King County

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

September 17, 2013

Motion 13972

Proposed No. 2013-0303.2 **Sponsors** Patterson

A MOTION acknowledged the assessment report and implementation plans on the integration of the departments of community and human services and public health - Seattle and King County called for in the 2013 Budget Ordinance 17476, Section 19, Proviso P6; and authorizing the release of $125,000 to the office of performance, strategy and budget.

WHEREAS, the 2013 Budget Ordinance, Ordinance 17476, contains a proviso in Section 19, stating that $125,000 shall not be expended or encumbered until the executive transmits an assessment report and implementation plans on the integration of the departments of community and human services and public health - Seattle and King County and a motion that acknowledges receipt of the assessment report and implementation plans and the motion is passed by the council, and

WHEREAS, King County government has a strong health and human service system at the government and community levels, with the department of community and human services and public health - Seattle and King County committed to continual improvement in the performance, quality, efficiency and effectiveness of their functions, and

WHEREAS, the council recognizes that significant changes in health and human services policies, service delivery and payments at the state and national levels present opportunities to improve how King County can produce a better experience of health and human services for individuals, better outcomes for the population and lowered or controlled costs, and

WHEREAS, the attached proviso report concludes that in order for the optimal delivery of services to the public in the most accountable, efficient, and transparent to occur, integration of King County health and human services departments must occur in alignment with Motion 13768, which directs the departments of community and human services and public health - Seattle and King County to develop, with involvement and input by stakeholders and community organizations, a plan for an "accountable, integrated system of health, human services and community-based prevention" in King County, and

WHEREAS, the executive's report called for by Motion 13768 states that to improve health and well-being and create conditions that allow residents of King County to achieve their full potential, improved performance of the system is needed at two levels: the individual and family level; and the community level, and

WHEREAS, the attached report includes options for King County government to better integrate to implement the strategies included in the Motion 13768 response, including an option for better coordination between the departments and an option for a full merger of the departments, and

WHEREAS, the response to the attached report also includes an analysis of current collaborations between the two departments; staff, stakeholder, partner and funder

implications of integrating services in different organizational structures; cost impacts; and opportunities for greater efficiencies, and

WHEREAS, the King County executive has transmitted to the King County council the requested report, and

WHEREAS, the King County council has reviewed the report developed by the department of community and human services, public health - Seattle & King County and the office of performance, strategy and budget;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

The proviso response is hereby acknowledged and the $125,000 currently held in reserve in Ordinance 17476, Section 19, Proviso P6, is hereby released.

Motion 13972 was introduced on 7/1/2013 and passed by the Metropolitan King County Council on 9/16/2013, by the following vote:

Yes: 7 - Mr. Phillips, Ms. Hague, Ms. Patterson, Ms. Lambert, Mr. Dunn, Mr. McDermott and Mr. Dembowski
No: 0
Excused: 2 - Mr. von Reichbauer and Mr. Gossett

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

Julia Patterson for
Larry Gossett, Chair

ATTEST:

Anne Noris, Clerk of the Council

Attachments: A. Assessment Report and Implementation Plans

13972

Assessment Report and Implementation Plans

On the Integration of the Department of Community and Human Services and Public Health-Seattle & King County

June 26, 2013

Submitted in response to 2013 Budget Proviso 6

King County

Proviso Response Executive Sponsors

Fred Jarrett, Deputy King County Executive

Rhonda Berry, Assistant Deputy County Executive

Dwight Dively, Director, Office of Performance, Strategy and Budget

Carrie S. Cihak, Policy and Strategic Initiatives Director, Office of the King County Executive

Dr. David Fleming, Director and Health Officer, Public Health-Seattle & King County

Jackie MacLean, Director, Department of Community and Human Services

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Executive Summary

In Ordinance 17476 adopting the 2013 budget, the Metropolitan King County Council included a proviso requiring the County Executive to prepare a report on "the integration of the department of community and human services and public health - Seattle and King County." The County Council's goal is to foster a more effective, efficient, and integrated health and human service system, while addressing any unnecessary duplication of services and reducing costs. From January to June 2013, the Executive Office, the Department of Community and Human Services (DCHS), and Public Health-Seattle & King County (PHSKC) worked together to analyze current roles and functions, assess for potential duplication, and explore options for increasing efficiency and effectiveness and for reducing costs. This report constitutes the Executive's response, and includes the required assessment, reorganization options, and implementation plans.

Commitment to an optimal organizational structure for health and human services

The response to the budget proviso reflects the high degree of value that the Executive branch places on an organizational structure that succeeds in supporting quality, outcome-driven health and human service functions in the most cost-effective way possible. Given the financial pressures facing health and human services, together with the significant changes occurring in those fields, the call to step back and assess organizational structure is a timely one.

While the proviso focuses on the two departments whose primary lines of business are in health and human services–Public Health-Seattle & King County and Community and Human Services—it is important to acknowledge that they are not the only entities in King County government that contribute to health and human potential. Relevant work takes place out of many departments as well as by the separately elected officials. This broad wingspan reflects the mounting science nationally that speaks to the extent to which factors such as transportation, economic development, public safety, parks, natural resources, and others influence the health and well-being of county residents. Given this reality, we know that the work of health and human services integration, and the work to reduce inequities, must increasingly involve tactics that cut across the lines of our organizational charts, regardless of structure.

An optimal structure needs to take into account future trends

In the proviso assessment, we took into account not just the work of health and human services today, but also of tomorrow. We scanned the environment for significant system changes and opportunities affecting the fields and the context in which the departments operate. Most critical are the myriad of ways that health reform will affect King County residents, community partners, and government in the years ahead. It will affect County government roles and

resources directly, with many of the impacts difficult to assess at this time due to some of the major provisions yet to go into effect in 2014. We also recognized, realistically, that the future will bring limited new resources in health and human services to address challenges and respond to opportunities. Funding reductions have already placed significant strain on people and communities, with entities such as DCHS, PHSKC, and community partners struggling to fulfill their missions.

Motion 13768's *Health and Human Services Transformation Plan* speaks to the future we need to build towards—and how

One of the most important indicators of future direction that we took into account in preparing the proviso response was Council Motion 13768. Recognizing the importance of strengthening the performance of the health and human services systems for King County residents, the County Council requested the Executive to develop a plan for an accountable, integrated system of health, human services, and community-based prevention. This work ran concurrent to the proviso response and, like the proviso, its aim is to improve the effectiveness and efficiency of the health and human services system. Executive staff approached the two as linked efforts in that the plan developed under the motion response should inform optimal organization of County departments.

The underlying premise of the new Health and Human Services Transformation Plan is that system performance requires a concerted focus on outcomes, as well as the alignment of strategies and tactics to produce those outcomes. It also requires an environment where the community can learn together, measure performance, and make course corrections along the way. The Transformation Plan also holds that we will be more effective in reaching desired outcomes by working collectively with other funders and stakeholders who get behind a set of shared goals. The plan includes two early strategies that constitute its action arm and will serve as a testing ground for working together across sectors in new ways: improving outcomes for high risk individuals, and improving outcomes in high risk communities.

Examining internal opportunities for greater efficiency and better value

In addition to assessing our external context and the nature of the critical work that lies ahead with new partners, PHSKC and DCHS also focused internally to examine whether and where duplication or inefficiencies may be occurring. An analysis of the specific program activities within each department was performed, and did not reveal duplicative services, programs, or contracting. What did emerge was a significant level of shared goals, customers, and community partners. In areas such as ending homelessness, integrating medical and behavioral health, healthy development of children and youth, substance abuse prevention, the criminal justice population, and healthy community environments, the two departments have a number of positive, fruitful partnerships and joint initiatives. As program managers from the two

departments came together to review these intersections, they quickly identified areas where further collaboration across program and division lines could result in better outcomes for clients and communities and help to reduce inequities.

In the area of administrative functions, certain activities are mirrored in each department, such as human resources, payroll, finance, and information technology. While there is consistency in certain functions driven by countywide systems and standards, we also found that each department has a number of tailored systems and policies designed to efficiently meet their business needs. Over time, consolidation of certain activities could result in some types of efficiencies, but these would likely be quite modest due to overall volumes and transactions of administrative activities remaining largely the same.

Two reorganization options emerged, both designed to produce greater value and better outcomes

After assessing both the external and internal context and opportunities for efficiencies, two reorganization options emerged. Implementation plans are presented for:

- **A two-department model** with a new coordinating infrastructure designed to bolster alignment of PHSKC and DCHS in support of shared outcomes. The implementation plan for this option contains details on specific impacts, identifies issues and how they would be mitigated, and lays out a timeline and milestones. This model keeps two separate departments but creates a formal inter-department planning and decision-making infrastructure between PHSKC and DCHS that allows for integrating health and human services in focused areas where there is the most to gain. The initial concrete work that would take place would be the implementation of the two early strategies identified in the Health and Human Services Transformation Plan.

- **A single department model**. This model reorganizes PHSKC and DCHS into a single department. The implementation plan for this option contains details on specific impacts, identifies the issues associated with transitioning to a single department, and lays out a timeline and milestones. Under this option, as with the two-department model, a new infrastructure appears in support of the alignment work that would need to take place across the operating divisions of the new department.

  The single department option reflects modest savings associated with a set of senior leadership positions that are mirrored in the departments, given that in a single department only one set of senior managers would be in place. In practice, however, the bodies of work carried out by the staff in these positions is not entirely duplicative, so new positions would need to be created (through an approach such as reclassifying the eliminated positions) in order to manage the combined workload, thus necessitating

a reinvestment of the potential savings. In addition, we found that in the near-term, the creation of a single department would bring increased costs.

Executive recommendations: focus first on the work to better align county functions in support of specific health and human service outcomes, and do this using a two-department model at this time

The Executive recommends achieving greater efficiency and effectiveness by focusing *first* on the work to better align county functions. Because the best form follows function, the recommended approach to improving the effectiveness and efficiency of the health and human services in County government has not to do with structure (our form), but with better alignment of county activities and resources that contribute to specific health and human service outcomes (our functions). The Executive recommends transforming functions across organizational lines to become more aligned, more effective, and more efficient at producing intended outcomes. This approach will directly support and help accelerate the two early strategies laid out in the Health and Human Services Transformation Plan: (1) improving outcomes for high risk individuals, and (2) improving outcomes for high risk communities. Specifically, DCHS and PHSKC should use Lean principles and tools to better align and coordinate their work in the two early strategies, producing better results while at the same time squeezing out as much "waste" as possible.

The Executive recommends carrying this work out under a two-department model at this time. The Executive recommends the two-department model as the preferred model at this time for strengthening the integration, efficiency, and outcomes of PHSKC and DCHS. We believe that work can be accomplished efficiently under a two-department structure, thus advancing the County Council's goals for a better performing health and human service system while avoiding the disruptions, distractions, and costs associated with a major organizational change.

Allowing learning to guide and inform restructuring

By focusing first on the creation of more efficient workflows across programs in support of shared outcomes, the work and its results will become more visible to all. This cycle of improvement can drive out waste and inefficiencies, providing higher value for our residents and communities by helping to assure the right service at the right time in the right place. Together, we will learn about who should best perform what functions and in what roles. We will learn about the ways in which activities need to be staffed, co-located, and coordinated, and how best to structure reporting relationships and accountability. Learning will then guide restructuring. Restructuring—if needed—becomes more effective and far less disruptive because it more naturally reinforces the ways that people and programs have grown to work with each other.

The importance of assuring that county attention is not diverted from health reform implementation opportunities in the years ahead

Another reason to begin the improvement work under a two department model is to avoid, at this time, the opportunity costs that shifting to a single department would entail. Our external environment is undergoing so much change—primarily due to the Affordable Care Act—that it is critical we not be distracted from leveraging these opportunities and influencing the development of new policies and state-level reforms that will affect our community for years to come. We know from the recent experience of the Office of Public Defense changes just how intensive organizational restructuring is and the attention it requires. This would be a particularly inopportune time to divert attention from health reform implementation.

Commitment to transparency and working together

The opportunity to work on the implementation of the Transformation Plan in a highly accountable two-department model is a first strategic step to strengthen the performance of the health and human service system. The involvement of the Council in further shaping this work with the Executive branch, and in being a partner in the learnings and change management ahead, will be critical. One avenue for collaboration may be the performance management and accountability system designed to foster all branches working together as One King County in support of the King County Strategic Plan. Through this, we anticipate having a structure and checkpoints to engage in shared review of progress against key countywide priorities. In addition, we have proposed separate progress reports and an evaluation report as tools we can use to jointly assess whether and to what extent the selected model is achieving the intended goals.

With this budget proviso, the County Council launched us on an important journey, one that shed new perspective on the need, and the opportunity, for County departments to evolve in ways that produce greater value, better outcomes, and reduced inequities for the residents of King County. We look forward to continuing the next phases of the journey together.

Proviso Text

As part of the adopted 2013 budget, the Metropolitan King County Council included a proviso regarding the integration of the departments of Community and Human Services and Public Health-Seattle & King County:

P6 PROVIDED FURTHER THAT:

Of this appropriation, $125,000 shall not be expended or encumbered until the executive transmits an assessment report and implementation plans and a motion that acknowledges receipt of the assessment report and implementation plans and the motion is passed by the council. The motion shall reference the proviso's ordinance, ordinance section, proviso number and subject matter in both the title and body of the motion.

The executive must file the assessment report and implementation plans and motion required by this proviso by June 26, 2013, in the form of a paper original and an electronic copy with the clerk of the council, who shall retain the original and provide an electronic copy to all councilmembers, the council chief of staff and the lead staff for the law, justice, health and human services committee or its successor.

A. The assessment report and implementation plans shall be on the integration of the department of community and human services and public health - Seattle and King County. The assessment report shall include but not be limited to:
    1. A summary of potential reorganization options for the department of community and human services and public health - Seattle and King County, including an option for integrating the two departments into one department
    2. A summary of potential impacts of each potential reorganization option;
    3. A summary of potential impacts to clients, providers, and the community for each reorganization option;
    4. A summary of potential impacts to federal and state contracts and revenue streams, including reporting requirements for each reorganization option.

B. To meet the requirements of this proviso, the Executive must transmit an implementation plan for each option. The implementation plans shall include, but not be limited to:
    1. Identification of duplicative programs and administrative structures and how integration will resolve duplication of programs and administrative structures;
    2. Identification of potential cost reductions to be achieved by integration of the two departments, reflecting a significant reduction in overhead expenditures and specifying what overhead expenditures would be reduced;

3. Identification of potential new or increased expenditures associated with integration of the two departments;
4. A draft organizational structure specifying reporting relationships and management duties of the merged departments;
5. Identification of potential issues involved with integration of the two departments and how the issues will be successfully managed or resolved, enabling integration to move forward;
6. A list of King County Code changes necessary to effectuate the integration of the two departments;
7. A schedule for integration of the two departments that specifies milestones, a timeline and phases of integration; and
8. Coordination with other county initiatives such as the health and human potential goal area of the county's strategic plan.

1. Introduction: King County's Commitment to Quality Public Health and Human Services

King County government has long supported a quality health and human service system at the government and community level, in organizational structures that have varied over the years. Today, Public Health – Seattle & King County (PHSKC) and the Department of Community and Human Services (DCHS) together carry out diverse roles in public health and human services, with both departments demonstrating commitment to continual improvement in the performance, quality, efficiency, and effectiveness of their functions.

The journey upon which the Executive embarked to complete this proviso response has shed new light on the depth of the collaborations that currently exist between DCHS and PHSKC, as well as the potential that exists for the departments to evolve in ways that produce even greater value for the residents of King County. We also recognize that several other Executive departments as well as the separately elected officials contribute to the health and well-being our residents–the County's work in health and human services is not limited just to PHSKC and DCHS.

The King County Strategic Plan (KCSP). The KCSP ("Working Together for One King County") adopted by the Metropolitan King County Council in 2010 guides the policy direction of both departments. This plan, informed by input from thousands of residents and county employees, highlights the importance of increasing opportunities for health and well-being in several of its goals. In particular, the Health and Human Potential goal, together with its four objectives, describes the County's commitment to residents:

> **Health and Human Potential Goal: Provide opportunities for all communities and individuals to realize their full potential**
>
> - Increase the number of healthy years that residents live
> - Protect the health of communities
> - Support the optimal growth and development of children and youth
> - Ensure a network of integrated and effective health and human services is available to people in need

The County's **Equity and Social Justice Ordinance 16948** also guides the work of PHSKC and DCHS. The departments work actively to adhere to the "fair and just" principle that underlies the King County Strategic Plan, and considered the Equity and Social Justice Ordinance in the preparation of this report. It calls for the intentional application of the fair and just principle in all the County does in order to achieve equitable opportunities for all people and communities. The determinants of equity—factors such as access to health and human services, living wage

jobs, affordable housing, quality education, early childhood development, strong, vibrant neighborhoods, and more – are deeply influenced by work of the departments, and our organizational structures must support and enable the work to improve community conditions so that all can reach their full potential.

In addition to the overarching policy guidance of the KCSP and the Equity and Social Justice Ordinance, a number of other plans and policies guide PHSKC and DCHS, including the Public Health Operational Master Plan, the King County Framework Policies for Human Services, the Service Improvement Plan of the Veterans and Human Services Levy, the Mental Illness and Drug Dependency Sales Tax Plan, the Ten Year Plan to End Homelessness in King County, the King County Consolidated Housing and Community Development Plan, the Mental Health, Chemical Abuse & Dependency Recovery Plan, the Plan for King County Developmentally Disabled Services, the Medic One/Emergency Medical Services Strategic Plan, and various other strategic plans associated with state and federal grant requirements.

2. Background: Public Health – Seattle & King County and the Department of Community and Human Services

The more than 1,700 full-time equivalent employees of DCHS and PHSKC are committed to improving the health and well-being of people in King County. The departments provide a range of services to individuals, organizations, jurisdictions, and communities, and they carry out their work both directly and through contracts. PHSKC's mission encompasses the entire county population, and DCHS' mission focuses primary on low-income residents.

Community and Human Services. DCHS is dedicated to helping King County's most vulnerable low-income residents achieve and maintain healthier and more independent lives and to strengthening its communities. DCHS is the largest human services department in the state of Washington after DSHS and plays a leadership role in coordinating regional housing and human services systems, including behavioral health. Mainly through contracts with community-based agencies, the department's mission is to help King County's low-income and special needs residents achieve stability, improved health, greater independence, and a higher quality of life. DCHS provides some direct services as well. While the department provides a wide range of services, it focuses efforts in five key areas: behavioral health prevention, treatment and recovery; ending homelessness; criminal justice services as alternatives to incarceration; employment and education; and services for veterans and their families.

Programs and services are coordinated through the Director's Office and three divisions: Community Services; Developmental Disabilities; and Mental Health, Chemical Abuse and Dependency Services. DCHS also provides planning and coordination for the Committee to End Homelessness and the Ten Year Plan to End Homelessness in King County, the Veterans and

Human Services Levy, and the Mental Illness and Drug Dependency (MIDD) Action Plan. These divisions provide a range of services and supports to King County's diverse individuals, families, and communities including services that provide assistance to seniors/older adults, early intervention services for children ages birth to three, housing and community development, mental health treatment, mental health crisis response, substance abuse prevention and treatment, veterans' services, women's program services including domestic violence and sexual assault, education and work training programs, and youth and family services. The annual budget of $373 million includes revenues from the following sources: federal (11%), state including Medicaid pass-through dollars (58%), local sales tax (13%), dedicated local property tax (8%), County funds including general fund (2%) and other grants and fees including local foundations and private grants (8%).

Public Health-Seattle & King County. PHSKC is the 10th largest metropolitan health department in the United States in terms of population size served. The department's mission is to identify and promote the conditions under which all people can live within healthy communities, achieve optimum health, and maximize the number of healthy years lived. Health is defined as a state of physical, mental and social well-being -- not merely the absence of disease or infirmity. To this end, the agency leads, mobilizes and coordinates community partners to advance the health and well-being of the community.

Programs and services of PHSKC are coordinated through five divisions: Prevention, Emergency Medical Services, Community Health Services, Jail Health Services, and Environmental Health. In addition, the department includes cross-cutting programs that serve all the divisions in policy development, community partnerships, assessment and evaluation, and emergency preparedness. PHSKC offers value through a broad range of programs designed to improve quality, increase access, and reduce the cost of health care (health provision); to keep our food, water, and air safe and to identify and protect us from new health threats (health protection); and to reduce deaths from common and preventable causes, such as tobacco, obesity, and injury (health promotion). Services are carried out in the community and through 40 sites, including 10 public health centers. The annual PHSKC budget of $361 million includes revenues from the following sources: federal (21%), state (13%), local sales tax (1%), dedicated local property tax (22%), County funds including general fund (17%), City of Seattle (5%) and other grants and fees including environmental health permits, local foundations and private grants (21%).

In both departments, the highly specialized staff are state and national leaders, as evidenced by the County's ability to secure funding, partnerships, and membership on influential national boards and committees, and by how often our local policies and strategies are held up as national best practices.

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Table 2-1 provides a current snapshot of the two departments:

Table 2-1: Department Comparison Snapshot

	Public Health – Seattle & King County	Department of Community and Human Services
Mission	Improving the health of all King County residents through health promotion, provision, and protection (via policy, contracts, & direct services)	Achieving and maintaining stability and quality of life for neediest residents, and strengthening communities (primarily via services contracted to community providers)
Budget 2013 Adopted	$361 M	$373 M (excludes public defense[1])
FTEs	1,412	287 (excludes public defense)
No. of Sites	40	4
Bargaining Units	11	8
Admin Functions	Generally more centralized (hybrid)	Generally decentralized
Divisions	• Environmental Health • Jail Health Services • Community Health Services • Prevention • Emergency Medical Services	• Developmental Disabilities • Community Services • Mental Health, Chemical Abuse and Dependency Services

[1] For reasons unrelated to this proviso, the Office of Public Defense was recently transitioned out of DCHS and established as a separate county department.

• • •

	Public Health – Seattle & King County	Department of Community and Human Services
Other	• Director's Office • Policy, community partnerships, and communications • Assessment and evaluation • Preparedness	• Director's Office • Planning and policy • Preparedness • Committee to End Homelessness • Communications

Additional information about each department's program and administrative functions are found in Appendix C.

