are adhering to budgetary allocations. The Department of Health has not had the audit capacity to review the regional centers on a systematic post-hoc basis. The regional center program must have both fiscal monitoring capability and post-hoc audit staff to provide systematic and on-going fiscal control over regional center funds.

The Legislature appropriated funds for regional centers to reduce client waiting lists. Regional centers, in the opinion of state program staff, are not accurately reporting these waiting lists and, in some cases, deliberately misrepresent the numbers by as much as 100 percent. Yet the staff of the regional center section has approved appropriations based on waiting list reports which they did not have adequate time or staff to verify.

Regional centers are legally private entities, thus fall outside of the constraints and controls of the state personnel system. There are some administrators within the Community Services Division who, along with the contracting agencies, desire to strengthen the authority of the regional centers and reduce the authority of the state.

Recently, the state Regional Center Section attempted to withhold special program funds from two regional centers until some of the problems identified could be resolved. Political pressures by state legislators were brought to bear upon the Agency Secretary, who released the funds.

Stronger program and fiscal control over regional centers is indicated. The addition of program staff and a tough policy against abuses may improve the situation. However, legal opinion and the political pressures may continue to hamper state control over the program. The time for drastic legislative action may have come--legislation which allows the State Department of Health to assume direct management and operation of the regional center system, dropping its contracts with private corporations.

16. Clients' Rights

The appeals procedures for developmentally disabled clients who are denied services by regional centers are archaic and ineffective in protecting client rights. Some clients are denied services by regional centers because centers claim they are not classified as developmentally disabled by physical diagnosis, or because of boundary disputes. Clients who want to appeal the denial of services have no method to appeal to the state regional center section for review and a decision. Consequently, regional centers are allowed to review

their own decisions on the disbursement of services to clients. This is a violation of due process for clients' rights to file a grievance and have a fair hearing.

17. Alternatives to State Hospitals

The absence of adequate alternatives for out-of-home residency care of developmentally disabled clients, which forces clients into the state hospitals, is created by a number of factors. First, as mentioned in the previous section, the rate paid by the Medi-Cal program for nursing home care and for board and care is clearly inadequate for developing treatment programs for developmentally disabled clients. Such rates of reimbursement barely cover the operation costs for facilities to maintain their licenses, and do not include rates for treatment programs. As a result, many nursing homes which served DD clients have gone out of business within the last few years, which, in some cases, forced clients into state hospitals because of inadequate community facilities.

Another factor creating an increase in state hospitalization of DD clients is related to the policy of regional centers and the allocation of state funds. Some regional centers are in close proximity to state hospitals and, therefore, find that state hospitals are convenient for both them and the clients families, and may, therefore, utilize this resource more than would otherwise be the case. Regional centers are given basic allocations for their programs, which does not include funds for the placement of clients in state hospitals. Thus, if a regional center is short of contract dollars, or wants to save contract dollars for services, the center may elect to place a client in a state hospital rather than have to pay money to a community facility for

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.

Program Services

1. Conduct an independent evaluation of the pattern and service network of all of the regional centers. Such a study should be focused on the client to assess how the individual fares in a complex mix of public and private care.
2. Following such a study, establish program policies and standards to specify the comprehensive service network required by the developmentally disabled and the best methods for building such a service network.

Regional Center Operations

1. Immediately undertake a comprehensive management study to determine the nature and extent of fraud, abuse, and misuse of regional center money and services, and develop methods for controlling and monitoring regional center activities.
2. Immediately establish policies which are uniformly applied to all regional centers and their staff:
 - a. Full-time employees of regional centers are not allowed to utilize time for activities outside the job description for the regional center.
 - b. Staff employed on a full-time basis by regional centers should not be allowed to have private practices.
 - c. Full-time staff should not be allowed to utilize the regional center facilities, staff, or time for activities not a part of the regional center program.

- d. All vendors and contracting agencies must submit data on their financial interests, investors, and contracts which demonstrate that no conflict of interest exists before vendors can be approved by the state.
 - e. Conflict of interest activities between regional center staff, boards of directors of parent corporations, and vendors is prohibited.
 - f. All regional center salaries must be in compliance with not only budgetary allocations from the state, but also with the state personnel salary schedule.
 - g. All regional centers, in conformity with the State Department of Health affirmative action plan and policies, must develop an affirmative action program before their new contract can be approved.
 - h. All regional centers must establish fair hiring practices in terms of open competition for employment as specified by the Fair Employment Practices Commission, and hiring of relatives is prohibited.
3. Notify all regional center staff, contract agencies, and vendors that cases of fraud and abuse will result in prosecution by the state and this should be undertaken.
4. Develop a policy of preferential contracting with public, non-profit agencies as vendors to reduce costs and to improve the quality of services.

Program Controls

1. Develop and enact legislation which would place regional centers under the direct operation by the State Department of Health.
2. Strengthen the number of staff and the professional and administrative capability of staff in the regional center section.
3. Review regional center contracts presently in effect with close program and fiscal auditing with efforts to strengthen control.
4. Apply sanctions to those centers which continue abuse and misuse of funds, or cancel contracts of those which fail to comply.
5. Replace any state officials not committed to strong regulation and control policies for the regional center system.

Clients' Rights

1. Immediate review of the policies which establish clients' rights for services, and strengthen such rights.
2. Develop a client grievance procedure and an appeals process which allows the state regional center section to review decisions made by regional centers which allow for due process and a fair hearing.

Alternatives to State Hospitalization

1. Develop publicly operated residential care facilities in communities for the treatment of clients which would reduce costs for care.

2. Determine more accurately what are reasonable rates for reimbursement for different levels of residential care for the treatment of developmentally disabled clients.
3. Design a supplementary program designed to pay needy families to maintain clients in their own home, with supplementary treatment programs, as an alternative to state hospitalization.
4. Provide preferential treatment for Department of Health contracts with public and non-profit agencies over private profit-making agencies for the care of clients.
5. Establish a regional program for the developmentally disabled which will plan and coordinate the most effective and cost-efficient programs for the clients, which would manage total costs of state hospitals and regional centers within the region.

D. Mental Disabilities Program

1. History

The State has played an important role in providing care for the mentally disabled since 1850 when the first state hospital was established. The State built up a network of large state hospitals with 37,770 patients in 1957, most of whom were mentally disabled but also including developmentally disabled. In 1957, the local mental health programs were first authorized by the Short-Doyle Act, establishing a partnership between the State and counties for providing community mental health services. Since that time, the population of the state hospitals gradually declined to approximately 6,500 patients in 1973, and three State hospitals (Modesto, DeWitt, and Mendocino) have closed. The mental health program and the state hospital system were historically administered by the Department of Mental Hygiene, until the reorganization in 1973, which placed this program in the Health Treatment System of the Department of Health. In May 1975, the name of the Health Treatment System was changed to Community Services Division and the State hospitals were removed and placed in the State Hospital Division.

2. Goals and Objectives

The Mental Disabilities Program in the Community Services Division is established to provide prevention, early diagnosis, and immediate treatment intervention of mental and emotional crises, as well as extended care services. This program includes community based treatment, supportive living services, acute hospitalization, and state hospitalization services. The program is administered by four distinct entities: (1) local program services;

(2) special services; (3) continuing care services; and (4) hospital services which is located in the State Hospital Division.

3. Program Components

Local Program Services: The Local Program Services Section is responsible for the administration of the community mental health services provided by the Short-Doyle Act and the Lanterman-Petris-Short Act. The Short-Doyle Act of 1957 provided a cost-sharing program with the counties, which has established Community Mental Health Programs in all counties and in two cities. The Lanterman-Petris-Short Act provides for the administration and enforcement of human rights for the mentally disordered and the mentally ill offenders. Staff in this program, located in headquarters and two field offices, review and approve community mental health plans, allocate program funds, monitor programs, evaluate program services, and serve as liaison with local programs. Community Mental Health Programs are planned by counties or cities in conjunction with local Mental Health Advisory Boards. Plans are adopted by county Boards of Supervisors before submission to the State. The State provides 90 percent of the funds with 10 percent matching from counties. During 1974-75, the local mental health programs provided outpatient services for 3.4 million visits and hospital services for about two million patient days.

Continuing Care Services (CCSS): The Continuing Care Services Section (CCSS) provides direct social services to those persons released from state hospitals and to mentally disabled persons in the community in order to promote and sustain the individual's optimal personal, physical, and social functioning.

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).¹ (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.

¹ 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.

7. Rates and Fees

The Welfare and Institutions Code, Section 5717, allows the Director of the Department of Health to delegate cost determinations in community mental health programs to the counties.

Rates and fees for the Short-Doyle local programs are determined on actual cost reimbursement basis by each local program, as allowed by the Short-Doyle legislation. The local programs determine costs based upon the expected units of services divided by costs for each care center and each treatment modality (inpatient, outpatient, day care, consultant, education or special treatment service). Thus, services within a county vary by each treatment center as determined by actual costs; seldom do the providers, even within one county, have the same rates.

The skilled nursing homes, hospitals, board and care homes, and individual providers whose services are covered by Medi-Cal are exempted from the regular Medi-Cal rates. In these cases, the Short-Doyle Medi-Cal rate, an actual cost-reimbursement rate, is applied. Flat rates are paid, however, to family care homes, and the State determines its own rate for state hospital care.

This method of allowing counties to establish actual cost reimbursement procedures, rather than establish standards rates for services across the State with certain allowances for cost of living differences, creates confusion and possible inequities. Any such system of cost reimbursement is subject to abuse by providers and may lead to higher program costs than a more regulated and standardized system of payment.

8. Advisory Bodies

The Community Mental Health Services Law requires supervisors of counties with populations of 100,000 or more to establish mental health advisory boards, to assist in the planning and development of its community's mental health effort. In addition, county programs are required to have a technical advisory committee on drug abuse and an alcoholism advisory board.

The California Conference of Local Mental Health Directors was established to assist the Director of Health in setting standards and regulations for the operation of local mental health programs, and also to ensure that local needs and points of view are given consideration in the policies and over-all planning of state-wide services.

The Citizens Advisory Council advises and assists the Director of Health in carrying out the provisions of the Community Mental Health Services Act, and provides direction and review for all mental health services in California.

The advisory system appears to operate satisfactorily, although the Conference of Local Mental Health Directors would like to have their role and that of the Department reviewed and clarified. The Conference complains that the lack of psychiatrically qualified and trained leadership in the state mental disability program requires the Conference to assume a greater leadership responsibility than otherwise should be necessary. The Advisory Council, while professionally dominated, attempts to represent the consumer and would like to see the Department show greater openness to consumer input in the area of mental health issues.

9. Administrative Organization

The mental disabilities program located in the Community Services Division is a complex operation involving staff in the headquarters office, staff in 47 county CCSS offices, and the six state hospital programs. In addition, the program provides funds and monitors programs in 57 counties and two cities in the State. Thus, the program provides direct services in the state hospitals and the CCSS program and indirect services in community mental health programs.

The total staff for the state mental disabilities program includes 21 professionals and 8 clericals in the local program services section; 500 staff in the CCSS program; and 15 professionals and 6 clericals in the special services section. The state hospital program includes approximately 5,216 staff, including 3,115 nursing staff, 685 other professionals, and 1,416 administrative support staff. The professional staff in this program are primarily community program analysts, social workers, and other health professionals.

In May 1975, the State Department of Health reorganized, creating a separate administrative division for the state hospital system and for the community mental health program. Our interviews with local program staff and with State Department of Health staff and administrators all indicated a dissatisfaction with the present division between the state hospitals and the community mental health programs.

The separation has contributed to increased fragmentation of services between hospitals and community programs, according to staff interviews. The poor quality of after-care services for patients discharged from the state hospitals

has been magnified by the administrative division. CCSS staff report that state hospitals are less open to working cooperatively with them in planning for discharge of patients and in visiting hospitalized patients, thus increasing the problems in providing for continuity of care. Staff who work in the two separate divisions receive different and sometimes conflicting communications from the department administrators. Staff in both divisions are not following the same procedures and communications are breaking down.

Separation of hospitals from community services has made communications between local mental health directors and the state hospitals much more difficult and confusing, and has increased community competition with the state hospital program. The danger is that state hospitals will increasingly develop goals and activities separate from and not relevant to the needs of local mental health programs.

10. The Delivery System

The state hospital program and the local mental health programs in theory form a single system for mental health care in the State. These two programs, however, continue to be poorly coordinated and the county programs are far from comprehensive. Counties have needs for mental health services which are frequently too expensive to provide on a county basis, and which are economically feasible only if planned and developed on a regional multi-county basis. For example, a regional program for autistic children is only possible if counties work together; the state hospitals provide those services which are too costly or unfeasible for counties to provide. Yet, there is no coherent regional planning or coordination of mental health services in this State.

State hospitals tend to serve geographic regions, but also serve certain patients on a state-wide basis. Counties and state hospitals do not work cooperatively for services in their region. They have not developed criteria for utilization of state hospital services, which vary considerably county by county. Some counties located in close proximity to state hospitals tend to utilize the facilities more for acute care cases than distant communities. Some counties have significantly lower utilization of state facilities for all types of cases than other counties. There are no written standards for admission to state hospitals and, consequently, planning and development of services is fragmented and haphazard.

The State Department of Health has not assumed a role of leadership in the development of standards for comprehensive mental health services or in the planning and development of services for the State. Counties have been encouraged to develop their own plans without regard to the over-all needs of geographic regions. County services vary considerably in the quality and quantity of services provided. In spite of a high level of expenditure, too many gaps in service persist. The State must work with the counties in designated geographic regions, toward a coordinated, regionalized service program, including the services of state hospitals.

For years now, the destructive competition between the state hospitals and community programs has been recognized and deplored. Little, however, has been done to ameliorate the conflict. As long as the State struggles to sustain and modernize an incredibly expensive, huge, and out-moded system, the proper development of a regionalized alternative modern system of local services is retarded. This observation must not be construed as an attack on state hospitals and the indispensable services they provide, which are,

for many patients, unavailable in the communities. Rather, we wish to point out that progress is being retarded because of the reality that standards of accreditation for physical facilities are based on a determination by accreditation bodies that mistakes of the past will not be repeated in the planning and construction of new institutions. The basic issues are: reduced size, location in proximity to the community (defined as a region), and use of institutional care as an integrated, indispensable and coordinated component of a comprehensive community system of care. If the State were in a fiscal position to build a new system of smaller institutions in a regional pattern, the incessant struggle between state and local programs would end.

As an alternative, counties must band together and begin to develop a regional system of community and hospital services. Most state hospitals are now physically located in reasonable proximity to population centers. Much of their physical space is in workable condition, but none can efficiently operate their full plant capacity - designed for times gone by.

A creative experiment may now be in order. Take the State out of the business of direct operation of the state hospitals. Convert these institutions into regional specialty centers for services too expensive to develop anew in community-based programs. Organize clusters of counties into regions for the purpose of planning for regional needs and the conjoint use and operation of beds in state hospitals - converted into regional specialty centers.

Planning for a successful regional service system could be undertaken first as a demonstration. Professional skills required to develop this demonstration should include innovative environmental design (maybe with assistance from

the newly appointed State Architect), professional planning for the full range of comprehensive services, consumer participation, and expertise in regional intergovernmental planning and cooperation.

The role of the State, if it can retreat from the direct operation of hospital services, would be to establish standards, provide technical assistance, seek federal assistance for such a demonstration, and monitor the results. The fragmentation resulting from destructive and continuing competition must end. We can not afford it, either in fiscal or humanitarian terms.

11. Program Services

According to the Welfare and Institutions Code, Chapter 4, Section 5401, the local programs may provide the evaluation, referral, intensive treatment, pre-petition screening, crisis intervention, and other services. Before the legislation was changed in 1971, the local programs were required to provide ten services:

1. In-patient services
2. Out-patient services
3. Partial hospitalization services, such as day care, weekend care, night care
4. Emergency services 24 hours per day available within one of the three services listed above
5. Consultation and education services available to community agencies and professional personnel and information services to the general public
6. Diagnostic services
7. Rehabilitative services, including vocational and educational programs

8. Pre-care and after-care services in the community including foster home placement, home visiting and halfway houses
9. Training
10. Research

Although the Welfare and Institutions Code does not now require all ten of these services, the regulations specified in Title 9 of the California Administrative Code continue to require these services and provide reimbursement for such services.

The state program is mandated to adopt standards for approval of the county mental health programs and to monitor the organization and operation of mental health services (Welfare and Institutions Code, Division 5). Evidence indicates that the State has not effectively carried out its responsibility for establishing standards outlined above which would ensure comprehensive mental health services. The state regulations only identify service categories and do not address minimum standards of services. County programs vary considerably in kinds of services and quality of services, so that comprehensive services are not guaranteed. For example, Alameda County does not provide an adequate number of beds for emergency care, and consequently over-utilizes the Napa State Hospital for acute short-term admissions. Without minimum standards for local mental health programs, the over-all programs are fragmented, duplicative, and have large gaps in service.

Although data on client groups served by local mental health programs is sketchy, the State is concerned that programs have not emphasized services geared to children and adolescents, aged, and ethnic minorities. Reports show that these groups are not as frequently served as they should be in relation to their population size. Programs do not place emphasis on low income clients, but tend to prefer middle-class clients. The mental

disabilities program does not require counties to report data on income levels of the population served. The State should establish methods of data collection which can measure what groups are under-served in the population and to determine when local programs are closing the gaps in service, especially to such groups.

The State Department of Health has not established specific priorities for local mental health programs. In 1976-77 plans the Department has issued four general priority areas. These are: preventive community services, reduction of acute services, children's services, and services to minorities. However, these are only suggestions, without guidelines or standards. If a county program continues to place major emphasis on serving clients from middle-class income groups, rather than serving low-income, disadvantaged clients, this is not in violation of state-wide policy. Study of the locations of community mental health programs indicate that most are located in middle-class areas, with few in proximity to low-income neighborhoods and ethnic groups. The State should establish priorities to ensure that services are provided to under-served populations.

12. Program Evaluation

The State Department of Health, despite a long-standing legislative mandate dating from 1968, and the counties have failed to develop and use a system for cost-effective evaluation of its mental health programs. The State has almost no data on who is being served and the outcome of treatment. One attempt to implement a system of evaluation in 1975 was aborted because of inherent weaknesses in the plan, which was opposed by the Conference of Local Mental Health Directors and the Director of the Department of Health.

Recent efforts to develop an evaluation system have involved consultants and the staff of the special services section.

To date, either the counties or state mental disabilities staff have demonstrated the technical capability to develop an adequate evaluation method for local mental health programs. The State Department of Health, in cooperation with the Conference of Local Mental Health Directors, should work with consultants to develop: (1) an adequate data collection system and (2) a system for comprehensive evaluation. The evaluation of program benefits should include input from clients and from community organizations and agencies as well as local staff. The evaluation system must include an objective survey of the experience of those using the services.

13. Continuing Care Services

Continuity of care which precedes and follows state hospitalization is still a major problem for patients. The Welfare and Institutions Code, Division 5, provides that county mental health programs include services to maintain and improve pre-care and after-care services which include: (a) a system to assure the appropriateness and quality of care for patients placed in out-of-home facilities; (b) a directory of facilities to aid in placement; (c) consultation, educational training and other special services; and (d) a referral and follow-up system for assuring that persons needing services receive them.

Only 14 counties have developed their own system of continuing care services. Previous studies of these programs indicate that these services are not of a uniformly high quality. Most counties have continued to contract with the State's Continuing Care Services Section (CCSS) to provide part or all

of the services mandated by law. The CCSS program placed a moratorium on counties "opting out" of state contracts for CCSS (allowed by the 1971 Short-Doyle legislation), until the State could study the problems and assess the quality of county services. Recent discussions in the Division of Community Services Services have suggested lifting the moratorium, thereby allowing counties to develop their own pre-care and after-care services.

The state mental disabilities program has failed to define the minimum criteria or standards for continuing care services in local mental health programs. Consequently, standards vary considerably by county and many clients do not receive services at all. The State has not insisted that counties develop comprehensive after-care programs independent of reliance on CCSS. Some counties utilize other agencies in addition to CCSS staff for after-care services. Thus, continuing care services are fragmented, duplicative and uncoordinated. State hospitals report releasing patients from counties which have made no provisions for follow-up and referral of patients. The high rate of recidivism to state hospitals is probably related in large part to inadequate continuing care services in local communities. Clients and residential care facilities report that they are confused by these overlapping responsibilities.

The inadequate rates of reimbursement for nursing homes (\$19.95 a day) and for board and care homes (\$9 a day) contribute to the shortage of out-of-home facilities for placement and treatment of clients with mental disabilities. Some facilities are closing for financial reasons, placing an increased load on state hospitals. When clients cannot find adequate care in community facilities, they must be placed in state hospitals at a cost of \$40-50 daily.

Many operators who care for mentally disabled individuals in community facilities are not adequately trained for providing special treatment services. Most provide only non-medical residential care, and consequently, facilities are not able to provide treatment services designed to return clients to their own homes and make them independent. State regulations for the minimum training of residential care operators are not effective in ensuring minimum skills required. Regulations do not describe or ensure an adequate level of treatment in the various treatment settings used for patients.

There is an over-reliance upon private profit-making facilities in communities for the provision of care and treatment to the mentally disabled. Such facilities, paid a low rate of reimbursement by the State, are inclined to provide the most minimal services possible for operation, in order to make profits required to stay in business. The state and local mental health programs have not adequately developed county-operated alternatives free of the problems encountered in profit-making institutional care, which tends to be the lowest common denominator of service.

The State has no funds for new facilities construction. The Short-Doyle Act allows for remodeling and purchase of equipment, but not for construction. There is a need to develop alternatives to state hospitalization; yet the initial capital investment required to build local facilities is not available, in spite of the prospect of long-range reduction in state cost.

14. Alternatives to State Hospitalization

Adequate alternatives for out-of-home placement within community care facilities have not been developed, forcing over-reliance and over-utilization of state hospital programs. Community care facilities in most local communities offer a limited range of services -- i.e., primarily nursing homes or board and care facilities. Clients for whom such facilities are inadequate are unable to find out-of-home placement where psychiatric and social service treatment programs are offered. Many clients could be successfully maintained in community facilities if adequate alternatives were available, such as day treatment centers, transitional residential care facilities, and self-help cooperative apartments. New programs are badly needed to develop a broader range of services designed to meet each community's needs.

