



May 19, 2015



Honorable Mike Antonovich, Mayor
Honorable Hilda Solis
Honorable Mark Ridley-Thomas
Honorable Sheila Kuehl
Honorable Don Knabe
Hall of Administration
500 West Temple Street
Los Angeles, CA 90012



Re: Los Angeles County Coalition for an Office of Healthcare Enhancement

Dear Supervisors:



The Los Angeles County Coalition for an Office of Healthcare Enhancement consists of over 135 organizations and agencies representing persons with mental illness and substance use disorders, family members, and providers serving those persons and their families, as well as public health, advocacy services, and other human services, all with a commitment to ensuring the highest quality healthcare possible for the residents of Los Angeles County.

LATCO

Latino Mental
Health Council

On behalf of the Coalition, we would like to begin by acknowledging and thanking you for listening to your constituents when agreeing last January to reconsider a proposed consolidation of the County Departments of Mental Health and Public Health into a single County Health Department, and at the same time to explore an alternative health agency model and allow for a stakeholder input process and an analysis of the pros and cons of that health agency model. Having carefully reviewed and considered that analysis done by the County CEO's office, as reflected in its March 30, 2015 Draft Response to the Los Angeles County Board of Supervisors Regarding the Possible Creation of a Health Agency, we respectfully believe that there is a better alternative model.



Maternal and Child
Health Access



As reflected in our enclosed response, the Coalition is proposing an Office of Healthcare Enhancement, which is based on the model of the Office of Child Protection that the County has established as a result of a recommendation by your Board's Blue Ribbon Commission on Child Protection. We believe that this model, which focuses on the joint development and implementation of a Strategic Plan for Integrated care, and holds the leadership of all three departments equally accountable to achieve specific integrative goals, offers the type of collaborative, problem solving approach that is fundamental to resulting better integrated care. Moreover, this alternative model will allow for the continued autonomy of each department, while ensuring that mental health and public health continue to be equity partners with physical health and the other County Departments, with direct reporting to the Board of Supervisors.



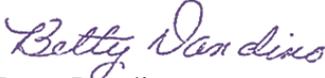
Honorable Board of Supervisors

May 19, 2015

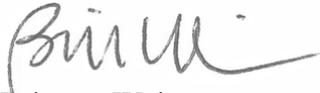
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Thank you for your ongoing support for the highest quality healthcare possible for Los Angeles County's residents and for your consideration of our proposed alternative County healthcare model.

Very truly yours,


Betty Dandino
LA County Client Coalition


Guyton Colantuono
Project Return: The Next Step


Brittney Weissman
NAMI LA County Council


Luis Garcia
Latino Mental Health Council


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**Los Angeles County Coalition for an Office of Healthcare
Enhancement Response to the March 30, 2015 Draft
Report on the Possible Creation of a Health Agency**

May 2015

Los Angeles County Coalition in Support of an Office of Healthcare Enhancement*

1. A Community of Friends
2. Aegis Treatment Centers
- 3. African Communities Public Health Coalition**
4. Alcoholism Center for Women, Inc.
5. Alcott Center for Mental Health Services
6. Alliance Human Services, Inc.
7. Almansor Center
8. Amanecer Community Counseling Services
9. American Drug Recovery Program, Inc.
- 10. American Indian Community Council (AICC)**
11. American Treatment Centers
12. Amity Foundation
13. Asian American Drug Abuse Program (AADAP)
- 14. Asian Pacific Policy & Planning Council (A3PCON)**
- 15. Association of Community Human Service Agencies (ACHSA)**
16. Aviva Family & Children's Services
17. Bayfront Youth & Family Services
18. Behavioral Health Services, Inc.
19. Bienvenidos Children's Center
20. BRIDGES, Inc.
- 21. California Association of Alcohol & Drug Program Executives, Inc. (CAADPE)**
22. California Center for Public Health Advocacy (CCPHA)
23. Child & Family Center
24. Child & Family Guidance Center
25. ChildNet Youth & Family Services
26. Children's Bureau of Southern California
27. Children's Institute, Inc. (CII)
28. CLARE Foundation
- 29. Coalition For Humane Immigrants Rights of Los Angeles**
- 30. Community Clinic Association of Los Angeles County (CCALAC)**
31. Community Family Guidance Center
- 32. Community Health Councils (CHC)**
33. Community Intelligence, LLC
34. Concept 7 Family Support & Treatment Center
35. Counseling4Kids, Inc.
36. Cri-Help
37. Crittenton Services for Children & Families
38. D'Veal Family & Youth Services
39. David & Margaret Youth & Family Services
40. Didi Hirsch Mental Health Services
41. Disability Rights California
42. El Proyecto del Barrio, Inc.
43. ENKI Health & Research Systems

44. Ettie Lee Youth & Family Services
45. Exceptional Children's Foundation (ECF)
46. Families Uniting Families
47. Five Acres
48. Foothill Family Service
49. For The Child
50. Gateways Hospital & Mental Health Center
51. Hathaway-Sycamores Child & Family Services
52. Haynes Family of Programs
53. HealthRIGHT 360
54. Hillside
55. Hillview Mental Health Center, Inc.
56. Hollygrove, An EMQ FamiliesFirst Agency
57. Homeboy Industries
58. Homes for Life Foundation
59. Impact Principles, Inc.
60. Institute for Multicultural Counseling & Education Services, Inc. (IMCES)
61. Jewish Family Service of Los Angeles (JFS)
62. Junior Blind of America
63. JWCH Institute, Inc.
64. Kedren Community Mental Health Center
65. Koreatown Youth & Community Center (KYCC)
66. LA Centers for Alcohol & Drug Abuse (LACADA)
67. Los Angeles Child Guidance Clinic (LACGC)
- 68. Los Angeles County Asian Client Coalition**
- 69. Los Angeles County Bicycle Coalition**
- 70. Los Angeles County Client Coalition (LACCC)**
- 71. Los Angeles County DMH Faith-Based Advocacy Council**
- 72. Los Angeles County DMH Service Area Advisory Committees (SAACs)**
- 73. Los Angeles County DMH System Leadership Team (SLT)**
- 74. Los Angeles County DMH Under-Represented Ethnic Populations (UREP)**
- 75. Los Angeles County Latino Client Coalition**
- 76. Los Angeles County Latino Mental Health Council**
- 77. Los Angeles County Mental Health Commission**
- 78. Los Angeles County Service Planning Area 6 Homeless Coalition**
79. Los Angeles LGBT Center
80. Los Angeles Neighborhood Land Trust
81. Maryvale
82. Masada Homes
83. Maternal & Child Health Access (MCHA)
84. Matrix Institute
85. McKinley Children's Center
86. Mental Health Advocacy Services (MHAS)
87. Mental Health America of Los Angeles (MHALA)
88. Narcotics Prevention Association

89. National Alliance on Mental Illness Los Angeles County Council (NAMI LACC)

90. National Asian Pacific American Families Against Substance Abuse (NAPAFASA)

91. New Directions for Women

92. Nuevo Amanecer Latino Children's Services

93. Olive Crest

94. Optimist Youth Homes & Family Services

95. Pacific Asian Counseling Services (PACS)

96. Pacific Clinics

97. Pacific Lodge Youth Services (PLYS)

98. Para Los Niños

99. Partners in Care Foundation

100. Penny Lane Centers

101. Personal Involvement Center, Inc.

102. Phoenix House

103. Police Chief Jim Smith, Monterey Park Police Department

104. Project Return Peer Support Network (PRPSN)

105. Prototypes

106. Providence St. John's Child & Family Development Center

107. Rancho San Antonio Boys Home, Inc.

108. Rosemary Children's Services

109. Sadler Healthcare Inc.

110. Safe Routes to School National Partnership

111. San Fernando Valley Community Mental Health Center, Inc. (SFVCMHC)

112. San Gabriel Children's Center, Inc.

113. Social Model Recovery Systems

114. South Central Health & Rehabilitation Programs (SHARP)

115. Southern California Public Health Association (SCPHA)

116. Special Service for Groups (SSG)

117. SPIRITT Family Services

118. St. Anne's

119. Star View Children & Family Services

120. Tarzana Treatment Centers

121. Telecare Corporation

122. Tessie Cleveland Community Services Corporation (TCCSC)

123. The Center for Aging Resources

124. The Guidance Center

125. The Help Group

126. The Prevention Institute

127. The Village Family Services

128. The Whole Child

129. Tobinworld

130. Trinity Youth Services

131. UCLA Fielding School of Public Health

132. United Advocates for Children & Families

- 133. United American Indian Involvement
- 134. Violence Prevention Coalition of Greater Los Angeles**
- 135. Vista Del Mar Child & Family Services
- 136. Volunteers of America Los Angeles (VOLA)
- 137. Western Pacific Med/Corp.
- 138. WISE & Healthy Aging
- 139. Youth Services Network

*Organizations are bolded.

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Executive Summary

The Los Angeles County Coalition in Support of an Office of Healthcare Enhancement (Coalition) includes more than 135 organizations and agencies representing persons with mental illness and substance use disorders, family members, and providers serving those persons and their families, as well as public health, advocacy services, and other human services, all with a commitment to ensuring the highest quality healthcare possible for the residents of Los Angeles County.