Union Representation. Both PHSKC and DCHS have a significant labor presence in their workforce. Approximately 41% of the DCHS workforce (117 employees) is represented and in PHSKC, 77% of the workforce (1213 employees) is represented. PHSKC has 11 bargaining units and DCHS has 8 bargaining units, as shown in Table 2-2:

Table 2-2: Department Bargaining Units

Public Health – Seattle & King County	Department of Community and Human Services
Professional and Technical Employees, Local 17	Professional and Technical Employees, Local 17 (information technology)
	Professional and Technical Employees, Local 17 (involuntary commitment supervisors)
Washington State Council of County and City Employees, Council 2, Local 21HD (epidemiologists, disease investigation specialists, psych eval specialists, disease research and data specialists)	Washington State Council of County and City Employees, Council 2, Local 1652M (social workers, business and finance, admin)

Public Health – Seattle & King County	Department of Community and Human Services
Washington State Council of County and City Employees, Council 2, Local 21HD (medical examiner staff)	
Office and Professional Employees International Union, Local 8 (dental, tobacco/prevention)	Office and Professional Employees International Union, Local 8 (chemical dependency employees, project managers, admin)
Teamsters, Local 117 (professional and technical)	Teamsters, Local 117 (administrative support)
Teamsters, Local 117 (administrative support)	Teamsters, Local 117 (joint units, pending)
International Association of Firefighters 2595	Public Safety Employees Union (social workers)
Plumbers and Pipefitters, Local 32/JC	
Washington State Nurses Association (staff nurses)	Service Employees International Union, Local 925 (involuntary commitment specialists)
Washington State Nurses Association (supervising nurses)	
International Brotherhood of Electrical Workers, Local 77	

3. Proviso Response Process

This section describes the collaborative process by which a cross-departmental team prepared the response to the proviso. Figure 3-1 depicts the workflow for the proviso response, in relationship to a concurrent body of work that the Executive branch undertook to respond to King County Council Motion 13768, the development of a plan for an integrated and accountable system of health, human services, and community-based prevention. While the motion and proviso were separate County Council requests, Executive staff approached the two as linked efforts in that the plan developed under the motion response should inform optimal organization of County departments (that is, form should follow function). This connection is

depicted by the arrow shown between the two work flows, and is discussed further in section 4. Situation Analysis.

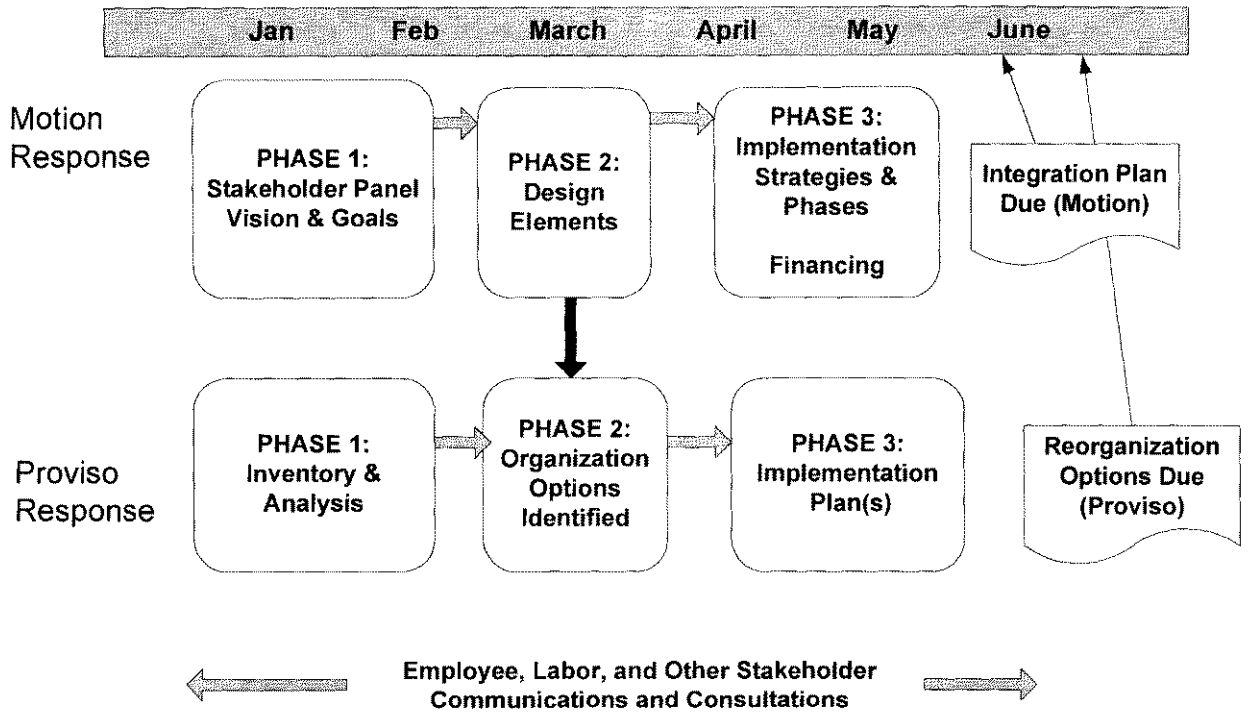

Figure 3-1: Motion & Proviso Response Workflow

3.1. Executive Sponsors Group and Core Team

The proviso response process was led by the King County Executive's Office, together with DCHS and PHSKC. The Executive Sponsor Group is listed on page 2 of this report. A cross-departmental core staff team, listed in Appendix A, was formed to support the work.

3.2. Principles for Assuring a Quality Proviso Response

Recognizing the sensitive nature of the proviso and the need to promote open and thoughtful engagement of leaders and staff in both departments in order to produce a high quality response, the sponsors and core team first worked together to articulate and agree upon a set of principles and commitments that they would hold themselves to in responding to the proviso (see Figure 3-2).

Figure 3-2: Principles for Developing this Response

- Stay focused on the goals of creating an organizational structure that allows for more effective and efficient services to residents and other customers, addresses unnecessary duplication, and identifies cost savings.
- Learn from the successes and challenges of other government entities that reorganized human services and public health functions.
- Assure that reorganization option(s) create best possible structure for advancing and sustaining the integrated system of care that is being designed in response to the motion, and the overall achievement of the King County Strategic Plan Health and Human Potential goal.
- Assure that customers help to identify both what is valued and working well, and where waste and inefficiencies may be present.
- Commit to designing organizational options that allow for the best from both of the existing departments and cultures to be shared, carried forward, and thrive.
- Design and sustain a strong, shared communications strategy to achieve consistency in high-level messages both to internal audiences and to external partners.
- Work proactively to reduce employee anxiety, sustain morale, and take steps to fuel enthusiasm for the benefits of integration.

3.3. Internal and External Input

The perspectives of department leadership, employees, and external stakeholders informed the analyses and options detailed in this report. It should be noted, however, that external outreach was minimal due to time constraints. Several stakeholders have indicated a desire for additional engagement in any next steps. Some community partners have expressed preferences about departmental reorganization and requested to weigh in formally prior to decisions being made.

Department Leadership and Management. Recognizing that both departments have complex programs and systems, the core team—which met weekly from February-May 2013—worked closely with managers and staff to better understand the specifics of each program and administrative function, learn about current ways that the two departments work together, and identify future opportunities where greater coordination or collaboration could prove mutually beneficial. To facilitate discussion, each department prepared a set of brief profiles that summarized its main administrative and program functions. These served as tools throughout the process for analyzing areas of potential overlap or duplication, as well as identifying areas where current partnerships exist between the departments and where goals and/or customers

might be shared. The breakdown of the programs was done for this purpose only; in some cases profiles were completed for small programs, while in other cases multiple programs were rolled up into a single profile. See Appendix C.

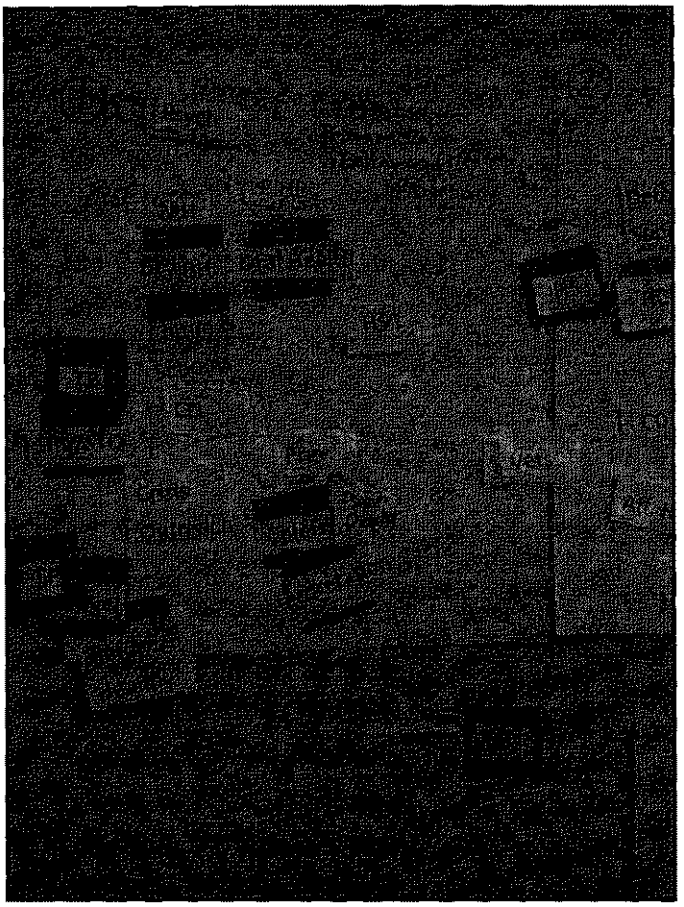

Figure 3-3: Photo from a Work Session

Information gathered included responsibilities and services provided, King County Code and RCW requirements, connection to boards and commissions, annual reporting requirements, budget, FTEs, contractual relationships, extent of existing collaborations with community partners and with the other department, and major funding sources. Managers and staff dedicated much time to provide this information; their expertise, responsiveness, and accuracy was invaluable.

Using the program profiles as a foundation, the core team convened a March 19 dialogue with approximately 30 managers and division directors from PHSKC and DCHS, supported by a neutral facilitator. In the four-hour session, they reviewed staff analyses, explored whether duplicative services might be occurring (none were found), discussed areas where further coordination or work together could improve customer service and reduce disparities, shared

information about external drivers that should be considered, and reflected on benefits and challenges of potential organizational structures, including a single department.

On March 26, a two-hour work session was held that brought together 15 DCHS and PHSKC lead staff and/or managers in Communications, Human Resources, IT, Payroll and Public Disclosure/Business Standards and Accountability. Facilitated discussions between the counterparts in each area were used to uncover similarities and differences among their practices, systems, policies, volumes, and customers, and to explore the impacts of a potential single department in each administrative function. On March 29, a similar three-hour meeting occurred with about 20 PHSKC and DCHS counterparts responsible for accounting, financing, contracting, and procurement functions.

PHSKC and DCHS employees. Updates on the work and information about how to provide input was included in email updates and monthly department newsletter articles. Updates were also provided at leadership meetings and all-staff department and division meetings. Each department hosted a special presentation for its respective staff about the proviso in May 2013. A meeting to update labor representatives from both departments was also held. Employee engagement was varied, with some groups –such as those who perceived they might be affected by a transition to a single department—naturally having more engagement and questions than others. Employees asked many thoughtful questions throughout the process, some of which could be answered and others not.

Major themes that the core team heard from staff throughout the process included:

- An interest in keeping the focus on our clients and communities, and ensuring that any organizational structure will improve services for them.
- An acknowledgement that creating a single department would be difficult and would require an investment of time and resources to be done properly.
- Questions and concerns about potential layoffs, morale impacts, changes in work duties, and changes in reporting relationships.
- A desire for decision-makers to be transparent and help reduce uncertainty about what organizational changes the near-term future may or may not hold.
- Interest in and expressions of support for the potential benefits that could come from being a single department, if resources were provided and workload and capacity issues were addressed.

External Stakeholders. DCHS and PHSKC staff provided updates to key external stakeholders during regularly scheduled meetings. These informal updates also provided a way to gather initial reactions and concerns from our major partners, and to respond to questions. Groups consulted include the South King Council of Human Services, the City Human Service Planners,

the Community Health Center Council, the Health Reform Planning Team, the King County Health and Human Services Transformation Panel, the Interagency Council of the Committee to End Homelessness, the Housing Development Consortium, the Mental Illness and Drug Dependency (MIDD) Oversight Committee, the citizen boards of the Veterans and Human Services Levy, Veterans' Program, Developmental Disabilities, Community Organizing Program, Mental Health, Women's Program, the Alcoholism and Substance Abuse Administrative board, the Advisory Council on Aging and Disability Services, and the Mental Health Partnership provider network. Board members and other community stakeholders stated that once the proviso response was developed, they requested an opportunity to provide public comment.

4. Situation Analysis

Known and potential changes in the environment were taken into consideration in preparing the assessment and organizational options. Across the human services and public health fields, new opportunities as well as areas of concern are emerging, many in connection with health care reform. These major change drivers are summarized below in sections 4.1 to 4.4.

4.1. Analysis of External Drivers

Response to Motion 13768 and its connection to the proviso. During the same time frame in which this proviso response was being prepared, the Executive Sponsors and core team were preparing a response to another directive of the County Council, Motion 13768. Both call for addressing how the County might improve health and well-being while controlling costs, with the motion focused on system-level improvements, and the proviso focused on County government structure:

- King County Motion 13768 calls for the County Executive to develop a plan for an integrated, accountable **system** of health, human services, and community-based prevention.
- This 2013 budget proviso calls for the County Executive to analyze and present options to better integrate **County** health and human services, specifically through potential reorganization options for DCHS and PHSKC.

With this policy direction, the County Council has recognized that there are opportunities to better coordinate health care, human services and community prevention as a way to improve the health and human potential of individuals, families and communities in the county. The County Council has recognized that a solution to our nation's health care crisis – and a way to improve health and human potential overall – is to foster a service delivery system in which health care, human services, public health, government and philanthropy work together in support of communities to improve the social determinants of health. Relatively speaking,

county government functions are a small – but important – piece of this context. King County does not directly control the majority of the service system or the resources within it.

A focus on assuring efficient systems, internal and external, that produce the greatest possible value. The health care system is shifting its focus to producing better health outcomes and driving out waste and inefficiencies from its operations. A framework known as the Triple Aim describes an approach to optimizing the performance of the health system, and is now in common use across the U.S. It calls for simultaneously achieving a better experience of care for individuals, better outcomes for the population, and lowered or controlled costs.[2] The County Council's policy goals weave human services into the Triple Aim, acknowledging that human services are health, and that health is human services. Like health care, the demand for certain human services appears to be on an unsustainable path. Vital work takes place daily to alleviate suffering and keep people safe, but leaves little time and resources to attend to what is contributing to that demand. In addition, there is emerging recognition of prevention as a cost-effective way to improve health and well-being.

Solutions for both systems include integration of these (as well as other) systems, including strategies that keep everyone focused on outcomes, create a better experience for individuals and families, and eventually result in a more balanced system of prevention with treatment and intervention services for health and social problems.

As detailed in the response to Motion 13768, one way of thinking about this is depicted in the evolutionary steps shown in Figure 4-1: Health & Human Services Evolution. While the community's efforts have already moved us away from yesterday's "version 1.0," the path to "version 3.0" is a work in progress. The strategies laid out in this proviso response and the response to Motion 13768 are designed to move our community in that direction.

[2] Institute for Healthcare Improvement: http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx Organizations and communities that attain the Triple Aim will have healthier populations, in part because of new designs that better identify problems and solutions further upstream and outside of acute health care. Patients can expect less complex and much more coordinated care and the burden of illness will decrease. Importantly, stabilizing or reducing the per capita cost of care for populations will give businesses the opportunity to be more competitive, lessen the pressure on publicly funded health care budgets, and provide communities with more flexibility to invest in activities, such as schools and the lived environment, that increase the vitality and economic wellbeing of their inhabitants.

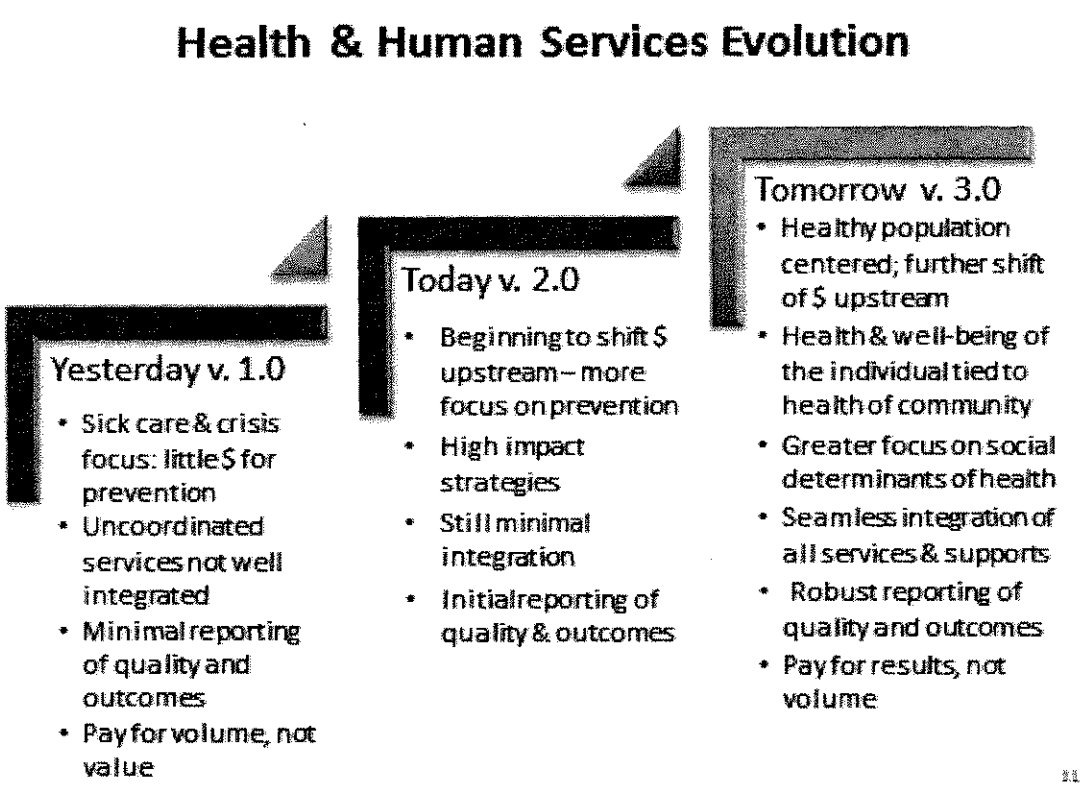

Figure 4-1: Health & Human Services Evolution

Implication of the direction laid out in the health and humans services Transformation Plan. The Transformation Plan that was developed in response to Motion 13768 calls for a shift to an outcome-based, person-centered and community-centered system of care. It also calls for the development of new structures across funders that will allow for working collectively to achieve intended outcomes and continually learn together. There is a clear recognition that a more efficient system and greater collective impact can be achieved when funders develop shared agendas, agree on complementary strategies, and measure results and outcomes.

Given this direction, the implications for DCHS and PHSKC are significant—regardless of their organizational structure. Not only will the departments need to be at the table working with community stakeholders, the County will have a responsibility to carefully analyze and take steps to align its own roles, resources, policies, and strategies across all of our functions in ways that better contribute to the specific outcomes that will be pursued as a result of the Transformation Plan.

"Early Strategies" Called For Under the Motion Will Be a Focus of 2014 Implementation Work. To catalyze improvement in the system's performance for everyone, the Transformation Plan calls for an initial focus on areas where improved performance is most critical. Two early

strategies, one focused on the individual delivery system and one focused at the community level, were found to present near-term, time-sensitive opportunities to accelerate progress (in part due to changes driven by the Affordable Care Act (ACA) implementation). The two areas are:

- Focused population – Improve health and social outcomes, while simultaneously reducing costs, by partnering with **adults in King County who have complex, multiple health and social needs** commonly characterized by high use of services and supports.
- Focused communities – Support **focused communities in developing capacity and solutions that will improve the community features** that shape the health and well-being of their residents and the vibrancy of the neighborhood, such as housing, physical environment, adequate employment, and access to services.

Model the change. Programs and resources across DCHS and PHSKC contribute to the achievement of the outcomes that will be sought through the two early strategies. To create maximum possible value, PHSKC and DCHS will need to carefully map out their "current state" – identifying what policies, activities, programs, data systems, and resources are currently involved in these two early strategies. Second, PHSKC and DCHS will need to work together to create a "future state" that lays out what policies, strategies, information flows, and investments will best help achieve the desired outcomes – and how to measure success.

By assuring that PHSKC and DCHS are employing strategies and using resources in ways that are well aligned and mutually reinforcing, the County can produce better value with its existing resources and proactively "model the change" with its external partners. While much of the relevant work occurs in PHSKC and DCHS, other King County agencies and departments that contribute to given outcomes would also be engaged in the work to align efforts as appropriate.

It is anticipated that undertaking this process could result in a strengthening of the integration of medical and behavioral health services, improved information sharing, addressing of gaps in services, and creation of robust measurement strategies and learning/improvement cycles.

In summary, this relationship between the Transformation Plan developed in response to Motion 13768 and the proviso response offers a concrete opportunity for the two departments to work on improving service integration and creating a better experience for their shared customers. Ultimately this is work that needs to occur regardless of the organizational structure of the departments.

Other external drivers. Change drivers exist through the Affordable Care Act that are affecting or may affect either or both departments and the context in which they operate.

- Service delivery system reforms: There will be an increased role of managed care organizations (MCOs) in the planning and delivery of health and human services, and there will be increased state-level attention on clinical and financial integration in the Medicaid program's medical, behavioral health, and long-term care services. The State is also organizing a new system of care management for certain Medicaid clients that will affect DCHS and PHSKC. As such, both departments are likely to have increased relationships with MCOs, although the basis for and goals of the relationships may differ.
- Service delivery payment reforms: DCHS currently operates a mental health managed care plan with capitation and case rates. The State Health Care Authority is in the process of developing new payment methods for federally qualified health centers (FQHCs), also designed to shift away from paying for volume of visits to paying for value. PHSKC is an FQHC and will be affected by these changes when they occur. At the state level, Medicaid programs are being reconfigured due to Medicaid expansion. For example, PHSKC will be impacted by the State's planned elimination of the Breast, Cervical, and Colon Health program in response to the expectation that many people served by that program should become eligible for Medicaid in 2014. In addition, the State is proposing budget cuts to certain mental health services based on the assumption that Medicaid will cover those cost in the future. These changes may impact PHSKC and DCHS in various ways, presenting both challenges and opportunities.
- Integration of public health and clinical care. The Affordable Care Act is creating incentives for a closer integration of public health and the clinical delivery system. Public health plays critical roles in the delivery system (such as assuring access to quality care), just as the delivery system plays critical roles in population-based preventive services (such as delivering immunizations and working to prevent chronic disease). A fuller integration of public health and the clinical care delivery system across the continuum of care –from clinical services to population health— will continue to be a high national and state priority for local health departments. Public health's role in this area applies to all providers in the community, not just the safety net.
- Health Insurance Coverage. Health reform will require that most people have health insurance. There is and will continue to be increased attention in both departments to enrollment in health coverage and linkage to medical and behavioral health services. County departments and agencies will be working in the coming year, along with many community partners, to help get uninsured people in King County enrolled in health care coverage.

