Health Services
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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

February 18, 2015

TO: Christina Ghaly, MD
Director of Health Integration
Chief Executive Office

FROM: Gerardo Pinedo
Director, Government/Board Relations and Policy
Department of Health Services

SUBJECT: **STAKEHOLDER INPUT: PROPOSED HEALTH AGENCY/INTEGRATION**

As requested, please find enclosed herein the input received from various units within the Department of Health Services with regard to the Board of Supervisors' motion from January 13th to approve in concept the consolidation of the Departments of Health Services, Public Health and Mental Health into a single integrated agency.

The input was received by this office in response to our broad request which went to all departmental managers encouraging widespread input about the proposed integration. All managers were encouraged to speak with their staff, as well as any and all interested internal and external stakeholders, to collect as many opinions, thoughts, questions, concerns and any other feedback relating to the proposal.

All feedback received from various units within our Department is attached in its entirety. Should we be able to provide you with any additional information, please let me know. Thank you.

c: Mitch Katz, MD
Director of Health Services

ACN Recommendations regarding the consolidation of LA County DHS, DPH and DMH
DRAFT 2-3-15

Opportunities

1. Having all facilities under one agency could enhance the geographic distribution of DHS, DPH and DMH services throughout the County by co-locating services.
    a. Better integration of services, especially mental health, with primary care
    b. Better coordination of care for individuals
        i. Potential to improve health outcomes
        ii. Single medical record number would further this
        iii. Leveraging staff responsible for care coordination (e.g. service coordinators, PHN's, case workers, etc.)
        iv. Easier navigation of services for patients (one stop shop)
    c. Identification of individuals who may be eligible for other services (e.g. TB patient who's eligible for PCMH.)
    d. Expanded access to primary care if coordination of space could allow for more Patient Centered Medical Homes (PCMH).
    e. Better geographic access to PCMHs
        i. Improved patient experience
        ii. Improved geographic coverage for managed care contracts
    f. Elimination of duplication of services (e.g. eligibility determination, radiology, etc.)
    g. Potential to maximize use of appropriate space for patient care (primary care, mental health and public health) and consolidate non-patient care functions

    Timeline:
    a. Conduct assessment of what exists and where
    b. Define core services by geographic area
    c. Prioritize transitions according to financial and patient care criteria
    d. Phase-in transitions over several years

2. Creation of a single Medical Record Number (MRN) for all County patients
    a. Demographic and financial information could be available throughout system
    b. Medical information (e.g. medication list, lab results, imaging) could be available to all medical providers
    c. Primary Care Provider could be known throughout system for follow-up/referral
    d. Opportunity to facilitate warm hand-offs/transitions of care among all providers of care

    Timeline:
    a. Evaluate existing systems
    b. Evaluate financial and programmatic implications with stakeholder input
    c. Make recommendation/decision
    d. Within six months

3. Consolidation of ancillary services
    a. Some facilities have duplication of services like radiology
    b. Laboratory services could be consolidated and standardized
    c. Formularies across all services could be standardized

Timeline:

a. Conduct assessment of what exists and where
b. Define services by geographic area
c. Implement transitions within one year where possible
d. Phase-in other transitions with co-locations

4. Improved relationships with agencies that are contracted with the County for services across all departments
    a. Better understanding of services that are available and how to access them
    b. Standardized referral processes
    c. Could expand contractual relationships under managed care
    d. Simplify and/or standardize reimbursement mechanisms for contracted agencies
    e. Consolidate auditing

    Timeline:
    a. Assess potential opportunities with stakeholder input
    b. Implement over time as appropriate
    c. Several years

5. Improved finances
    a. CBRC funding for services provided in facilities with primary care
    b. 340B pricing for STD, HIV and Family Planning services provided by primary care providers in sites with categorical funding

    Timeline:
    a. Evaluate prior to merger decision
    b. Prioritize key changes
    c. Implement as operationally feasible