Probably the single most important method of reducing over-all mental health costs and utilization of state hospital facilities is to develop adequate short-term facilities for the acute treatment of psychiatric problems. The Patch program is developed for intensive short-term treatment of patients in nursing home type facilities utilizing special professional staff. This type of program costs the State considerably less money, and is often more appropriate than state hospitalization for patients. If more facilities of this type were developed (as in Sacramento and Fresno), the more expensive use of state hospitals could be curtailed.

State hospitals are frequently utilized for short-term 72-hour patients rather than for long-term patients. In 1974-75, of the 26,747 admissions to state hospitals, 13,762 were for 72-hour hold patients. Such admissions

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.

15. Technical Assistance and Program Control

The state mental disabilities program has not provided adequate technical program assistance to county mental health programs nor monitored program activities in a satisfactory manner.

The state mental disabilities program is required by legislation to provide technical support to local mental health programs. Previous studies and data collected for this study indicate that the State has failed to provide the quantity of staff and the type of staff capable of giving professional technical assistance to local programs for both program development evaluation and fiscal management.

Community Program Analysts employed by the State vary widely in their ability to provide consultation. Some must actually be trained in their jobs by more experienced local staff, whom they in theory assist. Twenty-one professional positions allocated for this program are not enough to provide consultation services and to monitor local programs in 57 counties and two cities. The duties of program analysts have been made more difficult by the frequent reorganization and change in leadership within the program. The most serious deficiency in the state staff is the absence of qualified psychiatrists to guide the entire program. The existing staff is skilled and experienced in fiscal and administrative matters, but deficient in professional matters.

Technical assistance and program monitoring require a variety of skills, encompassing planning, budgeting, fiscal management, data systems, program evaluation, personnel, and other administrative and program skills.

While community program analysts may have some skills in psychiatric social work and related professional areas, they frequently do not have skills in technical areas of an administrative nature. The program clearly needs expertise administration to help determine if programs are adequate, funds are allocated properly, planning is comprehensive, and data information systems are developed. Because the mental disabilities program does not have this type of staff, the technical and monitoring ability of the section staff is severely inadequate.

The mental disabilities program has developed specialists in various program areas such as aging, rehabilitation, children and youth, and so forth. These program specialists add program knowledge and expertise to the community mental health area which is extremely valuable. Such specialty areas should be expanded by the Division, and developed into a multi-disciplinary professional team. Services for consultation and monitoring in the mental disabilities program should be developed on a team basis, rather than assigning to a program one community program analyst who is expected to be knowledgeable in all areas.

The mental disabilities program should develop procedures and processes for monitoring and evaluation of local mental health programs. Programs should be informed that allocations will in part depend upon demonstrated success of programs, rather than upon historical and incremental funding allocations. Programs should establish their own goals and objectives and then evaluation should determine how effective programs are in meeting their goals and objectives. Programs should also be compared between areas and such information made available to the public, and should be compared to minimum state standards for effective programs.

16. Budgetary Process

The current budgetary processes for local mental health programs are inadequate and unsatisfactory. Prior to 1973, the Short-Doyle Act required the counties to submit a preliminary budget in October for the next fiscal year, to be used in developing the Governor's Budget for January. In 1973, the Act was amended to require submission of the county budgets in March, after the Governor has submitted his budget to the Legislature. This change was made because it was apparent that the county plans were not being utilized by the administration in preparing the Governor's budget proposal, and the change was an attempt to avoid wasted county efforts on planning. Consequently, the county budgets are based upon allocations by the Governor, with revisions submitted by the counties in the Spring of each year. After the budget is approved, the counties must submit a revised budget to reflect the changes in the approved Governor's budget.

This procedure is a "top-down" method of budgeting which does not reflect the need for mental health services, but rather the amounts of money allocated in the budget. This method results in incremental budgeting--that is, existing programs are funded at the previous year's level plus a fixed percentage cost-of-living increase. Counties with older (and larger) programs receive an inequitably large proportion of state resources. The budget is based on historical allocations rather than upon data reflecting the need and demand for services, the effectiveness of local programs, or the need for new innovative programs.

Subsequent delays in the Department of Health to make allocations after the final Governor's budget is approved creates significant problems for

counties each year. Counties have a lag time where they are unable to plan and manage their program budgets, so that cash flow problems develop, surplus are generated, and claim processing is delayed.

17. Recommendations

Rates and Fees

Establish a more uniform system for setting rates that coincides with the over-all Department's rate-setting mechanism.

Administrative Organization

1. Immediately re-establish the state hospital program as a part of the Community Services Division.
2. Rename the Community Services Division to more accurately describe its activities, such as the Mental and Developmental Services Division.

The Delivery System

1. Establish regional boundaries across the State for comprehensive health planning and for the delivery of services, coterminous with the federal health service areas.
2. Administer the state mental disabilities program on a regional basis, designating state hospitals as an integral part of each regional system.
3. Develop planning and service delivery systems on a regional basis by state mental disabilities program staff, state hospital staff, continuing care programs, and county mental health directors and staff.

4. Ensure that each regional operation of the state mental disabilities program has full state consultative support for planning, evaluation of programs, monitoring of county programs, budgeting, fiscal control, and other administrative support services.
5. Plan and control mental health money and programs at the county level in each region. Counties should establish contract relations with the state hospital in their region for programs and services.
6. Undertake a demonstration project for county operation of a state hospital.

Program Services

1. Establish minimum standards for community mental health programs which will ensure that adequate comprehensive community services are available for prevention, diagnosis and treatment, emergency care, as well as for long-term rehabilitative care.
2. Establish general standards for utilization of state hospitals by community mental health programs which designate state hospitalization only for long-term care services not otherwise available within the community or for special services not offered in the local community.
3. Establish priorities for local programs which ensure that service gaps are closed for the aged, children and adolescents, ethnic minorities, the poor, and disadvantaged, before expanding services to other groups.

Program Evaluation

1. Immediately establish what data are needed to assess services, establish priorities, make allocations, and evaluate the effectiveness of counties in meeting their stated goals.
2. Establish an evaluation system which can be utilized for all local mental health programs that includes data on an evaluative nature by clients and families.

Continuing Care Services

1. Have the State make clear that county plans must include comprehensive programs for continuing care services, regardless of where such services are obtained (state, county, or private agency).
2. Establish minimum standards for statewide continuing care services in local communities and monitor programs to ensure that services are actually provided.
3. Ensure that contracts by counties for continuing care services provide for comprehensive services, and include provisions for regular reporting and communications with contract agencies as well as evaluation of the quality of services.
4. After counties develop comprehensive continuing care services in compliance with minimum state standards, lift the moratorium on counties "opting out" of CCSS contracts.
5. Adopt an official policy for Department of Health not to provide direct health care services, except in those cases where counties and regions are unable to provide for such services and request service from the State.

Alternatives to State Hospitalization

1. Develop publicly owned and operated residential care facilities for the treatment of mentally disabled clients at the county level.
2. Determine more accurately by the State as to what are reasonable rates for reimbursement for different levels of residential care and for the treatment of clients in various organized settings.
3. Specify in licensing regulations the minimum training and the continuing education requirements for care of mentally disabled clients in different types of homes and for different levels of care.
4. Establish a program of financial support for capital outlays to community mental health programs initiating public residential care and treatment program alternatives.
5. Study and implement incentive systems which would encourage families to care for and obtain treatment for family members in their own homes, rather than placing such individuals in hospitals.
6. Carefully determine the number and types of facilities needed for mentally disabled clients for each geographic region of the State and develop a plan for providing such services at the lowest cost and the highest quality of services.

Technical Assistance and Program Controls

1. Develop a multi-disciplinary team of professionals in the mental disabilities program which will be responsible for providing technical program support and for monitoring local programs.

2. Employ special staff who can provide technical assistance in areas of planning, budgeting, fiscal control, data systems, personnel, and program evaluation in the state mental disabilities program.
3. Review the current job requirements of the program and determine if the job classifications for program and technical support and monitoring should be changed for the mental disabilities program.
4. Establish procedures and processes for systematic monitoring and evaluation by the State of local mental health programs to ensure that programs are conforming with plans.

Budgetary Process

1. Initiate legislation to make local mental health program budgets an integral part of the State Department of Health budget, based on a system of zero-based budgeting. Budget requests for local programs should be submitted in July of the preceding year just as the requests for other departmental funds are submitted.
2. Utilize local program requests in approving budgetary allocations, based on data showing need, demand, and effectiveness of program services for the state mental disabilities program.
3. Change the Department of Health's allocation process to claim reimbursement for the first three months of the new fiscal year, or until their final budget is approved, on the basis of the level approved for the previous fiscal year.

E. State Hospital Program

The state hospital system serves clients from both the Mental and the Developmental Disability Programs. The state hospitals are managed by the Department's State Hospital Division.

The State Hospital Division is currently operated separately from the Community Services Division which includes both the Mental and the Developmental Disability Programs. Even though operated separately, the State Hospital program is intricately tied to both the Mental and the Developmental Disability Programs. Although the Mental and Developmental Disability programs within the state hospitals are separated, the hospitals are administered as single institutions. Consequently, the issues and problems of the State Hospital operation are related to both the Mental and Developmental Disability Program section of this report, but will only be discussed once in this section.

1. Budgetary/Fiscal Practices

Prior to consolidation, the Department of Mental Hygiene centrally controlled the budget of the State Hospital System. Less than the total amount available was allocated to the state hospitals to meet basic operating needs, while the rest was reserved in various accounts at central office. These reserved amounts were used to fund special projects or to cover operating deficits if and when they arose in the respective hospitals. Hospital management soon learned not to worry about budget controls. They knew that if they ran into trouble, someone at headquarters would have money somewhere to bail

them out. As a result, the hospital system generally lacked discipline regarding fiscal matters.

After consolidation, the Department of Health began to allocate all of the budgeted funds to the hospitals and to allow each hospital to manage its own budget. Hospital managers were told that there would be little or no reserving of funds in centralized accounts. Because of past practices, however, hospital management continued to believe that funds would be made available if they ran into trouble. Therefore, some hospitals did not monitor and control their expenditures.

During the first quarter of this year, the Department discovered that the expenditure rate of the state hospital system was running at a \$2 million to \$3 million deficit, which would result in a budget deficit of about \$10 million if allowed to continue for the rest of the fiscal year. The Department attributed the problem to several factors. First, the attrition or turn-over rates projected in the 1975-76 Budget were about 50% less than anticipated. Second, several hospitals were staffed above their authorized staffing level. Third, as of September, state hospitals had not received a budget allocation for the current year, and fourth, fiscal monitoring of hospital operations was weak.

To correct the problem, the Department asked the hospitals to reduce staff, institute monthly hospital accounting reports versus quarterly reports, and establish a review and approval process for budget expenditure documents and purchase orders. The Department believes that by using these measures the first quarter deficit can be reversed and that the state hospitals can manage within this year's budgeted funds.

The state hospital system maintains a separate accounting system from the Department's accounting system and reports directly to the State Controller. The Department's accounting office, which has the general responsibility for maintaining a control of departmental expenditures, does not receive information regarding hospital expenditures.

Recommendations

1. Allocate departmental budgeted funds to the state hospitals on a timely basis, including salary savings.
2. Review and strengthen the present departmental procedures for monitoring and reporting hospital expenditures.
3. Develop a procedure for inputting hospital expenditure reports into the Department's accounting system for informational and fiscal control purposes.

2. Patient Trust Accounts

State hospitals establish trust accounts to manage the funds of their patients which are received from a variety of sources. Typically these sources include, for the mentally disabled, disability insurance, back unemployment benefits, personal insurance and personal funds. For the developmental disabled patient, funds are derived primarily from the Supplemental Security Income Program. Such funds are deposited in a trust account for the individual patient. Amounts under \$500 are reserved and distributed to the patient for the purchase of such things as clothing, canteen items and personal effects. When the patient is unable to handle personal funds, purchases are made by staff. Amounts over \$500 are used to offset the State's cost for the care and support of the patient.

Hospitals, for the most part, have established their own methods for controlling and distributing funds to patients for personal use. These methods include catalog orders, canteen script, canteen purchase orders and cash. Over the years, the lack of adequate and uniform controls for managing patient funds has been of concern to the state hospital system. From time to time, there are reports of hospital staff diverting patient funds or personal items for their own use. Attempts to establish better controls are met with resistance on the part of some hospital directors and staff, who claim that increases in controls are too bureaucratic and not in concert with the concepts of patient normalization.

At the present time, the Department does not have the capacity to audit patient trust accounts or to evaluate the practices related to the management and disbursement of such funds. A task force was established to examine the problems related to management of patient funds. However, other priorities have diverted members of the task force and their work has not been completed.

Recommendations

1. Establish a uniform system of managing and disbursing the personal funds of patients in all state hospitals.
2. Develop departmental audit capability or contract with an appropriate state agency to conduct scheduled audits of state hospital patient trust accounts.

3. Dual Administrators

Prior to 1968, superintendents of state hospitals were traditionally physicians or psychiatrists. For many years it was debated as to whether or not hospital directors should be persons with an administrative background rather than a medical background. Proponents of the hospital administrative concept for the management of state hospitals pointed to the trend in local hospitals, where more and more hospitals were using administrators rather than medical directors. Also, proponents alleged that medical directors were more concerned with programs and not enough concerned or interested in hospital operations.

In 1968, legislation was enacted (Chapter 402, Statutes of 1968) which established the clinical director and the hospital administrator as co-equal managers of state hospitals. The Department of Mental Hygiene was slow to implement this new change. Part of the delay was due to getting State Personnel Board approval of classification changes. In 1971, the law was strengthened which in effect mandated the Department to establish the hospital administrator as an equal to the medical director. Basically, the hospital administrator is responsible for the administrative, support, business and security functions, while the medical director is responsible for the care and treatment of the hospital's patients.

The Commission Task Force found that many of the hospital functions can not be separated precisely. Often decisions made on the administrative side have program implications while many program decisions have administrative implications. There is no formal mechanism to resolve such issues when they arise.

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 interior 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.

During 1972, the facilities planning and construction requirements of H.E.W., the California Fire and Life Safety Code amendments, and the Joint Commission for Accreditation of Hospitals requirements for accreditation became increasingly more stringent. Additionally, the California Occupational Health Act and the Seismic Safety legislation required the state hospital facilities standards to be improved. In order to meet "conditional" requirements of the fire codes, the Department of Health instituted a "Fire Watch Condition" procedure as a holding action pending additional funding to meet other fire and life safety code requirements. In addition, the Department of Health has initiated a complete review of all plant facilities which will soon make recommendations for improvements in order to meet standards.

Department of Health estimates as to the specific structural changes which are needed in the plant facilities and the costs for such changes are not yet completed, but are estimated to be sizeable. The problem of obtaining funds for plant modernization for minimum compliance with fire life safety, and seismic standards remains a formidable obstacle.

The licensing surveys of state hospitals revealed numerous areas where the patient care standards are inadequate and in need of improvement. Many of the areas of poorest standards appear to relate to the services of specialists, and probably are a reflection of inadequate staffing of specialists. For example, pharmacists are not reviewing the drug regimens of patients on a monthly basis as required by regulations. Licensed psychiatric technicians are serving as charge nurses and not working under the supervision of a registered nurse or licensed vocational nurse.

The job descriptions of rehabilitation specialists, occupational therapists, physical therapists, and development specialists are inadequate. They do not work in unison with physicians under their supervision and do not keep physicians adequately informed in progress records. Case management plans by specialists are not re-evaluated on a monthly basis as required but sometimes only semi-annually. In-service education programs for specialists and for regular staff are not adequately provided nor documented. There is also a shortage of x-ray personnel in at least one hospital.

The in-service training programs and policies and procedures for controlling infectious diseases appear to be inadequate. The infectious disease shigella was reportedly endemic to the patient population at one hospital--a condition which requires isolation of patients and temporary closure of wards until the disease is controlled. The evidence suggests that the same standards for control and prevention of infectious diseases are not utilized by the State hospitals as they are in private facilities.

The number of dietetic service personnel supervising and directing the transport of food trays and carts from the department to the various units is not sufficient to maintain proper time, temperature and food handling controls, and in-service direction for dietetic service personnel is inadequate. Special diets for patients are not adequate and patients are served food items contraindicated by the diet manuals. Adequate controls are not utilized to insure that perishable foods are properly kept at correct temperatures.

The staff giving direct patient care services such as feeding and care of patients are also asked to do housekeeping duties. In some instances,

nursing personnel are scrubbing floors and cleaning bathrooms. This dual role is not permissible in any hospital setting. There is also evidence that housekeeping personnel are inadequate to provide minimum standards of cleanliness in some places. Restrooms are dirty, vents are dirty, janitors' closets are dirty and cluttered, shower rooms are cluttered, and drinking fountains are dirty and stained. In one case, cleaning compounds were stored in the same areas as food.

Task force members made a visit to Sonoma State Hospital in September to Phoenix Ward to observe a behavioral modification ward. The following is a summary report of this visit:

Upon our arrival to the behavioral modification unit for adult male retarded patients, we found that many of the patients were removed from the building for a walk with attendants minutes before we arrived. We observed that the facility is designed for detention in that all doors for entry into the building and between rooms within the building were locked, with keys held only by the attendants.

The large recreational area outside the building has a cement yard surrounded by a high wire fence, conspicuous by its absence of equipment and supplies, except for its metal exercise bars. Inside the building, we observed the kitchen to be in an unsanitary condition and unattractive in appearance, with such a large number of flies that the room was unpleasant to enter, even though it was almost dinner time (4:30 p.m.).

There were no personal effects, other than essential items of clothing, for patients in the building. The dark walls were bare, and the rooms contained only institutional chairs, benches, and tables. The sleeping facilities for patients were crowded into one large room with little space to walk between the small military-type cots. The community toilet facilities were in an unsanitary condition with paper and water on the floor and unflushed commodes.

Three patients were locked in a room with a television set, without the presence of attendants, which was admittedly against program policy. One patient was observed with large bruises and abrasions on his forehead. Other patients appeared in dazed, unresponsive conditions.

There was no indication that any treatment programs were available to patients and we did not observe individualized care being provided to patients. Nor did we observe staff relating to patients with warm, empathic feelings.

In summary, the facilities on the Phoenix Ward not only were physically unfit for human habitation but provided conditions hazardous to the patients' health. The unsatisfactory environment was not offset by any obvious treatment programs or by warm, personal patient-staff relationships.

Recommendations

1. Ensure that the State Department of Health comply with at least minimum licensing standards for the care of patients, including those for fire, life safety, and seismic standards, as well as staffing and patient care standards.
2. Until satisfactory progress can be made in improving the level of patient care, especially compliance with space and staffing standards, place a moratorium on patient admissions to the state hospitals.
3. Monitor progress in meeting minimum standards for licensure with staff from the Licensing and Certification Division on a monthly basis or more frequently.

5. Licensure of State Hospitals

State hospitals were required by SB 413 and AB 2262 to be licensed since 1973. The Department of Health's own Licensing and Certification Division was assigned responsibility for surveying, licensing, and certifying state hospitals. The licensing surveys of state hospitals conducted last year found the state hospitals to be out of compliance with state laws so that they could not be granted

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:¹

- (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:¹

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

¹ "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".

Aversive conditioning, however, seems to be an inhuman type of practice, regardless of the conditions under which it is administered. Hospitals may utilize a variety of battery-generated devices including cattle prods and electric belts. Even if such therapy is considered as a last resort, if consent is obtained from a parent or guardian, and if trained personnel are utilized in such treatment, we question the legitimacy of this treatment as substitutes for other more humane and personal treatment modalities.

Other observers report high dosages of tranquilizers being utilized frequently by program staff as a form of therapy. And in some instances, drugs which produce serious interactive effects with tranquilizers are administered.

Because of the many reports of misuse of behavioral modification and drug treatment modalities, there is an obvious need to have an investigation conducted by an independent team of psychiatric professionals. Such a review should include the policies and procedures of each state hospital as well as the actual practices within the state hospitals.

Some treatment modalities may be completely inappropriate under any circumstances, others misused under certain conditions, utilized without professional staff trained and knowledgeable about the treatment modalities, or not effective for selected problems.

Recommendation

1. Have an independent review made by psychiatric professionals of all treatment modalities in use by state hospitals.

7. Patient Treatment and Special Incident Reporting

Physical and psychological abuse of patients in state hospitals continues to exist. Although the Task Force was not able to determine the frequency of such incidents, a number of departmental employees familiar with hospital programs expressed concern that such incidents are all too frequent.

In assessing the Department's procedures for reporting and dealing with such incidents, the Task Force reviewed an incident at Porterville State Hospital which occurred on May 26, 1975. The incident involved several patients who were apparently beaten with wire instrument such as the handle of a fly swatter or a wire coat hanger. The Task Force found that the incident was fully investigated and reported in an expeditious manner. However, after a full investigation by hospital staff and the Porterville Police Department, the Department has not been able to determine who inflicted the injuries upon the patients.

The inhumane treatment of patients within the state hospitals has been a long-standing problem. Even though patient abuse has never been acceptable, it has been difficult to eliminate entirely. Department officials are not sure why such incidents continue to happen, but feel a variety of factors are probably involved such as:

- Inadequate employee screening procedures
- Inadequate training
- Understaffing

- Inadequate physical environment
- Lack of treatment alternatives for certain patients
- Inadequate supervision

Reports of incidents are categorized into two groups: Those which remain at the hospital and those which must be reported to headquarters. Those reports that remain at the hospital include incidents of a minor nature, such as falls, scrapes, cuts, and minor altercations. Those included in headquarters reportable group include such incidents as deaths, patient abuse and major injuries.

The procedures for reporting incidents appear to be adequate, but the interpretation of which reports must be sent to headquarters varies widely and is inconsistent.