- Prevention services. Another change driver triggered by the Affordable Care Act is that clinical preventive services are now required to be covered by most insurers, with no out-of-pocket costs. This affects PHSKC in terms of its role in assuring that providers and residents understand these changes and monitoring the extent to which residents are in fact accessing recommended preventive care. Clients served through DCHS programs stand to benefit substantially from this new requirement, as they have historically been poorly served with preventive services, due both to cost barriers and to lack of person-centered approaches to health care delivery. Collaboration between the departments to assure linkage to these services is a new opportunity and need.
- Recovery from behavioral health conditions. A focus on recovery brings together mental health consumers, family members, treatment providers, and advocates for a self-directed, strengths-based approach to care. Services support the person's whole life to promote health and resiliency. Over the past five years, DCHS has shifted the mental health system to a recovery-oriented system of care, and recently updated its Recovery Plan to move the substance abuse system to a more recovery oriented system of care.
- Health information technology systems. Both departments are moving toward increased use of electronic records for health and behavioral health services, although some of the business needs differ. In addition, both DCHS and PHSKC are working with subcontractors to encourage the implementation of electronic client records and registries. Health information exchange, both for individual-level care coordination and for population-level measurement and assurance functions, is becoming increasingly important and a component of some funding requirements in both federal and state contracts.
- New community benefit requirements on tax-exempt hospitals. The ACA requires hospitals to conduct community health assessments and invest in programs to address identified needs. PHSKC is convening area hospitals to help support the assessment work, and opportunities may emerge to coordinate efforts across King County hospitals to use their investments for community-based health and wellness interventions.

Funding trends. Over the last five years, PHSKC and DCHS have seen significant reductions in many critical programs, even as the need for health and human services has increased. The budget realities have required both departments to innovate, re-prioritize, limit or discontinue certain services, and increasingly rely on sources of funding that restrict their flexibility and scope of service.

4.2. Current areas where significant shared goals and customers exist

The core team's assessment of PHSKC and DCHS services programs found that the services provided by the two departments are generally complementary but not duplicative. Appendix C reinforces this conclusion, illustrating that the activities provided or contracted for are different, and/or their target populations are different. Some areas are quite distinct and there is clearly no overlap (such as PHSKC roles in restaurant inspections and communicable disease control, or DCHS roles in affordable housing financing). Importantly, however, the two departments do have a number of areas in which goals and customers are shared—mostly related to services that target low-income populations.

This has led, over the years, to documented, formal collaborations across department lines, particularly in the following areas: outreach and linkage to services, health care reform planning, ending homelessness, reducing criminal justice system involvement, coordination of medical and behavioral health services for people in jail, promoting the healthy development of children and youth, strengthening the integration of behavioral health and clinical care, emergency preparedness, and improving the environments and infrastructures of low-income communities. Many of these areas of coordination are formally reflected in the interdepartmental Memoranda of Agreement for the MIDD, Veterans and Human Services Levy, Substance Abuse, and Developmental Disabilities.

Specific examples of the nature and extent of these collaborations include the following (not an exhaustive list):

- To strengthen the integration of behavioral health and clinical care:
    - PHSKC and DCHS collaborated with community partners in the development and implementation of the nationally recognized Mental Health Integration Program (MHIP), a program which integrated mental health services into the safety net community health center system, resulting in improved mental health functioning for thousands of county residents since 2008.
    - DCHS and PHSKC collaborated with Washington State and community partners to secure and implement a federal grant to integrate evidence-based substance abuse screening (SBIRT) into community health centers' primary care.
    - PHSKC partnered with a community mental health agency, Navos Mental Health Solutions, to integrate primary care at a new Navos site.
    - PHSKC and DCHS are currently coordinating with community partners on the development of an integrated health, behavioral health, and human services model at the North Meridian campus.

- To strengthen the healthy development of children and youth:
    - DCHS provides enhanced education and employment services to the young first-time, low-income parents served by PHSKC's nurse family partnership program.
    - PHSKC serves as the front door (via the Community Health Access Program telephone line) for early identification and referral to services of children with developmental delays, under a contract with DCHS Developmental Disabilities Division.
- To support the goal of ending homelessness:
    - Both departments participate on the Interagency Council and its task forces.
    - DCHS is on the Steering Committee of the homeless recuperation program, Medical Respite at Jefferson Terrace, led by PHSKC. Funding from both departments (including MIDD funds, area hospitals, and federal grant funds) are among its revenues; the program has led to reduced health care costs and increased housing stability. Similarly, PHSKC coordinates with DCHS on issues related to the Crisis Solutions Center, led by DCHS.
    - PHSKC Health Care for the Homeless and DCHS MHCADSD co-lead the processes of developing a triaged list of homeless people who make high use of crisis services, and using that to link people to safe, service-enriched supportive housing.
    - The two departments have negotiated and defined roles of their contractors to avoid duplication in activities such as street outreach and case management.
- To promote and protect the health of the population:
    - PHSKC, through Communities Putting Prevention to Work funding, contracted with MHCADSD to impact 58,000 individuals through 47 contracted agencies that serve people with mental health diagnoses and substance use disorders. PHSKC provided funding and technical support for MHCADSD to include a provision in all provider contracts requiring tobacco cessation support. Additionally, the 40 agencies that manage campuses were required to have tobacco-free policies. The two departments also worked cooperatively to provide smoking cessation tools and support at more than 100 community provider locations by training over 400 community providers.
    - PHSKC and DCHS staff (MHCADSD) have been working closely together, along with community partners, since 2006 to develop a Disaster Behavioral Health Plan for King County. With PHSKC preparedness grant funds, a full time disaster response planner was hired who had a dual-reporting relationship with PHSKC and DCHS. Since 2010, PHSKC and DCHS staff have been working together with a consultant to develop a robust and detailed concept of operations plan for a

regional approach to delivering disaster behavioral health services. DCHS staff also participate on the PHSKC-led Vulnerable Populations Steering Committee.

  - PHSKC and DCHS have a close working relationship between the Needle Exchange program operated by the HIV/AIDS program, and access to methadone treatment services.

- To prepare for health reform:
  - PHSKC and DCHS are working closely together on the impacts of health care reform and have prioritized resources to influence the content and implementation of state and federal policies, rules, demonstrations, and initiatives that will affect King County. The work involves convening and coordinating with many community partners.
- To coordinate legislative agendas:
  - State and federal resources provide significant funding levels for the two departments – 69% in DCHS and 34% in PHSKC in 2013. Together with County government relations staff, the two departments coordinate legislative agendas at the state and federal levels.

Shared goals related to the development of vibrant communities. DCHS and PHSKC also share goals related to the development of healthy, vibrant community environments. For example, the DCHS Housing and Community Development program works to improve conditions in low-income communities, primarily through infrastructure, economic, and housing improvements. In PHSKC, the Healthy Communities Planning section of Environmental Health shares a similar goal, and works to support the creation of healthy environments through proper planning, design, and building. In PHSKC, the Prevention Division's chronic disease and injury prevention program also works to improve community conditions. This is an area where an enhanced level of coordination and collaboration may be fruitful, especially given that one of the early strategies proposed in the Transformation Plan focuses on improving community features where people live, work, and play.

Partnerships. Finally, as a result of their collaborations and shared customers, DCHS and PHSKC also share relationships with many private and not-for-profit service providers, including those in the areas of affordable housing, education/early childhood, schools, child welfare, mental health/drug alcohol, shelters and other homeless services. There are also other entities with whom DCHS and PHSKC share relationships, including emergency medical facilities, suburban cities, City of Seattle, human service coalitions and alliances, homeless service system, community health centers, service providers, philanthropy, business, and regional funders. The departments recognize that there are opportunities to better coordinate their engagement and planning activities with shared community partners, and work in support of shared outcomes.

4.3. Key Differences Between the Departments

The current organizational charts (see Appendix B) and administrative operations of PHSKC and DCHS reflect the existing missions, services, and business needs of their respective departments. This section highlights some of the key differences between the departments, apart from the missions.

Service delivery approach varies between departments. DCHS expends 85% of its budget on delivery of services through contracted community based organizations, and 9% on direct delivery of services. Services that DCHS provides directly are Crisis and Commitment Services, Emergency Services Patrol, Veterans program, Employment and Education Resources, and the Housing Repair Program. Most DCHS services are provided to individuals and families, in concert with many partners, with the goal of helping them to achieve and maintain healthier and more productive lives in the community. To achieve this mission, DCHS serves a critical role as the regional administrator of funding and service delivery for several key service systems, including mental health, substance abuse, and developmental disabilities and also oversees funding distribution from multiple funding streams to coordinate regional housing and community development and a range of criminal justice programs and services that serve as alternatives to costly jail and emergency services.

In PHSKC, about 65% of services are delivered by department staff, and about 35% are contracted to providers and agencies. PHSKC accomplishes its mission through a range of strategies, policies, technical assistance functions, and interventions to protect and promote the health of county residents, and to reduce disparities. Activities are focused on population-level assurance functions, and carried out both directly and through contractual arrangements. Part of what accounts for the number of employees in PHSKC (compared to DCHS) is that for many public health functions, no community-based organizations exist in King County that provide the functions. Examples include public health nurses, communicable disease investigation, Medical Examiner office, and restaurant inspectors. In addition, a significant PHSKC staff role is to provide technical assistance to community-based organizations and health systems.

Unique expertise, relationships and historical knowledge specific to the respective fields. Staff in both departments have highly specialized expertise that resides in what are fairly "flat" organizational structures. They possess critical relationships and historical knowledge that allows them to successfully and efficiently meet state, federal and local outcomes. Steps must be taken to ensure this expertise is leveraged, if any reorganization effort is undertaken.

Evaluation and assessment. Both departments are involved in evaluation functions, yet the nature of their work differs due to their missions and funding sources. DCHS has an evaluation team made up of staff from across the divisions and led by senior staff in the Mental Health,

Chemical Abuse and Dependency Services Division (MHCADSD). The team has developed management and systems improvements across multiple systems (i.e. Client Care Coordination for homeless high utilizers).Their focus is on evaluating the impacts of programs, including cross-sector impacts on system utilization as well as client-level outcomes. Examples include evaluation of the MIDD and the Veterans and Human Services Levy. MHCADSD uses data to improve the quality and efficiency of the mental health and substance abuse service systems.

Data and information are the foundations of modern public health systems, and robust data gathering, measurement and evaluation activities are fundamental to the achievement of PHSKC's mission. While some evaluation activities take place in specific programs of PHSKC, most expertise has been centralized in the Assessment, Policy Development and Evaluation (APDE) unit which carries out the majority of assessment and population-level measurement functions. PHSKC is the only source of comprehensive, community-wide health data – data which are used by PHSKC and community stakeholders such as policymakers, hospitals, cities, community health centers, academic researchers, and community-based agencies. These data are critical to building the evidence base, spurring action, and facilitating community engagement around efforts to improve health and well-being. PHSKC also uses data to support greater accountability -- that is, is the needle moving?—thereby contributing to a learning system and fostering improved performance in areas ranging from communicable disease control to the determinants of equity. Examples of current PHSKC measurement activities include the Community Health Indicators project, Communities Count, and evaluation of community based initiatives, such as Communities Putting Prevention to Work and the Community Transformation Grant. PHSKC also supports the measurement and evaluation of the KCSP Health and Human Potential goal, objectives, and strategies.

In preparing this proviso response, evaluation was identified as an area for further collaboration, and a logical place to start would be to collaborate on the evaluation and assessment functions related to the implementation of the two early strategies of the Transformation Plan, as discussed earlier (see section 4.1).

Administrative functions in DCHS other than Human Resources are largely decentralized; PHSKC is a hybrid approach. In DCHS, division staff have roles in finance, contracting, purchasing, etc., with a small centralized staff performing oversight functions. PHSKC has a greater degree of centralized administration for efficiency due to the size of its staff, its role in highly regulated direct delivery of personal care services, and the number of physical sites spread throughout the county. PHSKC program staff in divisions also have roles in finance, contracting, etc., with variations based on division size and business needs.

4.4. Lessons from Other Jurisdictions

Some jurisdictions across the country have adopted integrated models of health and human services delivery and also have made changes in organization structure. In an attempt to learn from others' successes and challenges, the core team interviewed six merged departments from around the country. It is important to keep in mind that in *most counties*, functions are separate – we looked only at a selection of locations that had undergone organizational structure changes.

Criteria used to determine appropriate departments to interview were: similar size or urban county profile, comparable complexity in service and contract functions, recent migration to a merged department, innovative strategies in improving health and human services delivery and outcomes.

Jurisdictions interviewed were: Hennepin County, MN (Minneapolis); Macomb County, MI (Detroit area); Marin County, CA (Bay area); Montgomery County, MD (Washington DC area); Wake County, NC (Raleigh area); and Washington County, OR (Portland area).

The services provided within a merged health and human services department are different in each jurisdiction interviewed, as described in Table 4-1. Many of the departments interviewed did not include functions such as emergency medical services, jail health, or emergency preparedness. On the other hand, some included functions not currently within PHSKC and DCHS, such as animal control and sheltering, and aging services.

Table 4-1 displays, for each jurisdiction interviewed, how typical health and human service functions were organized. Like colors in a given column indicate that those services were grouped into the same department. King County is also included in the table, for comparison purposes.

Table 4-1: King County Service Comparison with Jurisdictions Interviewed

SERVICE	KING COUNTY	HENNEPIN	MACOMB	WASHINGTON	MARIN	WAKE	MONTGOMERY
Public Health	PHSKC	HSPHD	HD (HCS)	HHS	HHS	HS	
Jail Health	PHSKC	HCMC	Jail	C	HHS	MCO/Jail	
Mental Health		HSPHD	CMHSD	HHS	HHS	ABH	
Substance Abuse		HSPHD	CMHSD	HHS	HHS	ABH	
EMS	PHSKC	HSPHD/ HCMC	HD (HCS)	HHS	Sheriff	EMS	FRS
Preparedness	PHSKC	EP	EM	HHS	Sheriff/HHS	EP	OEMHS
Medical Examiner	PHSKC	ME	HD (HCS)	HHS	Sheriff	State	DP
Aging	AAA (Seattle)	HSPHD	DSCS/ CSA(HCS)	HHS	HHS	HS	
Developmental Disabilities		HSPHD	CMHSD	HHS	HHS	ABH	
Housing/Utility Assistance		HCDP	MHA	DHS	MHA	HS	
Financial Assistance		HSPHD	CSA	HHS	HHS	HS	
Clinical Health Services	PHSKC	HSPHD	N/A	HHS	HHS	HS	
Veterans Services		HSPHD	VSD	HHS	HHS	VMS	

KEY TO ACRONYMS

Hennepin: HSPHD = Human Services and Public Health Dept; HCMC = Hennepin County Medical Center; HCDP = Housing, Community Development and Planning

Macomb: HCSD = Health and Community Services Dept; DSCS = Dept of Senior Citizen Services; MHA = Macomb Housing Authority; CMHSD = Community Mental Health Services Dept;

Washington: DHS = Dept of Housing Services; C = Corizons, Inc;

Marin: MHA = Marin Housing Authority

Wake: MCO = Managed Care Org; ABH = Alliance Behavioral Healthcare; EP = Emergency Preparedness Dept.; VMS = Veteran and Military Services Dept.

Montgomery: FRS = Fire and Rescue Services; OEMHS = Office of Emergency Management and Homeland Security; DP = Department of Police; HCA = House and Community Affairs

Jurisdictions interviewed cited a variety of reasons for reorganizing, including improved service delivery, cost savings, budget cuts, and alignment with health care reform. While the driving motivation behind many jurisdictions' reorganizations mirrored the goals set by the Council, the resulting organizational structure of jurisdictions interviewed varies greatly. Macomb County, for example, merged the various departments into one but did not eliminate duplication in administrative functions or program services; each previous department continued to operate

as it had before, but with an additional director overseeing the entire organization. In contrast, Hennepin County reorganized functions, programs, and administrative staff in significant ways by instituting a new work culture (Results Only Work Environment), and organizing staff and divisions by geographic area and the needs of the community, rather than by function. While these jurisdictions represent two ends of the cultural disruption spectrum, they present opportunities to make incremental changes that help drive improved outcomes and coordination.

Overall, the proviso team identified six broad lessons that were themes in all or most conversations with other jurisdictions interviewed.

1. **Integration is a multi-year endeavor.** Every jurisdiction interviewed warned that a full migration to a single department is a multi-year (in most cases three to five years) undertaking. Most jurisdictions interviewed first merged administrative functions and the Director's office, then began the process of integrating functions and services at a program level. Jurisdictions cited the following as longer term issues some still struggle to resolve: phased physical relocation and appropriate physical placement of staff in satellite or regional sites; a unified mission, vision, and strategic plan; a fully merged workforce using shared policies, systems, and technology; employee morale and productivity loss, as well as both voluntary and involuntary turnover; and organizational leadership and division directors aligning around shared goals.

2. **Many existing funding sources are out of alignment with integration.** Most state governments (including Washington) do not have a merged structure of health and human services. This creates siloed funding for each, which offers little opportunity to create flexibility around funding services that affect shared clients. While the federal government is organizationally structured to include a Health and Human Services Department, the internal structure is siloed. As a result, federal funding that flows to local governments remains siloed, rather than combined in ways that provide flexibility to address the needs of people and communities.[3] In addition to funding sources, several jurisdictions expressed frustration in information sharing systems and confidentiality laws that did not recognize the many disciplines that require access to better serve clients. In summary, many restrictions that make true integration difficult--such as different eligibility criteria, program rules, and mandated priority groups—still exist and

[3] The Dual Eligibles Financial Alignment demonstration project is one example of the federal and state government working to remove these historic silos. King County's proposed participation in this demonstration will be a way test integration across medical, behavioral health, long term care, and social services.

pose barriers that cannot be resolved simply by creating a single department at the local level.

3. **Co-locating staff improves some aspects of service delivery and outcomes.** Jurisdictions interviewed unanimously recommended co-locating program, administrative, research, and direct service staff where staff were providing functions that impacted each other. All cautioned that department integration and culture changes affected morale and work products, and a key action to mitigate those effects was to co-locate staff. In addition, direct contact and interaction allowed staff at a program level to identify further opportunities for integration and efficiencies, while working as a team to reduce duplication of work.

4. **Savings were varied among jurisdictions.** Cost savings were present in some jurisdictions, but highly variable. The most prevalent and logical savings came from reducing the Director's budget from two to one, allocating one manager or supervisor for administrative functions, eliminating some administrative and support staff, and reducing the number of program staff associated with duplicative programs. Still other savings were associated with increases in span of control (flattening), reducing office space at most costly staff centers, and creating uniform job classifications and pay scales. One jurisdiction that did not achieve savings did not make any organizational changes other than adding a director to oversee the work of the two directors of what were previously different departments.

5. **Integrating technology systems and data have continued to plague merged departments.** Not surprisingly, the merging of data, policies, contracts, and technology systems was a long-term and often challenging component of integration. In addition, developing shared intake (in direct service programs), unified health records, and cross training case managers were challenging for staff, as efforts were made to improve the direct service experience for clients. Many jurisdictions did not accurately predict the time or cost associated with systems integration.

6. **Supporting the development a new culture is important.** Bringing two different departments with different cultures together can result in one forcing its culture on the other. While redefining the collective culture is initially more challenging and complex, it more rapidly refocuses the organization on the work rather than the differences in culture, slows or stops the attrition of talented employees, and creates a common language for work goals, processes, and outcomes, which drives improved services and increased efficiencies.

A full matrix of jurisdictional differences and lessons learned is contained in Appendix D.

5. Assessment: Organizational Options for PHSKC and DCHS

Based on research and analysis discussed in the previous section, the core team developed a continuum of organizational concepts that were further analyzed and discussed with department leadership and the Sponsors Group. The continuum emerged due to a recognition that there were multiple structures through which a better performing health and human services could be achieved, each with benefits and challenges.

The core team developed principles as they considered potential reorganization options to share with the Sponsors. The core team principles, which built upon the County Council intent expressed in the proviso, held that any candidates for proposed reorganization options should ideally:

- Increase equity/social justice
- Improve customer and stakeholder satisfaction
- Enable optimal implementation of the vision emerging from Motion 13768 response
- Improve employee productivity and satisfaction
- Produce administrative and/or program efficiencies
- Reduce costs and risk
- Not jeopardize existing revenues

Four organizational concepts were considered and are described below.

Concept A. In this concept, there would continue to be two departments but with an increased emphasis on integration, formalized through a new interdepartmental agreement and coordinating infrastructure. See Figure 5-1.

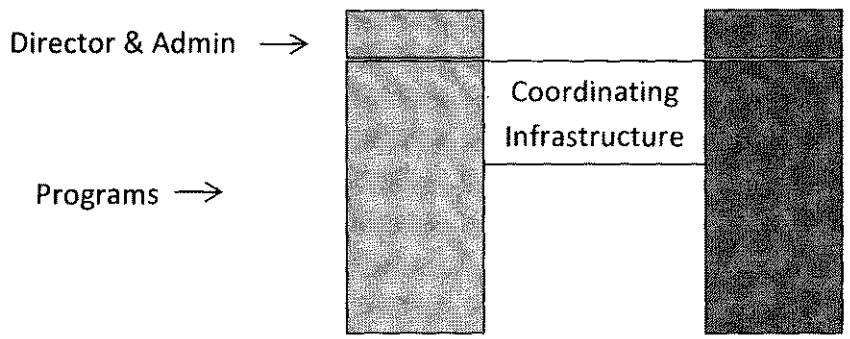

Figure 5-1: Two Departments; Increased Collaboration

Concept B. In this concept, PHSKC and DCHS would reorganize into a new, single aggregated department. The visual below shows that under a single department model, it would likely begin with the combined administrative and leadership functions, but with historic divisions/programs remaining largely unchanged in an initial phase. The arrow to the block to

the right shows that, over time, greater cultural and programmatic integration would occur as the "new department" evolves. See Figure 5-2.

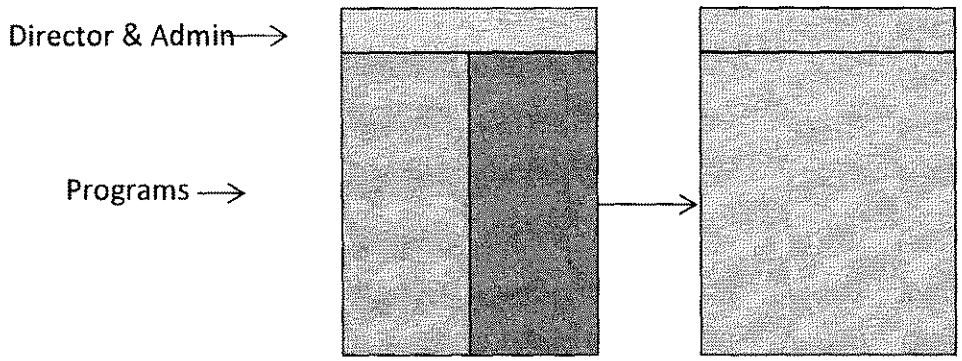

Figure 5-2: One Department; a New Culture Evolves Over Time

Concept C. In this concept, the core team considered whether there was value, given current and future change drivers, in shifting certain programs from one department to the other. See Figure 5-3.

