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TO: Christina Ghaly, M.D.
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FROM: Marvin J. Southard, D.S.W.
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SUBJECT: **LACDMH INTERNAL STAKEHOLDERS' FEEDBACK ON CONSOLIDATION**

In response to your memorandum of January 21, 2015, this document will summarize input from Department of Mental Health (DMH) internal stakeholder groups regarding the proposed consolidation of Department of Health Services (DHS), DMH and the Department of Public Health (DPH) into a single health agency model. We are grateful for the opportunity to provide you with this feedback culled from over 25 internal discussion groups held over the past three weeks. This summary includes the major themes related to benefits and disadvantages of a single agency model. As of this date, additional stakeholder input continues to be provided. As a result, this summary may be updated in future weeks and should be considered preliminary at this time.

This document will be divided into several sections including:

- Background
- Overarching themes
- Benefits to the integration of the current three health departments under a single umbrella
- Disadvantages related to the proposed integration of administrative functions into a single agency
- Recommendations and Additional Models to be considered

Background

DMH was initially established as an independent County Department in 1960. Historically, DMH has been a separate Department except for a six year period when it was consolidated under DHS during the period between 1972-1978. The 1972 consolidation was done primarily for financial reasons due to the precarious nature of health financing during those years. Articles and reports published during that period reflected the intent of the Board of Supervisors to capitalize on what was seen as an influx of federal dollars for mental health that could bolster DHS. However, the outcome

of these efforts was a decrease in mental health programs to support DHS's primarily hospital-based system. So serious was the erosion of mental health programs that in 1978, the Board once again separated DMH from DHS.

During the period of 2004-2005, the possible consolidation of DMH with DHS was once again contemplated; the Civil Grand Jury conducted an investigation into the benefits and risks of such an organizational change. The Civil Grand Jury completed their work by concluding that such integration was ill-advised for a number of reasons – including the very different nature of the work, culture and populations served by each Department. Research done on mergers, including public sector mergers, continues to support the conclusions of the Civil Grand Jury: typically, the primary reasons for the failure of mergers include the differing cultures of the organizations and core missions that are not well-synchronized in practice.

While history and research raise serious doubts about the benefits of a full *merger or consolidation* of the health departments, most DMH stakeholders reflected that *service integration, not necessarily administrative consolidation,* under carefully specified conditions could be beneficial for clients served. It should be noted that DMH has initiated a number of successful programs integrating mental health, primary care, and substance use providers. These programs include (but are not limited to):

- The development of Health Neighborhoods. A geographic approach to enhancing access to care, care coordination, and communication among providers, Health Neighborhoods also serve as a strategy for identification of local public health issues. DPH, LA Care, local Federally Qualified Health Centers (FQHCs) are joining mental health and substance abuse providers in six areas of Los Angeles County to collaborate on this integrative approach. This approach is receiving support from academic institutions and private foundations as well as federal funding.

- Co-location. DMH currently co-locates mental health teams in the DHS comprehensive health centers and Multi-Service Ambulatory Care Centers (MACCs). Mental health services are provided on-site for those with acute mental health conditions who do not require intensive rehabilitative services delivered in DMH's specialty clinics.

- Reverse co-location. DMH has begun introducing primary care services in several specialty clinics to address the medical needs of our vulnerable clients who are not easily served in general medical clinics. This effort has been supported by two FQHCs willing to deliver primary care services and health education within a primarily mental health setting.

- Inter-agency whole-person teams. Through the Mental Health Services Act (MHSA) Innovations funding, DMH has implemented three strategies for integrating care. Teams composed of mental health providers, substance abuse providers, FQHCs and (in one model) housing developers serve clients in concert. This approach was initiated with Project 50 and its replications and has had several modifications. *These teams continue to deliver evidence of their effectiveness.*

- DMH and Substance Abuse Prevention and Control (SAPC) have a number of integrated programs including integration of services through the Co-occurring Integrated Care Network (COIN) program that is part of AB 109, integrated services to individuals with co-occurring disorders through placement of substance abuse providers in mental health urgent care centers, etc.