The Department, when it initiates disciplinary action, is sometimes frustrated by employment procedures. For example, a hospital employee was convicted of a misdemeanor assault charge against a patient. When the Department attempted to dismiss the employee, the employee appealed to the State Personnel Board. The Board's hearing officer ordered the employee reinstated pending a State Personnel Board ruling. Subsequently, the Board ruled in favor of the employee, and refused to hear an appeal by the Department. The Department reports that there have been other incidents in which the State Personnel Board has overruled hospital management in cases involving disciplinary action against employees for patient abuse. As a result, employee organizations are charging that the State is condoning patient abuse.

Hospital employees are unwilling to testify against fellow employees at State Personnel Board hearings. Often the private attorney of the appealing employee cross-examines as in a criminal trial, while the employee giving testimony has no personal attorney. Reportedly, there have been incidents of retribution against employees who testified for the Department, such as slashed tires and sand in gas tanks. This occurs when the employees involved are returned to the same job situation, creating a tense situation.

Employee organizations have asked the Department to establish a policy regarding the employees' rights in such situations. The Department has been slow in responding to these requests. These organizations have asked for a definitive policy in these areas:

1. Under what circumstances will the Department provide legal representation?
2. Will there be a charge for legal services?
3. What kind of support will the employee receive from the Department in reporting incidents of patient abuse?

Managers believe that the Department has received inadequate legal representation from the Attorney General's Office in cases involving patient abuse. They also believe that the hospitals could do a better job of documenting these cases. Toward this end, the Department is providing legal consultation to medical directors of the hospitals to explain in legal terms the proper manner of documentation and the administrative procedures to follow in case of patient abuse.

Recommendations

1. Undertake a systematic review of hiring, training, treatment and supervisory practices in the state hospitals and their influence upon all treatment programs.
2. Review present policies and procedures for special incident reports to achieve a more uniform reporting of incidents.
3. Initiate an effort between the Department of Health and the Attorney General's Office to upgrade the quality of legal representation provided to the Department on disciplinary actions against hospital employees.
4. Establish a definitive departmental policy on employee rights in situations having legal implications.
5. Revise the policies and procedures for all treatment modalities in state hospitals to comply with the findings of the independent review, in order to protect patients' safety and rights.
6. Establish periodic program evaluations for each state hospital program in order to monitor compliance with state policies and procedures in the use of all treatment modalities.

8. Patients' Rights

The State Department of Health has not yet adopted an official policy for guaranteeing and monitoring the rights of patients in state hospitals.

Licensing surveys of state hospitals found that the following violations of patients' rights were occurring in some facilities:

- (a) Not every patient admitted is fully informed, prior to or at the time of admission and during stay, of services available in the facility and of charges for services not covered by Medi-Cal and Medicare or in the basic rate.
- (b) Not every patient is fully informed by a physician of his or her medical condition (unless medically contraindicated), and is not afforded the opportunity to participate in the planning of his or her medical treatment or to refuse to participate in experimental research.
- (c) Some patients are being transferred or discharged for reasons unrelated to medical indication. Patients are being discharged for nonpayment of hospital charges. Reasonable notice is not always provided for families to make alternative arrangements for care. Reasons for discharge in the absence of medical indication are not always documented in the medical record.
- (d) All patients are not accorded their rights as citizens to voice grievances or to recommend changes in policy or service. They are not free to choose outside representation to protect against abuse without interference and reprisal.
- (e) Not every patient is encouraged and assisted in activities of social, religious, and community groups at his or her discretion, unless medically contraindicated.
- (f) Not every patient, if married, is assured privacy for visits by his/her spouse; or, if both are inpatients in the facility, they are not permitted to share a room, unless medically contraindicated as documented by the attending physician in the medical record.

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.

10. Professional Activities

Section 19251 of the Government Code requires that a state officer or employee "shall not engage in any employment, activity or enterprise which has been determined to be inconsistent, incompatible, or in conflict with his duties as a State officer or employee..." The Department of Health policy and procedure manual elaborates on this requirement in its general personnel policies by saying that:

An employee licensed to practice in one of the healing arts may engage in the private practice of his profession, but must first receive specific written approval from the Director or his delegate. Such practice may be incompatible with official responsibilities and is permissible only on the individual's own time and where there is no conflict of interest with those of the Department.

In addition, the policy specifies that it is incompatible and prohibited for an employee to engage in (1) the "treatment or consultation services for a beneficiary of the California Medical Assistance Program; (2) consultation or services for any Medi-Cal certified provider; or (3) interest in a nursing home, proprietary hospital, ambulance service, drug store, pharmacy, clinic, clinical laboratory, etc....."

A brief, preliminary survey of physicians employed full time by the state hospital program disclosed many irregularities and considerable non-compliance with departmental policy. Some full-time staff at one state hospital reported to be spending 7.5 hours a day in private practice, in addition to their full-time hospital duties. It is questionable that these professional employees were performing their full-time duties. Certainly, if a physician is regularly treating psychiatric patients for 15 hours a day he is exceeding his capacity.

Physicians employed by the state hospitals are also apparently seeing Medi-Cal patients in their private practices, which is a violation of the Department's policy on conflict of interest. Some full-time state employed physicians at state hospitals were making up to \$29,000 from Medi-Cal patients in addition to their state salaries of approximately \$40,000. One psychiatrist employed for two-thirds time made \$45,000 from Medi-Cal patients seen in private practice.

Preliminary investigation also indicates that some physicians working for the state hospital program or for the community mental health programs are referring patients to themselves in their private practice. The practice of self-referral gives physicians an advantage of building a sizeable practice and diverting patients who would normally receive care from the state hospital or community mental health programs into private practice. In other instances, fraud may be involved when physicians are receiving regular governmental salaries and also billing Medi-Cal for the same patients as private cases. Certainly, the practice of state employees making large incomes in addition to their state salaries from Medi-Cal is a flagrant violation of conflict of interest policies, if not outright fraud.

A review of 20 psychiatrists known to be residing in one county in 1974 showed their total earnings from Medi-Cal to be \$257,000. These large earnings from Medi-Cal are unusual in that the population of this county is low, and both a large state hospital and a county mental health program are located in the county to serve Medi-Cal eligible patients. This county mental health program does not employ a full-time psychiatrist, but rather contracts with private psychiatrists for the care of patients. Private psychiatrists paid by the program are able to obtain a fee-for-service payment rather than a salary

and are able to refer patients to themselves as private patients. These psychiatrists may also be receiving double payments for the same services-- one from the community mental health clinic and one from Medi-Cal. We urge an investigation of this situation for possible improprieties.

The data from this review are preliminary but demonstrate that professionals employed by the State are not following the State's conflict of interest policies in their referral practices. Certainly such practices create higher costs to the State for Medi-Cal patients by diverting such patients from state clinics and hospitals into private practices of professionals, and in some cases into the private facilities where professionals have a financial interest. The data are indicative that a complete investigation is needed of all professionals currently in state service in the state hospitals and the community mental health centers.

Recommendations

1. Conduct a full-scale investigation into the private practices of professionals employed by the State.
2. Review the Department of Health policies and practices regarding conflict of interest and incompatible behavior to clarify and strengthen such policies.
3. Inform all professional employees of the Department of Health's policies and practices for conflict of interest and incompatible behavior and give notice that violations will subject employees to immediate dismissal from state service.
4. Subject state professional employees to prosecution if they are shown to be guilty of fraudulent billings.

F. Substance Abuse Programs

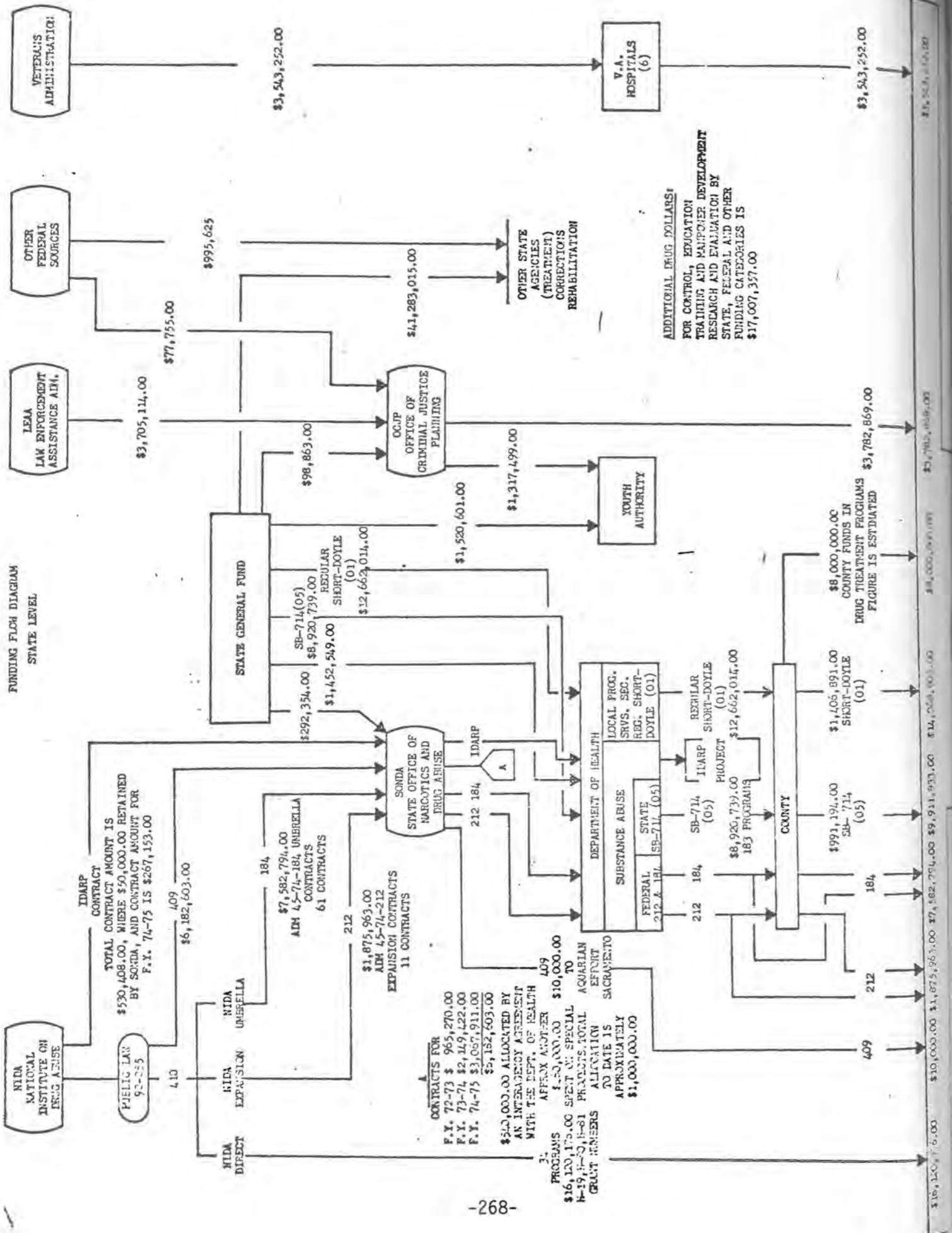
Substance abuse programs were selected for review because they represent a prime example of the impairments to effectiveness faced by new categorical programs. Time limitations permitted review of the drug program only, although much of what is wrong in drug abuse can be applied, as well, to the alcohol programs.

Federal initiatives expanded efforts to control the burgeoning problem of drug abuse. Prior to passage of legislation setting up a federal narcotics and drug abuse agency, California had already been operating drug programs within the Short-Doyle Community Mental Health Program.

Federal law called for the designation of a single state agency for planning and operating drug programs at the state level. The State Office of Narcotics and Drug Abuse (SONDA) was set up in the Health and Welfare Agency. This office is charged with planning and policy development and also serves as a conduit for federal funds granted by the National Institute on Drug Abuse (NIDA).

With passage of state legislation, SB 714 (1972), a Substance Abuse Branch was established in the Department of Health to carry out the responsibilities included in this legislation. Its creation coincided with the implementation of reorganization.

The administrative quagmire which has resulted is best illustrated by the following chart prepared recently by the Department of Health.



From a study of this chart, one is forced to make the following observations:

- It was a mistake to designate the Health and Welfare Agency as the single state agency for drug abuse program planning and policy development. Drug programs were already an integral part of the operating programs of the Department, which should have been designated as the single state agency for this purpose.
- The fragmentation of state administration occurred in response to fragmented sources of funding--federal (NIDA), state (SB 714, Short-Doyle), and local.
- Such fragmentation forces up the administrative costs and reduces dollars available for treatment.
- Data on programs, contracts, fiscal accounting, and utilization are scattered in several directions, making an assessment of program results and costs nearly impossible.
- The potential crossover of Medi-Cal funding needs to be studied carefully. At present, only inpatient care is paid under Medi-Cal for those who are eligible. Since the federal government supplies a 50 percent match under Medi-Cal, and none under Short-Doyle (except Medi-Cal crossover), one must speculate that extension of coverage under Medi-Cal for outpatient services might result in less pressure on the state budget to maintain effort as direct federal funds flow, earmarked for drug treatment, undergo reduction. This is because there is no federal match in Short-Doyle (90% State, 10% local), and none in the SB 714 funds. Maximum effort to identify eligibles (for Medi-Cal) in the local programs and coverage for

outpatient services, could result in a net gain for state monies (except in the medical indigent category under Medi-Cal which is not matched by federal funds). Experience with the drug abuse program emphasizes the distractions and disorder which can result from building aimless administrative structures which have the effect of tearing apart the continuity of programs and hampering even the best of administrators from doing an effective job.

The drug programs need a single point of coordination, within the Department of Health. Planning, evaluation, and control of cost must be lodged in one place. Funding sources, at present, require the use of multiple sources, but these also need a single point of reference in the Department so that program managers can clearly identify all sources of funds and their amounts. In addition, all programs dealing with drug abuse treatment should be managed by the Substance Abuse Branch, including those programs being funded solely out of Short-Doyle funds. Here again, local government would vastly benefit from clarity in regard to the divided authority and confusion about sources of funds. It is time to end the confusion and give the program administrators time to pay more attention to local programs, what they are doing, how much it costs, how they are set up, and what concrete results they are getting. No one is being helped by the indecision surrounding the administration of substance abuse programs.

The drug and alcohol (substance abuse) programs within the Department of Health are intricately tied to the Local Mental Health Programs of the California Mental Health Services Act. The Department has created separate branches for the Substance Abuse Program and the Mental Disabilities Program within the Community Services Division. We suggest that these programs cannot be treated separately as different programs or branches because of funding crossovers and the administrative structures at the county level which combine both programs. Substance abuse is one important component of the local community mental health programs and, thus, must be administered jointly.

Recommendations

1. Abolish both SONDA and the Office of Alcohol Program Management and place their functions in the Department of Health in the Substance Abuse Program.
2. Designate the Department of Health as the single state agency for both drug and alcohol programs.
3. Place the responsibility for the management of all substance abuse programs in the Substance Abuse Program without regard to the sources of funds which support drug and alcohol programs.
4. Transfer the Substance Abuse Program in the Department of Health to be administered as one section of the Mental Disabilities Branch.
5. Conduct a study in cooperation with the Department of Finance of the funding sources for drug programs for several purposes:

- a. To settle the sources and amounts available to these programs;
 - b. To study misuse of earmarked funds being diverted to other programs; and
 - c. To determine if outpatient coverage under Medi-Cal, permitted by the federal government, would expand the pool of dollars available to California for these programs.
6. When drug and alcohol programs display a semblance of administrative control, offer every assistance to local programs for integration of services for abusers into primary general outpatient and hospital settings.
 7. Establish a comprehensive and balanced approach to treatment so that local sponsors are required to show program efforts directed at prevention, education, early diagnosis, introduction to rehabilitation, and reintegration into society. Program segregation of alcoholics and drug abusers invites stigma and social ostracization.

G. Licensing and Certification Program

1. History

Prior to the reorganization of the Department of Health in 1973, there were three distinct and separate facility licensing programs: (1) The Department of Social Welfare licensed residential care facilities and home placements; (2) the Department of Mental Hygiene licensed community care facilities for mentally and developmental disability and alcoholic patients; and (3) the Department of Public Health licensed hospitals, nursing homes, clinics and other health related facilities. These three programs were merged with related programs, into the Health Quality System. In 1974 a reorganization removed some components of this program and the name was changed to the Quality Review System. In May 1975, the program was renamed the Licensing and Certification Division.

2. Goals and Objectives

The Licensing and Certification Division is currently responsible for the regulation of construction and operation of hospitals, nursing homes, clinics, group and family homes, nurseries and pre-schools, foster homes, half-way houses, day care centers, and similar types of community care facilities. The purpose of the Division is to assure the public that health and community care facilities meet established standards for the provision of such care and to minimize fraud.

3. Program Components

Facilities Construction Section: The objectives of this section are to assist in the addition, expansion, or modernization of needed health facilities and to assure that all construction results in functional, structurally safe facilities capable of being licensed. This section has four separate programs: (1) Hill-Burton and Community Mental Health programs, which allocate and monitor federal construction money; (2) the Architectural/Engineering Program, which ensures on-site inspection of facilities for construction and modernization; (3) The California Health Facility Construction Loan Insurance Program, which allocates loan insurance for construction; and (4) The Fire Protection Loan Program, which makes loans to improve fire protection on children's institutions. In 1974-75, this section approved 47 grant applications for a dollar value of 51 million, underwrote two insurance loans for a total of 9 million, and underwrote five loans for .2 million. Many survey activities of this section are contracted to the Office of Architecture and Construction and to the State Fire Marshal.

Investigations Section: This section conducts inquiries into allegations of violations of laws and regulations, primarily of suspected abuse by either providers or beneficiaries of Medi-Cal program services. In 1974-75, this section initiated investigations of 2,500 cases, closed 1,600 cases with action, and completed 4,000 cases, and identified overpayments of \$ 1 million. This section is primarily oriented toward investigation of providers of Medi-Cal services rather than facilities, which are investigated by the Licensing Section.

Services Approval Section: This section develops plans of correction for licensed facilities, conducts surveys for approval of specialized services, follows the progress of facilities in making corrections, provides expert witness testimony, investigates complaints, and provides group training and consultation to facility providers and evaluators. This section is composed of highly skilled professional staff in many health disciplines which provide technical skills and consultations to facilities and the staff of the Facilities Licensing Section. In 1974-75, the staff of this section provided 2,600 visits for investigation and correction activities, testified at 72 hearings, conducted 246 visits for specialized service permits, and held 575 training sessions for facility personnel.

Provider Participation Section: This section is responsible for the certification of institution health care providers pursuant to regulations for participation in the state and federally funded Medi-Cal program. The activities of certification are for skilled nursing and intermediate care facilities and the establishment of time-limited agreements with facility providers. Certification of a provider is based upon reports made by the Facilities Licensing Section and the Medical Social Review teams in the Medi-Cal section, rather than upon direct field work by staff of this section. This section monitors violations of agreements and implements suspensory action when necessary. In 1974-75, this section certified 2,370 facilities for Medi-Cal, 600 physical therapists, and issued 42 nonrenewals for Medicare and Medi-Cal program providers.

Facilities Licensing Section: This section's objective is to assure that all health and community care facilities providing out-of-home care meet established standards for physical plant, equipment, staffing, services, programs, and procedures in compliance with state licensing laws and with federal requirements for program participation. This section has responsibility for the licensing of 42,000 facilities in the State of which 2,400 are health facilities and the remainder are community care facilities. This section, however, contracts with counties for licensing three-fourths of the total facilities. In 1974-75, the section licensed 1,600 health facilities and 8,500 community care facilities, completed 635 Medicare/Medi-Cal surveys, investigated 2,000 complaints, and initiated revocation procedures and appeals for a denial of license on 30 institutions.

4. Client Population

The clients for services are primarily health and community care facilities who want to obtain and maintain licenses and Medi-Cal certification. The beneficiaries are the users of health facilities and the public at large. The Investigations Section primarily investigates providers and beneficiaries of the Medi-Cal program, which benefits the Department in the recovery of funds and prevention of abuse.

5. Financial Resources

The total budget for operations of this Division is \$18.4 million for 1975-76. Of this total, \$10.3 million is for the licensing section, \$4.2 million for

construction section, \$1.5 million for services approval, \$1.5 million for investigations, \$.2 million for provider participation, and \$.5 million for the administration of the Division Office. The funding sources include the following categories: \$4 million from federal Title 18 for Medicare and Title 20 of the Social Security Act, \$.3 million fees from facilities, \$4 million from Health Care Deposit Fund (Medi-Cal Program), \$3 million from the Hospital Construction Account, \$4.5 million from the General Fund, and from other funds and appropriations.

6. Advisory Bodies

The Licensing and Certification Division has five advisory bodies which provide advice and technical assistance: the Health Facilities Licensing Advisory Board; the Community Care Facilities Advisory Committee; the Building Safety Board; the Home Health Agency Advisory Committee; and the Renal Dialysis and Transplant Advisory Committee.

7. Administrative Organization

The Division is organized into five sections with different administrations, operations, field offices, and program activities. There are 25 different field offices for this division although some are located at the same geographic site.

This Division has a total of 502 staff, of whom 304 are assigned to facilities licensing, 15 to provider participation, 73 to services approval, 33 to

facilities construction, and 74 to investigations. The majority of the staff are classified as health facilities representatives, nurses, social workers, community program analysts, and other health professionals. Other staff include architects, special investigators, auditors, program analysts, health program advisors, and clerical staff.

a. Medical Social Review Team: The Licensing and Certification Division does not have authority for the Medical Social Review Teams located in the Field Services Section of the Medi-Cal Division.

The Medical-Social Review (MSR) program was established in compliance with Title XVIII and XIX of the Social Security Act to obtain federal Medi-Cal program funds. This program (1) insures that the quality of skilled nursing facilities and intermediate care facilities is commensurate with the medical and social needs of beneficiaries; and (2) insures that the quality of care is of a high level in accordance with the standards of the state and federal Medi-Cal program.

The Medical-Social Review (MSR) Teams, located in the Field Services Section and placed in 12 district field offices, conduct periodic surveys to insure high standards and determine level of care required. The Field Services Section, responsible for prior authorization processing activities, estimates that 45.5 of its 441 staff are full-time employees for the Medical Social Review activities.