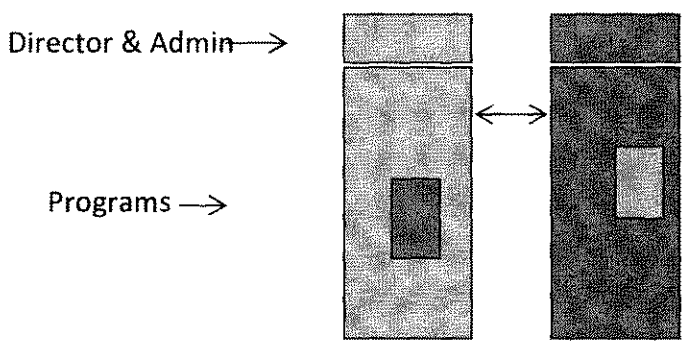

Figure 5-3: Two Departments; Programs Shift

Concept D. This concept explored whether some programs in DCHS or PHSKC (whether in their current separate state, or combined into a single department) might be better housed in another department or agency. See Figure 5-4.

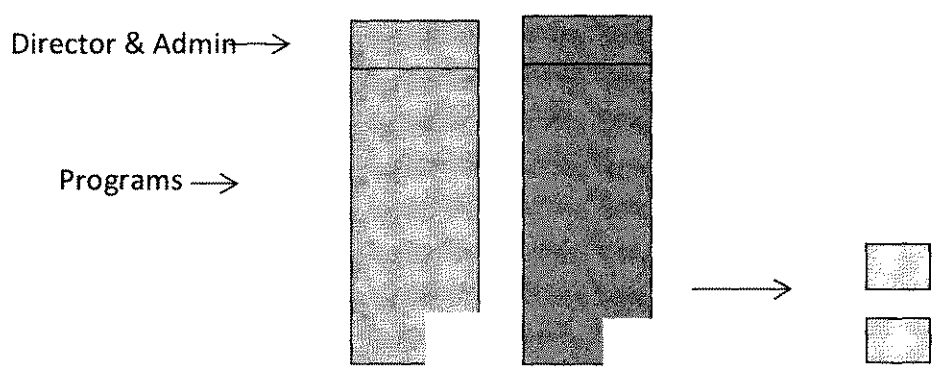

Figure 5-4: Programs Shift Externally

5.1. Analysis of Options

Of the continuum of four structural options reviewed, Concepts A and B were found to offer the greatest potential for meeting the objectives of the budget proviso, for aligning with all or most of the principles, and for supporting the implementation of the Transformation Plan.

- Concept A would establish a two-department model with a new coordinating infrastructure to work on meaningful integration and focus on shared outcomes across the two departments in areas where there is the most potential to make a difference. While it would not necessarily reduce costs to King County in terms of the PHSKC and DCHS budgets initially, it is possible that, over time, more alignment of planning, training, and contracting activities could create efficiencies. Also, successful integration work would be expected to reduce system/community costs, including those in other county systems such as criminal justice and crisis response.
- Concept B would establish a single department model, bringing the majority (although not all) of county health and human services under a single leader. Work on better alignment of activities in support of shared outcomes would also take place in this model, across divisions. Concept B holds potential for limited administrative efficiencies and streamlining over time, but this would likely be quite modest because so little of the two departments' work was found to be duplicative. Concept B would also involve costs, disruptions, and risks related to such a major organizational change, even though much of the work carried out in the departments are not candidates for integration work and would not change as the result of a single department (e.g., restaurant inspections, communicable disease investigations).

Concepts C and D were eliminated. For Concept C, the team considered options such as moving behavioral health services to PHSKC to bring all clinical care services into the same department, but recognized that doing so would then create an organizational separation of behavioral health from programs such as housing and employment. The goal of the Transformation Plan was to integrate across *all* of these domains, so that led logically to a full department integration (B), or separate departments with a coordinating infrastructure (A) as a better fit. Concept C, therefore, was eliminated. Concept D was also rejected, as we did not identify any programs or functions that were better housed in a department outside of PHSKC or DCHS. For reasons not related to this proviso, Public Defense was recently established as a separate department and is no longer part of DCHS.

5.2. Primary Impacts of the Two Proposed Organization Options

This report puts forward two potential structures for working on increased integration of public health and human services, each with its own set of opportunities and challenges. As

summarized above, Concept A continues two departments but creates a formal inter-department planning and decision-making infrastructure that allows for a focused approach to integrating health and human services in areas where there is value in doing so. Concept B creates a single department, and also includes strengthened infrastructure for working on improved service integration within that new department. Below are some of the primary impacts associated with each that were taken into consideration. More detail is provided in the Implementations Plan section of the report.

Impacts on community organizations and providers. Some impacts for community providers would be similar under both the two-department and single department model. This includes the planned work to align county strategies and resources to better support achieving certain outcomes, starting with the two early strategies proposed in the Transformation Plan. They could affect the County's investment approaches and the performance measures in contracts, for example. Under a single department model, community partners, providers, boards, funders, and others would need support understanding why a single department is being created, what effects to anticipate and when, and education on each department's bodies of work for context. Some may experience minor changes (such as name change on a contract), while others may experience more substantial changes.

Impacts on staff. Under the two-department model (A), staff impacts would likely be minimal. Because no administrative or programmatic consolidation would immediately occur, there would be no expected significant impacts on the workforce and less distraction for undertaking new work. Staff in some program areas would, however, be working in more intentionally aligned ways with colleagues in the other department. Under a single department model (B), more significant staff impacts would naturally be anticipated. These may range from changes in leadership positions and reporting relationships, to dealing with classification issues if similar positions in the two existing departments were found to be titled and compensated at different levels, to working through union jurisdiction issues. In addition, morale may be impacted, as employees are likely to feel distracted from their day-to-day work. These impacts, and methods for addressing, are discussed further in the Implementation Plans.

Impacts on grants and revenue streams. PHSKC and DCHS have highly diverse funding sources. In 2012, PHSKC had 211 revenue contracts, grants and agreements with governments (federal, state, and local), foundations, health organizations, and research entities. DCHS had 57 revenue contracts, grants and agreements with federal, state and local governments, colleges and school districts, non-profits, foundations and workforce development agencies.

Under the two-department model, no changes in grant and revenue streams are expected. Under the single department model, a number of potential impacts were identified on federal and state grants, primarily administrative changes that would be related to informing grantors,

processing a name change, and addressing potential shifts in the federally negotiated indirect rate. A structure change of this significance may, for some grants, trigger a formal review and approval process by the funder. This is the case, for example, with the grant that PHSKC receives under the Health Care for the Homeless program of the U.S. Department of Health and Human Services, which brings status to PHSKC as a Federally Qualified Health Center. In this situation, HHS would require proactive affirmation that the structure change would not result in reduction of people served by the program, or cause a shift in governance. Despite these steps, which would vary from grant to grant, there appears to be little risk of a negative impact to revenue streams.

Because significant funding relationships and multiple, complex agreements exist for both departments with the City of Seattle and with Washington State, more dialogue and analysis would be needed in conjunction with these partners to explore the impacts and work through any issues of concern – as well as opportunities—relative to either the two department or single department model.

Exploration of Medicaid Administrative Match. Another revenue impact would be the potential for certain DCHS Medicaid outreach and linkage activities, where funded with local or state revenues, to garner modest reimbursement through the Medicaid Administrative Match (MAM) administered by PHSKC under a contract with Washington State. The types of activities eligible for MAM are those that help link people to Medicaid coverage and services.

If PHSKC and DCHS were a single department, relevant programs of DCHS where matchable activities are occurring could potentially be added into the structure for capturing matching funds. There are administrative complexities and time study requirements related to MAM participation, however, and an assessment would need to be done to determine whether the potential revenues would exceed the costs of participation. Furthermore, DCHS already uses many of its local funds for another type of match in the Medicaid program, so it may not be available for this. Finally, the MAM contract is currently under negotiation, so there is no way to project potential increased revenues at this time. Despite these caveats, this is an important area to explore further.

5.3. Executive Recommendations and Rationale

Recommendation: Allow for form to follow function. Because the best form follows function, the recommended approach to improving the effectiveness and efficiency of the health and human services in County government has not to do with structure (our form), but with better alignment of county activities and resources that contribute to specific health and human service outcomes (our functions). We recommend transforming functions across organizational

lines to become more aligned, more effective, and more efficient at producing intended outcomes. This echoes the call to action laid out in the Health and Human Services Transformation Plan, with the two early strategies identified in that plan—(1) improving outcomes for high risk individuals, and (2) improving outcomes for high risk communities—serving as concrete areas for this improvement work to occur. And just as we have work to do with external partners to move that work forward, we also have our internal work to do. Specifically, DCHS and PHSKC should use Lean principles and tools to better align and coordinate their work in the two early strategies, producing better results while at the same time squeezing out as much "waste" as possible.

Engage the relevant programs and get them to own the work. To support this work, we are recommending that relevant programs from PHSKC and DCHS form an "Operations Integration Team." This team would comprise key managers or lead staff in the programs whose day-to-day work has a direct impact on the high risk/high need individuals and high risk communities initiatives. Their work would be supported by a new Integration Facilitator position that manages the necessary "boundary spanning" (relationship development and problem solving) that must occur across the cultures of the involved divisions and programs. Because the creation of one department doesn't make the division or program silos go away, this infrastructure needs to be in place under either Concept A (two-department) or Concept B (single department).

The graphics on the following pages show the ways in which DCHS and PHSKC (and other County programs) invest in a range of activities that target high risk individuals and high risk communities. While some programs have "connected the dots" others have not. This means there are opportunities for, and a need for, improving the flows of work so they become more efficient and avoid unknowingly working at cross purposes. The graphic also reflects the reality that King County government is far from the only investor. The State, philanthropy, cities, and others also have actions and investments that affect the outcomes. The County is an important player but far from the only one, and this is why the Transformation Plan calls for working collectively with other funders.

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Early Strategy 1: Improving Outcomes for High Risk Individuals:

PHSKC Activities (Examples)	**DCHS Activities (Examples)**	**Other King County (Examples)**	**OTHER PARTNERS/ FUNDERS AS POSSIBLE**
Enrollment in health coverage	Re-entry for mentally ill in jail	*DAJD Community Corrections programs*	*WA Health Care Authority & DSHS*
Nurses in supportive housing	Crisis Solutions Center	*Area Agency on Aging (King County Care Partners)*	*Housing authorities & other housing providers*
Intensive case management for chronic substance abuse	Identification of high utilizers across selected systems		*Philanthropy*
Smoke free policies in supportive housing	Permanent supportive housing development		*Harborview & other hospitals*
Jail Health release planning for complex patients	Intensive case management for people with serious mental illness		*Cities*
Access to clinical preventive services like cancer screening	Employment/education		*Others*
Community health workers	Sobering Support Center		
Emergency Medical Services			

+

PH/DCHS (OR Single Dept) Operations Integration Team

ACROSS ORGANIZATIONAL LINES - UNLOCK GREATER VALUE:

- Agree together – and with community partners - on what are the shared outcomes for high risk, high cost individuals?
    - Examples: better health, reduced crisis services, increased housing stability, reduced CJ involvement
- Get strategies and $$ better aligned → squeeze out any waste/duplication
- Produce a better experience for clients
- Track and measure success across the investments
- Make it visible, learn together, make adjustments – continual cycle of improving

• • •

Early Strategy 2: Improving Outcomes for High Risk Communities

PHSKC Activities (Examples)	DCHS Activities (Examples)	Other King County (Examples)	+	OTHER PARTNERS/ FUNDERS AS POSSIBLE
Community-level chronic disease prevention work Global to Local in SeaTac/Tukwila Community engagement Healthy Communities planning	Community development block grant programs Consolidated Housing & Community Development Plan Neighborhood revitalization activities Affordable housing policy and programs Community organizing program	*Transportation* *Economic development* *Natural Resources and Parks (incl. Duwamish)*		*WA State* *Puget Sound Regional Council* *Comm Devlp. Financial Institutions* *Low-income housing* *Hospital community benefit* *Cities* *Others*

PH/DCHS (OR Single Dept) Operations Integration Team

ACROSS ORGANIZATIONAL LINES - UNLOCK GREATER VALUE:

- Agree together – and with community partners - on what are the shared outcomes for high risk communities?
- Get strategies and $$ better aligned → squeeze out any waste/duplication
- Track and measure success across the investments
- Make it visible, learn together, make adjustments – continual cycle of improving

Learning needs to guide restructuring. By creating more efficient workflows across programs, learning together, and making adjustments, the work and its results will become more visible to all involved – including County leadership. Everyone will learn together who should best do what, in what roles. We will learn about which activities need to staffed, co-located, and coordinated, and how best to structure reporting relationships and accountability. Learning will then guide restructuring. Restructuring becomes more effective and far less disruptive because it more naturally supports the ways that people and programs have grown to work with each other.

The proviso's intent was, in part, to address the potential duplication of functions. The duplication that we found does not exist in the programs of PHSKC and DCHS *per se*, but rather shows up as inefficiencies in the system overall. Because strategies across the entire system aren't as well-aligned as they could be, people and communities don't get the optimal service at the optimal place at the optimal time. Through the Transformation Plan and the use of Lean tools with the County, we can work to improve this.

Recommendation: The two department model is recommended at this time. Taking into account the County Council's intent expressed in the budget proviso, the analyses conducted for this report, the lessons learned from other jurisdictions, and the goals of the Transformation Plan, the Executive recommends Concept A – the two-department model—as the preferred model at this time for strengthening the integration, efficiency, and outcomes of PHSKC and DCHS.

The rationale for recommending the two-department model—substantiated with more detail in the Implementation Plans – is that:

(1) As discussed above, the work over the past six months to develop the Transformation Plan has revealed that to improve the outcomes of our health and human services systems for county residents, greater alignment is needed among our actions and resources across the entire system. We believe that work can be accomplished efficiently under a two-department structure, thus advancing the County Council's goals for a better performing health and human service system while avoiding the disruptions and costs associated with a major organizational change.

(2) There is little duplication between the functions of the two departments and thus little opportunity for substantial savings; the costs involved in shifting to a single department could well outstrip any modest savings.

(3) Our external environment is undergoing so much change at this time (primarily due to the Affordable Care Act) that it is critical we not be distracted from taking advantage of these opportunities. If a change to a single department were implemented now, the years ahead could be consumed with structural and operational changes, rather than on the strategies to successfully implement the early strategies of the Transformation Plan and to shape health care reform in collaboration with Washington State.

(4) As we adapt to those external changes and carry out the work to implement the Transformation Plan, we will discover new ways in which we might organize ourselves in the future. Partnering with the County Council to evaluate this is part of the Implementation Plan.

(5) We have anticipated and mitigated the risks of a two-department model - namely whether the proposed coordination and integration infrastructure will be successful in driving the types of changes that may be warranted, or end up adding extra layers of internal negotiation that water down the impact. The Implementation Plan for the two-department model includes steps and infrastructure designed to avoid this.

When all of these factors are considered together, we believe Concept A provides the most strategic first step in transformation.

6. Implementation Plan A: Two Departments with a Formal Infrastructure to Produce Better Value and Outcomes

6.1. Overview

Implementation Plan A presents a two-department model that is linked by a new, formal infrastructure to bridge PHSKC and DCHS, facilitating greater collaboration in order to improve the quality, efficiency, and outcomes of the county's health and human services functions. The sections below describe in more detail the benefits and challenges of a two-department model, proposed organizational structure, cost impacts, and how anticipated issues would be resolved to support an effective implementation.

As identified in the Situation Analysis section of this report, PHSKC and DCHS currently collaborate in specific areas where goals and customers are shared, and this organizational option builds upon those successes and relationships, and takes us into new territory where more collaboration can happen. Recognizing that much of the work in the departments is

distinct and would not look much different under either a two-department or one department model, the proposed two department structure allows us to focus in meaningful ways on integration work in targeted areas where doing so will result in the biggest difference for the residents of King County.

6.2. Opportunities

The County Council's policy direction to develop a plan for an accountable and integrated system of health, human services and community-based prevention provides a specific, near-term opportunity for the County to align resources and expertise to change health and social outcomes. Using this two-department model, PHSKC and DCHS would initially focus integration efforts on the two strategic directions called out in the Motion 13768 response.

To catalyze improvement in the system's performance for everyone, the Health and Human Services Transformation Plan calls for an initial focus on areas where improved performance is most critical - areas where the we need to make sure the system works well for the people and the places who need it the most. Two early strategies, one focused on the individual delivery system and one focused at the community level, were found to present near-term, time-sensitive opportunities to accelerate progress – in part due to changes driven by the Affordable Care Act (ACA) implementation. The two areas are:

- Focused population – Improve health and social outcomes, while simultaneously reducing costs, for **adults in King County who have complex health and social needs** commonly characterized by high use of services and supports.
- Focused communities – Support **focused, high-risk communities in developing capacity and solutions that will improve the community features** that shape the health and well-being of their residents and the vibrancy of the neighborhood, such as housing, physical environment, adequate employment, and access to services.

The plan calls for improving alignment of strategies and investments across funders and sectors in support of these two strategies, and specifically indicates the need to model the change. That is, King County government will take steps internally to better align resources and strategies in support of the outcomes that these two early strategies intend to achieve. King County is one investor among many, and should model the change and the behavior that it is inviting and asking of others.

6.3. Organizational Chart

In this model, the organization charts for PHSKC and DCHS would, for the most part, remain unchanged and are found in Appendix B.

The figure below (Figure 6-1) reflects the intended integration of health and human services consistent with the strategies identified in the response to Motion 13768. Specifically, an Operations Integration Team would be established with appropriate representation from each department, with its intent and objectives defined in a formal memorandum of agreement between PHSKC and DCHS that would be developed in conjunction with the Executive Office. This team would review current interventions, information flows, resources, and outcomes relative to high risk individuals and high risk communities in each of the two departments. This effort would be managed by a dedicated staff facilitator.

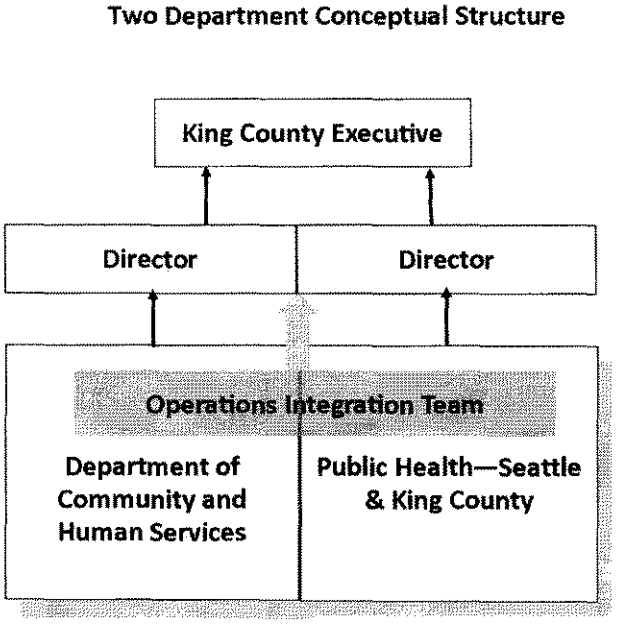

Figure 6-1: Two Department Conceptual Structure

6.4. Duplicative Programs and Administrative Structures

Although duplicative programs were not found to exist, some types of efficiencies may be identified over time. As the departments work to align their planning, interventions and performance measurement in selected areas, there may be streamlining in areas such as assessments, surveys, community outreach, and contract development and monitoring.

6.5. Anticipated Cost Increases/Expenditures

Under this organizational structure, resources would be needed to support the work of the cross-departmental Operations Integration Team. One anticipated cost increase would be for a position that would facilitate the team's work to align internal actions and resources in support of the Transformation Plan's strategies.

This work may also result in additional one-time or ongoing costs associated with internal system improvements, such as modifying or linking data systems where needed to provide better customer service.

6.6. Anticipated Efficiencies/Cost Reductions

No short-term cost reductions are anticipated under this option. There may, over time, be efficiencies in strategic planning and policy development to support similar clients and communities. Joint contracts and partnerships might also be anticipated. Long-term, focusing integration efforts on these two early strategies should result in reduced need for crisis services and reduced criminal justice involvement. To the extent that county systems see reduced costs in such areas as a result of the work, all or part of the savings should be reinvested back into the upstream health and human service strategies responsible for producing the cost reductions. This is a core principle laid out in the Transformation Plan's financing approach.

6.7. Potential Issues and How They Will be Mitigated

While the departments have historically shared expertise and coordinated their efforts, this new model will put into place a formal inter-departmental structure that allows for purposeful integration, including collectively developing goals and outcomes and aligning resources as appropriate. This model will require an infrastructure and accountability by both department directors, and strong communication and dialogue with the Executive Office.

One of the potential barriers is that program-level managers and staff may not always agree on priority strategies that would be most likely to produce the intended outcomes. Related to that, coordination of investments may be challenging due to the departments having separate allocation and decision-making processes. They may not be accustomed to having the other department involved in what historically may have been viewed as a "PHSKC specialty" or "DCHS specialty." To resolve these issues, the integration facilitator position will play a critical role, assuring that the focus remains on customers and outcomes, helping bridge across department cultures, making sure the right people are coming together, working to assure transparency, and facilitating the work to surface what strategies and investments stand to provide the greatest possible gain.

Other tools for proactively avoiding and resolving potential internal conflicts include the following:

1. **Memorandum of agreement**. DCHS and PHSKC will develop and execute a working agreement that defines and formalizes the business relationship by which both entities meet their objectives related to health and human services integration. The MOA will provide a framework for joint planning, strategy development, and resource development/allocation relative to priority strategies under the motion's Transformation Plan. Input from the Executive Office and County Council staff on this MOA will be important steps to help assure its success.
2. **Mechanisms for shared decision making regarding strategies and resources**. The Operations Integration Team will be expected to work collaboratively, making joint recommendations and resolving differences. Directors of PHSKC and DCHS will serve as sponsors of that team, supporting and guiding its work and resolving issues that cannot be successfully resolved by the team. If this second step of problem resolution were to fail, normal channels of resolution through the King County Executive would be activated.
3. **Examination of optimal organizational options.** The two-department model has in its implementation schedule periodic progress reports and check ins to assess whether the integration activities are producing the intended results, what is being learned, and whether course corrections may be warranted. This includes assessing whether or not organizing into a single department or other organizational structures would more effectively support the goals and outcomes.

6.8. Other Impacts

Contract/funder impact. No negative implications in deliverables to funders or contracts with agencies are anticipated with this model. As coordination efforts and planning become solidified, however, there is potential for shifts in contracts, contracting procedures, and reporting, as well as potential initial delays that can happen when changes are made in contracting. Feedback from some providers and advocates indicates a desire to preserve institutional knowledge, and this model would maximize that.

Staff impact. No significant staff impacts are anticipated with this option beyond the direction from leadership to continually identify ways to coordinate efforts. Some staff and managers would be expected to work in closer collaboration with fellow DCHS/PHSKC colleagues.