<u>Concerns</u>

1. Consolidation of administrative functions (e.g. HR, Contracts, Supply Chain) could result in reduced responsiveness to individual departmental and local needs
2. Loss of programmatic control and focus within larger agency
    a. DHS: cost control in hospitals
3. Questions regarding control of budgets and accountability; incentive to live within a budget
4. Impact on grant funding requirements; restrictions that would limit consolidation
5. Impact on reimbursement
    a. e.g. billing for multiple services provided in one day (probably not a problem for capitated or uninsured population)
    b. Increased costs for co-location with limited increase in revenue
6. Creation of a single MRN for County patients
    a. Protection and sharing of mental health record
    b. Control of records with more people having access throughout system (HIPAA)
7. Loss of patients seeking care in categorical clinics who may not want integration
8. How would patient populations outside of DHS target be integrated
    a. How would “Population Management” definitions be reconciled
    b. Implications for medical record system(s)

Staff Comments on Proposed Integration of DHS, DMH, and DPH

(Note: The comments below were collected by the Director of Planning and Data Analytics and are from DHS and DPH staff only)

Potential Benefits/Opportunities

- We have an opportunity under ACA funding to provide better coordinated care, especially for the most complex patients (homeless, mentally ill, chronic medical conditions)
- "Amazing things could be done" for a subset of clients under a unified structure by combining medical, substance abuse and mental health care – without interfering with more routine care being provided to less complex patients
- Some DPH programs make sense to be integrated with DHS: Substance Abuse Prevention & Control, STD Clinics, and Children's Medical Services.
- Health educators from DPH could be deployed to provide targeted health education to patients in DHS facilities.
- Data sharing: If data can be combined in a single medical record or at least in one data warehouse, with a unique identifier, patient care will be improved and programs can be developed with a more complete picture of the potential impact on patients.
- Evaluation of programs will be easier if data is shared across departments (e.g., it will be easier to identify the total cost of care for patients in a given program if data is shared across departments).
- Joint Data Governance activities could ensure that standardized definitions are being used across all three departments
- Opportunity to reduce duplication of administrative functions such as contracting & contract monitoring, human resources, IT help desk.
- Institutional Review Boards could be combined so there is a single IRB for all three departments, including DHS hospitals.

Concerns

- Many people expressed concerns about the process of proposing this change. Strong feelings were expressed regarding the level of secrecy involved. One person said she felt "blind-sided" and feared that the lack of collaboration would become the norm under an agency model with a single "dictator."

- The proposed consolidation/integration "relies on a single person with a vision (Mitch Katz). If/when he leaves the County, the entire structure could be at risk." " A personality-driven government is inherently unstable."

- If DHS begins to have budget problems again, the other departmental budgets could be negatively affected.

- More bureaucracy can mean more delays in dealing with emergent situations (e.g., outbreaks), implementing new programs, hiring, contracting, press releases, etc.

- DPH has a sense of identity with the Public Health Officer that could be lost under integration.

- DPH and DMH morale will be negatively impacted by integration.

- "Public health issues are deemed less important (by DHS leadership, and also by the BOS) than issues at DHS facilities (e.g., MLK crisis overshadowed everything else for about 2 years)."

- Too many things changing simultaneously could cause disruption to services and lower staff morale.

Other comments related to the DHS-DPH Separation in 2006:

- When separation occurred in 2006, DHS was in a constant state of fiscal crisis, disabled by hiring freezes and budget cuts. These negatively impacted DPH operations even though its revenue streams were stable. However, the situation is different now since the ACA has provided a more stable funding stream for DHS.

- Prior to separation, services were not integrated so separation did not impact patient care.

- After separation, DPH did not take advantage of the opportunity to "shake things up" and try to do anything differently. Most people (outside of a few administrative divisions) did not notice any difference.