Both the managers in the Field Services Section and the Licensing Section agree that the separation of the MSR function from the licensing program creates the following programs: (1) duplication of personnel time in conducting separate field surveys of facilities; (2) possible conflicts between the sections as to the standards of care in the same facilities; (3) poor coordination and confusion between programs; and (4) confusion in regard to final authority for setting the minimum standards for care.

Officials of both sections agree that the MSR activities should be transferred to the Licensing Section, but there are many management problems in integrating the MSR teams with the licensing teams. The licensing staff wants more staff to carry out its program. The MSR teams are reluctant to make the transfer. The transfer faces delay because the planning process is presently inadequate and does not involve knowledgeable professional staff from the MSR and Licensing Sections. The delay in transfer is impeding the development of an integrated licensing program.

Recommendation

Develop plans for transferring the MSR program to the Licensing Section and implement immediately.

b. Continuing Care Services Section Licensing: The Licensing and Certification Division does not have authority to license small family homes; this is presently assigned to the Continuing Care Services Section of the Community Services Division.

After the Licensing and Certification activities were merged in the 1973 re-organization of the Department of Health, an administrative decision divided the responsibilities for the licensing of small family homes between the Licensing Section and the Continuing Care Services Section of the Community Services Division. Although AB 2262, effective on January 1, 1974, requires the consolidation of all community care licensing activities, this has not yet been achieved.

Continuing Care Services (CCSS) licensing of small family care homes creates a number of serious problems. There is a conflict of interest in having social workers who find homes and place clients also license the homes, because the role of placement and case management requires a supportive and consultative function, while licensure and monitoring requires a client advocate and enforcement role. CCSS staff have many other duties in addition to licensing and find it difficult to keep current as to the complex licensing regulations and procedures.

Recommendation

Transfer the CCSS licensing activities to the Licensing and Certification Division immediately.

c. Los Angeles County Contract: Since 1947, Los Angeles County has performed licensing and certification of health facilities under contract with the State. The performance of the county has been under continuous criticism. Although the state standards are theoretically in use, many experts in the field point to scandal, lack of enforcement, lack of qualification of inspectors, and higher costs. If the State were to assume the

licensing activities of the Los Angeles County Health Department, the following benefits are anticipated: (1) a savings of state dollars; (2) solution of coordination problems between county, state, and federal officials; (3) elimination of different standards, procedures, philosophies, and staff qualifications between the county and state operation; and, (4) increased enforcement control over licensing and certification activities.

Recommendation

Transfer licensing and certification from Los Angeles County to the State.

d. Program Integration: The different sections within the Division are not integrated either administratively or geographically at any level, which interferes with the effectiveness and efficiency of programs.

There are five separate sections, each with its own administration, activities, and field offices. Currently there are 25 different field offices, although some are located at the same geographic site. All of the activities of the sections are closely related except for the Investigations Section.

There is general agreement within the Division that the following organizational problems exist: First, the profusion of different field offices creates confusion of the public as to the location for services and no doubt adds considerable cost to the department for multiple office operations at different geographic sites. For example, in the Bay Area the following

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.

Recommendations

1. Consolidate the field offices of the Licensing and Certification Division geographically within regional areas, coterminous with regional areas established by the Department of Health.
2. Consolidate the administrative operations of the Licensing Section, the Provider Participation Section, the Services Approval Section, administratively both within the headquarters and the regional offices.

e. Administrative Hierarchy: District administrators do not have access to the Division Manager but rather report to a hierarchy of administrators within the Division. Within the Licensing Section, there is an extra layer of administrative bureaucracy which does not seem to serve a useful purpose. District administrators report to the Supervisor for District Operations, who in turn reports to the Chief of the Licensing Section, who reports to the Manager of the Licensing and Certification Division. A licensing surveyor reports to a licensing supervisor in the district offices, who reports to the District Administrator. This makes a total of six layers of administration between the clients and the Division Manager. In addition, District administrators are sometimes asked to work directly with other administrative units within the Licensing headquarters such as the Legal Liaison Officer or the Policy and Support Unit, which further complicates the coordination, reporting, and accountability problems.

Recommendation

1. Reorganize within the Division to remove the administrative layers, layer by layer by having district administrators report directly to the Chief of Licensing or the Division Manager.

2. Organize the support services within the Licensing Section to report directly to the Chief of the Licensing Section.

8. Program Services

a. Enforcement: The Licensing and Certification Division has failed to establish a clear policy for its programs, which accounts, in part, for its poor enforcement record. In a 1973 report, the licensing program chief provided the following statement of the program's philosophy:

To insure that the highest possible quality of care and services are made available to those requiring them and that this be accomplished by providing assistance and consultation to facilities rather than by enforcement methods alone.¹

This same report pointed out that a lack of clarity existed as to when assistance and consultation ends and when the program should assume an enforcement role. This lack of clarity as to the overall policy continues to exist. Although the latest program statement of the Division indicates its goal is "to assure that medical and non-medical facilities meet established standards," this vague statement adds little information as to mission and direction.

The Licensing and Certification Division has been weak in enforcement of laws and regulations. First, the Division administration delayed until the Fall of 1975 the development and implementation of AB 1600, AB 1601, AB 2262, and SB 413, all approved in the fall of 1973. Staff within the Division

¹Stubblebine, J. M., California Department of Health, A Task Force Review of the Licensing and Certification Program Health Quality System, page 5, November 21, 1973

charge that the Division Manager deliberately delayed the implementation of the legislation because of his reluctance to play a strong enforcement role. Other staff charge that the regulations developed by the Division Administration were weakened to make concessions to the representatives of facilities.

The poor enforcement record of the Division indicates that there is a lack of emphasis on this activity as the primary mission. For example, during the last nine month period, 22 skilled nursing or intermediate care facilities have had license revocations although only three homes have actually ceased operations, and the other homes simply changed ownership. Of the community care facilities, 22 facilities have had license revocations or denials. Although this has increased over the 17 actions taken in 1973-74 fiscal year, this enforcement rate is considered low in relation to the extent of poor quality of care, especially in skilled nursing facilities, throughout the state.

Staff interviewed during this study indicated that they would like to see the Division take a stronger enforcement role against those facilities not meeting the minimum requirements, and they indicated confusion as to the program policies of the Division administration.

Recommendation

1. The Division should clearly define its policy as one of establishing and enforcing licensing standards, rather than only one of support and consultation to facilities.

b. Consultation: The special consultants in the Services Approval Section have poorly defined, confusing, and conflicting roles involving

both consultation and enforcement, which are, in turn, poorly coordinated with the activities of the licensing staff.

The special consultants in the Services Approval Section have been responsible for surveying health facilities to approve special services: assisting licensing surveyors with problem facilities; providing expert witness testimony; investigating complaints; and providing group training and consultation to facilities and licensing staff. The special consultant services are provided through a formal agreement with H.E.W., although the agreement does not prescribe, limit, or clarify the role of special consultants, and H.E.W. pays only 55 percent of the cost of this section.

Consultants, facility representatives, and H.E.W. officials all agreed that the role of special consultants is poorly defined, confusing and conflicting. The role of consultants clearly overlaps and duplicates the activities of licensing surveyors; consultants are able to provide a higher level of professional expertise because their job classification requires extensive professional experience in comparison to the requirements for surveyors. Such duplication and lack of clear distinction in roles could be reduced somewhat by integrating the special consultants from the Services Approval Section into the Licensing Section. By making consultants a more integral part of the licensing survey process, they would add considerable professional expertise to the process. The lack of professional knowledge by surveyors has been severely criticized.

When the functions of the staff in these two sections are so closely related, it is difficult to justify two separate administrations and separate field offices.

A more serious problem is that of conflicting roles, where consultants provide advice and assistance to facilities for meeting licensing standards and also play an evaluative and enforcement role, and at times give expert witness testimony against those facilities to which they provided consultative services. Nursing facilities reported their dissatisfaction with having consultants also play a role in surveys and enforcement of regulations and considered the roles of consultation and enforcement both confusing and conflicting.

This raises a larger issue as to why the state should be providing free consultation services to facilities, which are not intricately tied to the regulation and enforcement activities of the departments. It is our suggestion that the state should not be providing free consultant services to private facilities but rather that facilities should consider consultation to be a part of their anticipated operating expenses. Even the current practice of group training sessions and the organizing of facility representatives by state health consultants seems a questionable service for the state to provide, and is also a service duplicating the activities of H.E.W.

In our view, the Division should clarify the role of consultants to be one of serving as an integral part of the licensing process, which would limit consultation to time-limited agreements in conjunction with the plan of correction process, to expert witness testimony, to issuing special permits, and to training state department staff.

Recommendation

1. Merge the administration and functions of the Services Approval

Section completely with that of the Licensing Section at both the headquarters and field staff levels.

2. Have consultants assume the role of team leaders in the licensing program since they have greater professional experience and expertise.
3. Define the role of consultants as one associated with the licensing survey and enforcement process, providing consultation and training to licensing staff, and working with difficult facilities on a time-limited basis.
4. Discontinue the practice of individual and group consultation services to facilities on a request basis.

c. Investigations: The special investigations activities are dispersed within programs of the Department of Health and do not have autonomy from program operations. The Investigations Section primarily investigates cases of provider and beneficiary fraud for the Medi-Cal program, rather than cases of facility fraud. The staff and administration of this section indicate dissatisfaction in remaining within the Licensing and Certification Division. Their activities are directed toward a different population than the licensing section, and their work is more closely related to the activities of the Medi-Cal Division which is the primary beneficiary of the work of this section. The Investigations Section wants greater autonomy, because at times they have been involved in investigations of state providers, such as physicians at the state hospitals, and they want to report to the Director's staff rather than to program administrators. They also relate to the legal affairs office and the audit program, located in the Director's Office.

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.

The Architectural/Engineering Program in the Facilities Construction Section, which ensures on-site inspection of facilities for construction and modernization, is closely related to the activities of the Facilities Licensing Section. Program activities carried out by the architects and engineers, located in two field offices, should logically be combined with the other field survey activities of the licensing section. There is little justification for having separate offices for this program.

The loan program involves the collection and review of documents, obtaining certification of need from the Comprehensive Health Planning Office, and the disbursement of funds. This aspect of the program depends upon reports from the architectural/engineering program, the licensing section, and other state agencies such as the State Fire Marshal and the Office of Architecture and Construction. Although this program could be operated in a number of different parts of the organization, since it relates to the architectural/engineering program, it should remain as a separate section of the Division. Eventually, this program could be combined with certificate of need activities and called the Facilities Control Section.

Recommendations

1. Geographically locate the field offices of the Architectural/Engineering Program with the Licensing Section field offices.
2. Retain the Facilities Construction Section as a special section within the Licensing and Certification Division.
3. Consider combining the Facilities Loan Program with the Certificate of Need Program in a section labeled Facilities Control.

e. Nursing Home Services: Although inspected and licensed by the State Department of Health, the nursing home industry is characterized by patient abuse and inhumane living conditions, documented in innumerable investigations. This study will not elaborate upon the quality of life for patients but rather upon factors which create these conditions within the nursing home industry. The State has a responsibility to develop a stronger enforcement policy toward those homes which do not comply, even if this results in the closure of homes.

The nursing home industry has a complex economic base which leads to poor quality of care provided in facilities. Although there are a number of small family-owned and operated homes, three-quarters of the private nursing homes are operated on a for-profit basis.¹ The nursing home industry, however, generates lower annual revenues than the capital required to generate those revenues.² Thus, the factor that attracts capital into the industry is not the net income, but rather the net cash flow, which produces a tax-shelter that can be used for other investments.³

The nursing facility must seek to maintain an income sufficient to cover mortgage payments, by maximizing income and/or minimizing expenses. To increase the income, the facility attempts to maintain a high occupancy rate and to obtain a maximum income from Medicare and Medicaid. To reduce expenses, the facility cuts costs on labor, dietary expenses, services, and maintenance. Because of the low reimbursement rates from the government, the facilities have little choice but to reduce operation costs. It is the reduction in operating costs that leads to poor care for patients and serious consequences to patients lives.

¹Standard and Poor's, 1975.

²Shulman and Galanter, P. 8

³Ibid.

Financing of the nursing home industry as well as regulation comes from the government. Two-thirds of the industry's revenues come from Medi-Cal and other governmental funding sources.¹ In addition, the industry receives special subsidies: (1) the Medi-Cal reimbursement formula includes depreciation, interest on debt, and a return on the owner's equity; and (2) the shelter for taxable income from real estate investment. The regulation of nursing homes--not only the building, fire, and safety codes but also the quality of patient care--is provided by state and local governmental agencies. Under the current structure, the government pays most of the bills for the industry and also pays the major portion of costs for regulating the industry.

Rather than continuing to finance the nursing home industry with its skyrocketing costs which too frequently result in profit in the private sector and at a cost of poor, low quality of patient care, the government should experiment with other methods for reducing costs and increasing the quality of services.

One method would be for the state to experiment with alternative forms of government support to nursing homes. The state could finance a few counties for the purchase of marginal facilities with different types of services and sizes of operation. Local government could, in turn, contract for management with private non-profit corporations, if desired, to allow for competitive marketing of management service. If management were contracted to local government and/or non-profit corporations, the profit-making aspects and poor care could be reduced. Incentive systems could be established for

¹Standard and Poors

increasing management effectiveness. Also, utilization of a contract system would allow the state greater ease in cancelling agreements when facilities are out of compliance than the current complex system for license revocation or decertification. The state could expect benefits in terms of higher quality of patient care, which would in turn reduce the high costs of regulating the industry. The greatest benefit would be the expected reduction in the costs of Medi-Cal for nursing home care.

Recommendations

1. Adopt a strong enforcement policy by the State to maintain minimum standards for nursing homes, closing those homes which cannot meet standards.
2. Offer financial incentives from the State to encourage the development of non-profit nursing homes.
3. In the event that a more stringent enforcement policy leads to an inadequate number of skilled nursing beds, experiment with contracts to local government for the ownership and operation of a few skilled nursing home facilities of different sizes and types to determine methods of cost saving, quality of patient care, and cost effectiveness in regulation of facilities.

9. Program Administration

- a. Personnel and Professional Issues: Personnel and professional differences hamper consolidation efforts within the licensing section.

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

(HFRs) are professionally unqualified to be making decisions on quality of care or to explain to facilities how to correct deficiencies. HFRs might have been adequately qualified when licensing consisted primarily of building inspection rather than quality of care reviews, but this personnel classification should be reassessed as to its appropriateness for conducting the current licensing surveys.

Even though Registered Nurses have been added to the staff and work with HFRs as a team, the HFRs apparently at times resist a co-equal status for nurses. In addition, HFRs may have had an unequal advantage in being promoted to supervisory categories over nurses because this supervisory category is made up primarily of males.

One method to reduce professional differences, to improve the level of professional expertise, and to offset the lack of professional background held by HFRs is to utilize a multidisciplinary professional team approach to licensing both health and community care facilities. The professional consultants in the Services Approval section could be incorporated into a multidisciplinary team along with the Medical Social Review team staff (which includes nurses, social workers, and physicians.) The important aspect of this would be to clearly define roles for various health professionals and have teams which could work cooperatively.

Recommendations

1. Immediately study the job responsibilities of professional categories within the licensing section, to resolve inequities in equal work for equal pay.

2. Reexamine the hiring and promotion practices to eliminate the discrimination which appears to be occurring.
3. Establish multidisciplinary teams of health professionals for licensing community care and health facilities, and clearly define the role of various professionals on the teams.
4. Place a freeze on hiring health facility representatives until the appropriateness of this classification can be reevaluated.
5. Place health professionals, especially consultants as team leaders for licensing surveys.
6. Reexamine the functional activities required for a licensing and certification survey to maximize the use of professional staff and to determine if clerical personnel could be utilized to a greater extent.

b. Enforcement Procedures and Policies: The processes for revocation, temporary suspension, and non-renewal of Medi-Cal certification are time-consuming, vague, and cumbersome to the point that such processes are ineffective and infrequently utilized reducing the Division's enforcement capacity. District Administrators of licensing sections do not have the authority to make decisions on revocation, temporary suspension or non-renewal of certifications but rather must prepare requests which travel a complicated, slow path. A request for legal or administrative action must go to the Legal Coordinator within Licensing, to the Licensing Section Chief, and the Legal Counsel of the Director of the Department of Health. If approved, the request is sent to the State Attorney General's Office where the case is assigned to an attorney who proceeds with the action, which must be signed by the Director of the Department of Health. The temporary suspension can be granted within

a few days, but the actual licensure revocation process takes about 9 to 12 months, and a non-renewal action takes over 6 months.

The licensing staff and district administrators interviewed in this study seemed confused as to the actual legal process and the Division's procedures. Apparently, the Division has no formally approved procedures for such administrative or legal actions, and the staff stated that they had not been trained in such procedures. There was general lack of understanding as to what the criteria for license revocation or non-renewal procedures are and when to make a decision for such action. In this study, we reviewed cases of skilled nursing homes which were out of compliance with minimum standards for a period of several years and where hundreds of hours of professional time had been spent in consultation and repeated surveys, with no evidence of progress, before revocation action was finally taken.

Another problem identified by licensing staff is a lack of knowledge about or training in enforcement activities and legal requirements. Staff interviewed stated they felt uncomfortable in playing an enforcement role, and that this was compounded by their unfamiliarity with legal terminology, procedures, and activities. The district staff has no direct access to legal counsel or consultants, which makes them uncertain of what action or procedures should be taken and perhaps overly cautious, even when they know a facility is endangering the lives of patients.

Licensing staff also identified the problem of political pressure which they frequently receive from state and federal elected officials when they attempt to take strong enforcement action against facilities. In these instances,

licensing staff appear to be uncertain as to how to proceed and have not had legal counsel to assist them with such problems.

Some licensing staff suggest that it would be a faster, more efficient procedure for them to work directly with the county attorney in their area for legal procedures and action rather than having to work through the headquarters office and the State Attorney General's Office. Although this has been frequently suggested by outside groups and staff, the Division has not attempted a feasibility study on this procedure or other procedures which might facilitate the enforcement process.

Recommendations

1. Develop criteria for all administrative and legal procedures which can be utilized in the enforcement process.
2. Develop clear procedures and processes for legal and administrative actions and establish training sessions until the staff are comfortable and familiar with the procedures.
3. Study the feasibility of various methods which could reduce the time and increase the effectiveness of administrative and legal action against facilities not in compliance.
4. Reduce the cumbersome administrative process for legal action by giving District Administrators both the responsibility and the authority to make such decisions with advice and consultation services.
5. Provide legal counsel and assistance within the headquarters office of the licensing program if not also at the district level.

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

which regulations are properly enforced or to ensure that high standards of care are maintained. Even though AB 2262 passed in 1973 requires that the state establish formal contracts with the counties for licensing activities and to reimburse the counties for such activities, the licensing section has not yet developed contracts with counties and still does not monitor their activities.

Staff within the community care facilities charge that licensing leaders do not have a professional understanding of community care facilities, and consequently have established regulations which are rigidly applied to all community care facilities regardless of the type of client which they serve or the size of the facility. In examining the leadership within the licensing and certification division, most of the top administrators have not had professional experience with health or social services programs and those that did have experience were primarily from the former public health department. A definite absence of talented leadership within this division is noted by this task force.

The Division administration has attempted to minimize its licensing activities wherever possible. One example of weak regulations is that homes for persons recovering from alcoholism or drug addiction can be approved by the State Office of Narcotics and Drug Abuse instead of the licensing division. The division did not establish regulations that specifically apply to this type of home and abdicated their enforcement responsibility. Some social worker staff in the Division are extremely concerned about the welfare of individuals living in such facilities as some are known to be well below acceptable standards for other types of clients.

Because the state failed to appropriate funds for the licensing of day care facilities, after such facilities were exempted from paying licensing fees, the Division administration does not plan to continue such activities. Many staff interviewed are concerned about the welfare of children in day care facilities, and charge that the administration of the division does not understand the need for licensing such facilities and are not able to make professional judgments as to the appropriate priorities. They claim that day care facilities for children should have a higher priority for licensing than some other types of facilities.

Recommendations

1. Place professionals with health and social services program experience in positions of leadership within the Division.
2. Establish a commitment to community care facilities licensing which is equal to that of health facility licensing.
3. Conduct a complete reexamination of all licensing regulations utilized by the Division, in order to establish their appropriateness and adequacy, and to identify problem areas where special regulations should be developed for different types of clients or different sized facilities or levels of care.
4. Establish monitoring activities of county contracts to determine the quality and level of enforcement of state licensing regulations.
5. Utilize professionals within other divisions of the department and those staff in county government to reexamine and reestablish priorities within the Division.

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.

District administrators are not involved in the budgetary planning and allocation process nor in making decisions about their program needs. This is accomplished by the Division Manager of Licensing and the Administration Division.

District administrators interviewed did not know the budget allocation for their district nor did they have any fiscal data to determine whether or not they were proceeding within their budgetary allocation for the year.

One frequent problem within the skilled nursing home area is that of abuse of patient trust accounts, which are those established by Title XIX requiring special accounts for special needs such as clothing and supplies. Licensing surveyors in skilled nursing homes are asked to examine patient trust accounts to ensure that such funds are being held in a special account and are being utilized appropriately for the needs of individual patients. There is evidence that such abuse is common but that licensing staff may not have the expertise to examine complex accounting systems. Yet neither the licensing division nor the district offices have audit capability when there is suspicion of abuse of patient funds.

As mentioned earlier, the District Administrators do not have ready access to the legal counsel and advice which they need for making decisions on enforcement. They are forced to rely on such advice from the Legal Office and may be overruled by the Division Administrator.

Recommendation

1. Delegate to district administrators more authority for making decisions regarding their programs, without having final approval within the licensing section.

2. Provide support services to district administrators which will allow them to make personnel arrangements, participate in budgetary planning, be responsible for their financial accounts, to conduct audits of facilities, and to make legal and administrative decisions for enforcement actions.

e. District Administrators: Some district administrators may not be experienced enough, either with professional health and social service programs, or with administration, to competently carry out their current responsibilities or additional responsibilities.