The Coalition is proposing an alternative model to a health agency model which it believes will lead to better integrated client care – both more effectively than, and with significantly less disruption than, the imposition of a new health agency. The Coalition’s Response to the CEO’s “March 30, 2015 Draft Response to the Los Angeles County Supervisors Regarding the Possible Creation of a Health Agency” highlights the following significant points:

- 1) The Coalition’s Office of Healthcare Enhancement (OHE) model holds the leadership of all three County health-related Departments equally accountable to achieve specific integrative goals, while offering the type of collaborative, problem solving approach that is fundamental to resulting better integrated care.
- 2) The Coalition strongly disagrees with the Draft Report’s support for and reliance on a hierarchical model for the overall setting of strategic priorities for all three departments, in favor of a collaborative decision making model with an OHE Director imbued with clear authority by the Board of Supervisors to work with the three Department Heads to develop a Strategic Integration Plan that promotes integration in the areas of overlap of the three department’s client care responsibilities.
- 3) The Coalition rejects the notion of a need for a “radically transformed system,” and instead offers the ability to enhance current successful models of integration while working to remove those barriers that would allow for their expansion, and at the same time leaving alone the significant scope of departmental work that is currently working.
- 4) Rather than a focus on integrated governance, the County’s focus should be on better working relationships between DHS, DMH, and DPH, and their providers at the service level, where the true success or failure of better client healthcare actually occurs. The biggest barriers to better integrated care for the specialty mental health population that have been identified in mental health’s work with the health care system have had nothing to do with governance, but rather with such things as physician buy-in and limited time availability to devote to care coordination and planning, as well as limited financial resources. Working to overcome these barriers and better integrate care through an OHE makes more sense than focusing on integrating the governance of the three County departments.
- 5) The Draft Report’s “one stop shop” model is geared toward a non-specialty mental health population with mild to moderate mental health needs seen in health services clinics. Few if any individuals with serious mental health conditions, who are the

responsibility of DMH, and particularly those within underserved ethnic and cultural communities, will utilize a single entry clinic door. They are ensured better access with a “no wrong door” approach in which services are coordinated within the context of culturally welcoming recovery model services for adults and resiliency model services for children.

- 6) To quote from the Draft Report: “The major rebuttal to the opportunities presented [under a health agency] is that it would be possible to achieve almost, if not all of the opportunities without transitioning to an agency and that non-agency solutions can equally achieve these shared objectives.” The Coalition not only firmly agrees with this, but points out that its OHE model would do so without the disruption involved in creating a new health agency.
- 7) Children with serious emotional disturbances, who account for more than one-half of the County mental health system’s service expenditures, are, shockingly, basically ignored in the Draft Report (with less than one page devoted to them). The draft report is written with a focus on adults and says nothing about how a health agency model would improve services for children with serious emotional disturbances and their families.
- 8) Public Health became an independent department for very significant reasons that still apply today. As far back as 1997, the DHS Director found “a number of adverse effects on public health programming and services under the Health Services Department” (see footnote 4), a concern which was reinforced in a 2005 CAO Report to the Board of Supervisors that contained DHS’ acknowledgement that “consolidating Public Health Programs into a separate Department would allow...DHS [leadership] to devote their time and attention to the pressing patient care and operational issues in its hospitals and comprehensive care centers.” [See Appendix 5.]
- 9) The 2005 CAO Report goes on to highlight the fact that: “In the aftermath of September 11, 2001 and with the growth of global infectious disease threats, public health has grown as a critical priority responsibility. PHS has primary responsibility for early detection and control of all bioterrorism, as well as detection of chemical and radiological terrorism. In addition, PHS has the responsibility to prevent, detect and control new infectious diseases such as...SARS, pandemic flu, and the Ebola Virus.” These quotes highlight the critical significance of ensuring that the voice, visibility, and autonomy of Public Health must not be muted.
- 10) The Coalition agrees with stakeholder fears shared in the Draft Report “that closer integration with DHS in particular will result in a shift away from recovery toward medicalization of mental health treatment,” and that “this is a frightening possibility.” To use the Draft Report’s own words: “[M]any providers in the physical health care system still manage patients first in the medical framework, and then address social, psychosocial, and environmental factors when medical intervention doesn’t yield the expected result...They manage individuals with chronic diseases with narrow attention to medications and laboratory values rather than emphasizing coping mechanisms and social supports.”

11) Through the requirement that all three department heads would report directly to the agency head, it would not be possible to bring the current level of attention to mental health and public health issues and constituency concerns, which would be subsumed under the controlling authority of the agency head. Mental health would not be the number one priority of the integrated agency, plain and simple. Nor would DPH continue to have its public health concerns be the top priority under an integrated agency.

The buffer that the Draft Report is now recommending between the Board of Supervisors and the Department Heads in the form of a Health Agency Director is parallel to the CEO buffer that the Board of Supervisors just recently rejected in going back to the County's old governance structure and a CAO model, based on a desire to "retain departmental collaboration and interdepartmental communications, but reduce bureaucracy." [See Appendix 9.]

By adopting the OHE model, which is the best vehicle for delivering healthcare integration benefits without the health agency model risks, the Board will ensure that DMH and DPH are not the only two of the more than 30 Departments in the County run by non-elected officials whose Department Heads would not be reporting directly to the Board of Supervisors.

The Los Angeles County Coalition for an Office of Healthcare Enhancement

The Los Angeles County Coalition in Support of an Office of Healthcare Enhancement (Coalition) includes more than 135 organizations and agencies representing persons with mental illness and substance use disorders, family members, and providers serving those persons and their families, as well as public health, advocacy services, and other human services, all with a commitment to ensuring the highest quality healthcare possible for the residents of Los Angeles County.

The Coalition shares the Board of Supervisors’ desire that the people of Los Angeles County receive superior healthcare services, while supporting an alternative model to a new health agency model being considered by the County CEO’s office. This model, which we believe will better serve the needs of our clients, and better meet the needs of the people of Los Angeles County, is based on the model of the Office of Child Protection (OCP) that the County has established as a result of a recommendation by the Board of Supervisors’ Blue Ribbon Commission on Child Protection (BRC).

The Coalition Embraces the County’s Office of Child Protection Model for Use in Enhancing the Healthcare of the Residents of Los Angeles County

The BRC Transition Team, co-chaired by Department of Health Services’ Director Dr. Mitchell Katz, was directed by the Board of Supervisors (BOS) to work with the Board to provide input into the job description for the Director of OCP, as well as the desired qualities and experience for the position. In describing the OCP, the “Summary Position Description” for the Director of Child Protection notes that the Supervisors “adopted the basic principle...that a single entity be established to develop, coordinate, update and continually advise the Board on implementation of a Strategic Plan covering the total complex of child safety programs.” [See Appendix 1.]

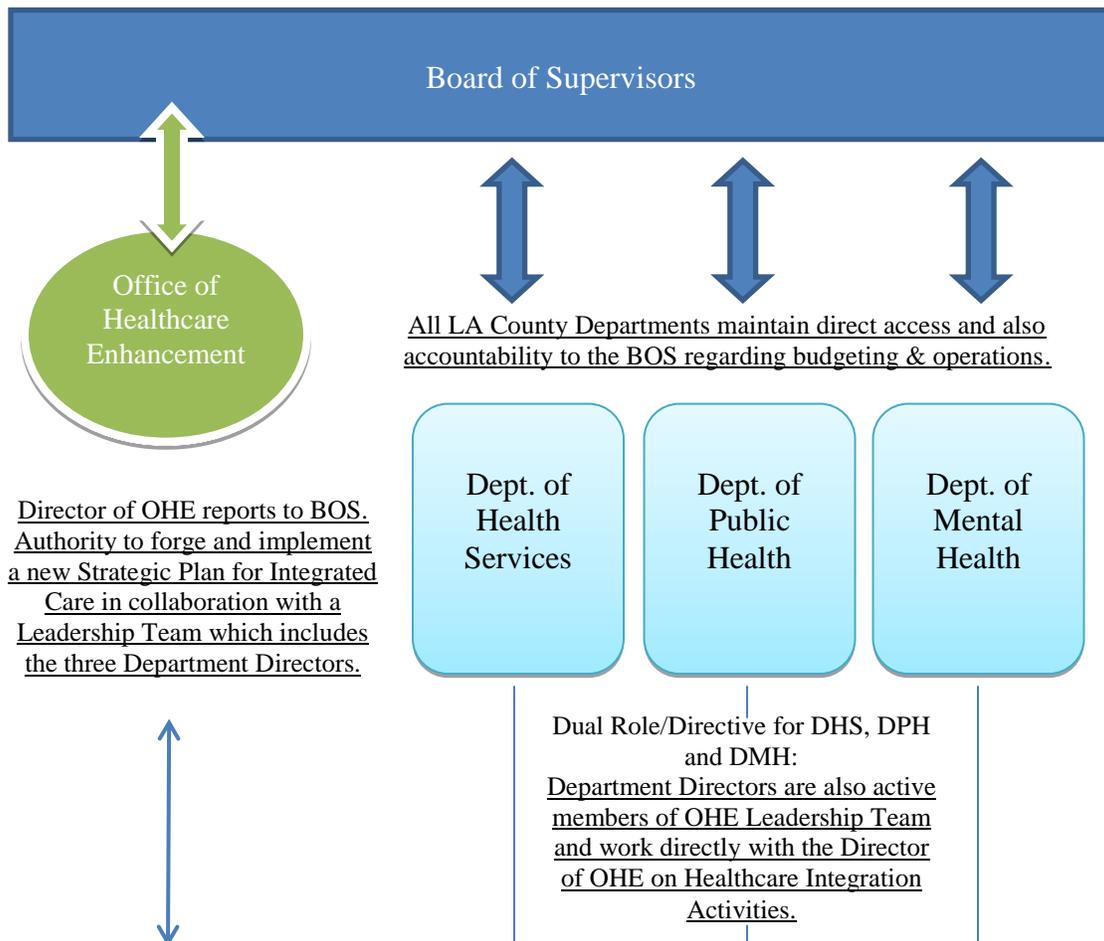
The Summary Description Position also makes the following important points pertinent to the Coalition’s position: 1) the Director of the OCP, who would report directly to the Board of Supervisors, would be supported by a small but very talented staff; 2) the operating agencies working with the new Director of OCP (e.g., DCFS, Probation, DMH, DHS, and DPH) would “continue to bear their operational responsibilities and budgetary authority while the new Director [of OCP] works with their Directors in a joint, ongoing Strategic Plan development and execution monitoring forum...”; and 3) “authority over day-to-day operations and budgetary authority [would] remain in the hands of very able heads of specialized Departments,” which would “require the capacity to lead collaboratively, mainly through facilitation...”