6.9. Code Changes Necessary

No code changes are required to implement this option. (Note: Independent of the proviso, PHSKC is working on house-keeping legislation at this time to update the code to reflect PHSKC's current structure (such as making Jail Health Services a division.)

6.10. Timeline and Milestones

Table 6-1: Implementation Plan A Timeline

Timeframe	Activities
Fourth Quarter 2013	• PHSKC and DCHS develop memorandum of agreement with input from Executive Office and Council
First Quarter 2014	• Cross-department Operations Integration team convenes, working on the two early strategies under Transformation Plan • Progress report (3/31/14)
Second Quarter 2014	• Operations Integration Team continues work to align PHSKC & DCHS services in support of the two early strategies
Third Quarter 2014	• Operations Integration Team continues work to align PHSKC & DCHS services in support of the two early strategies • Progress report (9/30/14)
Fourth Quarter 2014	• Operations Integration Team continues work to align PHSKC & DCHS services in support of the two early strategies • Report on initial evaluation of and learnings from the two-department model; review with County Council. (12/31/14)

Milestones

Execution of MOA:	By 12-31-2013
Progress Reports:	3-31-2014
	9-30-2014

Response to 2013 Budget Proviso P6

• • •

Initial Evaluation Report to County Council: By 12-31-2014

7. Implementation Plan B: Single Department with an Infrastructure to Produce Better Value and Outcomes

7.1. Overview

Implementation Plan B presents a single department model, one in which the functions of PHSKC and DCHS would be combined to establish a new department. This option is referred to as the "single department" model. The sections below describe in more detail the benefits and challenges anticipated by a shift to a single department, proposed organizational structure, cost impacts, and how anticipated issues would be resolved to support an effective implementation.

7.2. Opportunities

One of the key opportunities that exists under a single department structure is the same that was found to exist under the two-department structure—the opportunity to align internal activities and resources in ways that contribute in the most effective and efficient way possible to the outcomes being pursued under the Health and Human Services Transformation Plan. As discussed in the Situation Analysis, this is the chief work that needs to occur, regardless of whether PHSKC and DCHS are a single department or two departments. Under a single department model, concerted effort and an internal Operations Integration Team would still be needed given the diversity of programs, funding streams, and information systems that would be at play in a single, large department. In a single department model, the work would fall under the vision and leadership of a single director, eliminating the complexity of a dual decision-making structure regarding strategies and resources but requiring additional breadth of expertise and understanding of systems and services. Other opportunities of a single department are discussed in the sections that follow – along with the challenges.

7.3. Organizational Structure

The organizational chart for a single department is displayed below. It reflects a number of structural changes. First, it shows a model that includes eight operating divisions – the same divisions that exist today in PHSKC (five divisions) and DCHS (three divisions). Those divisions now would reside under one director. Over time, the department director may propose to modify the structure to more effectively and efficiently carry out functions, either adding or deleting divisions, or moving programs across divisions. The work to determine how the divisions and programs within a single department should be organized would need to be informed by the work to implement the Health and Human Services Transformation Plan and

more detailed analysis of the workflows and customers of specific programs. This was an important learning from the survey of other jurisdictions that had undergone structural changes—it was a process that occurred over time.

The organizational chart also shows the consolidation of PHSKC and DCHS cross-cutting functions (the organizational structure of which is not yet determined); these are department-wide functions that are not practical to base in a division because they lead or support agency-wide services and/or engage the community and external partners. In addition, business operations and administrative functions for the departments are reorganized into a single unit.

Another aspect of the single department structure is echoed from the two-department model—that is, the creation of the Operations Integration Team and an accompanying facilitator position, reporting to department leadership.

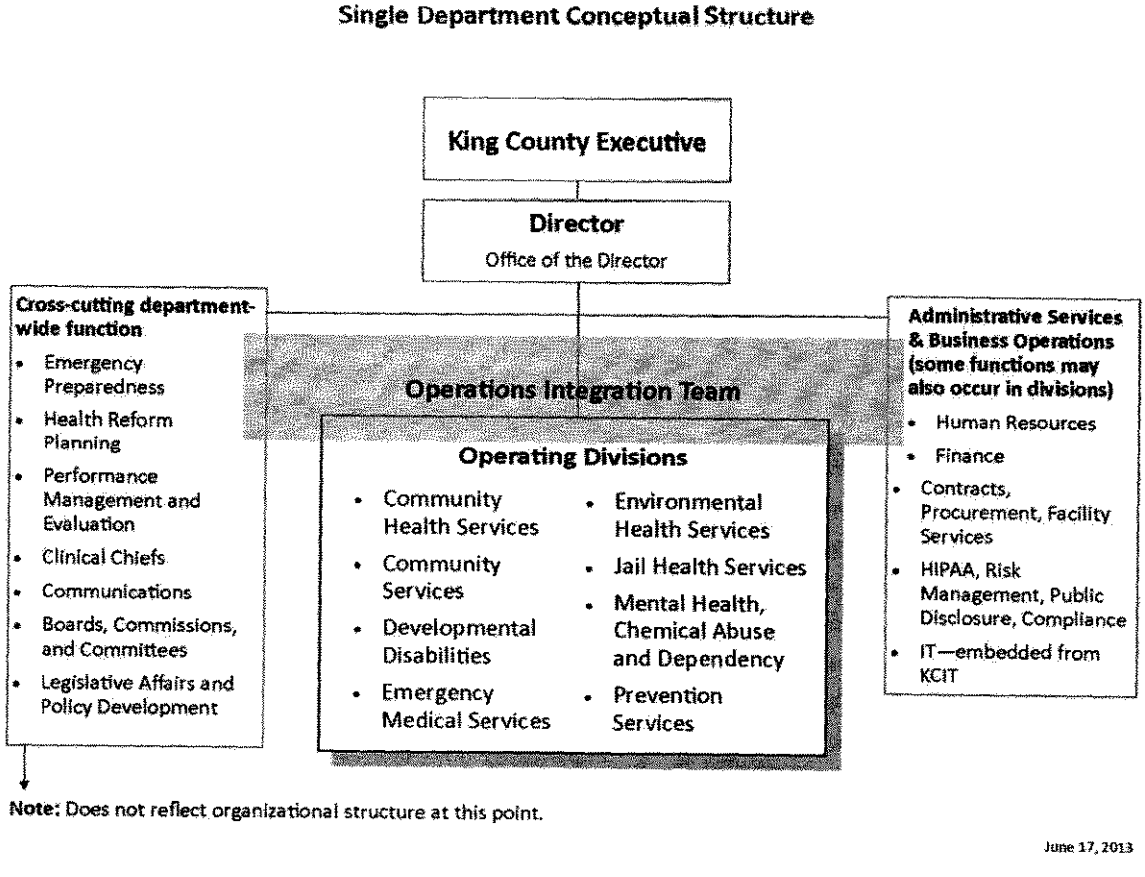

Figure 7-1: Combined Department Conceptual Structure

7.4. Duplicative Programs and Administrative Structures

In the area of program services, duplication was not identified. In some areas, common contractors, partners, and goals were found, but the nature of the work being provided or purchased was generally different, or in some cases targeted to different populations. For example, PHSKC contracts for certain behavioral health services, but for populations and/or services not covered by DCHS. As the programs work more closely in a single department structure, there may be streamlining in areas such as community assessments, community outreach, and contract development and monitoring. In the area of administration, some services were mirrored in both departments. Both departments have functions such as information technology, human services, finance, payroll, and contracting.

7.5. Anticipated Cost Efficiencies/Cost Reductions

Because the two departments provide different services to individuals and communities, significant savings would be unlikely to occur by bringing the two departments' services together. Some efficiencies, however, might be realized on a long-term basis once services staff are able to spend time working together and exploring options and opportunities at detailed levels. (Note that the same is true for the two-department model.)

Efficiencies in some administrative and business operations, over time. Some administrative and business operations are components of each of the two departments, which does present possibilities for business process re-engineering. Consistency in some functions--such as human resources, finance, payroll, and information technology—are driven by enterprise-wide systems and procedures. However, there are also complexities in this area. Some administrative processes and practices are highly tailored to each department's business needs and volumes, and they do not easily offer options to be combined in the short term for immediate savings.

Staff performing administrative functions in both departments are performing with full workloads and are at capacity. Administrative staff levels have been reduced in recent years due to the County's challenging budget and financial environment, but workloads have not been reduced commensurately. In many cases, changes in organizational structure would not change the volume of work (payroll transactions, contracts to monitor, invoices to process, media inquiries, or information requests, for example) and thus would have limited impact on the number of administrative employees needed.

Some desirable bodies of work have been repeatedly delayed or left undone in the current state, due to limited capacity and workload constraints. To the extent that some modest efficiencies are found, a single department could offer opportunities for administrative and business functions to perform work that is not well resourced now – as long as a merger/integration is not overly assumed to offer reductions in force in these functions.

KCIT savings may be possible, subsequent to system and business analysis and investment of funding to combine systems. Savings could not be expected in anything short of a three to five year horizon and would require a significant investment to analyze systems and make their functions seamless for clients and service provider staff. Also, it should be noted that KCIT staff knowledge of history and business uses for specific systems is highly prized by both departments.

Potential efficiencies with space. Although there does not appear to be any immediate opportunities for co-location of services, as was done when the DCHS Veterans Program moved into PHSKC space at the Fourth and Blanchard Building, there may be future opportunities for co-location of services.

Interdepartmental Memoranda of Agreement (MOAs) would shift to internal agreements. A single department would preclude the need for the interdepartmental MOAs and some elements of the associated financial transfers and tracking systems. However, internal working agreements between divisions and programs would still be needed to assure accountability.

There are five Memoranda of Agreement between DCHS and PHSKC:

1. Veterans and Human Services Levy MOA (approximately $3.9M from DCHS to PHSKC)
2. Mental Illness-Drug Dependency Action Plan (MIDD) MOA : approximately $5.1M from DCHS to PHSKC (includes supplantation funds)
3. Substance abuse services MOA. ($856,000 from DCHS to PHSKC)
4. Funding for phone line for Community Health Access Program to support Development Disability Early Intervention child find (approximately $30,000 from DCHS to PHSKC)
5. Business Associate Agreement between MHCADSD Forensic Assertive Community Treatment (FACT) and PHSKC Jail Health Services (No funding exchanged)

Potential for efficiencies with boards, commissions, and advisory groups. Currently constituted boards, commissions, and advisory groups should be reviewed in a single department structure to determine whether consolidation or reconfiguration could occur while still maintaining strong community partnerships and input. See Appendix E for a list of boards, commissions, and advisory groups.

Potential reductions in positions. The table below identifies potential position and budget savings that could be projected from the creation of a single department and the consolidation of administrative functions of PHSKC and DCHS. The two current departments use different organizational structures (one more centralized and one more decentralized) for performing some administrative functions. For dissimilar functions or structural models, more analysis would be required to determine the optimal structure for a single department, and to identify if any position reductions or other savings are possible. In addition, while some savings might be

anticipated via a thorough mapping of the individualized roles of specific administrative positions, more work is required to determine how such savings could be implemented due to the specialized nature of knowledge and work responsibilities assigned to individuals in the same job class across the two departments.

Table 7-1: Single Department Potential Position and Budget Savings

Preface: Position reductions identified below may not be able to be fully realized because, despite having the same classifications, the individuals performing the duties in the respective departments have full workloads and the work is not duplicative. To manage the combined workloads of the two departments and anticipated transitional work, an approach such as reclassifying any eliminated positions to create new positions would most likely be needed. The majority of any projected savings would therefore need to be reinvested into new positions.

								Potential Single Department Option Savings	
Department of Community and Human Services (DCHS) Administrative Functions	**FTE**	**Budget**	**Budget for Salaries and Benefits**	**PHSKC Administrative Functions**	**FTE**	**Budget**	**Budget for Salaries and Benefits**	Position	Potential $ savings (2014 total compen-sation)[4]
Department Director's Office (includes public disclosure, preparedness and process improvement)	5.0	$1,208,000	$729,000	Office of the Director	10	$1,600,000	$1,610,000	1 Director	$276,000
								1 Confi-dential Secretary II	$97,600

[4] This number does not represent a particular department's position. It is an average of the budgeted position costs in each of the two departments, which are themselves an average based on the salary plan and grade for the given position.

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								Potential Single Department Option Savings	
Department of Community and Human Services (DCHS) Administrative Functions	**FTE**	**Budget**	**Budget for Salaries and Benefits**	**PHSKC Administrative Functions**	**FTE**	**Budget**	**Budget for Salaries and Benefits**	Position	Potential $ savings (2014 total compen-sation)[4]
Human Resources	3.0	$636,000	$375,000	Human Resources (includes Employee Health)	13.5	$1,850,000	$1,693,000	1 HR SDM 2	$151,000
N/A (Public disclosure is included in Department Director's Office, Mental Health privacy and security in MHCADSD)				Business Standards and Accountability	9.5	$931,000	$986,000		

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								Potential Single Department Option Savings	
Department of Community and Human Services (DCHS) Administrative Functions	**FTE**	**Budget**	**Budget for Salaries and Benefits**	**PHSKC Administrative Functions**	**FTE**	**Budget**	**Budget for Salaries and Benefits**	Position	Potential $ savings (2014 total compen-sation)[4]
N/A (DCHS contracting function is distributed in the divisions to support services)				CPRES Contracts	4.0	$750,000			
N/A				CPRES Facilities	3.1	$325,000	$1,691,000		
N/A				CPRES Purchasing (Procurement, Warehousing)	7.2	$900,000			
N/A				CPRES Fleet Management	0.7	$200,000			
Finance and Administrative	24.5	$3,752,000	$2,682,000	Finance - Accounting	12.3	$1,520,000	$3,486,000	1 CFO	$151,000

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								Potential Single Department Option Savings	
Department of Community and Human Services (DCHS) Administrative Functions	**FTE**	**Budget**	**Budget for Salaries and Benefits**	**PHSKC Administrative Functions**	**FTE**	**Budget**	**Budget for Salaries and Benefits**	Position	Potential $ savings (2014 total compen-sation)[a]
Services - Accounting, Budget, Financial Planning, ABT support				Finance - Budget and Finance Special Services	9.0	$1,160,000			
				Finance - ABT Systems Support & Technical Assistance	1.0	$200,000			
Payroll	1.0	$173,000	$86,000	Finance - Payroll Services	6.4	$550,000			
Communications	1.0	$220,000	$133,000	Communication s	4.0	$455,000	$419,000		
KCIT (most staff not part of dept budget)	0.5	$4,082,000		KCIT (45 staff not part of dept budget)		$11,400,000		1 IT SDM in KCIT	$169,000
Total Admin	**35**	**$10,071,000**	**$4,005,000**	**Total Admin**	**80.6**	**$21,800,000**	**$9,885,000**	**5.0**	**$845,000**

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Preface: Position reductions identified below may not be able to be fully realized because, despite having the same classifications, the individuals performing the duties in the respective departments have full workloads and the work is not duplicative. To manage the combined workloads of the two departments and anticipated transitional work, an approach such as reclassifying any eliminated positions to create new positions would most likely be needed. The majority of any projected savings would therefore need to be reinvested into new positions.

								Potential Single Department Option Savings	
Department of Community and Human Services (DCHS) Administrative Functions	**FTE**	**Budget**	**Budget for Salaries and Benefits**	**PHSKC Administrative Functions**	**FTE**	**Budget**	**Budget for Salaries and Benefits**	Position	Potential $ savings (2014 total compen-sation)[4]
Total Services	**252.3**	**$363,167,000**		**Total Services**	**1,331.40**	**$306,000,000**		**N/A**	
Grand Total	**287.3**	**$373,238,000**		**Grand Total**	**1,412.0**	**$328,000,000**		**5.0**	

7.6. Anticipated Cost Increases/Expenditures

Development of a temporary transition manager/consultant team to execute the transition to a single department and manage the administrative, operational, labor, legal and communication changes. Significant planning is needed to successfully merge two departments. Failure to consider and plan for the long-term consequences can result in financial problems, loss of employee loyalty, lowered employee morale and reduced productivity. To assure a smooth transition, adequate one-time resources would need to be allocated to support the change process over a multi-year period. It is recommended that a temporary manager develop an implementation plan, hold the project to its schedule and budget, and serve as a point of accountability. The manager would coordinate activities across the former two departments (now one department) and across other County agencies that provide a variety of internal supports that may be affected by integration efforts or contribute to the health and human potential goal area. Effective change management practices will be critical to bridge the culture differences between the departments, in order to create a shared mission and vision for the areas that are being consolidated.

Costs associated with administrative function changes. Summarized below are several areas where cost increases are anticipated; most of them would be one-time costs. It is possible that some activities could be carried out as part of the normal responsibilities, while others may require added capacity or backfill of staff to allow time to work on the implementation of the single department.

a) **King County Information Technology.** Staff in KCIT that were consulted believe that the County is likely to see additional IT costs before savings because of the complex business needs of each department. The first step would be an analysis of business needs of a combined department and implementation of merged systems. It is important to recognize that each department has mission critical systems that must be maintained while the combined business needs are determined. Both departments utilize enterprise-wide IT systems, but each department has developed its own unique systems over time and IT staff for each department have been trained to support those systems and applications.
b) **Finance and Business Operations Division (FBOD).** Resources will be needed to develop the federally negotiated indirect rate or rates for a combined department. Currently DCHS has seven individual rates, ranging from 6.44% to 22.75%. PHSKC currently has one rate (25.85%) across the department, although previously it used multiple rates. Cost allocation schedules would need to be developed to reflect newly combined programs and establish a new rate or rates.

c) **Business Resource Center (BRC).** Resources will be needed to analyze how best to merge the departments' accounting structures, including providing best practice advice on what the resulting structure should look like. BRC staff and department staff will then need to transition accounting structures and redevelop reports for a combined department.

d) **Office of Labor Relations**. Costs will be associated with negotiation with bargaining units, which would need to occur before staffing changes can be implemented. This includes negotiating which bargaining unit will represent employees of the same job class, when there is more than one representing them in different settings now. It would also involve determining if there are other bargainable issues.

e) **Human Resources (HRD)**. Costs relating to employee moves are likely to affect both the HR staff in the departments and in the Human Resources Division. Updating employee information to bring them into a new department is estimated at six hours per position, which includes: drafting a new job description, providing a new hire letter to each employee to document the changes being made, entering changes into the Peoplesoft system, updating responsibilities in the EBS system, coordinating changes to position's bargaining unit, aligning salary and responsibilities with current standards, and resolving complaints/grievances.

f) **Payroll.** Costs would be associated with payroll changes, changes which would affect both central Payroll and the payroll staff in the departments. Specific changes, requiring about one and one half hours per employee, include: ensuring leave balances transfer, coordinating bargaining unit fees withdrawn from paychecks (if applicable) and implementation of other union contract specifics, and establishing payroll group and reporting structures.

g) **Communications.** Significant communications efforts will be required for a successful merger. This includes developing a single, consistent brand for the new combined department, developing and producing new signage and printed materials to help clients navigate the single department; developing communications for staff to explain the change and related milestones; and more.

Decrease in productivity and potentially revenue. The County can anticipate that creating a single department will have a negative impact in productivity for some individual staff or programs. A drop in employee productivity may result in lost revenue. PHSKC and DCHS both have funders that require completion of certain levels of services be met in order to draw down revenues. A drop in productivity, missing crucial deadlines, changes in workflows, and failure to catch financial irregularities leading to audit findings can all result from a loss or reassignment of key staff and the distraction of remaining staff. One jurisdiction interviewed cited a drop in productivity during the first year of merging departments, but also acknowledged it was in large

part due to reassignments without clear job descriptions, office moves that were not well executed, and poor communication which decreased both productivity and morale.

Decrease in morale and the ability to retain and recruit a skilled workforce. Bringing department cultures together will need to be addressed: The unsettling nature of a merger can result in the loss of key talent that is not easily replaced. King County employees have also experienced significant change in the last year, including the implementation of ABT, and "change fatigue" related to new initiatives is a very real factor. There have also been recent wage freezes, furloughs, and bargaining of wage concessions that have affected some parts of the workforce. While these are not reasons to avoid changes, the change process must take into account these and other recent environmental factors. Several jurisdictions interviewed underscored the importance of clearly communicating the reason for the change as well as benefits. Without articulating the 'why' behind the shift, the staff were under the false impression that merging was a change for change's sake, rather than a strategic and deliberate attempt to improve services and strengthen the organization's financial condition.

Opportunity costs. Perhaps most important, the shift to a single department carries opportunity costs. Staff and leaders would necessarily be focused inward at a time that may be particularly inopportune. The years ahead hold profound changes in a number of areas, such as health care reform and other changes and opportunities presenting themselves in the health and human services fields. Some highly significant changes in the delivery systems at the state and federal levels are being navigated at this time, and the departments will need to be increasing their focus to influencing these changes and addressing the impacts and opportunities they bring. Over time, as these changes evolve, they in turn may inform ore create opportunities for changes to organizational structure.

7.7. Potential Issues and how they will be mitigated

The path forward to successful reorganization into a single department will take action on a number of fronts, and require effective change management practices. Table 7-2 summarizes the major issues, discussed in other sections of this report, and the primary means by which they would be mitigated to enable the development of a single department to move forward.

Table 7-2: Issues and Resolutions

Issue	How resolved
Addressing potential negative impacts on employee morale, productivity, and retention	High quality, robust communications, transparency, and change management practices. Interventions to support morale.

Issue	How resolved
Addressing concerns of board and commission members	High quality, robust communications, transparency, and change management practices.
Contractor impacts and questions; community stakeholder questions	Frequent and effective communications
Assessment of specific impacts on revenues, funders, interlocal agreements	Inventory and proactively reach out to key funders (federal, WA State, City of Seattle, etc.) to inform them about the planned changes in order to identify and resolve impacts on revenue contracts.
Managing labor impacts	Tailored engagement with Office of Labor Relations and labor representatives Anticipate and plan for grievances
Use of different or tailored administrative policies, procedures, and systems in the two departments	Careful triaging of which policies, procedures, and systems must be immediately aligned or consolidated, versus those which can wait.
Opportunity costs: diversion of attention and capacity from health reform, Transformation Plan implementation, and other opportunities	Adequately resourced capacity to deal with the operational/administrative aspects of reorganization, plus adequately resourced capacity to work on implementation of the motion's early strategies. Even so, the issue of lost opportunities may not be able to be adequately mitigated due to the inherent level of day-to-day change and distraction that the move to a single department would entail.

7.8. Other Impacts

Contract Agencies. Both DCHS and PHSKC have a robust roster of contract agencies; PHSKC currently contracts with 206 agencies, and DCHS contracts with 291 agencies. Beneath these numbers are layers of complexity within larger entities like the University of Washington, which has multiple contracts in multiple departments with both PHSKC and DCHS. All told, DCHS has 921 active scopes of work with agencies and PHSKC has 270.