The Division has not done a careful analysis of the kinds of qualifications, both professional and administrative, that are needed to manage district operations. Administrative training and systematic evaluation of professionals are apparently inadequately utilized by the Division. Administrators of the Division suggest that many of the current district administrators are poorly qualified for administrative responsibilities and are not capable of assuming additional administrative responsibilities which would accrue to them as a result of consolidation of sections, and transfer of the MSR teams and the CCSS licensing activities. If district administrators are to be given more administrative responsibility and authority, the personnel classification for administrators should be upgraded.

Recommendation

1. Study the job requirements for district administrators to determine the correct job classification and description.
2. Reclassify the district administrator positions so that such administrators are better able to handle expanded administrative responsibilities.

f. Technical Support: The Licensing and Certification Division does not have adequate support staff for personnel, budgetary, data systems planning, fiscal control, audit and legal services.

As discussed earlier, the 1973 reorganization placed all administrative support services for programs into a central operation in the Administrative Division. Since that time, the Licensing and Certification Division has not had adequate staff to participate actively in making personnel decisions and changes, making budgetary plans for its programs, planning for program development, establishing an effective data information system, auditing facilities where fraud of patient trust funds is suspected, fiscal monitoring, spending, and legal decisions.

The Division has failed to develop an adequate data information system to give up-to-date reports of licensed facilities information even though this project has been under development for two years. The Division needs its own data experts for improving and developing this data system. The Division has not been able to compete with the Medi-Cal Division in obtaining data processing time and staff, and its own program has suffered. The Division should have its own program experts to develop the data processing system, and then be able to contract for the actual computer services from the Administrative Division.

The large amount of time required on revocation, non-renewal, temporary suspension, and the new penalty citation activities, all require additional legal support. The Division does not have its own legal staff but utilizes the legal staff in the Directors' Office, where they must compete with all

other legal affairs of the Department. While the Legal Staff of the Department of Health has provided outstanding services according to program staff interviewed, they do not have adequate time for additional workload required by the new licensing legislation. The Division certainly could keep at least one full-time attorney occupied with its special legal problems. If attorneys were specially assigned to this program they could devote full-time efforts toward specializing in the complexities of licensing and certification activities.

Certainly the Licensing and Certification Division is hampered in its ability to make decisions about its own budget and programs, if it does not have adequate professional budget staff. The licensing division has been overspending its allocations, which is partially related to ineffective methods of accounting and reporting (discussed in Item #8) and also because it does not know how much money it has spent on what activities. Without responsibility for fiscal control, the Division cannot be held accountable for overspending its budget.

Solutions to the many personnel problems discussed in this section could probably have been expedited if the Division had had some special staff assigned to solve the problems peculiar to this program. Without its own staff to work on personnel problems, the problems described earlier will no doubt continue.

Recommendations

1. Give the Licensing and Certification Division support staff for personnel, budget, planning, fiscal control, audit, program evaluation, and legal affairs so it can be held both accountable and responsible for its total program administration and operation.

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.

h. Financial Procedures: Poor financial reimbursement and accounting procedures for the Division has led to inadequate collection of fees from facilities and a low rate of federal reimbursement, creating a fiscal crisis for the program. A review of federal claim procedures conducted by the administrative division this year found that documentation for federal reimbursement is inadequate and incorrect, leading to a claim shortage. The inadequate accounting system by the Division also threatens to create a situation where federal audit exceptions might be made, because of inadequate justification for staff time spent on federal activities.

In addition, the current situation for federal reporting is based on time reports of current daily staff activities, rather than upon the actual time needed by the Division to conduct the type of surveys required by federal regulations. Consequently, the Division claims of understaffing are related to lack of documentation for both the state and the federal government. Because the Division has not justified its activities for federal requirements, the Division is now receiving lower national average payments for skilled nursing facility surveys than any other large state in the nation. The Division claims that the federal government is paying California a discriminatory rate for its surveys and that the state is being penalized because its laws are more comprehensive than those of the federal government and incorporate the federal requirements. While this may in fact be a fact, the Division must develop better methods of justifying its activity.

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.

H. Environmental Health Protection Program

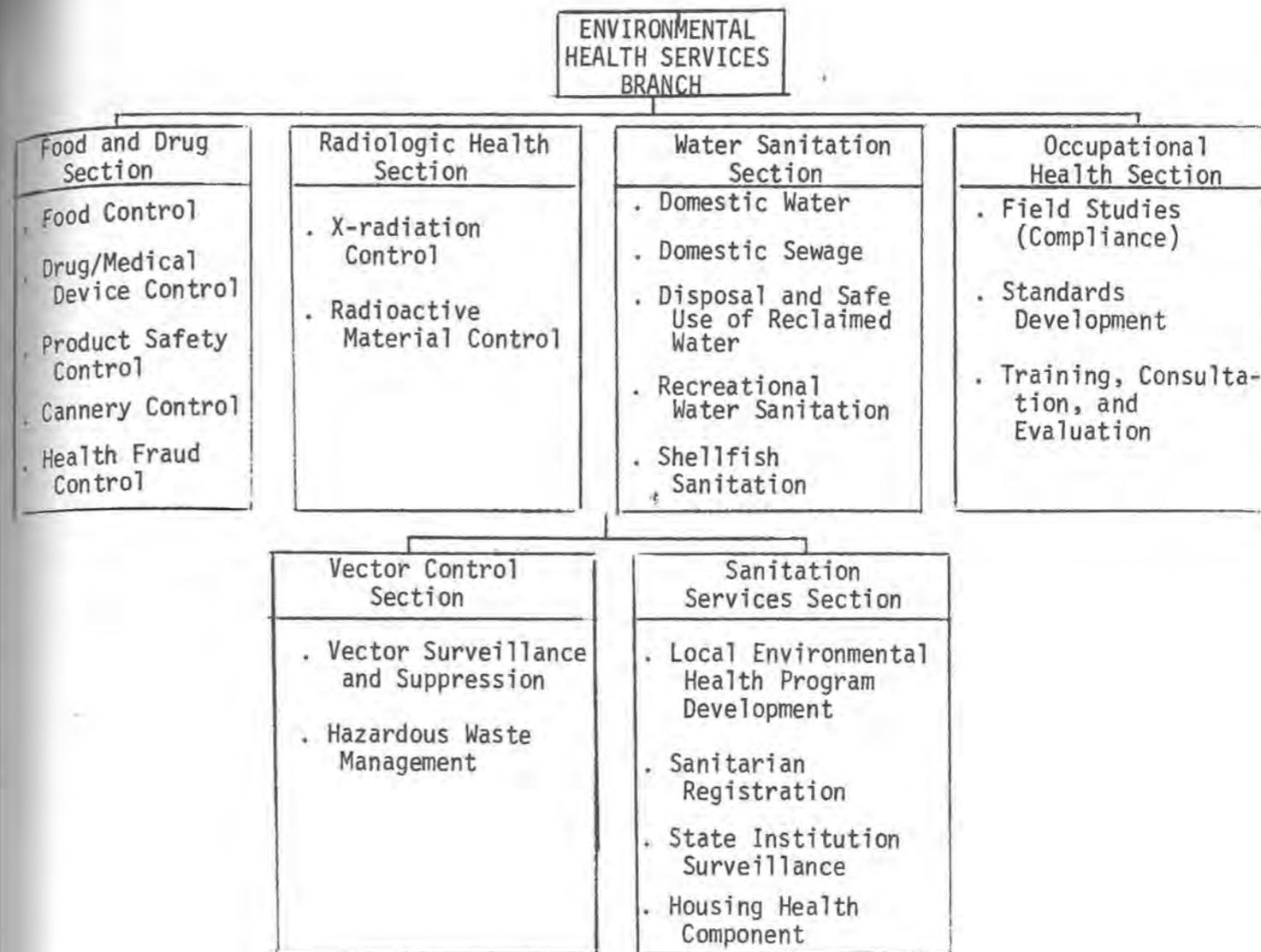
1. Environmental Health Functions

Historically, protection of the public against health hazards of the environment has been a major function of health departments. Environmental health activities have been highly effective in advancing the public health. Urban life depends upon safe water supply and other basic sanitary features of modern civilization.

With advancing technology and the accompanying increase in pollution of the environment by man, it has become necessary to develop even more sophisticated means for avoiding environmental health hazards. Now these hazards include slow-acting as well as acutely poisonous chemicals in industry, air pollution, and radioactive materials. Concern for environmental health protection has extended into rural as well as urban communities. Those working and living in rural areas need the same basic sanitation and, in addition, special attention in regard to insect and animal vectors of disease, pesticides and other health hazards.

The California Department of Health was for decades a national leader in environmental health protection. Among its notable accomplishments were the development of standards and enforcement procedures for food processing, especially in canneries; mosquito abatement districts, to minimize the risk of encephalitis; and ambient air and automobile exhaust standards.

At present the Department's Environmental Health Services Branch includes six sections, whose scope of function is indicated in the table as follows:



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

device manufacturers; adopt regulations (for) food sanitation and places where such is prepared (and) sanitation requirements for restaurants commissaries, and food mobile units; inspect canned foods and enforce laws pertaining (to such)"

2. Occupational Health Section, powers to "investigate sources of morbidity and mortality; administer a program of occupational health and disease prevention, (including) investigations, recommendations, technical assistance to other agencies and individuals, (and) collection of statistics"

3. Water Sanitation Section, powers to "examine and prevent the pollution of domestic water and ice supply sources (and) to maintain a program of sanitary engineering; inspect and regulate domestic water and water supply, (and) shall certify persons to supervise or operate water treatment plants; adopt rules and regulations regarding pollution of waters and public places; examine and determine shellfish area contamination; establish statewide water reclamation criteria and order abatement of water contamination; adopt rules and regulations (regarding:) recreational use of domestic water supply reservoirs, bottled water, public swimming pools, sanitation of public beaches, and public swimming place or resort, ocean water; abate contamination due to sewage discharges; investigate and report on technical factors involving water quality control"

4. Radiologic Health Section, powers to "be the Control Agency responsible for evaluation of hazards associated with use of ionizing radiation sources, for licensing and regulation of radioactive materials; issue rules and regulations necessary for the licensing, registration, and inspection of

radioactive materials; require maintenance of records on radiation exposure of individuals and records by users of radiation sources; issue emergency orders to protect public health and safety; impound a radiation source in an emergency, order the vacating of contaminated premises; promulgate rules and regulations on the control of all sources of ionizing radiation; provide for certification of X-ray operators and supervisors; develop programs to initiate, approve, and inspect schools of radiologic technology; institute disciplinary action against violators of the Radiologic Technology Act and associated rules and regulations; maintain continuing surveillance of radioactivity levels in the environment (and) report monitoring results at least once each month to the news media; maintain adequate control measures over storage, packaging, transporting, loading, and disposal of radioactive wastes; develop programs for evaluation of hazards,(and) for regulation of use, of radioactive material; issue rules and regulations necessary for inspection of such material; conduct compliance inspections of licensees authorized to receive radioactive waste for disposal as a customer service"

5. Sanitarian Services Section, powers to "make recommendation for air sanitation to the State Air Resources Board; certify qualified sanitarians; regulate the use (of) organized camps; administer the aid for Local Health Administration Law and adopt rules and regulations necessary thereto"

6. Vector Control Section, powers to "inspect rodent infestation and advise county officials; investigate and study mosquito and gnat control; perform solid waste and resource recovery activities directly affecting human health, prepare standards for protection of public health, and regulate hazardous wastes to protect human health domestic livestock and wildlife"

2. Effect of the Merger

The Environmental Health Services Branch has suffered less turmoil in the merger than most other units of the Department. This may be attributed to the special and technical nature of its activities, and the fact that it is not involved in any medical service activities.

While the environmental programs have come through the merger relatively intact, they have suffered from less attention in the Department. The budget and the most obvious difficulties of the Department are located principally in programs like Medi-Cal which may have less relationship to health than programs dealing with the environment. Yet the administrative units with huge budgets and current political sensitivity have received the most attention and support. Those concerned with the environment have been relatively neglected.

Perhaps more importantly, and like the rest of the Department, the environmental health programs have not maintained scientific and professional leadership. Although the staff includes several individuals with good technical backgrounds and experience, the tendency to emphasize "management" in leadership positions has eroded the professional competence of the Environmental Health Services Branch. The milieu encourages work patterns already established rather than undertaking new tasks in environmental health.

Furthermore, the extreme centralization of support functions such as statistical services has removed from the environmental health units--as elsewhere in the Department--that sense of program responsibility and control which is essential to good operation.

3. Problems

Two sets of problems should be mentioned as affecting the Environmental Health Services Branch. One is the decline in professionalism that extends through the Department generally. It arises not only from changes within the Branch but also from the attitude which accompanied the merger that administrators oriented exclusively to management can solve all policy questions, that professionals are present only for day-to-day technical matters. The erosion in professionalism is exemplified by the fact that the Department took forceful leadership in air pollution and radiation problems when these emerged as environmental health hazards during the 1950s and 1960s, but has not taken effective leadership in regard to occupational health problems during the 1970s.

The second set of major problems that affect the Environmental Health Services Branch involve relationships with other units of State government responsible for activities that impart on environmental health.

For example, the California Occupational Safety and Health Program, Cal/OSHA, is in the second year of a three-year development phase to come into compliance with the standards of the Fed/OSHA. The Division of Industrial Safety (DIS) of the Department of Industrial Relations is responsible for initiating safety inspections of work places and for enforcement of both occupational safety and occupational health standards. Under an interagency "master agreement" the Occupational Health Section of the Environmental Health Services Branch provides industrial hygienists for inspections, trains safety inspectors to recognize health hazards and arranges for laboratory services in the Department.

The entire budget comes through Cal/OSHA. Essentially all the resources of the Department of Health's occupational health program are thus absorbed in routine inspection work. There is substantially no provision for investigation of health problems in industry, to identify emerging hazards although the basic health statute mandates such investigation.

Migrant housing inspection is a responsibility of the Department of Housing and Community Development under the Employee Housing Act of 1974. One option provided in the Act is that counties may elect to name local enforcement agencies. Fourteen counties have done so and assigned the task mainly to their health departments, to be performed by sanitarians who relate mostly to the Environmental Health Services Branch.

Pesticide Control is placed administratively in the Agricultural Chemicals and Feed Unit of the Department of Agriculture where it cannot be defined as a discrete unit but rather a complex web of relationships extending into a variety of other governmental agencies. The Department of Health provides technical assistance for pesticide control and thereby exercises some influence but it does not carry responsibility for controlling the use of pesticides in which health has become a major issue.

4. Findings and Recommendations

Although less caught up in the turmoil of the Department in recent years, the Environmental Health Services Branch suffers essentially the same difficulties as those encountered in the other programs.

Hence the summary recommendations for the Department apply to the Branch.

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.

I. Division of Administration

1. Evolution

The Division of Administration serves as an umbrella for administrative service functions which, prior to 1973, were located in the Departments of Health Care Services, Mental Hygiene, and Public Health. The administrative services provided include financial management, management systems and computer services, manpower administration, program services, and disability evaluation. This division employs over 1100 persons and has an operating budget of about \$26.5 million.

Since 1973, the Administration Division has undergone several reorganizations. When first established, the division was called Health Administrative Systems. In April 1975, it was renamed the Administration Division and was given significant additional responsibilities. For example, the Rates and Fees Section was transferred from Health Financing Systems; the Evaluation Procedures Section and the Disability Evaluation Branch were originally established in the Health Quality Systems; and the Facilities Planning Section was moved from Health Treatment Systems. Also, two new units were created: the Employee Relations Section and the Health Manpower Development Section.

2. Goals and Objectives

The Administration Division provides the Department of Health with the centralized services required for logistic support and management control. The Division's functions are to provide broad consultation services to management along with specific financial advice, budgetary data, systems analysis, personnel services, office management, evaluation and statistical procedures,

and general administrative information.

The purpose of the Division is to ensure that administration and management of the Department of Health are supported by the maximization of resources available.

On July 29, 1975, the Administration Division stated its goals as follows:

1. To provide program management with fiscal management assistance and support.
2. To improve the fiscal systems and increase awareness of their purposes.
3. To relate fiscal resources to changing health needs.
4. To provide program management with reliable and valid program information.
5. To constantly improve the information systems.
6. To continually humanize the bureaucracy through development of a relevant organization.
7. To standardize and publish guidelines designed to promote more effective and widespread use of the services offered by the Division.
8. To increase timeliness and quality of the service provided.
9. To provide a personnel management program which will facilitate the accomplishments of departmental objectives.

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.

3. Shift the primary responsibility for the development, management, and evaluation of information systems to the operating programs. EDP should concentrate on processing information for programs on the basis of contract reimbursement for services.

Budgeting and Accounting

Since the 1973 consolidation, program managers have received only estimated budget allocations to operate their programs. These estimates are not received by the programs until late in the fiscal year. Funding for many of the programs is based on projected reimbursements or revenues. Managers are not provided with fiscal reports which reconcile expenditures with sources of funding. Therefore, if the projected source of funding does not materialize, and no adjustments are made in the rate of expenditure, managers thus run into unforeseen deficit problems. Expenditure reports are typically recorded by organization and not by program. Program expenditures cannot be reconciled with sources of funding. When deficits occur, the budget office moves funds from other programs to cover the deficit. This is often done without consultation with the program manager. Salary savings are managed by the budget office and not by program managers. Salary savings are not credited to special programs, but are held in a general reserve. The problem with this approach is that the program manager loses flexibility in managing program resources, especially where seasonal fluctuation in workload occurs.

In October, the 1973 consolidated budget was finally reconciled by the Budget Office, which also discovered that certain reimbursements had been

double-counted since consolidation (in the magnitude of \$4 to \$6 million). Both allocations to programs and reports of expenditure have been erroneous.

Under the Department's present fiscal system, program managers have little or no control over fiscal resources, and do not receive timely or accurate fiscal information. Managers are thus not held accountable for the fiscal integrity of their programs.

Recommendations

1. Assign responsibility for program budget allocations, including salary savings, to program managers and not to the Division of Administration.
2. Provide program managers with expenditure reports which reconcile expenditures with sources of funding.
3. Construct accounting reports by program and, if necessary, also by organization.
4. Transact the transfer of funds between programs or program components only with the full knowledge of the managers involved, and not arbitrarily by the Division or Administration.
5. Hold program managers fully accountable for the fiscal integrity of their programs including the reduction of program activity when projected revenues or reimbursements do not materialize.

4. Impact of Reorganization

The 1973 consolidation had an adverse affect on the Department's administrative functions, particularly on budgets, personnel, accounting and data processing.

At the time of consolidation, the administrative support functions of three departments were merged into the Health Administrative System. A collision of philosophies, loyalties and levels of sophistication had a profound impact on policies and procedures. Key administrative functions were filled with persons who did not possess competence in the administration of health programs. Neither the consolidated budget nor the consolidated personnel roster could be reconciled. The loss of control of Medi-Cal was reaching crisis proportion. Timely and accurate expenditure reports were not being produced. Computerized information systems were poorly designed and often unusable, either in form or content.

Workers began to look for other jobs. Medi-Cal problems overwhelmed other program considerations and required a great deal of attention from both top management and administration. Fiscal problems began to surface in other programs, which administration was relied upon to resolve. Program managers began to complain. Administration had become too centralized and too powerful. Service had deteriorated below the level that existed in the preceding departments. Reclassifications and the filling of vacant positions often took months. Funds were shifted between programs to cover deficits without consolidation of program personnel. Managers had little control, therefore little accountability, of their fiscal and personnel resources. Information systems were often inadequate and did not meet program needs.

Some managers began to suggest that the Department of Health should be reorganized back into separate departments, so that their program could get the services it needed. Others began to establish their own counter-

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.

The Contracts Coordinating Unit in the Financial Management Branch of the Division of Administration have responsibility for guiding the processing of contracts. This unit experiences peak loading at times and itself becomes a bottleneck.

The preparation of sound contracts requires a knowledge of program goals and some assistance in legal and technical matters. All service type contracts should clearly specify the product, include quantifiable output, give completion dates and state the penalties for noncompliance. The reporting format for contract compliance is of special importance, since direct program control is in the hands of the contractor. A majority of contracts are written with grossly inadequate program performance standards and reporting requirements. Contracts should be prepared in the operating programs, assistance provided in legal and technical matters, and the authority to sign off conveyed on program managers after division review.

Although the types of services performed by contract vary greatly, there are, nonetheless, some basic attributes to health services which can be put into a standardized form to enhance uniformity or data collection. The program planning and evaluation office needs to deal with the issue of service contract data requirements, since this unit needs to process statistics reported by service contractors.

Recommendations

1. Decentralize authority for contract approval to the operating divisions.

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				Total	# Employees
	604	605	606	607		
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

of these actions represents the most substantial workload to the transactions unit as well as to personnel analyst units within the Section, since classification review and approval is required in each case. This volume also reflects the amount of change occurring within the Department which impacts all functional areas within the General Personnel Services Section, as well as other sections of the Administration Division.

A comparison of volume, or rate of position changes, is shown below.

Health	One of every 2.7 positions is established, deleted, or changed during each 12-month period.
EDD	One of every 6.0 positions is established, deleted, or changed during each 12-month period.
Cal Trans	Comparison is not possible since only 1,300 of 16,700 positions are subject to line-item budget controls and Form 607 documentation requirements.

When the Personnel Information Management System (PIMS) was proposed, it featured the reduction of workload in departmental personnel offices and the expeditious handling of payroll documents. Although the sub-system relating to payroll documents has been implemented, two sub-systems designed to reduce workload have not been implemented. One would automate the posting of sick leave and vacation balances which are now done by hand. The other would produce periodic reports to individual employees and pre-print employee identification information on such periodic reports as reports of performance and probationary reports. The implementation of these two systems would reduce a substantial portion of Personnel's workload.

Another area of considerable concern is classification and pay. Over the years, state departments have brought constant pressure to bear on the

State Personnel Board to establish unique job classifications and salary structures within individual departments. As the Board's workload began to increase, it began to delegate classification and pay matters to departments. However, with each delegation came additional controls and workload. Classification and pay policies and procedures have become so complex and burdensome that they are nearly unmanageable at the department level. The State Personnel Board staff have been working on a proposal to implement consolidated series specifications and a level tracking system (a type of personnel auditing). Board staff plan to present their proposal to the Board in December.