We believe that, consistent with the OCP model, an Office of Healthcare Enhancement (OHE) should act to develop, coordinate, update and continually advise the Board on the implementation of a Strategic Plan for Integrated Care to enhance the healthcare of County residents in the areas of overlapping responsibility of the involved County Departments – DHS, DMH, and DPH. Similarly, those three County Departments should maintain their current operational responsibilities and budgetary authority, and the three Department Directors should report directly to the Board of Supervisors rather than an

agency director, and maintain their current authority over the day-to-day operations of their departments.

This organizational design holds the executive leadership of all three departments equally accountable to achieve specific integrative goals, which would be developed conjointly with the new Director of the Office of Healthcare Enhancement, as well as independently accountable for all of their other department based goals. In so doing, this model will result in better integrated care while maintaining the autonomy of each department and ensuring that mental health and public health continue to be equity partners with physical health.

Proposed Office of Healthcare Enhancement
FUNCTION & FLOW CHART



The Justification for A Health Agency Model Highlighted in the Introduction to the CEO's March 30th Draft Report (Pages 4 – 5) Fails to Make the Case

The Coalition would like to respond to the key points made in the Introduction to the Draft Report, which provides an overview of the justification for a health agency model:

- 1) “There was a strong and convincing rationale behind the re-establishment of an independent Department of Mental Health in 1978 and the creation of an independent Department of Public Health in 2006...The moves allowed each to develop a strong identity and reputation in their fields, to prioritize their work to achieve their missions, and to avoid program budget cuts that could occur in the setting of financial deficits.” (Emphasis added.)

Response: We wholeheartedly agree.

- 2) “Those supporting an integrated health agency model...see service integration as imperative to, over the long term, improving services and programs, decreasing costs, reducing disparities, and improving health outcomes across LA County, particularly for those most disadvantaged, and see organizational integration at this point in time as the most effective pathway to service integration.” (Emphasis added.)

Response: While agreeing that service integration is one of many important elements of enhanced client care, we disagree with the fundamental premise of the draft report that organizational integration is the most effective pathway to service integration and improved healthcare. [See a more in depth response to the premise for a health agency model in Theme Number 1 on page 7.]

- 3) “Those hesitant about the creation of a health agency do not oppose care integration and its attendant benefits, but rather question whether the creation of a health agency is a necessary or even helpful step in the quest for better care outcomes.” (Emphasis added.)

Response: We strongly agree and note that an Office of Healthcare Enhancement is a better way to promote care integration and its attendant benefits, while avoiding the real risks that a structural realignment presents.

- 4) “The US health care system is moving toward integration. As examples, under the Affordable Care Act (ACA), California has placed responsibility for treating mild to moderate mental illness on the local health plans which provide health services and not in the specialty mental health system.”

Response: This comment misses the point of what the state did, which was to reinforce their longstanding support for a separate specialized system of delivering mental health services to adults with serious and persistent mental illness and children with serious emotional disturbances to ensure that they

receive the proper level of care they need from County DMH, as opposed to from a system operated by local health plans, which were assigned responsibility for the non-specialty mental health population.

The California Department of Health Care Services’ website, under a section entitled, ‘MCMHP Consolidation and Managed Care,’ provides some historical perspective regarding the establishment of the specialty mental health “carve out” in explaining that “[s]ince research demonstrated that...the needs of persons with mental illness are not always paid adequate attention to in an all inclusive health care managed care system, the decision was made to ‘carve out’ specialty mental health services from the rest of Medi-Cal managed care.” (Emphasis added.)

- 5) “A key agency role would be to lead and promote service integration where integration would benefit residents of Los Angeles. This does not imply that all facets of each Department would benefit from integration-related activities... Those areas that would not benefit should be left alone to develop independently.”

Response: The report at various points both argues and acknowledges that its proposed organizational integration will not touch the vast amount of activities engaged in by all three departments for which there is no overlap. This raises the fundamental question, however, of why invest in all of the work required by the proposed organizational integration, with its inherent disruption, when there is no overlap for a significant majority of the work of the three departments. Rather, the Coalition’s OHE model will focus only on those areas of overlap and so will be narrowly tailored to engage only in those integrative activities. [See a more in depth response addressing the issue departmental overlap in Theme Number 3 on page 15.]

- 6) “As stakeholders often stated: “please, leave it alone, it’s working.” (Emphasis added.)

Response: We again wholeheartedly agree in terms of the basic operation of the three departments, with an acknowledgement that we can and must continue to improve our efforts at care coordination through an Office of Healthcare Enhancement.

- 7) “There have been some successful examples of integration, what stakeholders highlighted as ‘pockets of success,’ but they also pointed to much larger areas where the system and its separate, largely siloed, efforts, are not effectively serving the individuals and populations.”

Response: To argue that there are “much larger areas” where the system isn’t working ignores the overwhelmingly supportive public testimony in favor of the current mental health system by hundreds of mental health clients, family

members, and other stakeholders who filled the Board of Supervisors' meeting room on January 13th.

We would also like to highlight comments made by Dr. Christina Ghaly, the Director of the Interim Office of Healthcare Integration, at the February 18, 2015 DMH System Leadership Team (SLT) meeting in terms of successful DMH integration efforts. To quote: **“I also just want to acknowledge, obviously, that there is a lot of work of integration that is ongoing. There is a lot of good work that DMH has done in collaboration with other county departments, including DPH and DHS, but also with other county departments, with [the] Sheriff’s Department, with Probation, with DCFS, with CCS, and with a lot of different organizations.”** (Emphasis added.) [See 2/18/15 DMH System Leadership Team Meeting transcript, Appendix 2, page 4.]

With regard to the comment on the system’s “siloed” efforts, the Coalition acknowledges that there are significant barriers to the County’s delivery of seamless integrated health services. However, the County’s health services are financed through multiple funding sources that place restrictions on how funds are used and accounted for, over which the County has no control. More importantly, siloed programs protect vulnerable populations by protecting dedicated funding from being diverted for other purposes. Examples of such important programs include AB 109, the AIDS Drug Assistance Program (ADAP), Public Health Emergency Preparedness (PEP), and the Mental Health Services Act. At the same time, the Coalition continues to strongly support the County’s efforts to better coordinate and improve the delivery of seamless integrated health services through a “no wrong door” approach. [See discussion of Access to Care, a “One Stop Shop,” and “No Wrong Door” on page 12.]

- 8) “Specific groups, often many of the most vulnerable populations within the county...experience gaps in services and programs or remain entirely unserved.”

Response: This is primarily a resource issue that would not be impacted by the imposition of an agency model. [See discussion on Addressing Service Gaps for Vulnerable Populations at page 9.] On top of that, no public entity has done a better job than DMH of reaching out to unserved and underserved populations, with such examples as the Promontoras program for outreach to Spanish speaking populations, the TAY Drop-In Center in Hollywood run by the Los Angeles LGBT Center for the LGBTQI population, and the MHSA funded Innovations programs focusing on underrepresented groups, including the API, African and African American, Eastern European, Latino, Middle Eastern, and Native American communities.

Public Health, by its nature, serves all, so that a parallel set of examples for Public Health is not necessarily appropriate. However, its population-based work serves poor and vulnerable communities within Los Angeles County. For example, the

County's targeting of lead abatement disproportionately impacts housing for low-income residents. Lead-based paint and contaminated dust are the most hazardous sources of lead exposure for children, and lead exposure is linked to learning disabilities and health problems. Children of color and children living in poverty are disproportionately at risk.

- 9) "To address these gaps, the County must focus on building a radically transformed system that provides the highest quality health-related programs and services..." (Emphasis added.) [See also comments on page 40 that "the agency would be comprehensively responsible for all services provided," on page 45 that the agency would establish "...policies, strategic priorities, and performance objectives for health-related services in the County..." and also on page 45 that those arguing against the need for an agency "dramatically underestimate the amount of work and costs required at the operational level..."]

Response: The concept of a "radically transformed system" goes against the report's assurances of a limited agency role and that the vast multitude of things the departments are currently doing that are working will be left alone. It also flies in the face of the overwhelming support provided for current mental health and public health services, which were forged by the independence of these departments, as acknowledged in the report.

The Coalition's proposed Office of Healthcare Enhancement rejects the notion of a need for a "radically transformed system," and instead offers the ability to enhance current successful models of integration while working to remove those barriers that would allow for their expansion, and at the same time leaving alone the significant scope of departmental work that is currently working.

A Board of Supervisors' appointed Director of an Office of Healthcare Enhancement would best fill the role of County healthcare integration leader by focusing specifically on improved integrated care with the three departments, while allowing all three department heads to also continue to focus on the enormous responsibilities of running their departments.¹

Appointing an OHE Director further avoids the concern of providing controlling authority for a "radically transformed system" to an agency that sets the County's healthcare strategic priorities and goals, and an agency leader that has "direct reporting relationships" (p. 45) with the component department heads, which would make real the identified risks of loss of department autonomy, loss of voice,

¹ As indicated on page 5 of the February 17, 2015 Memo to Dr. Ghaly from Cynthia Harding, Interim Director of DPH, regarding "Public Health in the Proposed Los Angeles County Health Agency," (see Appendix 3) "should the agency be implemented, it would be comprised of approximately 30,000 employees – roughly one third of the County workforce. This would require significant administrative and managerial oversight by the Agency Director."

and modification of service delivery philosophy (e.g., mental health recovery and resiliency models).