Given the intensive efforts at whole-person care already in place, stakeholders question the need for consolidation into an agency to accomplish these stated goals and whether administrative integration might impede these practical efforts.

Overarching Themes

- Trust. Virtually every stakeholder group highlighted trust issues stemming from the manner in which the proposed consolidation was introduced. Comments from clients, family members National Alliance for Mentally Ill (NAMI) and staff universally included the following: "If this is such a good idea, why the stealth approach in introducing it?" "Given the manner in which this was done, why would we trust anything that is said regarding the consolidation?" The experience of staff participating in consolidation planning workgroups has not allayed concerns about trust. In one workgroup, despite being told that there was no written plan, an organizational structure previously developed was mistakenly revealed to those present.

- Confusion stemming from the structure of planning discussions. While participants in both stakeholder groups and workgroups understood the desire to build the agency concept from representatives' feedback, most groups asserted that it was impossible to provide meaningful feedback when there was no agency concept described (other than a general idea that there would be an overarching agency headed by DHS with DHS, DMH, and DPH as separate departments within the larger structure). A common suggestion was that a clearer concept should be developed at this point – followed by stakeholder discussions that might result in more informed input. *In the absence of a structure with demonstrated value added, most stakeholders felt that identified goals could be accomplished through strategic planning and collaboration – not requiring integration of staff or functions. Such an approach might build on the strengths*

of the three Departments while minimizing disruption for minimal or no gain. Further, it might begin the rebuilding of the trust needed to ensure long-term benefits of any kind.

- Confusion stemming from lack of semantic clarity. Several groups raised questions about how the following terms were being defined: Integration, Consolidation, Collaboration – even if the single agency will merely be DHS. There is much confusion when integration and consolidation are interchanged and no distinction is made between clinical integration vs. administrative integration or consolidation.

- Recognition and appreciation of the different cultures of DHS, DMH and DPH. Almost all groups highlighted the cultural differences among the three Departments, which appear (in literature) to be a prime cause of integration/merger failures when these cultural differences are neither recognized appreciated, nor addressed. More specifically, the DMH model is delivery of community-based services throughout the County and includes its community-based non-profit and for-profit contracted entities. These services include field-based and mobile services. This appears different than the DHS business model and stakeholders raised questions about a return to an institutional and traditional medical model of care. Further, the nature of the cultural competence required to deliver successful behavioral health care is different in kind from the primarily linguistic competence thought of in the primary care field. Finally, DMH and DPH deliver services to a much broader population than those that DHS currently serves or likely ever will serve: so integration if it is to be real it will mean integration with health providers other than DHS.

- Knowledge and appreciation of the DMH mission. Stakeholders worried that decisions could be made for the Department of Mental Health by a single agency whose primary focus is not the population served by DMH. Most groups questioned whether the recovery model, evolved over several decades, would be valued and preserved in an agency. Further, the process leads to doubt about whether there is appreciation in DHS of the value of community-based partnerships and customer orientation which are central to the mission of DMH.

Benefits to the Integration of the Three Departments Under a Single Umbrella

DMH staff leading discussions asked all participants to be open to considering benefits to integration. Virtually all groups saw benefit to better coordinating clinical services. In fact, most saw this as the central challenge for all health care in the United States – even in integrated entities like Kaiser. Within this concept some groups differentiated the types or circumstances in which care could be coordinated vs. integrated. There was universal consensus that seamless strategies such as universal authorization,

shared care plans, ability to transition data between providers for shared clients would be beneficial. Co-locations were seen as positive in certain circumstances (e.g., DMH staff located within DHS comprehensive health centers for clients with acute mental health conditions; DHS staff delivering primary care/health education within DMH clinics). Where done well, this could be a positive opportunity for whole-person care. Nevertheless, some staff mentioned that DMH is already co-locating within DHS, integrating clinical care through the Innovations projects, introducing primary care (solely delivered by FQHCs currently) into mental health settings; they wondered what additional incremental benefit would be derived from an agency in this area – other than improved collaboration.