There are 33 agencies that contracted with both PHSKC and DCHS in 2012. Those agencies are:

• • •

Abused Deaf Women's Advocacy Services
Asian Counseling & Referral Services
Birth to Three Developmental Center
Boyer Children's Clinic
Center for Human Services
Consejo Counseling & Referral Services
El Centro De La Raza
Evergreen Healthcare
Evergreen Treatment Services
Friends of Youth
Harborview Medical Center
Highline Medical Center
Kent Youth & Family Services
Kindering Center
Lifelong AIDS Alliance
Mount Si Senior Center
Neighborcare Health
Refugee Women's Alliance
SeaMar Community Health Centers
Seattle Children's
Seattle Counseling Service
Seattle Indian Health Board
Seattle Public Schools
Senior Services
Sno Valley Senior Center
Snoqualmie Indian Tribe
Solid Ground Washington
Southwest Youth & Family Services
St. Francis Hospital
Therapeutic Health Services
University of Washington
Valley Cities Counseling & Consultation
YWCA of Seattle, King and Snohomish County

Although both departments hold contracts with these entities, this does not appear to be an area that would generate meaningful time or cost savings under a single department. There are two primary reasons for this. First, the shared contracts represent a very small percentage of the overall agency portfolio and even if contracts were combined, it would have only a marginal impact on staff workloads. Second, the scopes of work are varied, with different requirements, milestones, and start and end dates. For example, PHSKC contracts with the Snoqualmie Tribe for a local hazardous waste management program and DCHS contracts with the tribe for a youth suicide prevention program. With bodies of work this divergent, a combined contract does not result in efficiencies for the contracting agency either because very different staff at the contractor must review these scopes of work. There may be opportunities to provide contractors with better customer service through more coordination of monitoring and site visits, although the degree to which this is feasible is affected by customer organizational structure and preferences.

Contract Cities/Public Entities. PHSKC and DCHS have contracts in common with 11 cities: Black Diamond, Burien, Duvall, Enumclaw, Redmond, Renton, SeaTac, Seattle, Shoreline, Snoqualmie, and Tukwila. Among these contracts, there is very little (if any) opportunity to coordinate or consolidate, due to the contracts being housed in different city departments. DCHS contracts with one additional city and PHSKC contracts with 22 cities, two of which are EMS services provided for cities outside King County.

Impacts Related to City of Seattle Partnerships. Longstanding, valuable relationships exist between the City of Seattle, PHSKC, and DCHS, as reflected in various interlocal agreements, contracts, and working relationships. If King County were to pursue consolidation of PHSKC and DCHS into a single department, further dialogue with the City of Seattle would be needed to explore in greater detail the impacts in each area of partnership.

Seattle has a unique relationship with PHSKC that is unlike its relationship with any other County department or agency. The City values and supports having a strong, visible public health system that works to improve the health of the entire community. The City has expressed that a potential shift to a single department must not inadvertently have the effect of lessening or eroding this population-level health focus and Seattle and King County's longstanding partnership concerning PHSKC.

- ***PHSKC / Seattle Interlocal Agreement.*** Under state law, a local health department can take the form of a combined city-county health department by agreement of a city of 100,000 and the county in which it is located (RCW 70.08.010). For many years, King County and the City of Seattle have had such an agreement in place, last updated and renewed by the City of Seattle and County Councils in 2011. The interlocal specifies that King County is responsible for providing core public health services to residents countywide; the City provides funds to enhance services for Seattle residents, making more services available to more people and improving access to health care for underserved populations. The County and the City also work jointly to develop public health priorities for the region and have established a combined department "in order to create the conditions that improve the health of all communities, eliminate health inequities and maximize the number of healthy years lived by each person." The interlocal also specifies the name of the department. Under a single department model, some terms of this interlocal agreement may be impacted and would need to be renegotiated and updated.
- ***Board of Health.*** Membership of the Board of Health is prescribed in King County code (2.35.021), to align with the County's relationship with the City of Seattle and the state law (RCW 70.05.060) duties and responsibilities. Among others, the Board of Health includes three elected officials from the City of Seattle, appointed by the City. No specific impacts on the Board of Health are anticipated under a single department model.
- ***Area Agency on Aging Interlocal Agreement.*** An Interlocal Agreement exists between King County, United Way of King County and the City of Seattle regarding the administration of the Area Agency on Aging (AAA) for King County. Because the AAA for the region is administered by Seattle Human Services Department, this agreement (which as of this writing is in the process of being renegotiated) establishes roles and

responsibilities of the administrators, sponsors, staff and Advisory Council for local AAA programming. Because the AAA Interlocal is with King County (versus one of the departments), there are unlikely to be impacts. There may be value in a closer working relationship between PHSKC and DCHS relative to the AAA, given the chronic disease burden of the growing older adult population, as well health reform impacts affecting the AAA.

- ***Public Health – Seattle & King County/Seattle Contracts.*** PHSKC has a significant financial relationship with the City of Seattle, in which the City invests $10.2 million in 2013 for enhanced public health services provided to Seattle residents and more than $5 million for early learning/student/school-based health services funded by the City's Families and Education Levy. The City's General Fund health investments are contracted to PHSKC through the City's Human Services Department (HSD) and includes funding in such areas as the community health center/health safety net system, health services for homeless individuals and families, access and outreach, HIV/AIDS services, Needle Exchange, oral health, and more. The City's Families and Education funding is overseen by the City's Office for Education. Contracts are also in place between PHSKC and HSD for health promotion and disease prevention services in Seattle child care facilities. Furthermore, the City provides a modest amount of funding to PHSKC leadership in recognition of the unique role that PHSKC has within Seattle City government.
- ***Seattle/ DCHS Contract.*** DCHS has revenue contracts with the City (through HSD) of over $1 million per year for mental health, chemical dependency, MIDD, geriatric drug/alcohol assessment services, and housing services coordination.
- ***Agreement with Seattle Office of Housing.*** DCHS has agreements with the City of Seattle Office of Housing regarding housing service planning, including a collaborative effort with the City of Seattle, Seattle Housing Authority, and United Way of King County to create an internet search engine to track real-time vacancies of rental units, to assist individuals and families in finding affordable housing, and as part of the long-term recovery planning for emergency management.
- ***Committee to End Homelessness.*** DCHS receives support from the City of Seattle Office of Housing and Human Services Department, and United Way of King County, to staff the Committee to End Homelessness.

7.9. Code Changes Necessary

King County Code revisions would be needed to describe the new department, its powers, and the duties of its divisions. This process likely would require at least six months. In the Code today, 2.16.080 describes the duties of each division within PHSKC, and 2.16.130 describes the duties of each division within DCHS.

Assuming the single department model results in a new department name, there are also a number of areas of code that will need to be changed to reflect this. These areas are listed in Appendix F.

7.10. Timeline and Milestones

This section provides high-level view of the major transition workflows, nature of action needed, and approximate timing.

Table 7-3: Implementation Plan B Timeline

Transition Issue	Actions Needed	Timing
Employee morale	• Quality communication strategy to explain why the merger is occurring, what benefits are expected, how employees will be affected, and how the change will be managed. • Design and carry out interventions to support morale, such as supplemental employee assistance program services, Lean events to support new workflows, team-building activities, and more.	Needs to be in place prior to merger occurring and continue as long as warranted.
Development of detailed organizational structure	• Assume most existing divisions would be maintained (at least initially). • Design of administrative and support units will involve the greatest complexity.	Process requires at least 2-3 months, and ideally having the organizational structure determined at least 6 months before a merger is desirable.
Process for selection of senior managers (director, HR manager, Finance director, etc.)	• Leaders need to be identified well in advance so they can plan and implement merger. • Process likely to be contentious; individuals not chosen for senior roles may depart, leaving gaps in leadership.	Ideally have team in place 6 months before a merger occurs.

Transition Issue	Actions Needed	Timing
Legal analysis and code revisions	• Identify and resolve legal issues, such as specific requirements of state law. • Revise King County Code to reflect new department and its powers.	Requires at least 6 months
Labor relations	• Work with unions on jurisdictional issues, bumping rights, and potential position reductions.	Must occur in advance of a merger and would likely take 4-6 months Depending on issues identified, expect to continue 6-12 months after merger occurs
Human resources	• Consolidate HR support staff, which would likely involve new assignments and reporting relationships for some. • HR staff are critical to success of a merger, so any stress in the HR unit would complicate the merger.	Requires careful planning in advance of a merger and requires at least 4-6 months.
Classification Issues	• Anticipate some classification issues will arise; similar positions may be titled and compensated at different levels which will become apparent over time.	Expect that this would take 1-2 years after a merger to fully resolve.
Finance, budgeting, and accounting.	• Need to merge these staff, which would likely involve new assignments and reporting relationships for some. • Would need at least one new appropriation unit (may be able to use existing ones for an interim period). • Eventual standardization of budget and accounting practices will be needed.	Some advance planning in this area would be needed, requiring 4-6 months. Full implementation of merged financial systems would likely require considerable resources and take at least two years. Coordinate timing with the biennial budgets.

Transition Issue	Actions Needed	Timing
Technology	• Would need to merge IT support staff within KCIT. • Gradually integrate networks and other systems.	Most can occur gradually during or before a merger
Facilities	• Need to plan for some space relocations over time. At first, staff may remain in existing locations but co-location of common functions will likely be desirable.	Can be done after a merger
Administrative changes	• Updating of phone directories, web sites, contracts, building signage, business cards, etc.	Anticipate to the extent possible and put in plans to implement these changes at the time a merger occurs
Customer and supplier communications	• Development of communications strategy for contracted service providers, advisory boards, and state and federal agencies. • Purpose is to explain why the merger is occurring, what benefits are expected, and how customers would be affected.	Needs to be in place prior to merger occurring and continue as long as warranted.

High-level Schedule for Development of a Single Department

Month 1:	County Council Legislation Communications plan
Months 2:	Transition team/consultants established
Months 3, 4:	Detailed organizational structure (by end of month 4)
Months 5, 6:	Selection of senior managers (by end of month 6)
Months 7, 8, 9, 10, 11:	Working through labor issues Consolidation of HR staff Consolidation of Finance staff Standardize certain budget & accounting practices Legal issues and code changes Staff morale interventions
Month 12:	Single department goes into effect

Month 12-36:	HR: Position classification issues Labor issues Administrative changes Integration of IT networks Budget and accounting standardization Space relocation (per business needs) Potential shifts in operating divisions if and when needed Staff morale interventions
Month 36+	Potential shifts in operating divisions if and when needed

Appendix A Acknowledgements

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David Bibus, Prevention Division Deputy Director, Public Health – Seattle & King County
Allen Cantara, Contracts Specialist, Public Health – Seattle & King County
Meagan Condon, Jail Health Project Manager, Public Health – Seattle & King County
TJ Cosgrove, Deputy Director of Community Health Services Division, Public Health – Seattle & King County

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George Dignan, Work Training Program Administrator, Department of Community and Human Services

Tyler Entrekin, Public Health – Seattle & King County Project Manager

Greg Ferland, Community Services Division Director, Department of Community and Human Services

Charissa Fotinos, Medical Director, Public Health – Seattle & King County

Rene Franzen, Department of Community and Human Services Program Manager

Sherry Hamilton, Communications Manager, Department of Community and Human Services

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Mike Holman, Goods and Services Administrator, Public Health – Seattle & King County

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Randy Inouye, Business and Finance Officer, Department of Community and Human Services

Betsy Jones, Health and Human Potential Policy Advisor, Executive's Office

Marcy Kubbs, Community Services Division Project Manager, Department of Community and Human Services

Ben Leifer, Chief Administrative Officer, Public Health – Seattle & King County

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Terry Mark, Department of Community and Human Services Deputy Director

Cheryl Markham, Housing and Community Development Program Manager, Department of Community and Human Services

Karen Millman, Prevention Division Director, Public Health – Seattle & King County

Don Moritz, Human Resources Service Delivery Manager, Public Health – Seattle & King County

Ngozi Oleru, Environmental Health Division Director, Public Health – Seattle & King County

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Dennis Worsham, Chief of Staff, Public Health – Seattle & King County

Esther Wu, Business and Finance Officer, Department of Community and Human Services

Alex Yoon, Finance and Administrative Services Manager, Department of Community and Human Services

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Appendix B Organizational Charts

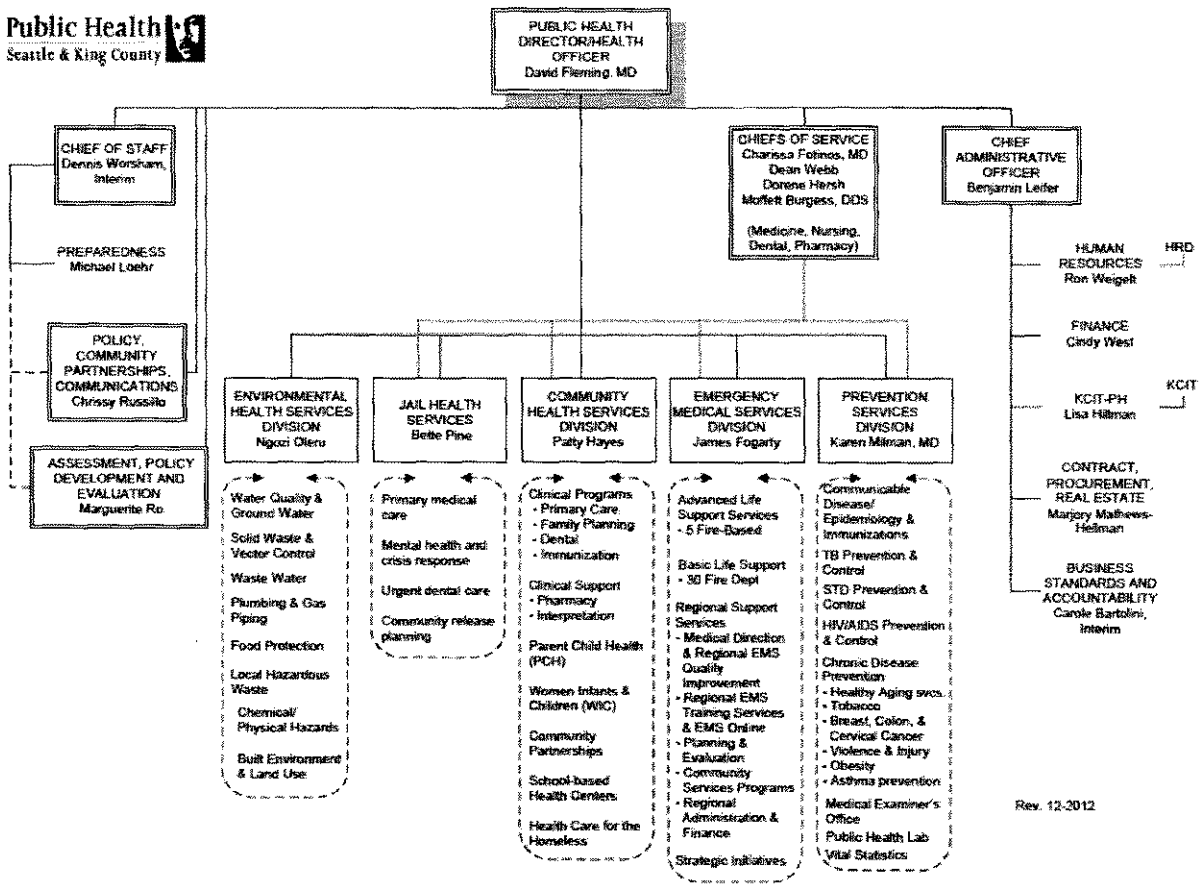

Figure B-1: PHSKC Organizational Chart

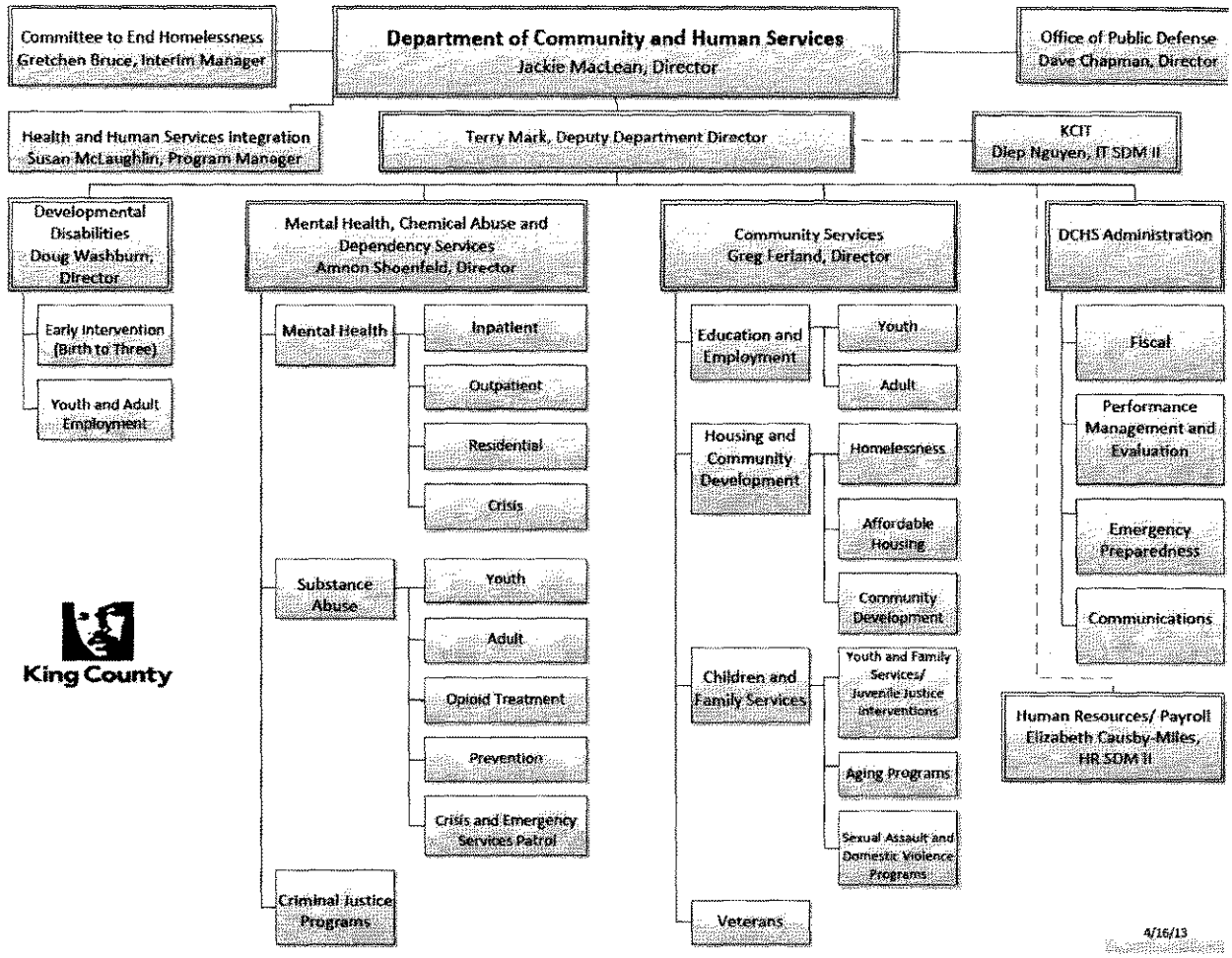

Figure B-2: DCHS Organizational Chart

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Appendix C King County's Current Programs in Public Health and Human Services

The tables below summarize the analysis the staff team conducted of the current programs and administrative functions of PHSKC and DCHS. The breakdown of programs and administrative functions was done only for the purpose of facilitating analysis and discussion of potential areas of overlap/duplication, and identifying areas where major collaborations exist today.

Table C-1 and Table C-2 represent the overview of program functions in each department, including which division a program is in, a brief description of the program, service provision makeup (direct service or contracts), funding sources and current collaboration with PHSKC (for DCHS) or DCHS (for PHSKC).