Key Themes and Critical Assumptions and the Coalition's Response

Theme Number 1 – Organizational Integration and Enhanced Healthcare: The Focus on an Integrated Governance Model is Misplaced: The most significant assumption in the draft report is that the institution of a health agency model is the best way to obtain enhanced healthcare in this County, based on the premise that organizational integration is the best way to obtain enhanced healthcare. This premise assumes both that organizational integration is most important to enhanced healthcare and that there is no better way to accomplish this end goal.

Response: The latter assumption, that there is no better way to obtain enhanced healthcare, is addressed in theme number two below. With regard to the former assumption, that organizational integration is most important to enhanced healthcare, it cannot be emphasized enough that departmental integration efforts are only one of a multitude of factors which impact client care, others of which are as important if not more important. These include, among other things, for persons served by the County mental health system: 1) fidelity to the recovery model for adults and the resiliency model for children; 2) client directed care for adults and family focused care for children; 3) access to community-based services; 4) the receipt of culturally competent services; and 5) significant client and family member involvement in policy and planning.

Rather than focusing on integrated governance, the DHS leadership and the draft report should be focusing on better working relationships with DMH, DPH, and their providers at the service level, where the true success or failure of better client healthcare actually occurs. Ironically, from a clinical perspective it has been DMH and not DHS that has taken the lead in promoting County health/mental health integration efforts over the past several years for the specialty mental health population, and it is not clear what DHS has brought to the table in that regard. [See attached chart of numerous DMH Led Service Integration Initiatives, whose focus is to better improve County integrated healthcare, Appendix 4.]

Moreover, in point of fact, it should be noted that the biggest barriers to better integrated care for the specialty mental health population that have been identified in mental health's work with the health care system have had nothing to do with governance, but rather with such things as physician buy-in and limited time availability to devote to care coordination and planning. Working to overcome these barriers and better integrate care through an Office of Healthcare Enhancement makes much more sense than focusing the County's energies on integrating the governance of the three County departments.

The Discussion of Opportunities in the Draft Report Is Not Convincing

On pages 6 through 32, the draft report attempts to set forth what it believes to be the opportunities afforded by a health agency. Two very important general comments are in order with regard to the Opportunities section: 1) a majority of the arguments made are aspirational or impractical, as opposed to real benefits; and 2) a large percentage of the arguments are generally related to the benefits of integrated care, which we agree with, but they do not support the argument for a health agency. We would like to highlight examples of these general comments in relation to four critical areas within the Opportunities section: 1) the integration of services at the point of care; 2) major service gaps for vulnerable populations; 3) information technology; and 4) streamlining access to care.

The Draft Report's Discussion on Integrating Services at the Point of Care for Those Seeking Services in the County

With regard to the goal of the integration of services at the point of care, the draft report begins with a number of examples of current successful service integration within the County. Obviously, none of these collaborative efforts required an agency to allow them to successfully integrate services.

We agree with the report that these “evidence-based models of service delivery... should be prioritized for implementation.” However, the expansion of these programs will require new resources or a redirection of current resources from other priorities, rather than the institution of a new health agency. [See the draft report's reference to Traumatic Brain Injury patients, at page 12, for whom “funding resources... are not currently available within the health care system.”] As with the draft report's discussion of service integration models, the discussion of bi-directional co-location of primary care and mental health services is nothing new. The draft report, however, refers to mixed success in current co-located projects, asserting that “[m]any individuals with mild or even moderate mental illness can be well-served by a medical home team if supported by the expertise and experience of mental health clinicians” and further that “[f]or other individuals treatment by a mental health professional may be required, but could often still be performed in a physical health setting”. (See pages 11 – 12.)

The report concludes that this work is “currently being undertaken by DHS and DMH to some extent but could perhaps be accelerated in the context of an agency” (See page 12; emphasis added). These passages are more than aspirational, they are impractical, unless there is a significant increase in resources or a redirection of resources from other priorities. Just as importantly, these passages are not focused on the DMH specialty mental health population. Furthermore, there is no rationale for creating an agency other than the assertion that it “could perhaps” speed up the process of integration, and the Coalition is proposing a better “new model to promote service integration.” (See page 12.)

In analyzing the draft report's discussion on improved access to substance abuse services, the following points must be made: 1) while the report claims that an agency is required

to improve clients' receipt of effective substance use disorder (SUD) services, the report more appropriately refers to the real reason for the lack of effective SUD services in its reference to "the past forty years of separate and unequal resources for the treatment of SUD" (page 13); 2) while the draft report argues that a health agency could leverage additional resources for substance abuse care through the upcoming Medicaid waiver process, we do not believe that having an agency would enhance the County's lobbying effectiveness; and 3) while the report acknowledges "the role of psychosocial interventions and more recovery-focused approaches," it refers to an "increasingly medicalized model for delivering substance abuse treatment."

A couple of additional comments are in order with respect to the draft report's discussion on complex care programs and the expansion of the recovery model into physical health care settings. In reference to the discussion of complex care programs, with respect to program development the draft report refers specifically to the success of Project 50, "which DMH facilitated in 2007." (See page 15.) This is a clear example that department led initiatives like Project 50 do not require a health agency to be implemented. In reference to the expansion of the recovery model, the report's reference to the fact that "an emphasis on recovery need not be reserved only for populations with serious mental illness" (page 16) raises the question as to why DHS has not done this already. Once again, this certainly does not require the creation of a health agency.

Addressing Major Service Gaps for Vulnerable Populations

In discussing major service gaps to vulnerable populations, the draft report asserts that the County is not making sufficient progress "despite the fact that many individuals have found excellent services and support from County-provided or funded programs..." (See page 17.) However, the proposed solutions for addressing the needs of these populations are highly aspirational and impractical, and the report acknowledges that the solutions to addressing the needs of these vulnerable populations must involve other departments and agencies besides the three health-related ones.

So, importantly, while multiple non-health related departments are critical for addressing the needs of these populations, the proposed agency would not have any authority over them, the draft report acknowledging that "the agency [would] not involve these other non-health departments." (See page 17.) Accordingly, the ability of a health agency to address these service gaps is seriously called into question. As importantly, working to improve existing partnerships to address issues which are broader than "health systems issues" does not require establishing a health agency.

While the needs of the County's most challenging and vulnerable groups certainly have not been fully addressed given the tremendous scope of their needs in relation to the available County financial resources, there has been significant progress made to increase access to care for these populations, as reflected in the following examples:

- Integrated Mobile Health Teams, funded with Mental Health Services Act dollars, have demonstrated highly positive health and mental health outcomes for homeless individuals with the use of an integrated care team -- including primary

care, mental health, substance use services and housing providers -- delivering coordinated care in permanent supportive housing programs.

- Mental Health-Law Enforcement Co-Response Teams have successfully diverted from the criminal justice system the majority of individuals with mental illness they have encountered during police calls.

The report minimizes the improvements in services for foster care and Transitional Aged Youth (TAY) that have occurred by stating that services “still operate on parallel tracks and are not well coordinated, leading to delays in care, poorer health outcomes, and unnecessary duplication of services,” and asserts that an agency led implementation of “whole person care” for DCFS-involved children and youth is the solution. At the same time, the report’s health-centric agency led approach ignores the fact that “whole person care” for this population must include other educational, cultural/spiritual, housing, and recreational components, among others. Moreover, the report fails to mention the planning for implementation of integrated services that will occur with the co-location of DMH social workers in the medical HUBs. Lastly, there already is the Office of Child Protection, which is a perfect entity to work collaboratively with the Coalition’s proposed Office of Healthcare Enhancement to address this issue.

With regard to the re-entry and incarcerated populations, the report states that, “Under an agency-led approach to re-entry service planning and coordination, there is an opportunity to create truly integrated and not just coordinated and co-located services. Currently, each Department has or is developing programs that target a specific subset of the re-entry population. These programs are mostly created independently from the other Departments.” (See page 19). Once again, this recommendation is health-centric and does not consider a broader system’s perspective and the necessary involvement of non-health related entities (e.g., law enforcement, the District Attorney’s office, Probation, the courts, housing, and employment) which is required for successful care coordination and client outcomes.

Many of the opportunities cited for the creation of an agency to address the needs of the homeless and those in need of psychiatric emergency services have begun already and are being implemented without an agency, including SB 82 programs. Further, the draft report’s reference to individuals with serious mental illness not being able to access housing using DMH’s resources “unless they have an open case with DMH or its provider network based on interpretations of restrictions on the sources of funds,” at page 21, reflects a lack of understanding of the supports that homeless persons with severe mental illness need in order to access and maintain their housing. Finally, with regard to the draft report’s proposed solution of “creating less restrictive shared housing and service entry criteria,” these criteria are not established by DMH, but rather by the funders or agencies that oversee the housing resources.

In discussing psychiatric emergency services, the draft report highlights the fact that “[o]n any given day, over half of DHS’ 131 staffed inpatient psychiatric beds are filled with individuals who no longer require acute inpatient admission but for whom a

placement is deemed appropriate by the discharging physician is not available.” (See page 21.) What the draft report fails to mention is the lack of adequate financial resources to provide the necessary alternate, less restrictive placements.

The draft report goes on to highlight, at page 21, the fact that “DHS and DMH have partnered... recently on an ‘all hands on deck’ discharge approach, which has yielded dramatic results but has not proven sustainable.” (Emphasis added.) Of course, the answer to this problem is certainly not the creation of a new health agency, but once again rather additional financial resources.