The use, or misuse, of the Career Executive Assignment (C.E.A.) classification within the Department is a matter of concern to both persons within the Department and outside observers.

When first established, C.E.A. classifications was intended to provide the state with a cadre of civil service executives drawn from the ranks of professional, technical and middle management. To give management more flexibility in selecting the persons who were more compatible with Administration policy, the State Personnel Board established assessment, selection, promotion, and performance evaluation procedures with fewer constraints than for civil service classifications. A provision was added which allowed either management or the employee to terminate the assignment, without cause. This proviso was for the protection of the employee who was viewed as serving the state above and beyond the employee's normal civil service assignment.

At first, C.E.A. classifications were established in parallel with key civil service jobs, such as executive officers of boards and commissions and division chiefs within departments. Typically, the civil service position was converted to C.E.A. only at the discretion of the incumbent, or of the

Department, when the position became vacant. However, this approach effectively nullified the C.E.A. termination provision. A person terminated would merely return to the parallel civil service position at the same salary and level of responsibility. Initially, candidates for vacant C.E.A. positions had to possess essentially the same minimum qualifications as were required for the parallel civil service position.

As time went on, the professional and technical minimum qualifications were dropped except for a few positions which, by law, required certain specifications, such as medical and legal. For C.E.A. classification, eligibility for C.E.A. competition was based solely on salary level. The underlying assumption here is that a person who has demonstrated certain managerial abilities in one program area could manage any state program.

The use of the C.E.A. classification was broadened to include not only all the top civil service management positions, but also many middle management positions. New C.E.A. positions were established without civil service parallel positions. In 1974, the State Personnel Board discontinued the concept of parallel classifications entirely. At the same time, the Board adopted a C.E.A. salary structure which was higher than for civil service counterparts. Therefore, the few managers remaining in parallel civil service positions, and who had not been willing to reclassify their jobs to C.E.A., were penalized. Anticipating wholesale termination of C.E.A. appointments with a change of administration, the State Personnel Board adopted a C.E.A. red circle rate policy--a policy which was to insure the return right of a C.E.A. employee to the salary level of the civil service position from which the employee was appointed. However, the adoption of the policy was permissive on the part of departments. Some departments implemented a strict interpretation of the policy, some a liberal interpretation, while others decided not to adopt the policy at all.

At the time of consolidation, the C.E.A. classification system was manipulated to expeditiously promote persons who were pre-selected for new, key management positions established for the new Department of Health. Some had little or no health program experience, but were put in charge of complex programs which, traditionally, required high level professional and technical expertise. The result is an erosion of the Department's credibility with professional, provider, and client organizations and a deterioration of program quality and performance.

On January 1, 1975, the Department had thirty-seven C.E.A. positions. In April 1975, the Department was internally reorganized resulting in the elimination of twelve C.E.A. positions. Since January, there have been twenty C.E.A. terminations. Some were merely demoted one or more C.E.A. levels and assigned to programs elsewhere in the Department. Others were returned to their permanent civil service position. For some, this meant returning to their former department.

We make the following conclusions:

1. The selection and termination procedures of C.E.A. appointments permits discretion of the appointing power.
2. The promotion of new, inexperienced persons into key positions, along with the wholesale C.E.A. appointments, has had a detrimental affect upon the Department's programs, and has resulted in a gross under-utilization of experience and skills potentially available

to the Department. There has been a general negative affect upon staff at all levels. Many feel demoralized and insecure.

3. The physical and psychological affect on the individual being terminated has largely been ignored. The consequences resulting from the "shock" of termination have yet to be determined.

Recommendations

1. Slow down the rate of departmental change, or increase the staffing in personnel operations.
2. Establish the personnel function less as an extension of the State Personnel Board and more service oriented toward departmental programs. This may mean resisting further attempts by the Board to delegate workload and increase controls.
3. Take a strong leadership position with control agencies to simplify the State's personnel pay and classification processes.
4. Ensure that the State Personnel Board take the necessary steps to either abolish, or correct abuses of, the C.E.A. classification plan, and to reverse the proliferation of C.E.A. classifications into middle management and non-sensitive areas.

7. Management

The task force conducted a survey of the top management in the Department of Health to understand the backgrounds, experience, education, and present

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

managers, 58 section chiefs, 11 clinical directors, 11 hospital administrators, and 9 unit chiefs in the Director's Office. Of the total top administrators, 67 percent were assigned to program areas, 22 percent were in the Administration Division, and 11 percent were in the Directorate.

a. Experience: Of the top managers in the Department, most have had considerable experience in state government positions. Ten percent have been in state government for five years or less, 38 percent had six to 15 years' experience, and 52 percent had 16 or more years' experience working in state government.

Most of the administrators in top management have had experience in the Department of Health, or its predecessors (Public Health, Mental Hygiene, Health Care Services, Social Welfare, Rehabilitation). Of the 11 individuals responding to this item, 13 percent reported less than one year of service, 17 percent from 1-5 years, 23 percent from 6-10 years, 28 percent from 11-20 years, and 19 percent for 21 or more years in the Department of Health.

Forty percent of the top administrators also held top administrative positions within state government prior to the 1973 consolidation of the Department of Health. The largest percent of top administrators came with backgrounds in the Department of Mental Hygiene. Excluding the 20 percent who were administrators in the state hospital system, 21 percent were with the Department of Mental Hygiene before 1973. Eighteen percent were with the Department of Public Health, and 16 percent were with the Department of Health Care Services. Only two percent came from the Department of Social Welfare, and 23 percent were not in state service at that time in the Department of Health's predecessors. This does not take into account the

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.

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.

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.

Capable managers are in the Department, but many are attempting to run health programs from a background devoid of experience in the health field. If an evaluation indicates that a high percentage of managers are not considered qualified they would be so classified not because of intrinsic incompetence, but because of a mismatch between their professional training and experience and the type of job to which they are assigned.

In studying the professional qualifications of top management within the Department of Health, criteria were established as a measurement of whether administrators generally appeared to have expertise related to their job responsibility. Based on the questionnaire, the Task Force concluded that the Division of State Hospitals and Division of Health Protection have qualified leaders for their positions of responsibility. Based upon the above criteria, the Task Force found an unusually large percentage of top administrators were not qualified for the job responsibility which they presently hold. There is a need for a better balance of the managerial skill and specialized professional expertise in the Administration Division, Community Services Division, Alternative Health Care Systems Division, Medi-Cal Division, and the Licensing and Certification Division.

These criteria were applied without regard to level of position, personality, or relationships. Many judged as unqualified for the positions they now hold are talented and dedicated individuals with high potential for competent performance in jobs more suitable to their training and experience.

Recommendation

Take steps where necessary to strengthen the professional and managerial qualifications of the key management personnel in the health programs.

II. RELATED HEALTH PROGRAMS IN OTHER AGENCIES AND DEPARTMENTS

The task force reviewed the following health-related activities located outside of the Department of Health:

- In the Health and Welfare Agency
 - State Office of Narcotics and Drug Abuse (SONDA)
 - State Office of Alcohol Program Management (OAPM)
 - State Office of Aging
 - State Office of Educational Liaison
- In the Agriculture and Services Agency (and the Department of Industrial Relations)
 - California Occupational Health and Safety Administration (Cal-OSHA)
 - Control of Pesticides
- In the Department of Benefit Payments
 - Medi-Cal Audits and Recovery
 - Fiscal Administration of Social Services
- In the Department of Consumer Affairs
 - The Healing Arts Boards
- In the Department of Housing and Community Development
 - Migrant Housing Inspection Program
- In the Department of Employment Development
 - Public Migrant Temporary Housing
- The California Health Facilities Commission
- The Health Advisory Council
- Citizens Advisory Council

The health task force staff studied these programs and have made recommendations primarily in relationship to their appropriate administrative placement in state government.

Because we have dealt with most of these functions in other parts of this report, this chapter will summarize our recommendations, with references made to discussions located elsewhere in this report.

A. The Health and Welfare Agency

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, Division 10.8, to give public visibility to the growing drug abuse problem. SONDA is responsible for administering all drug abuse programs, as well as responsible for planning, policy direction, program implementation, program evaluation, and administration of funds. In 1974-75, this program administered \$40 million of which 25 percent went directly to the Substance Abuse Program of the Department of Health, and the rest went to county programs. The Department of Health's Substance Abuse Program and the Mental Hygiene Program are programs for a broad range of mental health and drug programs at the county level, so that activities of SONDA are both confusing and overlapping with those of the Department of Health. (See Part I, Chapter V, Phase I)

Recommendations

1. Abolish the State Office of Narcotics and Drug Abuse (SONDA).
2. Place the SONDA activities with the Substance Abuse program in the Mental and Developmental Services Branch of the State Department of Health.

2. Office of Alcohol Program Management

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, and the Short-Doyle mental health program, which creates confusion for local agencies. (See Part I, Chapter V, Phase I)

Recommendations

1. Abolish the Office of Alcohol Program Management (OAPM).
2. Integrate the OAPM activities with the Substance Abuse Program in the Mental and Developmental Services Branch of the Department of Health.

3. 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. 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.

Recommendation

Allow the Office of Educational Liaison to expire at the end of this legislative period.

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.

B. Agriculture and Services Agency

1. California Occupational Safety and Health Program (Cal/OSHA)

The Cal/OSHA program, located in the Agriculture and Services Agency and established in 1974 to meet federal OSHA program requirements, is responsible for the occupational safety and health program. This program works closely with the Division of Industrial Safety (DIS) in the Department of Industrial Relations which inspects the safety of workplaces and enforces standards. Cal/OSHA coordinates with the Occupational Health Section of the Department of Health to provide industrial hygienists for inspections of places of work and is involved in training safety inspectors to recognize health hazards. The relationship between these three programs is established by inter-agency agreement. (See Chapter V, Part I)

Recommendation

1. Do not alter the present organization of Cal/OSHA.
2. Clarify the responsibility of the Cal/OSHA program, the Department of Industrial Relations, and the Department of Health for occupational health and safety programs.
3. Assign the Department of Health with the clear responsibility for and authority to establish minimum standards for occupational health in all workplace settings.
4. Continue the Division of Industrial Safety's program of industrial inspections, giving equal consideration to safety and health standards.
5. Establish the minimum standards for occupational safety in workplace settings by the Division of Industrial Safety.

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.

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.

D. Migrant Programs

1. Migrant Housing Inspection Program

The Migrant Housing Inspection Program, established by the Employee Housing Act of 1974, is administered by the Division of Codes and Standards in the Department of Housing and Community Development. The Division of Codes and Standards administers the Migrant Housing Inspection program along with four other programs. The division employs about 12 inspectors at a program cost of \$260,000 in 1975-76 to inspect about 880 camps. The program has three main activities: issuing pre-occupancy inspection permits; handling complaints about labor camp conditions; and ensuring that state housing standards are maintained. The division, by law, may contract with local governments for the inspection of the housing facilities. In January 1975, 14 counties were enforcing agencies, inspecting 600 of the camps. Most of the local enforcement agency contracts are with local health departments because they have sanitarians trained to inspect for health and housing problems and to maintain standards. Some regulations require building and construction criteria which can also be done by local health departments who have had responsibilities for community care facility inspections.

2. Public Migrant Temporary Housing

The Department of Employment has responsibility for the management of a program of temporary camps which provide housing to migrant workers and their families. Twenty-five camps in 14 counties accommodate 2800 families (16,000 individuals) annually as the work force moves through the State. As many are turned away due to a limited capacity. No reduction in the migrant work force is being experienced in this program.

The Department of Health has a small program aimed at the development of preventive and clinical services to the migrant population.

Neither the temporary housing program nor the migrant health program has received adequate support in the state budget. Money is desperately needed to keep the public camps from deteriorating and becoming a source of scandal. Medical services are not developed to meet the demand. This work force is extremely productive, contributes to agricultural production and is not involved in union organization nearly to the same extent as settled California workers.

The State has a clear moral obligation to provide a safe housing environment to these workers and to assure access to needed medical care. Loss of federal support to these programs must not be used as an excuse to abrogate the responsibility of the State toward this unique and productive work force.

Recommendations

1. Transfer the temporary housing program from the Department of Employment to the Department of Housing and Community Development.
2. Ensure that the Department of Health develops and enforces minimum standards for sanitation in both public and private temporary camps.
3. Ensure that the Department of Housing and Community Development enforces minimum standards of safety for such public and private camps.

E. California Health Facilities Commission

The California Health Facilities Commission, established in July 1975 to succeed the California Hospital Commission, has responsibility for administering financial reporting and public disclosure procedures for about 1,900 hospitals, skilled nursing, intermediate care, and mental health facilities. The commission's major task is to design, test, and implement a single data reporting

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

Health Coordinating Council to participate in the planning activities for the State Department of Health. (See Part I, Chapter IV)

Recommendation

1. Abolish the Advisory Health Council
2. Place the current functions of the Council with a State Health Coordinating Council

2. Citizens Advisory Council

The Citizens Advisory Council was established by the Welfare and Institutions Code in 1968 to advise the Director of the Department of Health on the development of a five-year mental health plan and its system of priorities; to periodically review all mental health services in the State; suggest rules, regulations and standards for such services, and coordinate community mental health resources on a regional basis. The activities of this Council are also subsumed by the State Health Coordinating Council required by Public Law 93-641 which requires all planning activities to be combined into one comprehensive body. (See Part I, Chapter IV)

Recommendation

1. Abolish the Citizens Advisory Council
2. Place the current functions of the Council with the State Health Coordinating Council

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Executive Officer

July 10, 1975

Dr. Lester Breslow, Dean
School of Public Health
University of California
at Los Angeles
405 Hilgard Avenue
Los Angeles, CA 90024

Dear Doctor:

The Commission on California State Government Organization and Economy has a continuing interest in the organization and operation of the Department of Health. Following a Commission recommendation some years ago, an extensive reorganization of this department was implemented in 1973.

The Commission is now interested in an update of the situation. Items which might be considered would include:

The extent to which the present organization follows the pattern set by the task force report of February 1970, and subsequent legislative modifications;

The efficiencies engendered by consolidation, and evaluation of the extent to which the department is meeting the goals and objectives outlined by statute; and

Any recommendations the task force might have on possible further organizational changes.

These suggestions are meant to be indicative of but not limiting to the nature of the Commission's concern regarding the effectiveness of the department.

The Commission Chairman, Manning J. Post, has appointed Donald G. Livingston and me, together with the Executive Officer, Les Halcomb, as a sub-committee to provide Commission liaison with the task force.

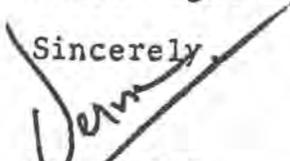
Dr. Breslow

-2-

July 10, 1975

We are delighted that you have accepted the responsibility of chairing the Commission task force on the subject and would appreciate receiving from you an outline of the nature and scope of a study which you feel your task force might effectively pursue.

Sincerely,



VERNE ORR
Commissioner

cc: Manning J. Post, Chairman
Donald G. Livingston, Commissioner
Bert Cohen
Dr. Paul O'Rourke
Charlene Harrington
James Miller

Memorandum

To : Donald Livingston
Verne Orr
Commission on California State Government
Organization and Economy

Date : July 24, 1975

Subject: Task Force on the
Department of Health

From : Dr. Lester Breslow, Chairman
Little Hoover Commission Task Force
744 P Street, Room 541



In your memo of July 10, 1975, you asked me to prepare an outline of the nature and scope of the Task Force study. The Task Force has spent considerable time in planning this report. We realize that time and staffing constraints necessitate selectivity in determining which areas of the Department to examine. We have chosen areas of concern which we believe reflect the priorities of the Commission as well as those of most Californians. Additional issues will probably arise during the course of this study. We will keep you advised if there are any changes in the emphasis or direction of the study. Specifically we intend to:

- I. Review statutory authority for consolidation of departments in 1972 which led to the present organization of the State Health Department.
- II. Undertake a comprehensive review of statutory, regulatory, and judicial authority which bears on the operations of the new Department.
- III. Assess the effectiveness of the new Department's program operations and administrative structure from these perspectives:

a. Program Integration

Has consolidation produced integration of closely related services at the point of delivery -- for example, preventive medical services with treatment, primary mental health services with general medical services, recovery and rehabilitation with acute hospitalization? Has consolidation helped to redirect the emphasis in both public and private sectors away from a crisis orientation toward prevention and health maintenance?

b. Fiscal Efficiency

Has consolidation resulted in demonstrable savings in administrative overhead?

c. Administrative Procedures

Has the red tape quotient increased or decreased? Are program directors finding their work easier or more difficult in the new Department?

d. Administrative Size

Is the Department too large, not large enough or of optimal size to fulfill its obligations?

e. Data Collection, Analysis, and Reporting

Has consolidation improved flow of information, analyses of programs and reporting of results? Does the Department have a system of information on its programs which permits stronger management?

f. Program Budgeting

Has consolidation produced a system of program budgeting which requires program operators to supply clear statements of goals and objectives, a description of methods of implementation, quantifiable performance standards, and a method of internal evaluation? Is there concrete evidence of improved program effectiveness in the consolidated Department?

g. Program Planning

Has consolidation improved Department-wide performance in assessment of needs for programs, setting of priorities, allocation of resources, and evaluation of program effectiveness within the budget of the Department?

h. Technical Assistance

Has consolidation improved the availability and quality of technical assistance to local government in the development and implementation of programs funded through the Department?

i. Federal Liaison Activities

Has consolidation resulted in improved participation in federal programs and communication with regional and federal program offices of HEW?

j. Statewide Health Planning

Has consolidation lent itself to improvement in the comprehensive health planning process through attainment of integration of planning for public health services, general medical care, mental health services, and services for the retarded, the elderly, the addict and the alcoholic?

k. In-Service Training

Has consolidation affected the extent or content of in-service training activities toward meeting the goals of the consolidated Department?

In short, is the Department organized in the best way to improve the health of Californians?

- IV. Review the health programs of the Health and Welfare Agency and of other departments of state government to assess the propriety of their administrative placement.

If you have any comments on this outline, please do not hesitate to contact me.

"A Department of Health for California"
Summary of 1970 Task Force Report

Summary of Proposal

The 1970 Task Force on Organization of Health Programs recommended that:

1. The State of California proceed with the establishment of a Department of Health.
2. The new Department include the following components:
 - a. All of the functions of the Departments of Public Health, Mental Hygiene, and Health Care Services, except for the two neuropsychiatric institutes now in the Department of Mental Hygiene. These would be transferred to the University of California.
 - b. Social service functions of the Department of Social Welfare.
 - c. Ten of the healing arts licensing boards in the Department of Professional and Vocational Standards.
 - d. Alcoholism functions of the Department of Rehabilitation.
 - e. Meat, dairy, and poultry inspection functions of the Department of Agriculture.
 - f. State Veterans Home and Hospital in the Department of Veterans Affairs.

3. An Advisory Health Council be created to assume the functions of the existing State Board of Public Health, the Health Planning Council, and the Health Review and Program Council, except that the regulation and licensing responsibilities of the State Board of Public Health would be assigned to the Director of the Department of Health.
4. The Department of Health have the following organizational segments:
 - Director's Office
 - Advisory Boards and Commissions
 - Comprehensive Health Planning
 - Health Facilities
 - Health Manpower
 - Personal Health
 - Environmental Health
 - Comptroller
 - Staff Services
 - Hospitals
 - Laboratory Services
 - Program Management

Benefits of Recommended Organization

The 1970 task force viewed the following as the most important benefits to be realized from the recommended organization:

"1. Better program planning and evaluation.

One of the weaknesses of the present organization of the State's health programs is the lack of an adequate system for assessing

total health needs, establishing health goals, setting program priorities, and evaluating the effectiveness of programs in meeting stated goals. Fragmentation of health programs among several departments has prevented the State from taking a broad approach to program planning and evaluation. Comprehensive health planning is a start in this direction, representing a significant departure from the traditional categorical approach to health planning. It is anticipated that the new Department of Health will rely heavily on the Comprehensive Health Planning function to do the statewide planning for optimum use of total health resources, both public and private. Planning and evaluation, as it relates to the programs of the Department of Health, will be the responsibility of the Staff Services function.

"2. Improved resource allocation.

The task of coordinating health programs and seeing that funds are allocated properly among them has fallen largely to the Human Relations Agency, since it is only at that level where the State's major health programs come together. However, the Agency, because of its small staff and broad scope of responsibilities, has had little time to consider health goals, program priorities, and resource allocation.

"The new Department of Health, with broad staff resources, will be in a better position to conduct the program analyses and to draw sound conclusions on the most rational allocation of health resources. One of the program planning and evaluation responsibilities of the proposed Staff Services function will be to raise such fundamental questions about departmental programs as: Should more of the health dollar go into preventive programs? Should we give more attention to hazards

related to consumer products? Should we put more emphasis on family planning?

"3. Program consolidation and coordination.

The first task force that examined the present organization of health programs concluded that certain programs were fragmented and uncoordinated. Among these were alcoholism, mental retardation, facilities licensing, and research. In designing a new organization, the task force attempted to consolidate the various aspects of these programs, wherever possible, and to provide for effective coordination where consolidation was not feasible. Thus, all of the facilities licensing functions are consolidated under Health Facilities, and responsibility for the research activities is centered under Staff Services. Since it was not practical to consolidate in one organizational unit within the Department all of the functions related to alcoholism and mental retardation, the task force provided for program managers for these two areas, plus drug abuse and addiction.

"4. Greater impact on total health care delivery system.

One of the primary concerns of the Department of Health in carrying out its comprehensive health planning responsibilities will be the delivery system. It is anticipated that the Department will explore a number of alternative forms of health care that will provide quality service at reduced cost. Some examples of such alternatives are more ambulatory and nursing home care in lieu of hospitalization, and use of health visitors in lieu of nursing homes for certain patients. As a major purchaser of medical care under the Medi-Cal program, the Department of Health will be in a position to influence constructively the nature of the health care delivery system.

"5. More attention to health manpower needs.

It is becoming increasingly difficult to meet the rapidly expanding demand for health manpower. The State should assume more responsibility than it has in the past in meeting this need. The recommended organization will facilitate coordination between those assessing manpower needs and developing plans to meet them, on the one hand, and those licensing health occupations, on the other. The Department will also be in a position to have a significant influence on health manpower training programs in the colleges and universities.