CONSOLIDATION OF THE DEPARTMENTS OF HEALTH SERVICES, PUBLIC HEALTH, AND MENTAL HEALTH INTO AN INTEGRATED AGENCY

RISK MANAGEMENT ASSESSMENT & STAKEHOLDER INPUT

Department of Health Services staff has been requested to provide stakeholder input pertaining to the consolidation of Health Services, Public Health, and Mental Health into an integrated agency. This narrative addresses the areas of quality, patient safety, and clinical and non-clinical Risk Management (RM), and is a high level assessment that is limited through a partial acquaintance with existing Public Health and Mental Health staffing—and organizational reporting structures—related to clinical and non-clinical RM initiatives.

Summary

From the perspective of patient safety, and clinical and non-clinical risk management, arrangement of the three departments in a single agency structure would provide opportunities to take advantage of shared resources and economies of scale. We envision that clinical and non-clinical risk management would be consolidated at the agency level. Doing so would also present opportunity to consolidate regulatory compliance and privacy functions, as well as rearrange these at the department level.

Changes would largely benefit DMH and DPH, each of which is smaller, and has fewer resources to address patient safety and risk management. It would also provide opportunity to further coordinate quality and safety initiatives such Safety Intelligence incident reporting, Just Culture, and adverse event disclosure, that all three departments are currently launching.

From the perspective of quality of care, consolidation would likely provide significant opportunity to better coordinate care between DHS and DMH, for patients with mental illness. Research to date shows that such coordination can improve health status for patient with severe mental illness, but it may not decrease utilization. Quality reporting is unlikely to be impacted, as there is little overlap of reported data across the departments.

Many front-line staff feel that reorganization of department oversight will not affect them directly; others expressed concern that consolidation of certain operations with the other two agencies would result in increased workload for DHS staff in certain areas where DMH and DPH currently lack resources. One person expressed concern that DHS and its employees would bear the brunt of cuts made because it is the largest of the three departments, and that integration could increase bureaucracy.

Integration of risk management would likely take 6-12 months, and require formal discuss among the three departments. Integration of clinical care for mentally ill patient will likely take a few years to effectively implement.

Oversight of the Sherriff's Medical Services Bureau will provide significant opportunity to improve, standardize, and better coordinate quality of care in the jails. Currently, MSB lacks formal peer review structure, and has limited resources to enhance care provided in the jails. Assumption of this responsibility will incur additional operational and liability cost for DHS, although the overall costs to the County may go down.

Discussion

Proposed Structure

It is proposed that DMH, DPH, and DHS be placed under a single county agency, each with its own director reporting to the agency director, and possible with one of the department directors acting as the agency director. For clinical and administrative functions, there are a number of structures that may fit into this basic framework, ranging from full integration at the agency level to no change, with operations remaining essentially separate for each department.

We support this proposed structure. We presume over time, that administrative and quasi-administrative functions such as patient safety and risk management will be consolidated at the Agency level in order to take advantage of efficiencies described below.

It is our current understanding that non-clinical RM staff for Public Health and Mental Health are comprised of a group of less than 10 dedicated employees with items that range from Staff Analyst Health to lower level safety positions (Safety Officer, Assistant and/or Inspector), and that patient safety and clinical risk management are comprised of similar, very small units. General RM structures for both of the aforementioned organizations appear to report into their respective Administrative Deputies, although we do not yet fully understand the extent to which RM functions are addressed by non-dedicated staff. DHS currently has a full complement of non-clinical staff that address all forms of non-medical malpractice government tort claims and civil actions; litigation management; occupational health, safety and environmental initiatives; and return to work functions. Additionally, clinical RM personnel address all aspects of patient safety including advocating on behalf of the Department in medical malpractice related government tort claims and civil actions; implementation of a full service safety intelligence suite; triaging patient safety complaints; and facilitating adverse event reporting to outside regulatory agencies.

Benefits

With regard to quality and patient safety, there is significant opportunity to improve coordination of care, particularly with patient cared for by DMH and DHS. We are aware that these opportunities are being discussed elsewhere in this process.