Finally, the draft report also recognizes the excellent work of DMH in this area in discussing the fact that, “DMH has increased the level of engagement with law enforcement to link field personnel with mental health training and divert people whenever possible to non-ED settings. DMH has also opened additional urgent care facilities able to serve as alternative destinations for a portion of individuals who would otherwise be transported to PES.” (See page 21.) While the report mentions that “[m]uch more should and can be done to accelerate the movement of patients through the continuum of care” and then outlines several potential new options for addressing this problem, several points are relevant here: 1) this begs the question of why the report’s focus isn’t on the already successful models instead, which don’t require a health agency; 2) the options/examples provided themselves don’t require a health agency; and 3) the issue is once again the need for more financial resources.

Using Information Technology, Data, and Information Exchange to Enable Service Integration

With regard to the draft report’s discussion of using information technology to enable service integration, at pages 23 through 25, the report is at various times both aspirational and impractical, or again provides information which does not support the institution of an agency model. The section starts by discussing the shared benefits of IT integration, which nobody would disagree with but which are not linked to an agency model. The section then moves into a lengthy aspirational discussion of an Electronic Health Record (EHR) and information sharing, referring to it as an “optimal solution” and predicating it on “assuming the EHR could meet the differing needs of directly-operated and contracted sites without compromising different documentation, reporting, and care delivery methods.” (Emphasis added.) It goes on to say that “[w]hile there is broad agreement on the value of a shared EHR, there is also a shared recognition that achieving this goal will not be quick or easy...” (Emphasis added.)

The draft report does mention that “DPH has been working with DHS since 2014 to explore the feasibility of adopting ORCHID as the EHR for its fourteen Public Health clinics,” and that “[t]he Departments are working to resolve several technical and operational design issues before finalizing a contract,” **but of course it must be noted that this is being done already without the need for a new health agency.**

As importantly, as the draft report acknowledges, the County has already invested heavily in LANES (**it should be noted again without the need for an agency**), which would in

effect do much of what an integrated IS system would do with regard to the sharing of critical clinical information, with the additional potential benefit of allowing for EHR data exchange across private healthcare systems in the future. LANES also significantly enhances the capabilities of the pharmacy data exchanges currently in use, which could link prescription information across any system a client might be accessing medication from. LANES provides the best solution to overcoming the barriers of data exchange across multiple healthcare data management systems by providing an infrastructure for transferring electronic information relevant to integrating client care.

Finally, the draft report talks about the potential for additional IT opportunities beyond the possibility of an EHR, including: 1) physician credentialing/master provider database; 2) pharmacy benefit management; 3) health care claims clearinghouses; 4) referral management systems; 5) active directory; 6) Picture Archiving and Communication Systems; and 7) a single health care data warehouse. Most of the additional IT opportunities listed would only provide limited benefit to County IT infrastructure and, more importantly, none require the creation of a new health agency to achieve.

Access to Care, a “One Stop Shop,” and “No Wrong Door”

Throughout the Opportunities section of the draft report there is an underpinning of the agency model with respect to client care “[i]ntegrating all three service spheres – mental health, public health, and substance abuse – into the same site in a ‘one stop shop’ model...” (See page 15.) This idealistic vision of every recipient of healthcare services having a single door to enter where all of their healthcare needs are taken care of is aspirational at best. Even the draft report acknowledges, at page 22, that “the operational barriers to making true headway on the issue are sizeable.”

This model is geared toward a non-specialty mental health population with mild to moderate mental health needs as seen in health services clinics. The focus of the proposed “one stop shop” toward a medical model is illustrated by Dr. Katz’s reference to the use of “a single eligibility doctor” as the gatekeeper in his remarks before the Public Health Commission.² Individuals with serious mental health conditions, and particularly those within underserved ethnic and cultural communities, will not utilize a single entry clinic door but are ensured better access with a “no wrong door” approach in which services are coordinated within the context of culturally welcoming recovery model services for adults and resiliency model services for children.

Theme Number 2 – Accomplishing Enhanced Healthcare without the Significant Disruption Created by an Agency: “The major rebuttal to the opportunities presented [under a Health Agency] is that it would be possible to achieve almost, if not all of the opportunities without transitioning to an agency and that non-agency solutions can equally achieve these shared objectives.” (Emphasis added.) [See draft report page 6.]

² [See Draft Minutes, 4/9/15 Los Angeles County Public Health Commission meeting, Appendix 7, page 14.]

Response: We not only agree, but would go further in saying that our proposed Office of Healthcare Enhancement would be able to address the client and population enhancement goals identified in the report without having to go through the extra work and disruption involved in setting up and transitioning to an agency.

Role of the Office of Healthcare Enhancement

Similar to what was spelled out for the Office of Child Protection in the “Summary Position Description” for the Director of Child Protection, we would expect the Office of Healthcare Enhancement to “[d]esign and manage a joint strategic planning process involving the heads of the relevant operating Departments... which develops for Board approval a comprehensive County Strategic Plan” for healthcare enhancement. This Strategic Plan for Integrated Care would “articulate measureable goals and time frames and provide for regular and continuous joint monitoring and progress assessment, together with provision for mid-course corrections as lessons are learned and new problems and opportunities arise.”

Disruption Avoidance

In carrying out its integrative role, an OHE would eliminate the significant disruptive factor that would go along with the development and institutionalization of a health agency. In that regard, it is commonly understood and agreed upon that any large organizational restructuring is excessively time and staff intensive, particularly where the cultures of the merged entities are so significantly different. As referenced stakeholder input at page 44 of the draft report so aptly provides, “The process of building an agency is a distraction from the real work; it could be a transitional quagmire lasting years.” (Emphasis added.) This disruption is certainly felt by the clients or customers of the impacted organizations. Such a “quagmire lasting years” has been experienced by the Department of Homeland Security, referenced in the draft report and discussed further on page 24.

Dr. Ghaly Highlights Disruptive Factor

Dr. Ghaly aptly described the disruptive impact that an agency could produce at the February 18, 2015 DMH System Leadership Team (SLT) meeting, where she provided a frank and honest articulation of the risks and potential costs of a health agency. She begins, “You can’t simply move a finance department out of a department and into an agency level without disrupting billing, claiming, cost reports, [and] financial documents that are critical to departmental operations. The same can be said for a number of different administrative functions such as HR, contracting, and others.”

Dr. Ghaly goes on to say that, “People are worried about long, drawn out planning phases where they go to multiple different meetings and processes where they have to think about a 1 year plan to be able to move 1 tiny unit over to another area. I think this overlaps a lot with the issue [of] bureaucracy and a concern about administrative layers. People want to do the work that they do because they want clients and patients to get better services and not because they want to sit in a room full of meetings talking about what should move on an org chart.” (Emphasis added.)

Draft Report's Disruptive Elements

With regard to the specific elements of disruption in the draft report, there is a recommendation on page 49 to promptly reassign departmental units (or portions of those units) to a data/planning group. Taking current critical departmental IS and planning resources required for the current day-to-day operations of those departments and moving them immediately to an agency would be terribly disruptive to the departmental IS operations and attention given to evaluating the effectiveness of client programs. For example, DMH has multiple analytic, outcome and reporting requirements related to its role as the Mental Health Plan, including but not limited to, MHSA reporting, External Quality Review Organization (EQRO) reporting, and analyses related to the fiscal management of contracts and claiming. More importantly, data is tied to claiming and failure to be able to analyze claims data timely could have a significant impact on revenue generation.

Most significantly, the draft report hinges its agency structure and its desire to keep staffing costs and bureaucracy low, and the agency “operationally efficient” (page 45) on the core concept of “dual role” staff. There is no way getting around the fact that staff pulled away from their current day-to-day departmental responsibilities because they are expected to devote half their time to agency work would only be half as effective in performing their regular responsibilities. It’s like taking a part of an FTE and assigning it to the agency. Paying for a small team of experts to address the areas of integration overlap, as set forth in the Office of Child Protection model that the Coalition is recommending be used, would be a much more cost effective way of doing this.

The draft report itself does a great job of highlighting this problem. To quote from page 39, “While this approach has the advantage of minimizing cost and bureaucracy, several stakeholders criticized it as unrealistic, thus compromising the agency’s ability to make progress in achieving service integration goals given people’s inability to take on both roles. Further, this structure was thought to erode Departments’ ability to meet their existing commitments...” **What the draft report fails to do is to provide any type of response which addresses this fundamental problem.**

Draft Report Attempts to Dispute Argument that an Agency Isn't Required Based on Lack of Authority

In discussing the proposed structure of the health agency, stakeholders are quoted on page 45 of the draft report as arguing that “‘you don’t need an agency to do this’ and ‘[t]he Departments can simply establish priorities and work together to achieve them.’” The report goes on to say that “this view has not been proven feasible in practice.” The draft report, at page 52, also includes a comment that a non-agency structured model similar to the Coalition’s OHE model would be ineffective because it would offer “‘accountability but no authority’ to get things done on a practical, operational level.”

In the draft report’s view, a hierarchical model where one person has controlling authority over the overall setting of strategic priorities for all three departments is necessary. We strongly disagree and note that the evidenced based management

literature does not support the premise that such a model can actually result in achieving integrative goals. Rather, literature on strategic alliances published in the past decade, including studies from healthcare and the public sector, have refocused attention away from this traditional hierarchical model to a collaborative model of leadership among top executives of the partner organizations.³

We further strongly disagree that a model like the OHE model would be ineffective. First and foremost, the ultimate authority rests not with either an agency director or the OHE Director, but with the Board of Supervisors themselves. The Office of Healthcare Enhancement’s OCP inspired model which the Coalition is proposing was in fact based on that fundamental principle, and thus clearly goes far beyond having the Departments themselves “establish[ing] priorities and work[ing] together to achieve them.”