"6. Integration of health and related services.

The task force believes that certain health-related functions of State Government can be carried on more effectively if included in a Department of Health. One of these is the licensing of health occupations, which is now performed by the Department of Professional and Vocational Standards. The Department of Health will play a major role in meeting health manpower needs. In carrying out this responsibility, it is essential that decisions with respect to licensing of health occupations be consistent with and supportive of health manpower planning decisions.

Another example of this integration of health and related services is the transfer of the social service functions from the Department of Social Welfare to the Department of Health. It is the task force's view that integration of these services at the State level will encourage integration at the local level, with a consequent improvement in service to the public.

"7. More attention to health facilities.

The recommended organization draws together a number of existing functions related to health facilities--planning, funding, standard setting, licensing, and approval for purchase of health services. Responsibility for these functions is now divided among the Departments of Mental Hygiene, Public Health, and Social Welfare. Consolidation of these functions will enable the State to eliminate this fragmentation and provide better service to the public.

"8. Improved health information system.

Good information is essential to good program planning and evaluation. One of the responsibilities of the proposed Staff Services function will be to develop a fully integrated health information system for the Department of Health.

"9. Fixed responsibility and accountability.

One of the consequences of the present fragmentation of programs among several State departments is that it is difficult to establish accountability for program results. By consolidating all of the functions related to such programs as licensing of health facilities, alcoholism, health manpower, and research in a Department of Health, it will be possible to pinpoint responsibility for these programs in a way that is not possible now.

"10. Flexibility in meeting changing health needs.

The entire field of health is undergoing rapid change. The State organization charged with responsibility for administering health programs must be capable of recognizing changing health needs, and of making adjustments in programs and priorities. Under the recommended

organization, the Director of Health will have sufficient authority over a broad range of health programs to exercise this kind of flexibility.

"11. Reduced administrative costs.

By consolidating three major departments, plus certain functions of three other departments, the Task Force believes it will be possible to effect some savings in administrative costs. There are approximately 1,075 headquarters administrative positions associated with the programs being consolidated in a Department of Health. The annual cost of these positions is \$18 million. It should be possible through more efficient organization to make a 10 percent saving in these costs, or about \$1.8 million.

"12. Potential for more effective use of Federal funds.

The present fragmentation of health functions makes it difficult to maximize Federal financial participation in State health programs. The recommended organization fixes responsibility on the Comptroller for grants management. In this way it will be possible to develop an expert staff that can identify additional sources of Federal funding and ensure that the State realizes the maximum benefit from these funds.

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

11th & L Building, Suite 550, (916) 445-2125
Sacramento 95814



September 24, 1975

Manning J. Post, Chairman

Subcommittee on Health
Dept Organization
Donald G. Livingston
Verne Orr

TO: SECTION CHIEFS AND ABOVE
MEDICAL DIRECTORS AND HOSPITAL ADMINISTRATORS

Study Task Force
Lester Breslow, M.D.,
Chairman
Burt Cohen
Charlene Harrington
James Miller
Paul O'Rourke, M.D.
322-6587

FROM: COMMISSION ON CALIFORNIA STATE GOVERNMENT
ORGANIZATION AND ECONOMY - TASK FORCE
ON THE ORGANIZATION AND OPERATION OF THE
DEPARTMENT OF HEALTH

As a task force of the Little Hoover Commission, we are studying the present organization and operation of the Department of Health, with particular reference to the reorganization process that began in 1971. The consolidation of departments into one Department of Health was an attempt to achieve increased efficiency and effectiveness.

In order to assess the overall effects of the 1973 reorganization, it is necessary to trace the changes from what was before 1973 to the present time in terms of programs, work responsibilities, and personnel assignments. The attached forms have been designed to give us information to assess personnel and organizational changes.

We would appreciate your prompt response and return of the questionnaire to our task force office, 744 P Street (OB-9), Room 541, Sacramento, CA 95814 by October 3, 1975.

Thank you for your cooperation.

Lester Breslow, M.D.
Chairman

Please complete the questionnaire and return to Room 541 of OB-9. Thank you.

Name _____
Last First Initial

Personnel Classification: _____

Working Title of Present Position:

- 1. Deputy Director _____
- 2. Division Manager _____
- 3. Asst. to Division Manager _____
- 4. Branch Manager _____
- 5. Asst. to Branch Manager _____
- 6. Section Chief _____
- 7. Other (please specify) _____

Length of time in State Service:

- 1. Less than 1 year _____
- 2. 1 - 5 _____
- 3. 6 - 10 _____
- 4. 11 - 15 _____
- 5. 16 - 20 _____
- 6. 21 or more _____

Length of time in DOH or its predecessors-
(Public Health, Mental Hygiene, Health
Care Services, Social Welfare, Benefit
Payments):

- 1. Less than 1 year _____
- 2. 1 - 5 _____
- 3. 6 - 10 _____
- 4. 11 - 15 _____
- 5. 16 - 20 _____
- 6. 21 or more _____

Division currently assigned:

- 1. State Hospitals _____
- 2. Community Services _____
- 3. Health Protection _____
- 4. Alternative Health Systems _____
- 5. Medi-Cal _____
- 6. Licensing & Certification _____
- 7. Administration _____
- 8. Other _____

Length of time in present position (in years with decimal for months): _____

Briefly describe your present responsibilities: (Please attach the official
description of your job responsibilities if readily available)

- Age:
- 1. 24 or under _____
 - 2. 25 - 34 _____
 - 3. 35 - 44 _____
 - 4. 45 - 54 _____
 - 5. 55 - 64 _____
 - 6. 65 or over _____

Educational Background (check multiple answers)

Major or Field of Specialty

- 1. High school degree or equivalent _____
- 2. Associate Arts degree _____
- 3. Bachelor's degree _____
- 4. Master's degree _____
- 5. M.P.H. _____
- 6. Ph.D. _____
- 7. M.D. _____
- 8. J.D. _____
- 9. D.D.S. _____
- 10. Other (please specify) _____

Experience before entering State Service:

Job Title	Time (in years)	Organization
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Title of position held in state government in January 1973 (i.e., before consolidation):

- 1. Deputy Director _____
- 2. Division Manager _____
- 3. Asst. to Division Manager _____
- 4. Branch Manager _____
- 5. Asst. to Branch Manager _____
- 6. Section Chief _____
- 7. Unit Chief _____
- 8. Other (please specify) _____

Dept. of state government where employed in January 1973 (i.e., before consolidation):

- 1. Public Health _____
- 2. Mental Hygiene _____
- 3. Health Care Services _____
- 4. Social Welfare _____
- 5. Benefit Payments _____
- 6. Other (please specify) _____

In what Division of that Department were you employed in January 1973: _____

Please list the title, department, division, and length of employment in that
position in months, and time period which you have held consecutively since Jan. 1970:

Title	Department	Division	No. Months	Time Period
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

Clayton, Norman, Chief, Continuing Care Services Section/DD
Ehrlich, John, President of Board of Directors, Golden Gate Regional Center
Erony, Michael, Social Worker, DD/CCSS, San Francisco Office
Fehr, Virginia, Supervisor, Social Worker, DD/CCSS, San Francisco Office
Fisher, Steve, Dr., Program Chief, Mental Health Services, Napa County
Fraser, Maggie, Attorney, California Association for the Retarded, Sacramento
Gideon, Fred, Community Development Specialist, North Bay Regional Center, Napa
Graves, Barbara, Chairperson, Mental Health Advisory Board, Alameda County, Berkeley, University of California
Green, William, Director, California Mental Health Association
Grenny, Guy, Community Organization Specialist, Fairfield Community Mental Health Center, Solano County
Horn, Ben, Program Development Section, Napa County
Jack, Olive, Dr., County Health Officer, Napa County
Jersey, Laurie, Director of Rehabilitation Services, Northern Region, Oakland, Alameda County
King, Roger, Manager, Substance Abuse Branch
Koch, Richard, M.D., Manager, Community Services Division
Kubelbeck, Jim, Former Chairman, Area Board No. 5
Lain, Joe, Chief, Services Operation Section
Lee, John, Office Supervisor, Oakland
Lipscomb, Travis, Liaison Coordinator, North Bay Regional Center, Napa
Long, William, Manager, Developmental Disabilities Services Branch
Marzolf, Tom, Supervisor of DD/CCSS Area, San Francisco Office
McElroy, William, Administrative Services Officer, Fairfield Community Mental Health Center, Solano County
Merritt, Sam, Director, North Bay Regional Center, Napa
Middlebrook, T. Richard, Chief, Continuing Care Services Section/MD
Murrey, Clyde, Chief, Special Services Section
Nelson, Tom, Continuing Care Services Chief, Golden Gate Regional Center
O'Dell, David, Director, Health Care Services Agency, Oakland, Alameda County
Porter, Frances, Assistant Director, Department of Social Services, Oakland, Alameda County
Price, King, Acting Director, Mental Health Services, Southern Region, Oakland, Alameda County
Price, William Knox, Chief of Case Management Services, Golden Gate Regional Center
Pye, Ed, Director, Golden Gate Regional Center
Rausser, Carl, Manager, Mental Disabilities Services Branch
Roche, George, M.D., Member of Developmental Disabilities Council, Napa County
Rudolph, Rhona, Dr., Physician Chief, Golden Gate Regional Center
Ryan, Mary, Line Counselor, Golden Gate Regional Center
Schook, Connie, Office Supervisor (DD), Oakland
Seltzer, Albert, Chief, Social Services Branch
Sjoberg, Gary, Deputy Director, Mental Health Administration, Alameda County
Snyder, Sandra, RN, CCSS/DD San Francisco Area Office
Sullivan, Mary, Chief, Adoption Services Section
Takehara, Gerald, Chief, Case Management, Golden Gate Regional Center
Tannenbaum, Jack, Area Supervisor, MD (CCSS), Oakland
Toedter, Allen, Chief, Program Development Section, Napa County
Van Der Sluis, Mehl, Continuous Care Coordinator, Napa County
Williams, Merwyn, Chief, Services Management Section
Wilson, Don, M.D., Director, Solano County Mental Health Program, Fairfield Community Mental Health Center, Solano County

Licensing and Certification Division

Alywood, Marie, Nurse Consultant, Services Approval, Berkeley Office
 Anderson, Beth, Nurse, Los Angeles County Health Licensing
 Bamberg, Jack, Supervisor, Los Angeles County Health Facilities Licensing
 Bates, Robert, Director, Post Street Convalescent Home
 Burkett, Don, Special Assistant to Division Manager
 Burton, Leroy, Chief, Policy and Support Services Section, Licensing
 Facilities Section
 Callahan, Tom, Supervisor, Licensing Health Facilities, Santa Rosa Office
 Cameron, Wally, Chief, Policy Unit, Licensing Facilities Section
 Cassidy, Edna, Community Care Surveyor, San Jose Licensing Office
 Chamberlain, Jerry, Deputy Director, Los Angeles County Health Department
 Chavis, Dennis, Surveyor, Licensing Health Facilities, Santa Rosa Office
 Collins, Jack, Investigator for Licensing Health Facilities, Berkeley Office
 Denhert, Arlo, Assistant to the Division Manager
 Dunne, Dennis, Chief, Facilities Licensing Section
 Franklin, Bamford, Manager, Licensing and Certification Division
 Gibbens, Steve, Chief, Services Approval Section
 Gould, Paul, Supervisor for Licensing of Health Facilities, San Jose Office
 Heerhartz, Tom, Chief, Facilities Construction Section
 Kelly, John, Assistant Chief, Services Approval Section
 Kopp, Art, Supervisor, Health Licensing, Santa Ana State Licensing Office
 Lambeth, Lyman, Supervisor, Investigations Unit, San Francisco Office
 Lester, Kathy, Director, State Community Care Licensing Office, Los Angeles
 Lillick, Lois, M.D., Assistant to Chief Deputy Director of Department of Health
 Lopez, Ralph, Investigator, Los Angeles County Health Licensing
 Lyne, Jean, Director of Nursing, Post Street Convalescent Home
 McEven, Nancy, Nurse Consultant, Santa Rosa Office
 Moss, Richard, Chief, Provider Participation Section
 Poindexter, W. Ray, Psychiatrist Consultant, Medical-Social Review Team,
 Santa Rosa Office
 Rafino, Steve, Director of Los Angeles County Health Facilities Licensing
 Rohlfes, Gerald, Chief, Investigation Section
 Rollins, Robin, In-Service Director, Post Street Convalescent Home
 Schacter, Hal, Chief Support Services Unit, Licensing Facilities Section
 Schenlin, Hank, District Manager, Santa Rosa Licensing Office
 Vought, Marian, District Administrator, Berkeley Licensing Office
 Weber, Joe, Director, Investigations Unit, San Francisco Office
 Wells, Kathern, Supervisor for Licensing of Community Care Facilities,
 San Jose Office
 Welsh, Louise, Supervisor, Community Care Facilities, Santa Rosa Licensing
 Office
 Wilmer, Gilbert, Chief, Licensing Field Services
 Yammetta, Don, Supervisor, Health Facilities Licensing, Santa Rosa Office

Preventive Medical Services

Bond, Lloyd, Chief, Contract Counties Health Services Section
 Corrigan, Daniel, D.D.S., Chief, Dental Health Unit
 Cunningham, George, M.D., Chief, Maternal and Child Health Unit
 Farag, Saleem A., Ph.D., M.P.H., Chief, Comprehensive Health Planning Section
 Gardipee, Charles R., M.D., Chief, Family Health Services Section
 Hodges, Frederick, M.D., Manager, Health Protection Division
 Mozar, Harold, M.D., Chief, Chronic Disease Unit

Smith, Esmond S., Chief, Crippled Children's Services Section
 Weilerstein, Ralph W., M.D., Branch Manager, Preventive Medical Services Branch
 Wray, Jo Ann, Assistant Chief, Family Health Services Section
 Yeagle, Alice, Assistant Chief, Administrative, Crippled Children's Services
 Section

Environmental Health

Buell, Ken, Manager, Environmental Health Services Branch
 Holstein, Donald, Assistant to Division Manager, Health Protection

Medi-Cal Division

Brown, Jack R., Chief, Fiscal Intermediary Section
 Gould, Jay, Chief, Medi-Cal Benefits Section
 Helsel, Lee, Manager, Medi-Cal Division
 Larrea, John, Chief, Field Services Section
 Tarantino, John, Medi-Cal Benefits Section
 Williams, Wade, Chief, Medi-Cal Eligibility Section

Administrative Division

Boyd, James, Manager, Financial Management Branch
 Luttgies, C. Del, Chief, Data Processing Section
 Matao, Manual, Chief, Budget Section
 Matsumoto, Mickey, Chief, Special Personnel Services Section
 Moody, Robert, Manager, Disability Evaluation Branch
 Newlin, Philip, Manager, Management Systems and Computer Services Branch
 Shields, Merle, Chief, Vital Statistics Section
 Soderberg, Doris, Manager, Manpower Administration Branch
 Stahlberg, Edward, Manager, Program Services Branch
 Todd, Jackie, Chief, Systems Analysis Section
 Weeks, Layle, Chief, Center for Health Statistics
 Wilson, Larry, Chief, General Personnel Services Section
 Yarwood, Bruce, Manager, Administration Division
 Yockey, Sam, Assistant Branch Manager, Financial Management Branch
 Hoagland, Dale, Manpower Section

Healing Arts Boards

Buggy, Michael, Executive Secretary, Board of Registered Nurses
 DeWalt, Dick, Assistant Executive Secretary, Board of Medical Examiners
 Kersten, Elisabeth, Deputy Director, Department of Consumer Affairs
 Levin, Samuel, Executive Secretary, Board of Dental Examiners
 Reid, Ray, Executive Secretary, Board of Medical Examiners
 Smallwood, Lee, Division of Investigation, Department of Consumer Affairs
 Thomassen, John H., Chief, Division of Investigation, Department of Consumer
 Affairs
 Woods, Maryellen, Executive Secretary, Board of Vocational Nurses and
 Psychiatric Technicians

Office of Educational Liaison

Gonzales, Ray, Dr., Director, State Office of Educational Liaison

State Office of Narcotics and Drug Abuse and State Office of Alcohol Program Management

Archer, Loran, Director, Office of Alcohol Program Management
 King, Roger, Branch Manager, Substance Abuse Branch
 Wilder, William, Director, SONDA
 Wyatt, Paul, Assistant Director, Office of Alcohol Program Management

Office on Aging

Balaba, Ignacio, Assistant Director, Office of Aging
 Levy, Janet, Director, Office of Aging

California Occupational Safety and Health Program

Jablonsky, Steve, Director, Cal/OSHA
 Ottoboni, Fred, Ph.D., Gubernatorial Appointee to Facilitate Functioning of Cal/OSHA
 Smith, Warren, Assistant Program Manager, Environmental Health Services Program, Department of Health
 Starr, Albert, Former Director, Occupational Health Section, Department of Health
 West, M.D., Irma, Occupational Health Section, Department of Health

California Health Facilities Commission

Smith, Phyllis, Chairperson, California Health Facilities Commission
 Murch, Robert, Director, California Health Facilities Commission

Health, Education and Welfare, Region 9

Beck, Wayne, Office of Long Term Care
 Brook, Robert, Director, Division of Financing and Health Economics
 Byrd, John, Office of Long Term Care, Nursing Home Branch
 Coleman, Harold, Office of Long Term Care, Nursing Home Branch
 Currie, Ronald, Chief, Health Planning Branch
 Hoodwin, Jean, Social Rehabilitation Services
 Kolenda, Louis, Chief, Health Planning Branch
 Lee, Bruce, Dr., Human Development
 Loso, Dorine, Chief, ADAMH Branch
 McCurry, William J., Director, Division of Prevention
 Ruthig, Dr., Director, Division of Quality and Standards
 Sprague, Daniel, Deputy Regional Director
 Steed, Henry, Chief, Grants Management Branch
 Wellington, Charles, Dr., Chief, Family Health Branch
 Wilburn, Dewford
 Woffinden, Charles, Social Rehabilitation Center

Department of Finance

Clark, Wally, Health Department Budgets

Hoover Commission Task Force

Questionnaire

These questions are guides. They may require slight rewording or supplementation for specific interviews. Not every question will be relevant for each manager, nor should the list be considered a limit on the questions to be asked.

It is hoped that this format and these basic questions will be used for interviews on all levels to facilitate comparisons and compilation.

Interview teams should have familiarized themselves with resource material before the interview (see "Required Reading List" attached).

The format for background data and program descriptions to be requested is intended to shorten the actual interview and give us a set of program data on a common form. Program issue questions will be compiled by interview teams.

Interviews should be recorded.

A copy of decisions reached and issues discussed will be returned to each interviewee for his approval and records.

In every question area, it is of utmost importance to secure specific examples and concrete reasons for opinions.

In all areas, interview teams should carefully check the information we have (including recent Division reports) to avoid repetitious requests.

Manager's Questions

General

1. What do you see as the major strengths of this Department? (your Division, Section, Unit?)
2. What major problems do you encounter in managing this Department? (your Division, Section, Unit?)
3. Has the Department met the expectations of the 1970 Task Force? (see excerpts attached)
4. Is Health responsive to the public? To the Administration? To the Legislature? How could this be improved?

1970 TASK FORCE REPORT EXCERPTS

Recommends: The Task Force recommended that a new Department of Health be formed incorporating:

- "a. All of the functions of the Department of Public Health, Mental Hygiene, and Health Care Services, except for the two neuropsychiatric institutes now in the Department of Mental Hygiene. These would be transferred to the University of California.
- b. Social service functions of the Department of Social Welfare.
- c. Ten of the healing arts licensing boards in the Department of Professional and Vocational Standards.
- d. Alcoholism functions of the Department of Rehabilitation.
- e. Meat, dairy, and poultry inspection functions of the Department of Agriculture.
- f. State Veteran's Home and Hospital in the Department of Veterans Affairs."

An Advisory Health Council would assume the sole advisory role.

The Department would include these segments:

Director's Office	Environmental Health
Advisory Boards and Commissions	Comptroller
Comprehensive Health Planning	Staff Services
Health Facilities	Hospitals
Health Manpower	Laboratory Services
Personal Health	Program Management

Expected Benefits: The Task Force expected these benefits from reorganization:

- "1. Better program planning and evaluation.
2. Improved resource allocation.
3. Program consolidation and coordination.
4. Greater impact on total health care delivery system.
5. More attention to health manpower needs.
6. Integration of health and related services.
7. More attention to health facilities.

8. Improved health information system.
9. Fixed responsibility and accountability.
10. Flexibility in meeting changing health needs.
11. Reduced administration costs.
12. Potential for more effective use of federal funds." (.p. 99-105)

Criteria: In evaluating various organizational alternatives, the Task Force was guided by a number of criteria which should be met by a new Department of Health. The Task Force felt that the new Department should be capable of...

- conducting comprehensive health planning, giving consideration to the needs of all Californians.
- establishing goals and setting program priorities.
- making a rational allocation of health resources among programs competing for these resources.
- consolidating or coordinating programs that are now fragmented.
- fixing responsibility and accountability for program results.
- evaluating program effectiveness in accomplishing stated goals.
- exerting a major impact on environmental issues that affect people's health.
- fostering better service to the public through the integration of health services and protective social services.
- influencing constructively the nature of the health care delivery system.
- making effective use of advisory boards and commissions.
- demonstrating a concern for people's health, in the broadest sense, and moving away from the archaic dichotomy between the physically ill and the mentally ill.
- maintaining sufficient flexibility to modify programs and organization structure in response to changing public needs.

- placing more responsibility for health-related services at the local level, with a gradual reduction in the State's role as a provider of direct services.
- making optimum use of federal funding without resorting to cumbersome organizational arrangements in order to meet federal requirements.