Significant synergies are also possible with the proposed integration of services between the three departments; specifically with the integration of Public Health and Mental Health RM resources into DHS' existing structure. The clinical and non-clinical Risk Management team at DHS is relatively new and has a progressive leadership team that has worked to implement various initiatives that have improved operational efficiencies and resulted in enterprise benefits—i.e. Safety Intelligence, Safe & Just Culture, GenSuite, Rule 16 Algorithm, and Sorry Works. Benefits related to said initiatives could be leveraged to Public Health and Mental Health with nominal financial impacts given their scalability. Further, consolidation of services into DHS's existing structure would enable dedicated RM resources to address issues of prospective risk more effectively for the entity as a whole.

The consolidation would also provide the opportunity to revise oversight of certain other administrative functions that are currently scattered throughout DHS, such as regulatory compliance, policy and procedure management, and privacy oversight, among others.

Specifically, integration would provide the smaller departments at DPH and DMH the following:

1) Full access to a compliment of industrial hygiene equipment and technicians that are housed within DHS—including a Certified Asbestos Consultant

2) Ability to leverage the technical expertise of Certified Safety Professionals (CSP's) and an Associate Risk Manager (ARM)

3) Access to subject matter experts in environmental, hazardous material, and hazardous waste compliance and permitting

4) Full complement of dedicated resources in the area of medical malpractice and non-medical malpractice tort, litigation management, workers compensation, and return to work dedicated to claim adjudication

5) Contemporary patient safety and quality performance measures

Proposed Implementation Steps

Clearly, in order to better understand the steps necessary for potential consolidation of Risk Management services, we would propose formal meetings with the Administrative Deputies of Public Health and Mental Health as well as the leads for patient safety and clinical risk management. This would provide a clear picture as to the existing reporting structure, resource allocation, items, and current encumbrances/vacancies. Additionally, this would serve as an opportunity to determine what operational and/or technical challenges exist within the sister departments that DHS may be able to assist with through collaborative efforts. We anticipate that this process would also include examination of DHS resources and reporting structure, with appropriate reorganization and re-allocation of DHS resources as well.

Timeframe for Achievement

Initially, we would estimate 6-12 months to fully integrate the DHS shared service RM model. This estimate is could vary significantly depending upon the outcome of proposed meetings with the Public Health and Mental Health Administrative Deputies. Further refinement to the proposed timeline would occur as information becomes available.

Integration of clinical functions is likely to being in the first few months, but will likely take a few years to achieve full implementation.

Drawbacks

In general, our "front-line" staff feel that consolidation into a single agency will not affect them detrimentally, but has the opportunity to improve patient care and take advantage of economies of scale over time.

In-depth review and consolidation efforts could identify service and/or staffing gaps that need to be addressed through requests for additional resources and/or reclassification of existing items. These matters would be addressed with CEO upon determination and on a case-by-case basis.

Los Angeles County Board of Supervisors
Integrated Agency for Departments of Health Services, Public Health and Mental Health
Department of Health Services
Managed Care Services (MCS) Staff Input

Area	MCS Staff Comments
Proposed Structure	No comments
Proposed Implementation Steps	Finance Unit 1. Assess areas that can be consolidated and level of department-level support requirements to achieve administrative and operational efficiencies a. Corporate i. Finance/Budget 1. It will be necessary to procure a cost-accounting and Finance system 2. Create a robust analytics department that can support health plan contracting and other revenue-type contracting 3. Consolidate all billing and collections 4. Each DHS hospital would need to have its own budget/finance infrastructure consistent with corporate Finance/Budget practices and governance 5. New Finance leadership will be necessary to support the transition from primarily public finance/budgeting to an environment that will require knowledge of healthcare financing in a new operating environment. ii. Human Resources 1. New Human Resources leadership will be necessary to manage the diversity of culture and prepare the "health agency's" human capital to function in a competitive environment and prepare existing workers to be more efficient and adaptive to the new demands that will arise from the changes in the health care market and labor-pool market. iii. Information Technology Services/Operations 1. Each DHS facility would need to have local control and operations of their own HIT systems based on corporate-level standardization and governance. 2. Consolidation of similar systems and operations should occur (e.g., patient care systems operated by health, mental health and public health) 3. New HIT/IT leadership will be necessary to manage the diversity of systems and the development and consolidation and implementation of HIT and IT master plan. 4. New HIT/IT leadership will also be key to support the "super agency's" service and operations strategy (ies). 5. Merge patient data into a single data warehouse to create information and analytics to