The OHE’s small group of talented staff would be led by a Director which the Board of Supervisors could imbue with clear authority over the areas of overlap of client care responsibilities that promote integration. This would be reinforced by the high visibility of the position, as well as regular Board of Supervisors’ monitoring and public hearings on progress, with the Department Heads being held accountable to the Board for their collaborative work in this area.

Theme Number 3 – Limited Overlap of Departmental Missions Minimizes the Purpose of an Agency:

“DHS, DMH, and DPH have distinct missions. They each employ a different mix of activities in pursuit of their mission, including those related to policy development/advocacy, regulatory functions, population health programs, and direct clinical services.”
[See draft report page 40.]

Response: In an ideal scenario justifying departmental integration, there are substantially overlapping missions, closely compatible cultures, and a significant overlap in the responsibilities and scope of services delivered by the integrated departments. This is simply not the case here.

As articulated below in the section on Risk of Cultural Differences, the 2004-2005 Los Angeles County Civil Grand Jury reported on the significant differences between DMH and DHS. Similarly, Dr. Jonathan Fielding, the former Director of the County Department of Public Health, highlighted the fundamentally different missions of DPH and DHS in his testimony before the Board of Supervisors on January 13th, noting that, “At a time when it’s recognized the greatest determinants of health are in the social and physical and environmental conditions, combining all of these into one service

³ 1) Agranoff, R. (2012), Collaborating to Manage: A Primer for the Public Sector, Georgetown University Press; and 2) Judge, W.Q & Ryman, J.A. (2001, May), “The Shared Leadership Challenge in Strategic Alliances: Lesson from the U.S. Healthcare Industry,” *The Academy of Management Executives*, Vol. 15, No. 2, pp. 71-79.

organization that takes care of 10 percent of the population threatens the progress we've made to protect and promote all 10 million County residents."

At the same time, the quote above from the draft report highlights the distinct missions of the three departments and the fact that "[t]hey each employ a different mix of activities in pursuit of their mission." **While the report goes on to say that a health agency "would not focus on those areas where there is no benefit from greater collaboration," this begs the real question of why then institute an agency in the first place, as opposed to working to better coordinate those aspects of the three departments' missions, client care responsibilities, and service delivery for which there is overlap.** This is what the Coalition is proposing with the OHE, which will allow the County to reach its goal of improved integration without the disruption caused by an agency.

There Are a Multitude of Non-Healthcare Services and Programs Critical to Successful Mental Health Client Outcomes

While there is no denying that proper healthcare is extremely important to persons with mental illness who fall within the specialty mental health population served by DMH, it is only one of a multitude of things that are critically important to their success and well being that DMH must address. Among other things, these include: 1) mental health treatment, including screening and assessment, prevention and early intervention, case management, counseling and psychotherapy, and crisis response and stabilization; 2) mental health prevention and early intervention; 3) learning how to properly perform activities of daily living, such as hygiene, shopping, feeding, household chores, and preparing meals; 4) learning how to coordinate transportation needs; 5) housing assistance; 6) working to promote educational/occupational opportunities; 7) recreation and other meaningful life activities; 8) learning how to coordinate their own care and advocate for themselves; and 9) learning how to manage disruptive behaviors.

The Children's Mental Health System Is Basically Ignored

Children with serious emotional disturbances, who account for more than one-half of the County mental health system's service expenditures, are, shockingly, basically ignored in the draft report (with less than one page devoted to them). The draft report is written with a focus on adults and says nothing about how a health agency model would improve services for children with serious emotional disturbances and their families.

For children with serious emotional disturbances and their families, the County Department of Mental Health has had a long established, effective systems of care model, which DMH has been working to supplement in the last several years with the development of integrated care model Health Neighborhoods. It has taken many years for the County to successfully develop its systems of care model and for County operated children's programs to develop critical ties to their local communities and community resources, along with vitally important school-based programs and in-home mental health services for children. In addition, the children's system of care has made a huge investment of resources in developing expertise in the utilization of evidence based practices, which have proven very effective in delivering care.

The core values of the children’s system of care philosophy, which are inconsistent with a medical model, clinic-based orientation, are that services must be: 1) family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided; 2) community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level; and 3) culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

While the children’s system of care model provides an outstanding foundation, the Office of Healthcare Enhancement is perfectly designed to work with the Office of Child Protection to continue to improve coordination of mental health services for youth within the foster care and probation systems, as well as to promote the expansion of the Health Neighborhoods model. Accordingly, an agency model really has nothing to add for children with serious emotional disturbances and their families served by County DMH.

Extremely Broad Scope of County’s Public Health Responsibilities Requires Maximum Visibility and Attention Outside of a Health Agency

As clearly articulated in Theme 4 below, the scope of public health responsibilities that fall today under the County Department of Public Health is staggering. Just as importantly, that scope of responsibilities has continued to grow over the years, as our County residents have faced growing public health threats in the aftermath of 9/11 and growing threats of new infectious diseases, which is spelled out so well in former County CAO David Janssen’s 2005 memo to the Board of Supervisors. [See Appendix 5.]

The County Department of Public Health “strives to serve all of the nearly 10 million people in Los Angeles County to prevent infectious and chronic disease, protect the public from disease outbreaks and public health emergencies, and promote healthy lifestyles and community well-being...Stakeholders are concerned that the stated emphasis [of a health agency] on improving patient-centered services will overshadow and curtail investment in important individual-, school-, worksite- and community-based interventions as demonstrably occurred when DPH was under DHS until 2006.”⁴

Importance of Focus of Integration Efforts

In sum, the Coalition would like to reiterate its support for an Office of Healthcare Enhancement’s focus on those limited areas of departmental overlap where the County can continue to work on enhancing current successful models of integration to improve client care, as opposed to having the County invest time and energy in the development of an integrated governance model which brings with it all of the extensive disruption discussed above and all of the inherent real risks discussed below.

⁴ February 17, 2015 Memo to Dr. Ghaly from Cynthia Harding, Interim Director of DPH, regarding “Public Health in the Proposed Los Angeles County Health Agency,” page 6. [See Appendix 3.]

Theme Number 4 – Public Health Became an Independent Department for Very Significant Reasons that Still Apply Today

Response: “In 1972, Public Health, which for many decades was a stand-alone department, was merged into the same department as Personal Health Services. During the 1980s and 1990s, public health resources and capacity [were] significantly eroded and disease rates in the County rose. During this same timeframe, the per capita investments of County resources in public health declined.” [See Appendix 3, page 2.]

Accordingly, in 1997, the Director of DHS at the time found “a number of adverse effects on public health programming and services under the Health Services [Department],” which he outlined in a memo to the Board of Supervisors. Cited were the following: “1) a significant decline in local appropriations for public health relative to personal health; 2) severe loss of capacity to perform basic public health functions (e.g., disease surveillance and prevention, and community health activities); 3) neglected prevention and control of chronic disease; and 4) lack of any system-wide public health planning and quality assurance of health care services.” [See Appendix 3, page 3.]

The Draft Report Provides an Excellent Summary in Support of an Independent Department of Public Health

Appendix II of the draft report also does an excellent job of laying out the rationale for and principle factors in the Board of Supervisors’ decision to separate the Department of Public Health from the Department of Health Services in 2006, upon a motion by Supervisor Knabe. These factors included: 1) anticipated budget reductions for public health activities as a result of projected deficits in DHS hospitals and clinics; 2) different missions, with DHS to care for low income individuals while DPH has a broader population mission, and the risk that DHS problems and larger size would lead to the de-prioritization of public health activities; 3) perceived greater ability of public health to advocate for interests before the Board of Supervisors; 4) anticipated growth in size and scope of public health activities and roles; and 5) the need for an experienced public health physician leader to act as the County’s Public Health Officer.

A 2005 CAO Report to the Board of Supervisors Provides Additional Detailed Supporting Documentation for an Independent Department of Public Health

A much more detailed analysis of the thinking behind an independent DPH was provided in a June 9, 2005 “Report on Public Health as a Separate Department” from the County CAO David Janssen to the Board of Supervisors. [See Appendix 5.] It is quite instructional.

Interestingly, it begins by acknowledging the benefit of a unified health and public health system in terms of the integration of prevention activities into the delivery of personal health care services, which is one of the draft report’s primary justifications for a health care agency. In discussing this benefit, the CAO’s Report notes that, “While these efforts can continue even with a separate Public Health Department, having a single Director over both Public Health and Personal Health Services can provide an advantage in

ensuring collaboration and cooperation when apparent conflicts may arise.” (See Appendix 5, page 2 of Attachment; emphasis added.) The Coalition would argue that an even better way to ensure this collaboration and cooperation is with our recommended OHE, which would serve as an honest broker between the departments.

The bulk of the CAO’s Report is focused on the reasons why Public Health as a separate department would be beneficial. The Report provides additional supporting/clarifying language related to the five factors laid out in the Draft Report’s Appendix II, discussed above. It notes that “a separate Public Health Department would eliminate the layer of DHS management between the Public Health programs and your Board, allowing the Public Health Director to come directly to your Board regarding the financing needs of Public Health in the face of public health threats or projected service reductions.” (See Appendix 5, page 2.) Also importantly, the Report focuses on the “growth in size and complexity of the various Public Health programs. The combined Public Health programs have a very wide scope of responsibility, ranging from regulatory functions to more than 30 separate programs to protect health, prevent disease and promote improved health in the population.” (See Appendix 5, page 3.)

It goes on to say on page 4 of the Attachment to Appendix 5 that “[g]iven both the growth in size and complexity of Public Health Programs and the myriad [of] critical issues facing the Personal Health Care system, the responsibility of administering both major parts of the public healthcare system presents tremendous challenges to DHS senior managers. Therefore, DHS indicates that consolidating Public Health Programs into a separate Department would allow the Director of Health Services and senior leadership in DHS to devote their time and attention to the pressing patient care and operational issues in its hospitals and comprehensive care centers.” (Emphasis added.)