LITTLE HOOVER COMMISSION TASK FORCE

REQUIRED READING LIST

GENERAL

Legislative Analyst's Budget Analysis (74-75 & 75-76)

Governor's Budget (75-76)

1970 Task Force Report

PROGRAM SPECIFIC

Powers & Duties - Appropriate Code Sections

- Recent Legislation

Transition Briefings-Selected

Policy - Procedural Manuals

Audit Reports - Finance

- Legislative Analyst

- Auditor General

- Internal Audit Report- Selected

Annual Reports to Legislature

7-30-75

I. ADMINISTRATION

A. Fiscal Effect

1. In the last two year, have you been able to cut costs or increase productivity? Where and how was this accomplished? What prevents you from making further progress?
2. What fiscal surveillance system do you have? Cost control? Reporting?
3. How do you assure yourself that funds are being used as intended?
4. How do you know spending is in accordance with legal requirements (SAM, federal requirements, etc.)?
5. How do you evaluate performance on contracts, grants, etc.? What can you do about it?
6. Are you in compliance with state, local, and federal requirements? If not, where and why? How much is this costing the Department?

B. Administrative Procedures

1. Have administrative procedures become simpler or more complex? Better or worse?
2. What services does the Administration Division provide your program? How could the situation be improved?

C. Budgeting

1. What input do you have in the budgeting process? What information is required of you? What data base do you use?
2. How does your input affect results? Who else has input and how does that affect results?
3. Is there any system of cost-effectiveness analysis used?
4. Are you satisfied with allocations within the budget? What would you change?
5. How do you manage your budget? How could that be improved?
6. If your budget were increased by 10 to 15 percent, how would you spend it?
7. If your budget were cut by 10 to 15 percent, where would you prefer to make the cuts?

II. ORGANIZATION

1. How has the organization of your program changed since 1972? What are the good and bad points?
2. What further organizational changes would improve program outcomes? How much does organizational structure affect your program?
3. Are there programs in other departments that should be moved to Health?
 - The healing arts boards?
 - The Office of Aging?
 - The Office of Educational Liaison child care functions?
 - The Offices of Narcotics and Drug Abuse or Alcohol Program Management?
 - Others, i.e., Pesticide Control, Meat and Dairy Inspection?
4. Are there Health programs that should be moved elsewhere?
 - Disability Evaluation
 - Social Services
 - Medi-Cal
 - Others
- *5. Should Health have independent administrative status in state government? Should it have cabinet-level input?
- *6. Do Health programs receive appropriate attention from the Agency and the Governor's Office?
- *7. How does the Agency communicate with the Department? With whom? What screening functions does it perform?
- *8. What Agency functions are being performed by Health?
9. How well does the Director's staff (Legal, Legislative, Press, Internal Audit, Planning and Evaluation, etc.) work for you?

III. PROGRAM

A. Program Impact

1. Does the Department meet statutory objectives? Does it work toward statutory goals?
2. How do you measure program impact?

* These questions are intended primarily for the Director and his Chief Deputies.

3. What program impact do you have? Are you satisfied with this?
4. What are you doing to improve program impact? What do you feel are your constraints?
5. How much of the population in need do you reach?
6. What enforcement powers do you have?
7. Do you have the capability to meet your objectives? Where do you need more support? What will happen if you don't get it?
8. How many individuals are in the service delivery chain between you and the ultimate client (including state, county, and private personnel)?

B. Program Integration

1. Is there integration of services at the point of delivery? What kinds of integration? Did that improve services? What integration is planned (short and long range)?
2. Has the emphasis shifted from a crisis orientation toward health prevention and maintenance? How was this accomplished?
3. Have the prior organizational problems persisted? What fragmentation, duplication, and overlap remains? How systematic is planning and service?
4. How would moving other programs to Health improve your ability to meet stated objectives?
5. What interfaces do you have with other sections and units (both in and out of DOH)? What coordination exists? What problems have you had? How could coordination be improved?

C. Technical Assistance

1. What technical assistance is available to local government for programs funded by the Department? How good is that assistance? What improvements have been made since 1973?

D. Federal Liaison

1. What coordination is there with federal programs? How do you communicate with HEW? What improvements have been made since 1973?

E. Data Collection, Analysis, and Reporting

1. How do you obtain feedback on programs? What mechanisms do you have? What do you monitor for?
2. What quality assurance and corrective action mechanisms do you have to maintain program quality?
3. How do you assess program needs, set priorities, allocate resources, and evaluate program effectiveness within the budget?
4. What reports, memos, etc., must you write? Which of these do you consider unnecessary? Why?
5. What data do you collect? What do you do with it? When you have insufficient information for decision or action, how do you get more?

F. Program Planning and Evaluation

- *1. What do you see as the short and long range goals and objectives of the Department?
- *2. What do you see as the long range goals for each of the following program areas?
 - Medi-Cal
 - Developmental Disabilities
 - Environmental Health
 - Mental Disabilities
 - Licensing and Certification
 - Preventive Medical Services/Crippled Children Services
3. Where do you feel the Department is now in relation to its goals and objectives?
4. How do you assess the population in need?
5. How do you intend to evaluate progress and set new objectives?

IV. MANAGEMENT

A. General

1. Are you satisfied with the competence of the top-level managers?
2. What do you expect from the division managers?

* 1 and 2 have been answered by division managers and the Director.

3. What is your perception of the Director's role? Of the Chief Deputy Directors' roles? Why do we have three Deputy Directors?
4. What is your role in the Department? In the Director's Office?
5. How do you assign responsibilities?
6. How do you evaluate the performance of managers, provide feedback, and facilitate development?
7. Is the Department responsive to your needs? Who do you bring problems to formally? Informally? Who would you like to talk to?
8. How would a citizen or client reach you?
9. What informal duties do you have?

B. Decision Making

1. What decisions do you make? How do you pick the problems to pass up or down? How do problems reach you?
2. What criteria do you use in making decisions? i.e.,

Formal Department Policy	Cost-Benefit
Client Interest	Program Goals
Budget Constraints	Common Sense
3. Who do you consult in reaching decisions? Does anyone review your decisions?

C. Control

1. How much control do you have over your operations? Where do you need more? Why, and what is holding you back? How do you control program direction?
2. Are you responsible for things that others have authority over?
3. Do you have authority over things for which you are not asked to account? Does the Department know what you do?
4. Are you responsible to more than one boss? i.e.,

Board or Commission	Agency Personnel
Task Force	Federal Personnel
Multiple Managers	Local Personnel

5. Do you get conflicting demands? How does this happen?
6. How do you assure yourself that your decisions are implemented as you intended?

D. Policy

1. Who sets policy for your program? Do you understand Department policy? How does it affect you?
2. What are your day-to-day objectives? i.e.,
 - Maximize Resources for Clients and Staff
 - Smooth Program Operation
 - Crisis Intervention
 - Crisis Prevention
 - Delivery of Maximum Services
 - Cost Minimization
 - Meeting Legitimate Needs
 - Surveillance
3. Are there actions you must take contrary to Department policy? What type of actions? How does this happen? What would you do about it?

V. COMPREHENSIVE HEALTH PLANNING

1. How does your program coordinate with Comprehensive Health Planning? How do your activities fit into the State Health Plan?

VI. ADVISORY GROUPS

1. What advisory groups do you work with?
2. What is their function? How much authority, autonomy, and input do they have?
3. How would you change the advisory system? Why?

VII. MANPOWER

1. Do you have appropriate training support? What deficiencies are there?
2. How do you identify and develop future managers?
3. What has been the rate of personnel turnover in your program in the past year? How has this changed?
4. Do you have an affirmative action policy and objective for your program? What is it?

5. Is your mix of classifications appropriate? How would you change it?
6. What kinds of people are you recruiting? How would you change the process?

FORMAT FOR PROGRAM QUESTIONS

Background Data (to be requested in advance)

- statutory authority
- federal, regulatory, other authority
- population characteristics
- organization through unit level
- staff (professionals, supervisory ratio)
- evolution of program since 1972
- assessment of the political, legal, and social milieu

Program Description (to be requested in advance)

- workload and budget data
- routine program indicators
- narrative

Program Issues (to be compiled by teams)

- as needed for interview

History of Consolidation of the
Department of Health

The California State Department of Health was created pursuant to Governor Reagan's Reorganization Plan No. 1 of 1970, as approved by the California State Legislature. The Reorganization Plan consolidated the Departments of Mental Hygiene, Health Care Services, and Public Health together with certain programs within the Departments of Consumer Affairs and Social Welfare. Subsequent to the approval of the Governor's Reorganization Plan, legislation was enacted which delayed implementation of the plan from July 1, 1972 until July 1, 1973. Also, the transfer of the healing arts boards from the Department of Consumer Affairs to the Department of Health was delayed, by legislation, until July 1, 1977.

The Legislative Analyst's 1967 report titled "Availability and Cost of Health and Medical Care in California" is generally credited with providing the first strong impetus for a thorough restructuring of the State's health organizations. The report noted that with the enactment of Medi-Cal legislation in 1965, "California took a major step toward assuring the availability and adequacy of high quality health and medical care to all of its citizens regardless of the individual economic circumstances." The report also noted that while the Medi-Cal program committed substantial additional tax resources at the federal and state levels to provide increased and improved health and medical care to indigent persons, the program did not provide a single comprehensive health and medical care program based on need or other common criteria for channeling benefits to areas of highest priority or to assure that resources are applied for maximum benefit.

The analyst found that health and medical care funds were being administered through the mechanisms of almost 50 major programs within 15 separate state agencies. A majority of the programs addressed their services to the same general population. The analyst concluded, "While reorganization appears necessary in order to best utilize the resources currently being expended, such reorganization of itself will not automatically provide solutions for all of the current problems."

In November 1968, Assemblyman Gordon Duffy, Chairman of Assembly Committee on Public Health, submitted a report to the Commission of California State Government Organization and Economy (commonly known as the Little Hoover Commission) entitled, "The Department of Health: A Preliminary Proposal". This report pointed out that even though many departments administered health-related programs, only three had health and health care as their major responsibility. These were the Departments of Public Health, Mental Hygiene, and Health Care Services. The report dealt primarily with the functions of these three departments. The Committee found that the three departments had grown in response to immediate needs and pressures rather than according to a general plan for delivering health and medical care services. Agreeing with the analyst's findings, the Committee report noted there was not only a substantial duplication and overlap of functions, but also serious gaps in important services. The Committee concluded, "At this point, the question is not whether we should reorganize the health care departments, but rather what form the reorganization should take." Also in November 1968, and shortly before the Assembly Committee's report was published, Spencer Williams, Secretary, Human Relations Agency, appointed the first of three task forces that over the next 14 months were to develop the basis for the Administration's reorganization plan.

First Task Force

In his charge to the task force, Mr. Williams pointed out:

"State Government has both direct and indirect involvement in many aspects of personal and environmental health...Generally, these areas of state involvement may be divided into five categories: (1) Licensing, regulations, and supervision; (2) Financial assistance; (3) Direct health care and environmental health assistance; (4) Education and training; and (5) Research."

He further indicated that:

"A question has been raised as to whether the consolidation of all or a portion of these services and programs into a single department or into related departments can provide an improvement over the current method by which these programs are administered."

Williams then requested the task force "to conduct a broad overview examination to determine whether there appears to be sufficient merit to the suggestion to warrant further detailed study". In December the task force submitted its report. In commenting upon fragmentation and duplication of services, the task force concluded that "in all too many instances, coordination is left up to the consumer". Nonetheless, the task force did not recommend consolidation but instead proposed criteria for further study.

Second Task Force

Three months later in March 1969, Williams established a second task force to become known as the Consultants Task Force. This group was asked to examine "programs related to mental retardation, alcoholism, research, and licensing and to determine whether their problems could be resolved within

the current department structure or whether to proceed toward a major reorganization". This second task force was subdivided into four study groups, each assigned one of the problem areas. Each group was made up of three to four state people and one outside consultant who served as chairman. The four consultants and one other outside consultant made up a fifth group which provided overall guidance. This task force became known as the Consultants Task Force. In its report to Spencer Williams in May 1969, the task force recommended:

"That the Administration consider consolidation of health-related departments into a unified Department of Health, provided that certain organizational innovations for managing the new Department also be considered:

- "1. Selection of a generalist administrator rather than a health professional as Department head.
- "2. Early attention by the Director to eliminating unnecessary duplication and overlap.
- "3. Development of a program management structure and system to help the Director coordinate and direct health programs."

Third Task Force

Based upon the recommendations of the second task force, Williams appointed a third task force in July 1969 to recommend a general structure for reorganization. This task force submitted its report in February of 1970 to Mr. Lucian B. Vandegrift, who had succeeded Spencer Williams as Agency Secretary. In summarizing its recommendations, the task force recommended that:

1. The State of California proceed with the establishment of a Department of Health.
2. The new Department include the following components:
 - a. All of the functions of the Departments of Public Health, Mental Hygiene, and Health Care Services, except for the two neuropsychiatric institutes now in the Department of Mental Hygiene. These would be transferred to the University of California.
 - b. Social services functions of the Department of Social Welfare.
 - c. Ten of the healing arts licensing boards in the Department of Professional and Vocational Standards.
 - d. Alcoholism functions of the Department of Rehabilitation.
 - e. Meat, dairy, and poultry inspection functions of the Department of Agriculture.
 - f. State Veterans Home and Hospital in the Department of Veterans Affairs.
3. An Advisory Health Council be created to assume the functions of the existing State Board of Public Health, the Health Planning Council, and the Health Review and Program Council, except that the regulation and licensing responsibilities of the State Board of Public Health would be assigned to the Director of Health.
4. The Department of Health have the following organizational segments:
 - Director's Office
 - Advisory Boards and Commissions
 - Comprehensive Health Planning
 - Health Facilities
 - Health Manpower
 - Personal Health
 - Environmental Health
 - Comptroller
 - Staff Services

4. Hospitals
Laboratory Services
Program Management

The task force viewed the following as the most important benefits to be realized from the recommended organization:

1. Better program planning and evaluation.
2. Improved resource allocation.
3. Program consolidation and coordination.
4. Greater impact on total health care delivery system.
5. More attention to health manpower needs.
6. Integration of health and related services.
7. More attention to health facilities.
8. Improved health information system.
9. Fixed responsibility and accountability.
10. Flexibility in meeting changing health needs.
11. Reduced administrative costs.
12. Potential for more effective use of Federal funds.

In transmitting the report to Vandegrift, the task force stated, "The task force has developed an organization plan that the Governor can submit to the Legislature at the 1970 session." The task force further stated, "The proposal represents a major change in organization of the State's health programs. The task force recognizes that organizational change by itself is no panacea for the many complex problems related to health policies and programs."

The organizational scheme proposed by the third task force grouped licensing, education, and manpower planning under a Health Manpower Division. There

would be an analogous division for health facilities. Programs on alcoholism, drugs, and mental retardation would form the Program Management Division. An Environmental Health Division would cover the surveillance and control functions of Public Health. Social services, Medi-Cal, and other community services would form a Personal Health Division. Hospitals, Laboratory Services, and Comprehensive Health Planning would each be separate divisions. Finally, administrative services would be provided by Comptroller and Staff Services Divisions.

This Organization emphasized planning. There were to be three levels: (1) Comprehensive Health Planning, which covers the statewide public and private effort, (2) Departmental planning, to define its role and objectives within the Comprehensive Health Plan, and (3) Program line planning, to implement the Department role and attain its objectives.

Hearings

On January 16, 1970, Vandegrift submitted a preliminary draft of the third task force's plan to the Little Hoover Commission for review and recommendation. Subsequently, the Commission conducted two days of public hearings on January 28, and January 29, 1970. Testimony was received from 36 individuals representing 23 health organizations and associations. The majority of those who testified supported the general proposal for a single department. Some complained that they had not been consulted by the task force and some disagreed with the way the proposal was to be carried out. Of particular concern was the proposed 19 member Advisory Health Council and the details of the new department structure which were yet to be decided. The California Conference of Local Health Officers supported the proposal but recommended that a Local Health Unit be created to integrate various

local health responsibilities. The California Medical Association proposed its own plan which was similar to the task force's proposal. However, their proposal would give the new department agency status rather than departmental status. The CMA also believed that the single advisory body would not be sufficient to deal effectively with the broad range of problems and issues that would confront the new department. The CMA recommended that the reorganization be delayed until these and other matters could be studied further.

The strongest reaction came from the California Chapter of the National Association of Social Workers. NASW called for the transfer of social service functions to the new department a "meaningless dismembering" of the Department of Social Welfare. The Association also called the plan a "political ploy" that would result in "local chaos".

On February 10, 1970, Vandegrift transmitted to the Governor the report of the third task force entitled, "A Department of Health for California". Commenting upon the report, Vandegrift said, "I concur in all the recommendations of the task force, except those pertaining to the Veterans Home and Hospital of the Department of Veterans Affairs and the meat, dairy, and poultry inspection programs of the Department of Agriculture. I feel that these programs require further analysis and review, and I am not prepared to recommend their inclusion in a Department of Health at this time". He continued by saying, "Establishment of a Department of Health, consolidating the health and related functions now performed in several departments will permit us to do a more effective job of evaluating total health needs and developing and implementing programs to meet them. It is our intention to create the new department within the staffing that is currently authorized

The Assembly Committee on Government Organization set up a special subcommittee on efficiency and cost control to hold hearings on the proposal. The opponents of the plan continued to express dissatisfaction with the lack of study that had gone into the plan, feared that centralization would result in a less effective health services delivery system and doubted that promised cost savings would actually be achieved. Nevertheless, the subcommittee issued a report on August 4th recommending that the Assembly take no action, thus allowing the plan to go into effect. However, the subcommittee did recommend that the proposed transfer of social service functions from the Department of Social Welfare and consolidation of existing health boards and councils be delayed one year.

On the Senate side, the plan was assigned to the Senate Rules Committee. Senate opponents of the plan charged that the plan was too sketchy and vague to be approved as submitted. They were able to force the measure out of committee and onto the floor for debate. The Administration defeated these efforts to kill the plan, but it became evident that the plan could not be put into effect in 1971. Governor Reagan agreed to seek legislative approval to postpone implementation until July 1, 1972. Accordingly, the delay was approved following approval of the plan itself.

Implementation

As it turned out, the Governor had to go back to the Legislature again in 1972 and ask for an additional one year extension. Detailed planning for the new department had produced an organizational structure that was considerably different from that proposed by the third task force and approved by the Legislature. This planning was the work of a Health Reorganization Committee which was established on September 1, 1972 by James Hall

who had replaced Lucian Vandegrift as Secretary of the Human Relations Agency. Members of the Committee were the Directors of the three Departments being consolidated plus Hall who chaired the Committee. The Committee relied heavily upon advice from departmental staffs working through two subcommittees, one for program and one for administration, made up of the Chief Deputy Directors from the three departments. The two subcommittees were supported by eight sub-units assigned to specific elements of the consolidation plan. However, these sub-units were disbanded in January 1972. On October 21, 1971, legislation was passed which postponed the operative date of Reorganization Plan No. 1 of 1970 to July 1, 1973.

To assist and advise the Health Reorganization Committee, the Human Relations Agency contracted with the Rand Corporation, through the Department of Public Health. Rand submitted three quarterly progress reports to the Agency Secretary. In its first report covering the period October 26, 1971 to January 26, 1972, Rand commented on the reorganization process, "The Reorganization Plan was developed by a task force directed by a former Human Relations Agency Secretary and led by staff members no longer associated with the Agency. The present health-related department directors have not fully supported the plan. Therefore, reorganization has proceeded with no particular commitment to the recommendations of the February 1, 1970 task force report. To some extent, a leadership vacuum has developed with respect to implementation." In its second quarterly report of January 26 to April 26, 1972, Rand summarized, "Little progress has been made toward implementation of the Governor's Reorganization Plan. The Reorganization Committee has not reached consensus on the goals of the Department, its structure, or a strategy for implementation. The Committee simply lacks leadership and commitment to reorganization. If reorganization is to proceed, it appears

to us that the Agency will either have to develop a tentative implementation plan itself or select one of the department directors to develop one". In its last progress report ending July 26, 1972, Rand noted that little work had been done on reorganization since their last report.

Dr. Earl Brian replaced Hall as Agency Secretary in July. On September 1, 1972, he appointed an agency committee whose members were Deputy Directors from the departments of Health Care Services, Public Health, and Mental Hygiene. Their charge was to prepare an operational organization plan and a budget for the new Department. This group essentially carried on the work of the 1971 Health Reorganization Committee. In October, Brian announced the details of the reorganization plan.

The new plan called for the subdivision of the consolidated Department into five divisions called systems: Health Treatment Systems; Health Financing Systems; Health Protection Systems; Health Quality Systems; and Health Administrative Systems. It also called for a consolidation of the various advisory boards.

With the major features of the plan decided upon, the committee was disbanded and in November an Office of Health Planning was established within the Agency to carry out the new plan. Dr. James M. Stubblebine, Director of the Department of Mental Hygiene was named to head the new office. On July 1, 1973, Dr. Stubblebine was named as the first permanent Director of the Department of Health.

Staff Reductions

The Governor's proposed 1973-74 budget, submitted to the Legislature on January 18, 1973, included the new Department of Health for the first time. The budget proposed that "Consolidation of the various state health programs into a single Department of Health will provide both economies in state operation and greater effectiveness in program delivery. This will result in a departmentwide cut of 600 positions, and a \$7,000,000 savings to the General Fund in the budget year. In the subsequent year, it is estimated that an additional 400 positions can be eliminated through continued identification of duplication of effort, continued program review, and further streamlining of the departmental administration". In a March 12 letter to the Legislature, Stubblebine detailed the nature of the 600 position reduction to be accomplished in the first year. During the budget hearings however, the Legislature restored 146.5 of these positions while making further reductions of 52.4 positions.

Following is a summary of the administration's proposal and the Legislature's actions:

DEPARTMENT OF HEALTH 1973-74 POSITION REDUCTIONS

Administrative Proposal	Legislative Actions		
	Reductions	Restored	Reduced
Director's Office	0	0	-19.0
Health Treatment System	-185.0	+ 49.5	- 1.0
Health Financing System	-105.0	0	- 8.5
Health Protection System	- 75.0	+ 38.0	- 4.0
Health Quality System	-103.0	+ 59.0	- 2.0
Health Administrative System	-132.0	0	-17.9
TOTALS	-600.0	+146.5	-52.4
Administration Proposal:	-600.0		
Legislative Action--			
Reduced:	- 52.4		
Restored:	+146.5		
Net Reduction:	-505.9		

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