ensure agency uses information to improve service delivery
6. Create a project management and business analyst infrastructure to support department operations (these functions should be standardized so that there is a single corporate approach, including quality management program for all systems and applications developed in-house)
7. Create a corporate level training and development program for HIT/IT professionals
8. Outsource services that cannot be efficiently supported in-house

iv. Contracting
1. Contracting should be streamlined with consolidation occurring over time (three to five years). This will allow adequate time to merge contracting systems and specialized knowledge and practices into a single corporate culture

b. Department Level Operations
i. Finance/Budget
1. All services/functions can be consolidated into a super-finance/budget division except for onsite billing for health and mental health services
2. Strengthen billing services at DHS and other "super agency" facilities
a. Health Facilities (hospitals, outpatient health facilities)
b. Mental Health Facilities
c. Public Health Centers

ii. Human Resources
1. Employee Development & Training
2. Employee Relations

iii. Information Technology
1. All services/functions can be consolidated into a super-HIT/IT division with certain services/functions remaining at DHS hospitals to effectively manage their HIT/Electronic Health Records operations and patient transactions. The level of function at the facility level will depend on the need of each facility, e.g., applications developers, SQL/Oracle/Cognos report writers, web-masters, project managers, etc.
2. Project management and business analyst support should be created at the corporate level and support operations at the facility or department level

2. Assess the culture of each organization and identify potential pitfalls and develop an effective change management strategy
a. Create a change management strategy
b. Create communications strategy
i. How will employees be impacted?
1. What changes will take place and when
2. How will employee jobs change?

ii. How will employees benefit?

Area	MCS Staff Comments
Time Frame For Achievement	The creation of a super-agency should take place within one to two years. Begin consolidation/merger of administrative areas with the greatest common factors; proceed to other areas where existing organizational cultures may be more challenging. Some items for consideration are: 1. Bring/hire the new corporate team 2. Develop the transition plans 3. Address stakeholder concerns 4. Acquire/establish the new agency's office
Benefits	<u>Finance/Claims Unit</u> I look forward to the merge of three departments. It is necessary to be able to share the patients' information among three departments and this is going to be a great move to provide better services to the patients. It is all about customer services. I like it. In my point of view, consolidating three health departments (DHS, DMH & DPH) is a great idea. It would be beneficial in the public interest (member services) and stakeholders. Though in every merger it has different possible benefits and costs. It would cut out duplication and create an optimum health services to patients in one Health Department. It is a good idea to integrate the activities of the Health Services, Public Health, and Mental Health Departments under one agency. By doing this, I believe there are many benefits for patients, physicians, and the administration of these three departments in the Los Angeles County. Some benefits include: 1. Patients: • Convenience: saving time and money for the transportation to visit physicians. • Reduce chances of repeated tests, i.e. X-rays, blood tests… • Be treated effectively and efficiently 2. Physicians: • Gain access to patient's complete medical file from all three departments to effectively diagnose patients • Save time, save care, save life • Treat more patients • Better communication between physicians of different departments 3. Administration: • Reduce cost from repeated tests (X-rays, blood tests, etc.) and doctor's visitations. • Better relation between these three departments • Increase the outcomes of health care services