The increasing importance of Public Health responsibilities and Public Health’s scope of responsibility in today’s environment are then highlighted on pages 4 and 5 of the Attachment:

“In the aftermath of September 11, 2001 and with the growth of global infectious disease threats, public health protection has grown as a critical priority responsibility. PHS has primary responsibility for early detection and control of all bioterrorism, as well as detection of chemical and radiological terrorism. In addition, PHS has the responsibility to prevent, detect and control serious old and new infectious diseases such as Severe Acute Respiratory Syndrome (SARS), pandemic flu, and the Ebola Virus.” (Emphasis added.)

“The combined Public Health programs have a very wide scope of responsibility, including significant regulatory functions, such as licensing all 36,000 retail food establishments and all hospitals (except DHS and federal) and nursing homes. Further, it operates more than 30 separate programs to protect health, prevent disease and promote improved health in all segments of the population. These include alcohol and drug prevention and treatment programs, HIV/AIDS

prevention and treatment programs, a variety of programs to improve maternal and child health, women's health, lead poisoning prevention, prevention and control of toxic exposures, assessment of health of the overall county population and major ethnic/racial groups, services for children with special care needs, smoking prevention and control, prevention of injuries and of chronic illnesses, bi-national border health, tuberculosis control, control of sexually transmitted diseases, detection and control of acute communicable diseases, bioterrorism prevention and response, public health laboratory functions, including both biologics and chemical health threats, veterinary public health, public health nursing, dental health, radiological health and others.” (Emphasis added.)

Finally, the Report highlights (on page 8 of the Appendix 5 Attachment) the fact that **the then Department of Health Services believed that “a separate Department of Public Health would increase the visibility of Public Health Services and help residents understand the important benefits every resident derives from public funds spent on these services.** In addition, a separate department may increase the County's ability to obtain outside discretionary and program-related funding. A smaller, more focused County department may be more attractive to grant funders because it can be more responsive and accountable, and has a history of financial responsibility.” (Emphasis added.)

The Value Added That Has in Fact Been Provided by an Independent Department of Public Health Reinforces Support for its Continued Independence

As noted in an August 22, 2014 memo from Dr. Jonathan Fielding, DPH Director and Health Officer, to the Board of Supervisors regarding “Health and Disease in Los Angeles County: The Impact on Public Health Over the Past 16 Years”: “Independence allowed the Department to advocate for and allocate its own administrative and fiscal resources. This flexibility has been essential in our prioritizing disease prevention and control efforts, diversifying and establishing effective partnerships, and evolving into a more prepared and responsive agency when public health emergencies arise.” (See Appendix 6, page 8.)

Dr. Fielding goes on to say that, “**No longer eclipsed by DHS complexity and competing priorities, DPH has focused public resources on mitigating the biggest disease burdens in our population and reducing yawning disparities in health that undermine quality of life and economic productivity for many.** Our increased flexibility contributed to development of an appropriately diverse and highly-skilled workforce.” (Emphasis added.) Among the major successes of an independent DPH then outlined include: 1) the restoration of the Chronic Disease and Injury Prevention Division, which focuses on areas which account for 80 percent of premature death and disability and 75 percent of the nation's healthcare spending, and which had been dismantled in 2001 “due to budget crises and shifts in DHS priorities;” and 2) the relocation of the Public Health Lab to a “new state-of-the-art facility,” allowing for “an expanded menu of testing services and the capacity to rapidly detect agents with bioterrorism.” (See Appendix 6, page 9.) As well, DPH's Division of HIV and STD Programs has “successfully implemented program improvements to reduce HIV

transmission in LAC and meet benchmarks set by the 2010 National HIV/AIDS Strategy.” (See Appendix 6, page 7.)

Finally, it must be noted that, “DPH has financially sustained its programs in large part due to the repeated success in securing competitive grants over the past five years.” (See Appendix 6, page 11.) Among the examples provided in the memo are the receipt of over \$10 million annually for the Emergency Preparedness and Response Program, and funding for the Chronic Disease and Injury Prevention Division, which grew from \$6 million to over \$40 million as a result of the Department’s outstanding efforts in obtaining grant funding.

These significant Department of Public Health accomplishments, which reflect on DPH as a pre-eminent national leader in the public health arena, can be attributed to the autonomy they have been afforded through independence to: 1) prioritize their own activities without concern for staffing or other resources needed at county clinics; 2) obtain critical funding for DPH specific programs; 3) cultivate effective and beneficial partnerships; 4) build staff capacity and expertise to ensure effective and dedicated staff over the long term; and 5) shift from traditional practices to innovative methods for creating healthier communities.

An In Depth Review of Several of the Health Agency’s Most Significant Risks Articulated in the Report

The Risk of History Repeating Itself and Deprioritization of County Functions

In discussing the theme of historical risk at the February 18, 2015 DMH System Leadership Team meeting referenced previously, Dr. Ghaly noted, “I think there is a very real concern that somehow, in part because of the lack of transparency into the budget process in the county system, that there would eventually be a risk of service cuts and a risk of the budget being put at risk for critical population health and mental health services.” (See Appendix 2, page 5.)

Historical risk can also be presented more graphically. Testimony provided by a family member at the January 13th Board of Supervisors meeting presented the following scenario: “If two men were to enter the room right now and one of them was dragging his leg that was partly severed and it was bleeding, and the other man was here quietly but is considering killing himself and his children, which one would get all of our attention?” This telling story about the way in which persons with mental illness have historically been treated subordinately to persons with physical healthcare problems can just as easily be seen as an analogy for the way in which mental health has been treated subordinately when subsumed under the control of health services, at the County level several decades ago and today at the State level after the elimination of the State Department of Mental Health.

County Mental Health Transformation Upon Gaining Independence

When mental health was subsumed under the County Health Department over 35 years ago, the result for mental health, as attested to by those who were involved in the mental

health system at that time, was a complete lack of identify and autonomy -- in effect, a second class citizenship. Upon gaining its independence from the County Health Department, DMH began a transformation from a system of care driven by professionals, based on the medical model, to one driven by consumers and their families, focused on recovery and resiliency, which was tailored specifically for the complex and extensive needs of the County's adults with serious mental illness and children with serious emotional disturbances.

Elimination of California State Department of Mental Health

With regard to the State's elimination of the State Department of Mental Health, on page 36 of the draft report there is a reference to "mental health issues [being] 'functionally forgotten' at the State level." As significantly, at the February 4th Los Angeles County Health and Mental Health Services Cluster meeting, Dr. Ghaly responded to a question about the impact of **California's movement of mental health under health services** (which occurred almost three years ago) with the honest acknowledgement that **"in practice there's been no real integration as it affects services."** (Emphasis added.) It is clear that the State Department of Health Care Services' (DHCS) attention has honestly been elsewhere over that period of time.

New York City Department of Mental Health Experience

Testimony at the January 13th Board of Supervisors meeting from Dr. Louis Josephson, **former Commissioner of Child and Adolescent Services within the New York City Department of Mental Health when that Department was subsumed under the Department of Health** in 2001, was similarly instructive, and provides context for the reference to the example of New York City on page 40 of the draft report. According to Dr. Josephson, "There were many of the high hopes you have here for L.A. County for that merger – efficiencies, integration of care, [and] all the things that we value...But there [are] always winners and losers in mergers and mental health lost."

Dr. Josephson continued, **"First mental health fell in priority compared to health initiatives. There are many, many pressing mental health initiatives that need attention, and with doctors in charge they just did not get the mental health needs as being a priority. Second, the goal of integration was undone frequently by our federal partners. So we have different masters at the federal level in mental health and healthcare and we were often pulled away from integration by their reporting and other requirements. Third, it was incredibly disruptive to the work of the mental health and health care community."**

The final observation from Dr. Josephson, that he did not have the time to make at the Board meeting, was that the merger **reduced the voice and influence of mental health consumers and families in public policy and decision making**, which they had fought years to obtain, resulting in less attention and fewer resources for individuals who had been long stigmatized and marginalized.

California State Department of Public Health Has Maintained Its Independence

Today, the State Department of Public Health remains a separate department from the State Department of Health Care Services for the same reasons that the Los Angeles County Department of Public Health separated from the County Department of Health Services in 2006.

“The California Department of Public Health was spun off from its predecessor (Department of Health Services) in 2007 as a direct response to the terrorist attacks of September 11, 2001. The state wanted a department focused on threats to the public from bioterrorism, as well as emerging antibiotic-resistant diseases and environmental threats, that was not bogged down with the responsibility for tending to the health needs of low income and uninsured Californians. And that is what it got. A department with physician leadership guided by an expert advisory panel devoted to shoring up a public health system that was identified by the independent Little Hoover Commission in 2003 as the ‘weakest link in California’s homeland defense.’”⁵

Draft Report’s Efforts to Reassure Stakeholders Are Inadequate

The draft report does attempt to provide reassurances to stakeholders that “[p]ractical steps...can help build confidence that the needs of each Department will not be deprioritized...in an agency.” The primary step outlined in the report to address this is the selection an agency director with experience in all three areas to help “establish credibility, build trust, and decrease the likelihood that the agency will narrowly advocate on a limited set of issues.” We are not convinced.

This step ignores the most significant factor in play here, which is the lost or at best muted voice of each departmental constituency. **Through the requirement that all three department heads report directly to the agency head it would not be possible to bring the current level of attention to mental health and public health issues and constituency concerns, which would be subsumed under the controlling authority of the agency head. Mental health would not be the number one priority of the integrated agency, plain and simple. Nor would DPH continue to have its public health concerns be the top priority under an integrated agency.** Rather, the focus and attention given to each of these departments would be muffled, particularly if the head of DHS were also made the head of the agency (which is clearly implied in the report),⁶ to the considerable detriment of the clients served by the mental health system and the public at large.