Reduction of stigma for clients receiving their mental health care on a larger health campus was appealing to stakeholders – assuming that clients with behavioral health needs would be welcomed into primary care clinics and that they did not require a full continuum of mental health rehabilitation services better delivered in specialty settings.

Combined and coordinated efforts among the three Departments to outreach and engage under-served ethnic and cultural communities using proven culturally relevant approaches could not only assist in destigmatizing mental illness but reduce disparity. However, it is believed that this could be achieved without the establishment of a single agency but rather a commitment to do so by all three Departments.

Finally, possible development of new one-stop centers was seen as a positive option. Clients could receive an array of services in one setting, including prevention services.

Disadvantages Related to the Proposed Integration of Administrative Functions into a Single Agency.

In addition to the overarching issues described in the first section of this report, the following disadvantages were commonly identified:

- Placing an agency director between the Director of Mental Health and the Board of Supervisors will result in the loss of meaningful input to the Board around the needs of individuals with mental illness.
- Integration of some services is desirable, but this should not require integrating administrative functions. Administration should be located close to the programs it is intended to serve.
- Adding another layer of bureaucracy through the creation of an agency may slow the work of the Departments.
- Although staff has been promised that they will not face lay-offs, it has been stated that the new agency will be financed partly by elimination of positions through attrition. Furthermore, concerns were expressed that existing dedicated resources at the Department levels will be reallocated and redirected to focus on

other assignments. This will ultimately diminish the ability of Departments to do the work that needs to be accomplished.

- Adding another administrative layer will result in CEO Classifications specialists "down-grading" the levels of staffing permissible in subordinate Departments. Over time, this will weaken Departments' ability to recruit and will decrease the qualifications of those needed to perform the work of each entity.
- There is a risk of a return to the medical model with a loss of innovative mental health programming, diminished focus on the recovery model, and reduction in field-based services.
- DMH values meaningful inclusion of the voices of clients and family members in planning, service delivery and advocacy. There is great risk that this will no longer be valued if an agency director is providing direction for service delivery.
- All groups expressed concern that an agency could influence the expenditure of funds even if it did not directly control funding. In a hospital-dominated system, likely overseen by the Director of Health Services, there is concern that DMH could suffer the erosion of funding that occurred during the period of 1972-1978 when DMH was part of DHS.
- Mental Health clients receiving primary care services from agencies and physicians other than those affiliated with DHS may not receive the level of attention that they ought in an Agency dominated by DHS.

Recommendations and Additional Models to be Considered

1. Undertake immediate efforts to reap the benefits of more practical alignment so that any outstanding problems such as access to primary care from DHS for DMH clients can be swiftly resolved.
2. Implement a structure to resolve issues and expedite solutions where problems emerge. This structure might jointly consider fiscal strategies as health care funding evolves.
3. Make efforts at the highest levels possible to heal the trust issues that have arisen in our communities.
4. Clarify the problems the proposed agency is designed to address and develop specific strategies that match the level of the problems. Consider whether some functions might be best served through joint strategic planning or high-level communication and collaboration. Consider the move of functions to an agency only if there is demonstrated added value in doing so, understanding that reorganizing functions has the potential to cause significant disruption for little gain.
5. Consider a range of alternative re-organizational models, including agency, single department, interdepartmental coordination group that does not stand between current reporting lines, and realignment of existing departmental service functions.

6. Ensure that the Board mandated preliminary plan is returned to the stakeholder groups before final Board action and contains a clear description of the new administrative structure alluded to in the Board Motion with sufficient detail for meaningful analysis, containing the following:
    a. Clearly defined terminology, distinguishing service integration from administrative consolidation.
    b. Description of positional ordinance reporting lines
    c. Description of administrative units, e.g., HR, Facilities, and their relationship to both the umbrella structure and its subordinate service divisions
    d. A defined list of problems that the structure is intended to address, and a description of the manner in which the proposed structure addresses each.
7. Continue a clearly defined and public stakeholder process, containing the following elements: Defined stakeholder groups that encompass the interests of the full community, a process that is properly structured, documented and reported, with the purpose of creating a comprehensive analysis and alternative structures. Provide a comprehensive public of report of the findings and recommendations of the stakeholder groups.

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