Area	MCS Staff Comments
Benefits (continued)	Information Technology/Systems Unit 1. Opportunities for economies of scale/purchasing program for hardware, software, office automation tools, etc. 2. Opportunities for consolidating, integrating, expanding use of systems/applications for continuity of patient care across the three disciplines of personal health, public health, and mental health. My Health LA Unit 1. Integration of Substance Abuse and Mental Health within health care 2. MHLA "benefits" could eventually be expanded to include mental health and substance abuse disease treatment. 3. Could reduce duplication and overlapping efforts in key areas – purchasing, contracting, audits etc. Other MCS Units Combining the agencies may seem like a daunting task but I see it as a good opportunity to be able to provide better service to our patients. Benefits, ability to: 1. See greater efficiencies, which could result in budget savings over time 2. Leverage human capital across shared organizations 3. Eliminate redundancies from merged administrative and Information Technology functions 4. Increase customer services across similar services 5. Increase federal/state dollars for County services Provider Network Operations 1. Systems: Centralized systems that will be able to support the core functionality of the departments, resulting in cost savings and efficiency. 2. Care Coordination: Care coordination of various services rendered by the different departments to the same population, hence will increase patient satisfaction. Unified framework will allow for consistency in processes. 3. Policy Development & Application: Provide clarity to common policies across all agencies. Opportunity for policy revisions for greater affinity between all Departments. 4. Centralized Contracting: Contracting of commonly used supplies and services will present opportunities for lowering cost, leveraging the high volume / utilization. Strengthened County contracting presence and position – introduces opportunities in negotiations (e.g., more variable rates and material costs) for lowering expenses. 5. Support Services: Alignment of support services that are common to all departments which is expected to present and enhance patient oriented care delivery system(s), better goals and objectives overall. 6. Human Resources: Opportunity to inventory positions/ items with similar duties and associated skill sets and knowledge that are commonly employed in all departments. Easily identify commonly used positions for greater opportunities and equality in salaries and wages. 7. Communication: Improve communication among all agencies including sharing of client information that will result in client satisfaction. Departments no longer operate in "silos". Opportunity for an effective multi-department communication forum dedicated to continually improving the medical and social care delivery systems for eligible Los Angeles residents

Area	MCS Staff Comments
Benefits (continued)	Quality Management Unit 1. Increase accountability for Directors – demonstrate performance 2. Expectation to compress upper level executive/leadership. Less chiefs, more worker bees (Indians), less bureaucracy 3. Increase referral process btw DHS and DMH 4. Utilize DMH to provide behavioral health (BH) services in DHS facilities 5. Full integration of BH in all clinic sites, including CPs 6. Coordination btw medical/physical health & behavioral health, must demonstrate for Knox-Keene license 7. One electronic medical record – ORCHID 8. Centralization of resources, especially natural disaster 9. Increase grant funding (PH resource) 10. Utilize established training program (PH: Organization Development Program) 11. Direct linkage & referral for SBIRT. F/U and intervention to PH resources 12. Improve TB liaison btw wards and TB Control 13. Require all PH physicians to provide clinical services/rotation. May improve access since more physicians in clinics 14. Utilize PH centers for provision of PCMH – integrate primary care 15. Utilize PH centers for provision of specialty care – increase specialty care access 16. Centralize data collection, e.g. lead poisoning, etc. 17. HR: no more departmental promotions – across all DMH, DHS, DPH
Drawbacks	Finance Unit Besides these benefits, the drawback of this integration is the patient's sensitive full medical history may be wrongfully exposed. However, the benefits of combining these three health care departments outweigh this drawback and helping us fulfill our Los Angeles County mission statement "To Enrich Lives through Effective and Caring Service". Information Technology/Systems Unit Combining different departments together is easier said than done. Differences in operational, data, hardware/server architecture, network, budget, leadership, and personnel infrastructures may be so diverse and different that combining such departments may not be feasible and may actually cause more damage than good to LA County as a whole. My Health LA Unit 1. DHS functions will "take priority over" mental health and public health, especially funds and budgets 2. Was a lot of work to "divorce" DPH and DHS, "now we have to do it all over again"