Table C-1: DCHS Program Functions

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Criminal Justice Diversion/ Mental Health, Chemical Abuse & Dependency Services Division (MHCADSD)	These programs reach individuals with mental health and substance abuse disorders at all junctures of the criminal justice system and link them to appropriate services and supports. Individuals as screened and assessed for mental health and substance abuse disorders in jails or community corrections programs and linked to treatment and housing resources.	DCHS contracts with a range of community mental health and substance abuse treatment providers as well as housing programs. Funding sources include the Mental Illness Drug Dependency sales tax, the WA Department of Social and Health Services (DSHS), the Veterans and Human Services Levy, the City of Seattle, and Medicaid	MHCADSD collaborates with PHSKC release planners in the jails to ensure connection to services

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Early Intervention Services/ Developmental Disabilities Division (DDD)	These programs assist parents with building the skills needed to meet the developmental and health needs of their children from birth to three who have special needs, including opportunities to meet and share experiences with other families. They also help families learn more about using community resources and connecting to the community.	DCHS contracts with 16 community agencies to provide intervention services. Funding comes from a variety of sources including Medicaid, school districts, Individuals with Disabilities Education Act Part C, King County DDD millage funds, and charitable contributions	This programs provides partial funding through an MOA for PHSKC's Community Health Access Program phone line and to support efforts to identify children with developmental delays in hospitals, other medical settings, or home visits by agency nursing staff
Adult Employment and Day Services/DDD	These programs provide employment support services to individuals with developmental disabilities including individual and group employment support, a school to work program to assist high school students with jobs in community settings, and a community access program to assist adults over age 62 to participate in community activities.	DCHS contracts with a network of approximately 30 providers. Funding comes from the state Division of Developmental Disabilities, State Division of Vocational Rehabilitation, school districts, DDD millage funds.	There are no current connections with PHSKC

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Community Information and Education/DDD	These programs provide outreach, information and referral, advocacy and leadership training, parent training and emergency housing assistance to families of individuals with developmental disabilities. They provide family support through ongoing Parent Coalition meetings and parent-to-parent programs that provide opportunities for parents who have children with developmental disabilities to connect with other parents.	DCHS contracts with community-based providers to deliver services. Funding sources include the State Division of Developmental Disabilities and King County millage funds.	There are no current collaborations with PHSKC.
Community Outreach/ MHCADSD	This program provides outreach to hard to reach substance-abusing individuals and links them with assessment and treatment services	DCHS contracts with community-based substance abuse providers. Funding comes from grants, federal and state sources and local sales tax revenue	Contracted agencies collaborate with PHSKC staff at jail health, the public and community health centers, and Healthcare for the Homeless to find and link these hard to reach individuals to treatment

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Chemical Dependency Outpatient Treatment/MHCADSD	MHCADSD provides outpatient chemical dependency treatment for adults and youth and include individual and group treatment as well as Opioid Treatment services. The Opioid Treatment Program is a specialized program for treating addictions to opiates.	DCHS contracts with over 40 certified community-based substance abuse treatment providers. Funding comes from grants, federal and State dollars and local county sales tax.	Outpatient treatment providers collaborate with PHSKC staff at jail health (intake and release) and with the public health centers. MHCADSD has multiple points of collaboration: (1) substance abuse screening in health centers. (2) nicotine dependency treatment to individuals in the OTP program via PHSKC Tobacco Prev. Program. (3) the PHSKC Needle Exchange Program to manage the OTP waitlist

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Crisis Diversion, Intervention and Stabilization/ MHCADSD	These adult programs provide crisis outreach, stabilization, and temporary placement for children, youth, adults, and older adults experiencing a mental health crisis. Services include the adult crisis diversion facility, mobile crisis teams for children, adults, and older adults, and crisis diversion interim services (respite housing) while permanent supportive housing is being located. Services also include a 24/7 crisis line and Crisis Intervention Training for law enforcement officers and other first responders.	DCHS contracts with a range of licensed community-based providers to deliver crisis services. Funding comes from the Mental Illness Drug Dependency (MIDD) sales tax.	Providers coordinate with PHSKC EMS staff, public health center staff, and targeted other public health services to meet the health and recovery needs of clients.
Crisis Telephone/ MHCADSD	This program provides 24/7 telephone screening, initial assessment for triage, and referral to services for individuals experiencing a crisis and/or emergency for whom a mental health disorder cannot be ruled out	DCHS contracts with the King County Crisis Clinic. Funding comes from State Mental Health Funds	There are no current collaborations with PHSKC

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Crisis Outreach and Involuntary Commitment Services/ MHCADSD	These services are intended to provide rapid assessment and intervention and linkage to stabilization services for adults and children/youth. Crisis and Commitment Services also conduct involuntary detention evaluations, and exercise authority under the Involuntary Commitment Act to involuntarily hospitalized adults and children age 13 and older who meet legal criteria. Services also include involuntary commitment for severely alcoholic or addicted individuals who meet legal criteria under law.	DCHS contracts with a variety of licensed community-based providers. Crisis and Commitment Services are provided directly by County staff. Funding comes from Medicaid, state general funds, the MIDD sales tax, federal block grants, and the State Division of Child and Family Services	There are no current collaborations with PHSKC
Employment and Clubhouse/MHCADSD	Supported Employment Programs provide assessment, job placement, and ongoing support for individuals with mental illness to find and retain jobs. Clubhouse programs provide a peer community to support individuals with mental illness community that is structured on a work-ordered day.	DCHS contracts with licensed community-based providers. Funding comes from state funding, the Mental Health Block Grant and MIDD sales tax	There are no current collaborations with PHSKC

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Detox/Sobering/ Emergency Services Patrol/MHCADSD	These services provide 24/7 access to services for individuals who are affected by alcohol or other drugs. They provide a safe and secure place for persons to sleep off the acute effects of alcohol or other drug intoxication; 3-5 days of medically supervised detox; case management, nursing and linkage to outpatient treatment services. The Emergency Services Patrol provides engagement and transportation to detox and other services to relieve fire, police, and medics.	DCHS contracts with Pioneer Human Services for Sobering and Recovery Centers for Detox. The Emergency Services Patrol is staffed by King County employees. Funding comes from a variety of sources including Housing and Urban Development (HUD), the City of Seattle, federal Substance Abuse Prevention and Treatment grants, the MIDD sales tax and the Veterans and Human Services Levy	This program collaborates with PHSKC Emergency Medical Services regarding transportation issues and with the Health Care for the Homeless program on case management services and nursing service integration.
Mental Health Outpatient Services/ MHCADSD	These programs provide a range of services including individual and group therapy, medication management and care coordination to children and adults with mental illnesses.	DCHS contracts with 19 licensed community mental health centers. Funding sources include Medicaid, State funds and MIDD sales tax.	Providers coordinate with public health centers. MHCADSD collaborates extensively with PHSKC on disaster behavioral health planning
Housing and other supports/MHCADSD	These services are designed to help people find and retain housing and include treatment provided in housing settings, daily living skills development, case coordination, housing locator, eviction prevention and rental assistance	DCHS contracts with community mental health and chemical dependency treatment providers and community-based housing providers. Funding comes from Medicaid, federal grants and local county funds	There are no current collaborations with PHSKC

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Psychiatric Inpatient/ MHCADSD	Services include acute care provided in psychiatric hospitals and free-standing evaluation and treatment facilities	DCHS contracts with hospitals and free-standing evaluation and treatment facilities. Funding comes from Medicaid and State mental health funds	There are no current collaborations with PHSKC
Prevention/ MHCADSD	These programs work with communities to develop and implement programs, coalitions, and/or stakeholder groups for the prevention of youth alcohol/drug use and violence. These programs provide school-based youth suicide prevention as well as mental health and substance abuse treatment	DCHS contracts with community-based providers. Funding comes from the State Department of Commerce, the State Division of Behavioral Health and Recovery and the MIDD sales tax	Collaborations with PHSKC include the Traffic Safety Coalition, the MOMS Plus program (targeting pregnant women with substance abuse issues), and the Tobacco Prevention Program
Wraparound and Family Support/ MHCADSD	Wraparound provides a team-based approach to meet the needs of children and families involved in multiple systems. The Family Support Organization provides peer specialists to help families navigate child-serving systems and provide training, mentoring, advocacy and networking	DCHS contracts with licensed community mental health centers and family support organizations. Funding comes from the MIDD sales tax, Medicaid, federal block grant, and the Department of Social and Health Services	There are no current collaborations with PHSKC
Residential Treatment Services/MHCADSD	Provides supervised residential treatment with individual and group treatment, medical supports and assistance with daily living for individuals with mental illness	DCHS contracts with licensed community mental health and chemical dependency providers. Funding comes from Medicaid and State funds	Providers collaborate routinely with public health centers

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Affordable Housing/ Community Services Division (CSD)	Provides funding for new units of affordable housing and preservation of existing housing as well as funding for health and safety improvements to low-moderate income homeowners	DCHS provides grants to eligible housing agencies/authorities and directly to homeowners. Funding comes from federal Community Development Block Grants and HOME Block Grants; document recording fees, and local Veterans and Human Services Levy	There are no current collaborations with PHSKC
Human Services/ CSD	Provides funding for 26 programs in three categories (1) ending homelessness; (2) improving health and behavioral health; (3) strengthening families. Programs also include domestic violence and sexual assault survivor services, senior and older adult services, juvenile justice intervention, and youth and family services	DCHS contracts with 105 community-based organizations and provides funding to other King County programs including PHSKC. Funding comes from the Children and Family Services fund, County General Fund, Veterans and Human Services Levy and MIDD	DCHS maintains formal contracts/ agreements for the following programs: (1) homeless street outreach; (2) integrated care; (3) health care reform work; (4) nurse family partnership; (5) healthy start; (6) family, friend and neighbor care; (6) cultural navigator; and (7) promoting first relationships train-the-trainer program

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Veterans Services/ CSD	These programs provide crisis intervention, outreach, safety net services, case management, connection to employment and education services, linkage to treatment and housing, and an information and referral line for veterans and their families.	A combination of direct services and contracts with the Washington State Department of Veterans Affairs, Workforce Development Council, Committee to End Homelessness, Aerospace Alliance, and community providers. Funding comes from the Veterans and Human Services Levy and King County millage	DCHS has formal contracts with PHSKC for ending homelessness and increasing access to behavioral health services
Homeless Housing/ CSD	These programs provide time-limited homeless housing, emergency shelters and transitional housing, rental assistance, permanent supportive housing and other on-site services	DCHS contracts with community-based providers. Funding comes from the state Department of Commerce, MIDD sales tax, the Veterans and Human Services levy, document recording fees, a variety of federal grants, and private foundation grants	Providers collaborate with public health centers. DCHS collaborates with PHSKC on data sharing
Community Development/ CSD	These programs administer the federal Community Development Block Grant for projects that benefit low to moderate-income communities and households. Activities include rehabilitation and construction for facilities providing vital community programs, infrastructure projects such as water/sewer, roads, sidewalks, lighting, disability accommodation and parks rehabilitation, and economic development such as microenterprise business support and small business loan programs	DCHS provides annual competitive funding for capital community development and contracts with non-profit agencies, housing authorities, and local jurisdictions. Funding comes from the federal department of Housing and Urban Development, primarily CDBG	There are no current PHSKC collaborations

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Employment and Education Resources for Youth/ CSD	These programs provide strength-based assessment, individualized education/employment planning, work experience/internships, General Education Degree (GED) preparation, career counseling, and access to post-secondary education/advanced training. These programs also provide Youth and Family Service Agency (YFSA) services and juvenile justice prevention and intervention.	Employment programs are provided by DCHS staff. Youth and family services are provided through contracts with 21 community agencies. Funding comes from the Workforce Development Council, Shoreline Community College, Bellevue College, Renton Technical College, King County Superior Court and Public Health-Seattle & King County.	DCHS partners with PHSKC on the Nurse Family Partnership Employment and Education Enhancement project for young parents
Employment and Education Resources for Adults/ CSD	These programs provide education, training, and employment services to dislocated workers, adults with criminal backgrounds, and the homeless individuals. Services include assessment, individualized career planning, enrollment into education and training programs, including funding for training when applicable, job readiness training, job search assistance, and job placement, and retention support.	Services are provided through a combination of King County staff and contracts with community-based agencies. Funding comes from the Workforce Development Council, Washington State Department of Employment Security and Labor and Industries, Renton Technical College, Basic Food Employment and Training Funds, Job Corps, the King County Children and Family Services fund and the Veterans and Human Services Levy	There are no current collaborations with PHSKC

DCHS Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with PHSKC
Health Reform Planning/Director's Office	These programs provide planning, briefing, impact analysis and implementation of health reform-related initiatives and activities for the entire department.	Services are provided by DCHS staff; costs shared by divisions within DCHS.	DCHS collaborates extensively with PHSKC director's office and health reform staff including co-chairing the Health Reform Planning Team
Data and Performance Management/ Director's Office	This section is responsible for evaluation design, performance measurement, contracting and business process improvement; conducting evaluations of DCHS programs, data collection, surveys and focus groups	Services are provided by DCHS staff; costs shared by divisions within DCHS	DCHS and PHSKC collaborate on Communities Count data as well as the Health and Human Potential performance measures for AIMS high; the departments will be working together on examining the capacity of the health and behavioral healthcare systems.
Psychiatric Medical Director/MHCADSD	This section provides guidance, leadership, oversight, utilization management, and quality assurance for the mental health programs of the King County Mental Health Plan	Services are provided by DCHS staff; funding from state	DCHS collaborates with the PHSKC medical director

Table C-2: PHSKC Program Functions

PHSKC Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with DCHS
Access and Outreach/Community Health Services	This program provides assistance for individuals to enroll in publicly funded health insurance and other benefits - includes education, referral and linkage to health and human services	Services are provided by PHSKC staff, with partnerships with many community organizations. organizations – including health systems, human services agencies, and managed care organizations. Primarily grant funded.	PHSKC collaborates with DCHS on shared clients
Assessment, Policy Development and Evaluation	This unit is responsible for assessment and evaluation of population-based data and interventions as well as policy development	Services are provided by PHSKC staff. Funding from King County General Fund; State Local Capacity Development Fund; Medicaid Administrative Match; State Public Health Funding; City of Seattle; and grant revenue for specific studies	PHSKC and DCHS collaborate on the Communities Count data as well as the Health and Human Potential performance measures for AIMS high; the departments will be working together on examining the capacity of the health and behavioral healthcare systems

PHSKC Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with DCHS
Chronic Disease and Injury Prevention/Prevention Division	These programs focus on preventing behaviors leading to disease, averting injuries, and preventing and managing chronic health conditions such as asthma and diabetes	Services are provided by PHSKC staff as well as contracts with 40 service delivery providers. Funding comes from State Public Health Funding; State Local Health Fund funding; State Local Capacity Development Fund funding; and grants for Obesity and Tobacco Prevention, Breast and Cervical Health, Asthma prevention, and other smaller grants	PHSKC collaborates with DCHS around issues in low-income housing such as tobacco prevention, developing built environments for healthy living and management of asthma and other chronic illnesses.
Chiefs of Service/Director's office	Chiefs of Medicine, Nursing, Dental and Pharmacy professional services. Oversees credentialing of care providers, recruitment of nursing workforce; monitoring of professional licenses; staff development and training; quality assurance	Services are provided by PHSKC staff Funding comes from operating units of PHSKC that provide clinical services	PHSKC chiefs coordinate with DCHS on the design and clinical quality aspects of various medical/ behavioral health integration projects and issues.

PHSKC Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with DCHS
Communicable Disease, Epidemiology, and Immunizations/Prevention Division	These programs detect, monitor and control the occurrence and impact of infectious diseases of public health significance in King County and assure immunization coverage	Services are provided by PHSKC staff, in collaboration with healthcare providers, WA State Department of Health, King County Medical Society and WA Chapter American Academy of Pediatrics, WA Immunization Coalition, and Global to Local Funding comes from King County General Fund; State Public Health funding; State and Federal grants; Medicaid Administrative Match and Fees for Service	There are no current collaborations with DCHS
Community and School-Based Partnerships/Community Health Services	These programs manage outcomes-based investments and provide technical assistance, training and program quality oversight. Includes school-based health services to youth and young adults; health promotion and disease prevention consultation to child care centers; support community health centers mental health, medical and dental services	Services are provided by PHSKC staff in partnership with community organizations and schools. Funding from the Veterans and Human Services Levy, MIDD sales tax, Seattle Families and Education Levy, federal Maternal & Child Health Block Grant and WA State Department of Early Learning	PHSKC holds formal agreements with DCHS for the Veterans and Human Services Levy and MIDD funding and partners with DCHS in implementation of the Mental health Integration Program (MHIP) and Screening, Brief Intervention and Referral to Treatment (SBIRT).

PHSKC Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with DCHS
Dental Program/Community Health Services	This program provides clinical dental services at public health centers, on through the mobile dental van services, and through the school-based sealant program	Services are provided by PHSKC staff Funding from patient-generated revenues and grants.	Downtown Dental Clinic is part of the chronic homeless system coordination and partners with supportive housing to prioritize access. Also prioritizes clients of Drug Court.
Emergency Medical Services/Emergency Medical Services Division	PHSKC manages the countywide Medic One/EMS system, a partnership with five dispatch centers, six paramedic providers, and thirty fire departments. Includes collaboration with local hospital emergency departments, private ambulance companies, jurisdictions, and other organizations. The program provides advanced Life Support, Basic Life Support, Regional Services and Strategic Initiatives	Services are provided by PHSKC staff and through contracts. Funding comes primarily from the Emergency Medical Services property tax	Coordination between EMS and DCHS occurs related to transport issues involving those with behavioral health issues
Environmental Health Services Environmental Health Services Division	This program provides five categories of service (1) Food and Facilities Protection; (2) Environmental Hazards; (3) Community Environmental Health; (4) Engagement, Equity and Social Justice; (5) and Healthy Community Planning, Enforcement and Emergency Preparedness	Services are provided by PHSKC staff; Funding comes from fee for service revenue collected from customers	PHSKC has some but limited coordination with DCHS on the Healthy Communities planning

PHSKC Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with DCHS
Family Planning/Community Health Services	This program provides access to reproductive health, sexually transmitted disease screening, breast and cervical cancer screening and referral, health education and risk reduction to low income women, men and teens.	Services are provided by PHSKC staff Funding comes from patients generated revenue, dedicated federal and state funding, and grants	There are no current collaborations with DCHS
Healthcare for the Homeless Network/Community Health Services	This program organizes access to an integrated array of medical and behavioral health services, street outreach and case management, health services in shelters, day centers, transitional, and supportive housing, and recuperation program through clinics specialized for homeless individuals	Services are provided through contracts with safety net health and behavioral health providers, and through PHSKC staff who provide technical assistance and clinical services. Funding comes from federal healthcare for the homeless grant, City of Seattle, Veterans and Human Services Levy, MIDD, United Way, grants, and McKinney Housing and Urban Development funds	PHSKC has extensive coordination with Sobering Center, connecting clients to mental health services, needle exchange/ methadone clinic, committee to end homelessness, medical respite and MIDD data reporting

PHSKC Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with DCHS
Parent Child Health/Community Health Services	Targeted services and supports for low-income mothers, infants/children, and families. Programs include Maternity Support Services, Infant Case Management, Early Post Birth Services, Early Intervention Project, Early Family Support Services, Children with Special Health Care Needs, Infant Mortality Prevention Program	Services are provided through contracts and by PHSKC staff Funding comes from patient- generated revenue (primarily Medicaid), state funding, grants, Veterans and Human Services Levy, City of Seattle, King County general fund, and contracts with managed care organizations	Partners with DCHS on the Nurse Family Partnership Employment and Education Enhancement project for young parents enrolled in NFP, and on certain Veterans& Human Service Levy funded early childhood intervention programs
HIV/STD/ Prevention Division	This program provides HIV Care Planning, HIV Prevention Planning, STD Clinic, HIV/STD Partner Services, Syringe Exchange, HIV/STD Education, HIV/STD Surveillance & Epidemiology, Program Leadership and laboratory testing	Services are provided by PHSKC staff and through contracts with community-based agencies. Funding comes from federal grants, state, MIDD sales tax, and City of Seattle	PHSKC has a formal contract with DCHS for the Syringe Exchange Services Treatment Readiness and for the waiting list for methadone vouchers.
Interpretation/Community Health Services	This program provides medically qualified interpretation services to limited or non-English speaking patients	Services are provided by PHSKC staff and through contracts. Funding comes from federal and King County General Fund	There are no current collaborations with DCHS

PHSKC Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with DCHS
Jail Health Services/Jail Health Services Division	These programs assess and stabilize serious health problems for the detained population of the King County Correctional Facility (KCCF) and the Maleng Regional Justice Center (MRJC)	Services are provided by PHSKC staff Funding comes from the King County general fund, the City of Seattle, DCHS, MIDD sales tax, the inmate welfare fund, and Medicaid Administrative Match	PHSKC has extensive collaboration with the DCHS criminal justice initiatives, mental health court, care coordination for psychiatric inmates, methadone dosing, MIDD, and community training on benefits and services to inmates and transition planning
Policy, Community Partnerships and Communications/Director's office	This section leads, develops and coordinates internal and external communications and partnerships including government relations, health care reform strategy and implementation, administration and staffing of the Board of Health, legislative monitoring, community and stakeholder engagement and other external relations	Services are provided by PHSKC staff Funding comes from State Public Health Funding; State Local Capacity Development Fund revenue; King County General Fund; Medicaid Administrative Match; MIDD sales tax; and King County Veterans and Human Services Levy.	PHSKC collaborates with DCHS on health reform activities including co-chairing the Health Reform Planning Team

PHSKC Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with DCHS
Public Health Preparedness/Director's office	This section coordinates preparedness response, ensures infrastructure is in place for vulnerable populations, builds partnerships, and develops and maintains Public Health Reserve Corps	Services are provided by PHSKC staff, with partnerships with many community organizations; Funding comes from federal government	PHSKC collaborates with DCHS around multiple areas of response planning, especially as they relate to vulnerable populations including disaster preparedness for behavioral health system
Primary Care and Integrated Behavioral Health/Community Health Services	These programs provide primary care services at four public health centers, in four schools and through a clinic at Navos Community Mental Health Center; Services include screening and linkage to behavioral health services at public health center sites	Services are provided by PHSKC staff. Funding comes from grants, Medicaid, Managed Care Organizations, patient generated revenue, the Veterans and Human Services Levy, and the Families and Education Levy	PHSKC collaborates with DCHS around behavioral health integration including Screening, Brief Intervention and Referral to Treatment and the Mental Health Integration Program
Refugee Health/ Community Health Services	This program provides health screening (including screening for behavioral health conditions), linkage, and interpretation for newly immigrated residents.	Services are provided by PHSKC staff Funding comes from patient generated revenue and dedicated grant funding	There are no current collaborations with DCHS

PHSKC Program/Division	Brief Description	Key Service Providers/Funding	Current Collaboration with DCHS
Travel Clinic/Community Health Services	This program provides travel assessment, travel immunizations, and prescription medications for malaria prevention, altitude sickness and treatment of travel-related conditions	Services are provided by PHSKC staff Funding comes from patient generated revenue	There are no current collaborations with DCHS
Women, Infants and Children/Community Health Services	This program provides health screening; nutrition and health education; breastfeeding promotion and support; and linkage to other services, such as medical, dental and social service referrals; It also provides checks for nutritious foods on a monthly basis.	Services are provided by PHSKC staff and through subcontracts Funding comes from federal and state grants and King County General Fund	PHSKC collaborates with DCHS through referrals to services provided by or contracted through DCHS
Tuberculosis Control/Prevention Division	This program provides Tuberculosis prevention, case management, treatment, and disease monitoring	Services are provided by PHSKC staff Funding comes from federal grants, the state, King County General Fund, and Medicaid Administrative Match	PHSKC collaborates with DCHS around TB prevention and treatment services to the homeless population
Medical Examiner and Vital Statistics/ Prevention Division	The Vital Statistics program provides birth and death records. The Medical Examiner's Office provides death investigation	Services are provided by PHSKC staff Funding comes from King County General Fund	There are no current collaborations with DCHS

Administration. Table C-3 and Table C-4 represent the overview of administrative functions in each department, including which division a program is in (if not centralized), a brief description of the program, the extent to which functions are centralized, and current collaboration with PHSKC (for DCHS) or DCHS (for PHSKC).