Area	MCS Staff Comments
Drawbacks	<u>Provider Network Operations</u> 1. Too much responsibility for one director to oversee a large County organization, which may result in hiring more high positions. Might create another layer of leadership/bureaucratic team. 2. General stakeholder malaise from historical results from previous County cycling through centralization and later decentralized initiatives. Proposal provides little information to assure it is not just the beginning of another cycle or ignite interest initiating another cycle. 3. Resistance from employees affected by the changes which could result in performance challenges and disruption in production. Might result in "finger pointing". <u>Quality Management Unit</u> 1. How will this restructure improve quality of care for patients in LA County? Increase access? 2. Hire executive team from outside County, pattern to look outside. Failure to acknowledge strengths and experts of current staff. 3. Other agencies not focused on increase PCP, in line with unmet state of healthcare (need more PCP, more mid-levels, increase access and retention). 4. Too much power in one direction 5. Not clear direction from leadership at all levels 6. Learning curve of managed care environment (ACA) of DMH & DPH 7. Prior history: communication does not improve with increase executive leadership 8. Lack of communication to all levels, more staff expected to work together 9. Director may be working for own self-interest not for benefit of population of LA County; springboard for Washington DC position 10. Concern for nursing: another reclassification, cross transfers within consolidated departments? Concern for acute care nursing. a. Taskforce for nursing b. Workgroups for nursing 11. HR: longer time to get exam results & promulgate cert lists. <u>Other MCS Units</u> 1. Short-term employee angst 2. Divergent organizational cultures – may be difficult to manage 3. Loss of community identity 4. Customers may perceive a larger agency as less "friendly" and much more bureaucratic

General Comments (Note: Comments reflect a variety of staff and are not meant to present the perspective of MCS overall. As a result some comments may seem contradictory).

- Overall, team seemed not terribly concerned with consolidation
- Seems like a "done deal" – most think it's probably going to happen with or without comment period.
- Staff would like clarity on which functions would and would not be consolidated (i.e., audits? contracting? counsel?)
- Question asked about whether this would affect My Health LA restructuring efforts or timeline.
- From a very high point of view, it may be logical to group these services together assuming they have more things in common than differences.
- There are so many components, visible and hidden, in these kinds of consolidations that it is impossible to make a reasonable conclusion of whether this is a good idea or not.
- I don't really know what it means to join with other department but if it give me job security and more opportunities then I don't see a problem with it.
- In my humble opinion, the merger will mostly be semantic, and it will probably only impact a select few at the top, as theoretically we are already sister units in the same organization, and I haven't yet heard talk of staff reduction, or changes in funding, etc.
- I'm afraid I don't have any constructive input as well, since I'm still more or less learning about our operations and don't know well enough how the merger will impact DHS-MCS.

Questions

1. How will this restructure improve quality of care for patients in LA County? Increase access?
2. Will the communication & integration between physical and behavioral health improve?
3. How will the dynamics of ORCHID change? What is the financial cost to consolidate access for DHS, DMH, & DPH? Consider different modules required by each department.
4. Patient population from all three different departments will now access DHS - Won't combining all departments affect access to care/delay services?
5. Will it change human resources rules on Certification List (some cert list are only for a specific department)? How can current employees have better opportunities?
6. Have there been any documented negative drug interaction outcomes to patients who received medications, vaccinations, or prescriptions; from having been seen concurrently in the three departments?
7. Are we trying to achieve the "Kaiser" model of care?
8. How will this merger affect our job?
9. How soon will this merger take place?
10. Will the standalone clinics of each department be renovated to see patients from each department?
11. How will the integration affect the contracts with the health plans?
12. What units will be consolidated during the merger?
13. How will the integration affect the profit sharing arrangement (AB 85) with the State of California?
14. Are the Finance Divisions of the three departments will also be combined into one?
15. Are we going to move to another office location since we are merging into one Health Department?
16. How are they going to manage redundancy in terms of job positions?