Table C-3: DCHS Administration

DCHS Admin Function	Description	Centralized or Decentralized?	Current Collaboration with PHSKC
Director's office	This section is responsible for leadership and oversight of programs and services, strategic planning and coordination of business functions	Centralized	DCHS collaborates with PHSKC on initiatives and issues that involve both departments
Human Resources	This section is responsible for hiring and retaining workforce, employee/labor relations, leave administration, training, and PeopleSoft Administration	Centralized	
Payroll	This section is responsible for accurate and timely paychecks to employees and the work study program through Youth Source	Centralized	
Finance and Budget	This section is responsible for financial management, financial planning, budget preparation, budget defense and Enterprise Business Suite support for the department	Decentralized – a division level with a small centralized staff in the Director's Office	
Communications	This section is responsible for media, communication liaison to Executive, draft proclamations and recognitions, write/edit department documents and reports, website page development, and emergency response communication	Centralized	DCHS collaborates with PHSKC on initiatives and issues that involve both departments
Information Technology (IT)	This section is responsible for workstation phone and computer services and support for internet and intranet	Centralized	Same department (KCIT)

DCHS Admin Function	Description	Centralized or Decentralized?	Current Collaboration with PHSKC
Contracts/ CSD, DDD, MHCADSD	This section is responsible for contract solicitation and selection, negotiation, processing monitoring, invoicing and reporting	Decentralized – at division level	DCHS collaborates with PHSKC on contracts/agreements between the two departments
Prepaid Inpatient Health Plan (PIHP)/MHCADSD	This program is responsible for authorization of Medicaid mental health treatment benefits and inpatient psychiatric services. As a managed behavioral health plan, it also provides utilization management client services and quality assurance for the Medicaid mental health benefit	Decentralized at division level	

Table C-4: PHSKC Administration

PHSKC Admin Function	Description	Centralized or Decentralized?	Current Collaboration With DCHS
Accountable Business Transformation (ABT)	Responsible for employee training, onsite assistance and protocol development in transition to new management system	Centralized	
Accounting	Responsible for financial services for the department	Centralized	
Business Standards and Accountability	Responsible for oversight of the Health Insurance Portability and Accountability Act (HIPAA) law, risk management, public disclosure, and human subjects research compliance	Centralized	

PHSKC Admin Function	Description	Centralized or Decentralized?	Current Collaboration With DCHS
Budget and Special Services	Responsible for budgeting and forecasting; managing Medicaid Administrative Match and managing the Consolidated Contract with WA state	Primarily centralized, but some division level decentralization in financial monitoring	
Communications	Responsible for public information and education, employee communication, and crisis and emergency risk communication	Centralized	PHSKC collaborates with DCHS on initiatives and issues that involve both departments
Contracts	Responsible for managing contracts received and paid for by the department	Hybrid – scopes of work and budgets negotiated and monitored at the program level; most other functions are centralized	PHSKC collaborates with DCHS on contracts/agreements between departments
Facilities	Responsible for managing county-owned facilities and non- county properties (40 worksites in total)	Centralized	
Fleet	Responsible for managing and maintaining the 210 vehicle fleet for the department	Centralized	
Human Resources	Responsible for recruiting, hiring, developing and maintaining quality workforce	Primarily centralized, but some division level decentralization in CHS	

PHSKC Admin Function	Description	Centralized or Decentralized?	Current Collaboration With DCHS
Information Technology (IT)	Responsible for phone and computer services as well as training	Centralized	Same Department (KCIT)
Office of the Director	Responsible for leadership, oversight, strategic planning, accountability, and relationship building	Centralized	PHSKC collaborates with DCHS on initiatives and issues that involve both departments
Payroll	Responsible for accurate and timely paychecks to employees	Centralized	
Purchasing	Responsible for managing supplies for public health centers. They also act as a warehouse and distribution center to healthcare partners, and provide procurement and training services	Centralized	

Appendix D Jurisdictional Interview Matrix

Table D-1: Jurisdictional Interview Matrix

	Hennepin	Macomb	Washington	Marin	Wake	Montgomery
Snapshot (population, size of county, number of employees in HHS, annual budget)	1,168,431 residents 606 square miles 2,067 employees $465M	842,145 residents 570 square miles 548 employees $52M	540,410 residents 726 square miles 350 employees $96M	255,031 residents 828 square miles 720 employees $146M	989,780 residents 857 square miles 1585 employees $182M	989,794 residents 507 square miles 1558 employees $252M
Mission/Vision Statement	Vision: Better Lives, Stronger Communities Mission: Strengthen individuals, families and communities by: -increasing safety and stability -promoting self-reliance and livable income, and -improving the health of our communities.	**Vision:** residents lead healthy lives in supportive communities **Mission:** Promote community well-being, and to assure that the basic human needs of county residents are met.	**Mission:** No overarching mission for department; each division has its own mission	**Mission:** Promote and protect the health, well-being, self-sufficiency, and safety of all people in Marin County.	**Mission:** WCHS, in partnership with the community, will anticipate and respond to the public health, behavioral health and the economic and social needs of Wake County residents. We will coordinate and sustain efforts that assure safety, equity, access and well-being for all.	**Mission:** Promote and ensure the health and safety of the residents of Montgomery County and build individual and family strength and self-sufficiency.

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	Hennepin	Macomb	Washington	Marin	Wake	Montgomery
Contract or Direct Service Profile	No primary care; six regional service centers provide population-based services and co-locate with community providers; contracts with outside providers occupy 2/3 of budget	Dental and population-based services at three regional locations; no primary care; MCCSA operates and staffs three community action centers and provides eligibility screening and direct service	No primary care; population-based services at 3 locations; most services are contracted out	Contract CD 100%, MH 50%, no primary care services; one clinic provides population-based services	6 clinic locations offering population-based services, eligibility; also house sheriff deputies and housing inspectors; no primary care; 100% of MH/CD/DD is contracted out to a local non-profit	Dental, Healthcare for the Homeless, and Population-based services at 23 locations; 40% of services contracted
Department Divisions	Protection and Assessment; Eligibility and Child Support; Public Health and Case Management; Veterans' Services; Workforce Resources and Regional Development; Internal Supports	Public Health (Medical Examiner, Emergency Preparedness, Health Promotion/Disease Control, Family Health Services, Environmental Health); Community Services (Head Start, Senior Nutrition, Food Program, Weatherization,	Human Services; Public Health; Aging and Veterans; Children and Families; Animal Services; and Administration	Prevention; Administration; Community Health Services (Mental Health, Public Health and Clinical Services); and Human Services (Public Guardian, Public Assistance, Employment and Training, Children and	Social Services (Entitlement Programs, Child Protection, Employment, Child Support Enforcement, Youth Services, Other Family Services); Public Health (Health Promotion, Community Outreach, Immunizations, Health Clinics,	Aging and Disability Services; Behavioral Health and Crisis Services; Children, Youth and Family Services; Public Health Services; Special Needs Housing; Office of the Director (Community Affairs, Planning, Accountability and Customer Service, Policy and Risk Management, Legislative Coordination and

	Hennepin	Macomb	Washington	Marin	Wake	Montgomery
		Transportation Assistance, Community Programming); Senior Citizen Support; MSU Extension		Family Services, and Aging and Adult Services)	Vital Records, School Health); Administration and Operations (Transportation, Homeless, Housing, Regional Services)	Intergovernmental Relations)
Lessons Learned from Integration	-developed the organizational structure for new department, then devised the service delivery plan and program-level structure over 3 years	-first combined departments into one, then organized at the program level -created a "Bridging Cultures" group to help find areas of common interest, build relationships among employees who hadn't worked together previously	-first organized divisions by function, but found that program area divisions are more productive	-not a short-term process – taking several years to fully implement -are still determining ways to organize at a program level -did not communicate with staff and unions enough, which hampered ability to move things through quickly	-staff were excited about integration when the stated goal was to improve services rather than cut positions	-went through several iterations of org chart and found that what's more important is the informal access and coordination -most helpful change was co-locating health and human services employees/contractors at regional sites

	Hennepin	Macomb	Washington	Marin	Wake	Montgomery
Year(s) Integrated	2004; 2006-2009 reorg services and divisions	Charter passed in 2011; ongoing reorg work	Mid 1990's	2011-2012; ongoing	1996	1996
Pros of Integration	-case managers and community health workers have more interaction and work together to identify hard to reach communities -six regions have a combination of hubs and satellites, where public health and human services staff co-locate to provide services and referrals, allowing better coordination and understanding of programs and services, as well as a more specialized	-the integration of programs and services has not yet occurred; the only integration thus far is the name and scope of the department	-staff have easier access to each other and carry multiple messages when providing direct services -managers meet regularly as an operations group to plan and coordinate services	-physical relocation has improved staff communication, but otherwise, too soon to know since still going through integration process	-services are more accessible and client friendly -technology system alignment (state tech is still a challenge) -outreach staff are now carrying multiple messages, which makes encounters with community more robust and efficient -centers/clinics offer a greater variety of services -easier to implement training for	-significant and sustained cost savings -more centralization resulted in increased efficiencies -can better serve all client needs by co-locating multi-disciplines at regional sites

	Hennepin	Macomb	Washington	Marin	Wake	Montgomery
	menu of services based on the community's needs -changed the work culture as well as the organizational structure, by implementing a complex telework system, then ROWE -integrated case management team reduces the number of people and processes clients have to go through to access needed services				employees across agencies -streamlined boards and commissions	

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	Hennepin	Macomb	Washington	Marin	Wake	Montgomery
Efforts to integrate/collaborate with community providers	-call center now addresses all health and human services needs with one phone number -single assessment for every client to assure that all needs and referrals are handled upon intake -six regional, geographically distributed centers where residents receive and intake assessment, apply for services, make appointments and find out information about county and community services	-created a 'bridging cultures' group, comprised of staff from all over the department and community organizations, which looks at broad areas like food and nutrition, aging, and cultural competency	-play a much more central role in overall community planning and grants/rfps, now that department has a role in most, if not all, aspects of health and human services -county acts as an advocate for health and human service providers to the State and feds – interviewee reflected that this is easier because they don't compete for dollars or roles	-regularly convene FQHCs to try and coordinate mental health services with primary care -pay for pilot programs with a state tax on millionaires, which creates goodwill with providers; pilots include a 'hot spotters' team, which are multi-disciplinary and include emergency triage and placement for highest utilizers	-county is divided into 8 planning zones and each works with the local providers to identify service needs and delivery at the neighborhood level -clinics/centers provide a mix of services that , through data collection and community outreach, are found to be most in need in the geographic region – includes community providers in service delivery -working to bolster volunteer numbers and involvement	Primary Care Coalition – a non-profit that connects the 5 hospitals, 11 CHCs, the county, and others. Past successes are: -built a pro-bono network of specialists -created a shared EHR and point of service pharmacy -established consensus quality and outcome metrics Current work includes: -pilot to reduce ED visits -expansion of EHR and implementation of shared, more advanced HER (Manages Montgomery Cares and Cares for Kids; IHI Triple Aim Initiative partner)

	Hennepin	Macomb	Washington	Marin	Wake	Montgomery
Health Care Reform Initiatives	-very involved with CTG, State efforts to reform payment and create health homes -created Hennepin Health, which is (essentially) a community-wide and multidisciplinary ACO (see link in key docs section)	-staff team created to track and coordinate health care reform related news/info	-anticipating less demand for separate, population-based clinical services, WA county is working with providers to create a true one- stop shop for patients -part of a three county CCO, HealthShare of Oregon	-no major initiatives of note re: health care reform	-community care collaborative of hospital and community providers to identify opportunities to better leverage funding -no major initiatives of note re: health care reform	Montgomery Cares – a coordinated network of providers that provide services to low income and homeless adults; transitioning to Medicaid outreach and enrollment

Appendix E Boards, Commissions, and Advisory Groups

Boards and Commissions. Both departments have responsibilities related boards, committees, and advisory groups. Table E-1: RCW- or KCC-Required Boards and Commissions outlines the boards and commissions that DCHS and PHSKC have purview over, and Table E-2 shows other major committees and advisory groups. Some are required by state or local code, with appointments approved by the County Council. Others are committees or advisory groups associated with grants or special initiatives. With further analysis, there may be opportunities to streamline boards and advisory groups. The scope of work varies greatly among boards and advisory groups, and depending on the County's flexibility around scope and membership, some could potentially be combined or given additional responsibility in order to create more value for the County and the board and commission members.

Table E-1: RCW- or KCC-Required Boards and Commissions

Requirement	Name of Board or Commission	Description	PHSKC or DCHS
Interlocal Agreement between King County, the City of Seattle, and United Way of King County for oversight of the Area Agency on Agency	Aging and Disability Services Advisory Board	• Identifies the needs of older people and of adults with disabilities in our community, • Advises on services to meet these needs, and • Advocates for local, state, and national programs that promote quality of life.	DCHS Director is the current representative for King County
RCW and KCC	Alcoholism and Substance Abuse Administrative Board	• Recommends policies and programs to King County that will ensure the availability and accessibility of alcohol and substance abuse services, including prevention, intervention, treatment, and rehabilitation	DCHS

Requirement	Name of Board or Commission	Description	PHSKC or DCHS
RCW	Board of Health	• Establishes fee schedules for issuing or renewing licenses or permits • Enacts local rules and regulations in order to preserve, promote and improve the public health • Enforces the public health statutes of the state • Supervises and provides oversight of public health department activities and mandates • Governance board for the Federally Qualified Health Center grant (Health Care for the Homeless)	PHSKC
RCW, KCC	Central Regional EMS and Trauma Council	• Plans and conducts ongoing evaluation of emergency medical services in King County.	PHSKC
KCC, as optioned in RCW	Developmental Disabilities Board	• Advises King County on community services for children with developmental delays, adults with developmental disabilities, and their families. • Develops plans, advises on funding priorities, and advocates for increases in funding and improvements in services	DCHS

Requirement	Name of Board or Commission	Description	PHSKC or DCHS
RCW	EMS Medical Program Directors Committee	• Oversees the pre-hospital medical care provided by paramedics and EMTs. • Writes and approves medical protocols, • Approves all initial EMT and continuing EMT medical education, • Initiates new and ongoing medical quality improvement activities, • Takes disciplinary actions when indicated	PHSKC
KCC, required as associated with property tax	Human Services Levy Oversight Committee	• Reviews funding proposals • Assures that funding plans follow guidelines in the Service Improvement Plan • Provides recommendations about the expenditure of the human services portion of levy proceeds	DCHS
KCC	Mental Health Advisory Board	• Oversees activities of the Regional Service Network • Provides information to residents on system change issues and the de-stigmatization of mental illness • Advocates for policy/ legislative change related to mental health including prevention, treatment and recovery • Serves as liaison between service provider boards, Chief Executive Officers, and clients	DCHS

Requirement	Name of Board or Commission	Description	PHSKC or DCHS
KCC, required as associated with MIDD sales tax	Mental Illness and Drug Dependency (MIDD) Oversight Committee	• Ensures that the implementation and evaluation of the strategies and programs funded by the MIDD sales tax revenue are transparent, accountable, collaborative and effective.	DCHS
KCC, required as associated with property tax	Veterans Citizen Levy Oversight Board	• Reviews funding proposals • Assures that funding plans follow guidelines in the Service Improvement Plan • Provides recommendations about the expenditure of the veteran portion of levy proceeds	DCHS
RCW	Veterans Program Advisory Board	• Reviews the activities and plans of the Veterans Program • Advises county government on matters of concern to the veterans in King County • Reviews guidelines concerning the allocation of benefits to eligible veterans and their families • Hears and rules on any grievances brought to the Veterans Program.	DCHS
KCC	Women's Advisory Board	• Makes recommendations to the Executive and County Council to ensure the needs, rights and well-being of women are taken into account by County government	DCHS

Table E-2: Other Advisory Boards or Committees Connected to Federal and State Grant Requirements

Requirement	Name of Board or Committee	Description	PHSKC or DCHS
Associated with decision-making related to federal Housing and Community Development block grants	King County Consortium Joint Recommendations Committee	• Inter-jurisdictional body that provides specific funding recommendations and advice on guidelines and procedures for King County and its consortia city partners on a wide range of housing and community development issues	DCHS
Federal Title X Family Planning grant	Family Planning Community Advisory Board	• Provides input and recommendations for community assessment, placement of services, budget, information to stakeholders • Reviews and approves patient education materials to certify that they accurately represent the needs of the community	PHSKC
Connected to requirements for homeless continuum of care planning (federal McKinney homeless funds)	Committee to End Homelessness	• Coordinates community providers and stakeholders on an overall plan to reduce homelessness • Leverages funding that aligns with strategies and goals to end homelessness	DCHS
Grant from state	Community Organizing Program Citizen Advisory Board	• Advises on the programming, policy, and direction of the Community Organizing Program	DCHS
Federal grant	Ryan White HIV/AIDS Planning Council	• Prioritizes and allocates federal Ryan White Act Part A & B funds for King, Island and Snohomish counties	PHSKC
Federal grant	Healthcare for the Homeless – Advisory Planning Council	• Provides consumer and provider input, reviews policies that could affect access to and quality of care for homeless people • Serves as the mechanism for	PHSKC

Requirement	Name of Board or Committee	Description	PHSKC or DCHS
		consumer input connected to a waiver of governance requirements for Federally Qualified Health Center status, since the Board of the Health is the formal governance board.	

Appendix F Code Changes

Table F-1 reflects all sections of King County code that reference Public Health – Seattle & King County or Department of Community and Human Services by name.

Table F-1: King County Code Referencing PHSKC or DCHS

Code Section/ Number	Title	Change Needed
2.15.010	Citizenship and immigration status - provision of county services - limitations on use of documentation, police powers- provision of health benefits, opportunities or services - use of documentation - limitations on liability - review of county applications, questionnaires and interview forms	Department name, referenced in C.
2.16.081	Healthcare coalition – solicitation and acceptance of gift bequests and donations	Department name, referenced in A and B.
2.16.120	Department of adult and juvenile detention – duties	Department name, referenced in B8.
2.22.110	Opiate substitution treatment	Department name, referenced in A4 and 5.
2.24.110	Medical examiner	Department name, referenced in title.
2.36.055	King County emergency management committee	Department name, referenced in B19.
2.40.030	Membership, terms and ex-officio members (2.40 is King County Agriculture Commission)	Department names, referenced in C.
2.43.015	Adoption and implementation of a recovery plan (2.43 is Mental Health)	Department name, referenced in B.
2.50.020	Duties (2.50 is Children and Family Commission)	Department name, referenced in title.
2.50.025	Human services review and recommendations report	Department name, referenced in title.
2.50.045	Staffing	Department name, referenced in title.

Code Section/ Number	Title	Change Needed
2.51.010	Framework policies (2.51 is King county framework policies for human services)	Department name, referenced in B.
2.99.030	Policies (2.99 is Fees charged by county agencies)	Department name, referenced in G.
2.130.010	Established - duties - composition - selection - rules - staffing - compensation (2.130 is Mental illness and drug dependency oversight committee)	Department names, referenced in C (7 and 10) and G.
3.12.335	Supported employment	Department name, referenced in C.
4A.620.100	Addiction treatment – fees – billing of third party payment – Cedar Hills – reduction of fees	Department name, referenced in A and C.
4A.650.010	Notary services fee (4A.650 is Public health section)	Department name, referenced in title.
4A.650.110	Medical examiner reports fee - waiver	Department name, referenced in title.
4.08.015	First tier funds and designated fund managers	Department name, referenced with following fund numbers: PH- 119, 122, 128, 180-1; DCHS – 106, 112, 113-5, 114-1, 114-2, 246-4, 1421
4.08.025	Second tier funds and designated fund managers	Department name, referenced with following fund numbers: DCHS – 107, 126, 224, 246; PHSKC – 180
4.08.230	Housing opportunity acquisition fund	Department name, referenced in C.
4.08.300	Public health fund	Department name, referenced in C, D and E.
4.08.318	Mental illness and drug dependency fund	Department name, referenced in C.
4.08.320	Alcohol and substance abuse services fund	Department name, referenced in

Code Section/ Number	Title	Change Needed
		title.
4.08.321	Children and family services fund	Department name, referenced in A.
4.08.322	Health and human services levy fund	Department name, referenced in C.
4.08.324	Veterans services levy fund	Department name, referenced in C.
4.56.070	Facilities management division, county departments - responsibilities and powers in declaring county real property surplus.	Department name, referenced in E.
6.40.080	Requirements for licensing/operation (6.40 is Massage parlors and public bath houses)	Department name, referenced in A (title and 3)
8.64.010	Definitions (8.64 is remains of indigent persons)	Department name, referenced in J
8.64.030	Procedures	Department name, referenced in A5 and E (title and 4).
8.64.040	Right of appeal	Department name, referenced in title.
9.12.025	Discharge into King County waters	Department name, referenced in D1.
9.14.050	Lead agency –department of natural resources – responsibilities	Department name, referenced in D7, 10 and 11.
9.14.070	Vashon-Maury island groundwater protection committee	Department name, referenced in D.
10.04.020	Definitions (10.04 is King County solid waste code)	Department name, referenced in QQ.
11.04.050	Animal shelter cattery, pet shop, grooming service and kennel license - Information required.	Department name, referenced in title.
11.04.080	Animal shelters, kennels, catteries, grooming service or pet shops - inspections - unsanitary conditions unlawful.	Department name, referenced in A.

Code Section/ Number	Title	Change Needed
11.04.500	Euthanasia rate targets	Department name, referenced in A.
11.12.010	Quarantine order	Department name, referenced in title.
11.12.020	Notice of rabies hazard – quarantine period	Department name, referenced in title.
11.12.040	Euthanizing of infected animals	Department name, referenced in title.
11.12.050	Vaccination order	Department name, referenced in title.
11.12.060	Enforcement	Department name, referenced in title.
12.16.170	Sources of apprenticeships	Department name, referenced in title.
12.19.020	Definitions (12.19 is County contracts – nondiscrimination in benefits)	Department names, referenced in B.
12.46.050	Anchoring and mooring permit required	Department name, referenced in A3.
12.87.030	Administrator (12.86 is declaration of policy and finding of special conditions)	Department name, referenced in title.
13.24.080	Utilities technical review committee – creation and compositions	Department name, referenced in D.
13.24.090	Utilities technical review committee - authority	Department name, referenced in B4.
13.24.136	On-site sewage and disposal systems in the urban growth area	Department name, referenced in C.
13.24.140	Water facilities in urban areas	Department name, referenced in B1b.
13.28.035	Vashon water system plan	Department name, referenced in A1.

Code Section/ Number	Title	Change Needed
13.28.055	East King County water system plan	Department name, referenced in C.
14.44.055	Emergency construction permits	Department name, referenced in A1.
14.44.100	Notice by permittee of construction commenced	Department name, referenced in title.
14.44.110	Enforcement	Department name, referenced in title.
14.46.090	Review and certification by agencies.	Department name, referenced in C.
14.46.110	Notice of proposed use and commencement	Department name, referenced in title.
14.46.120	Notice to agencies of construction date	Department name, referenced in title.
14.46.130	Permit revocation	Department name, referenced in title.
16.04.500	Swimming pool enclosures and safety devices	Department name, referenced in title.
16.04.980	Inspection and enforcement	Department name, referenced in A.
16.32.195	Authority having jurisdiction	Department name, referenced in title.
16.82.105	Clearing and grading activities – hours of operations – variations.	Department name, referenced in B.
18.17.010	Definitions (18.17 is green building program)	Department name, referenced in B.
19A.16.040	Final plat and final short plan engineering plan review requirements	Department name, referenced in B.
20.20.040	Application requirements	Department name, referenced in A3a and 4.

Code Section/ Number	Title	Change Needed
21A.08.050	General services land uses	Department name, referenced in B20b2, B20c2.
20A.24.250	Zero rise floodway	Department name, referenced in G2.
20A.24.316	Critical aquifer recharge areas	Department name, referenced in A13b, B9b and G.
21A.24.510	Septic system design and critical area designation	Department name, referenced in title.
21A.26.120	Measurements and monitoring	Department name, referenced in A, B and D.
21A.26.180	NIER compliance criteria	Department name, referenced in title.
21A.26.190	NIER enforcement	Department name, referenced in title.
21A.26.200	Periodic review of NIER standard	Department name, referenced in title.
21A.28.030	Adequate sewage disposal.	Department name, referenced in B.
21A.28.130	Special district overlay – agricultural production buffer	Department name, referenced in B.
21A.45.020	Definitions (21A.45 is homeless encampments)	Department name, referenced in D.
21A.50.030	Violations defined	Department name, referenced in C.
23.02.010	Definitions	Department name, referenced in D2.
24.22.010	Authorization of program agreements	Department name, referenced in title.
24.22.040	Funding source restrictions - interest rate - maximum term - loan-to-value ratio - lien affordability covenant	Department name, referenced in A.

Code Section/ Number	Title	Change Needed
	agreements - process to secure permanent financing required - insurance.	
24.22.050	Procedures for compliance – establishment by the department of community and human services (24.22 – Interim loan program for property acquisition for low-income housing)	Department name, referenced in title.