⁵ AllGov California, “Department of Public Health,” 2015 AllGov.com.

⁶ This is based on the following report passages: 1) “Having one of the three Department Heads serve as agency Director would be consistent with an effort to reduce administrative layers and agency costs.” (page 39); 2) “[A]t this time the CEO does not support an agency structure that would require additional investment by the county.” (page 39); and 3) the report’s recommendation to select “an agency director who has leadership experience in all three fields: mental health, public health, and physical health” (page 37). This conclusion was also confirmed by Dr. Katz himself in his appearance before the Public Health Commission on April 9, 2015. [See Draft Minutes, 4/9/15 Los Angeles County Public Health Commission meeting, Appendix 7, pages 13 and 20.]

The draft report, in arguing at page 39 that “[h]aving one of the three Department heads serve as the agency Director would be consistent with an effort to reduce administrative layers and costs,” makes the comment that “[t]o increase fairness and transparency, the Board could consider conducting an open, competitive recruitment for the agency director position, considering various candidates rather than immediately appointing an existing Department director as the agency director.” This comment is an attempt to respond to stakeholders’ “intense criticism” that this idea “would lead the agency director to favor the department he/she ran [and] prioritize initiatives related to that department,” and “wouldn’t be able to be a fair arbiter” or honest broker.

We once again are not convinced by the draft report’s recommended solution, this time for two reasons: 1) the open recruitment recommendation pertains only to potential concerns related to the hiring of a particular individual, as opposed to general structural concerns that exist regardless of who is hired; and 2) given that no new money is being recommended, the concept of an open, competitive recruitment process for hiring a new agency director who is not currently a County department head would be nothing more than a useless exercise.

The best way to ensure that none of the interests of three departments are deprioritized is not to appoint an agency director with experience/knowledge of all three department areas, as suggested on page 38 of the draft report, or to hold “an open, competitive recruitment for the agency director position,” as suggested on page 39 of the report, but rather to support the OHE model, whose Director would be expected to meet the same general qualifications as the Director of the Office of Child Protection. [See Appendix 1.]

The Risk that Cultural Differences Will Compromise Integration Efforts

In the draft report’s discussion of the risk of cultural differences, at pages 42 to 43, there is never a response provided as to how this risk would be addressed or mitigated in an agency model. There are references to a lack of knowledge about the cultural characteristics and strengths of each department, a “[f]ear of the unknown,” an opportunity to have the agency model promote “positive attributes of each Departments’ culture,” and an ability to identify and leverage cultural differences, but nowhere in the draft report is this most significant, legitimate risk dispelled.

Department of Homeland Security

The draft report, at pages 41 to 42, does, however, use the Department of Homeland Security as a relevant case study identified by some stakeholders. The draft report acknowledges the “large number of departures from high-level staff blamed on clashing department cultures,” which led to a set of recommendations from a task force in 2007 “to address the culture-related portion of [the Department’s] challenges.” It then references those specific recommendations, including “the importance of clearly defining the new Department’s role,” “build[ing] trust between component parts over time,” and “striv[ing] for a ‘blended’ rather than single organizational culture” as supposedly applicable to an LA County health agency.

What the draft report does not do is make reference to the outcome or success of those recommendations in exploring what actually happened at the Department of Homeland Security over the more than 10 years that it has been in existence (and about eight years since the draft report referenced recommendations were made). In fact, those recommendations have clearly not improved that Department's outcomes, as reflected in the following relevant quote: "Their decision to combine domestic security under one agency turned out to be like sending the Titanic into the nearest field of icebergs."⁷

"A report by the nonpartisan Congressional Research Service last year [2013] found that more than a decade after the Department of Homeland Security's creation – and despite the specific language of the law that created it – the sprawling agency still didn't have a clear definition of 'homeland security,' or a strategy for integrating the divergent missions that are supposed to achieve it. The report suggested the uncertainly could actually be compromising national security."⁸ (Emphasis added.) **"Forged in 2002 in the panicked aftermath of the 9/11 attacks, the department remains the source of the least cost effective spending in the federal government. Many outside DHS view it as a superfluous layer of bureaucracy in the fight against terrorism and an ineffective player in the ongoing efforts to handle natural disasters and other emergencies at home."⁹ (Emphasis added.)**

Health/Public Health Cultural Differences

Health and public health cultural differences are reflected in the fact that each field approaches problems from a different point of view. For example, the word prevention related to clinical care focuses on the prevention of disease for one individual, while prevention for public health professionals means preventing disease for an entire population or group of individuals. Clinical practice can be autonomous and direct activities from within the walls of a clinic, while public health must collaborate with a range of community partners and focus on its interventions outside of clinical settings.

Accordingly, public health has demonstrated an appreciation for community input and a willingness to partner on challenging health issues in meaningful ways. Public health, by its nature, is an inclusive field that recognizes strength in numbers and routinely engages external leaders for advice or guidance in an advisory capacity. For example, positive relationships that have been developed with faith-based leaders and community clinics have been instrumental in advancing emergency preparedness efforts and expanding health prevention messages to underserved populations and communities that have had a traditional mistrust of government. By comparison, health care practitioners tend to be non-inclusive decision makers who exclude community partners in their planning.

⁷ Kramer, M. & Hellman, C. (2013, February 28), "Homeland Security: The Trillion-Dollar Concept That No One Can Define," *The Nation*.

⁸ Balko, R. (2014, May 7), "DHS: A wasteful, growing, fear-mongering beast," *The Washington Post*.

⁹ Hudson, J. (2015, February 26), "Who Needs the Department of Homeland Security Anyway?," *Foreign Policy*.

Health/Mental Health Cultural Differences

The County's mental health delivery system is uniquely different from the County Department of Health Services' primary care system, both in terms of culture and in terms of focus. This was the finding of a 2004-2005 Los Angeles County Civil Grand Jury, in making its recommendation that DMH should continue as an independent County department in its final report on the proposed integration of the County's drug and alcohol programs with mental health. The Grand Jury noted specifically that "[s]ervice delivery methods, the client base and the funding structure for mental health services differ significantly from the safety net physical health services provided by DHS for the County's uninsured and indigent populations."

Input provided by the law enforcement representative at the February 18th DMH System Leadership Team meeting with regard to cultural differences in the two departments is also instructional. To quote: "One of my main concerns from the law enforcement perspective is that the vast majority of the calls that we receive and manage are crisis related mental health calls along with public health issues. While we've had a very good working relationship with the DMH in developing strategies to combine our efforts to mitigate these types of calls for service and manage them we haven't received the same feedback when dealing with the psychiatric emergency departments in DHS. **My concern is that there might be a trickle down or pollution of the culture of cooperation because of the perspective from the DHS side as opposed to the DMH side.**" (Emphasis added.)

While DHS has been the propelling force behind the push for the consolidation of the three departments, it is interesting that Dr. Katz himself acknowledged DHS significantly trailing behind its DMH counterpart in terms of consumer orientation and stakeholder involvement in his testimony before the Board of Supervisors at the January 13th Board meeting: "I think in listening to many of the mental health advocates speaking, I was thinking that **I wish we could, the Department of Health Services, encourage the same level of consumer involvement.** Listening to the mental health advocates is a wonderful lesson. We've made some small steps in DHS in now having a community advisory group." (Emphasis added.)

DMH has for more than two decades had active countywide stakeholder planning groups and for many years now has had an SLT Budget Mitigation Workgroup where departmental budgetary decisions get made transparently with significant input from the department's key stakeholders. It is of great concern to the Coalition that a health agency model would foreclose this level of community mental health stakeholder participation and input.

Cultural Differences within the Context of An Agency Model

It is clear that the different DHS and DMH cultures, highlighted above by Dr. Katz, are critical to an analysis of an agency model, as culture is perhaps the most important factor in determining the success or failure of efforts to integrate organizations, governance

structures and services.¹⁰ In fact, as reported in the research literature, the failure rate of attempts to integrate multiple entities into one centralized entity to achieve super-ordinate integration goals is alarmingly high when there is a misfit of organizational cultures coupled with a proposed hierarchical governance structure where one of the participating entities controls the setting of priorities and has operating authority.¹¹

Within this context, it is important to consider the mental health culture that has evolved and developed over many decades. It has gone from institutionalization and the DHS type medical model to an extensive, community-based, recovery model continuum of care for adults and a resiliency based system of care model for children. It has gone from DHS type “professionally driven care” to care driven by adult consumers and children and their families. DMH has built over these many years, among other things, culturally competent outreach and engagement systems, ethnic and cultural partnerships, and consumer self advocacy and family support models to be welcoming and engaging to serve children and adults who have historically been stigmatized and rejected by the community.

This cultural shift, which has taken so many years to polish and refine, has resulted in crucial, hard earned improvements in the mental health system that must be preserved. Moreover, for this significant cultural transformational shift of the mental health system, significant staff training has been required over many years, as has the development and transformation of the administrative infrastructure necessary to support and maintain these changes.

While we agree with the draft report that “[t]here is much that the physical health community can learn from the mental health community about empowerment, hope, wellness, and recovery,” (page 43) we firmly believe that an agency is not required for DHS to begin working to adopt these principles, and that this learning process could be coordinated through the OHE, which would avoid the inherent real risks and disruption that would be caused by the creation of a new health agency.

The Risk of Medicalization of Community-Based Mental Health

We strongly agree with the statement made in the draft report, at page 42, that mental health clients, providers and advocates “fear that closer integration with DHS in particular will result in a shift away from recovery toward medicalization of mental health treatment,” and that “this is a frightening possibility.” In fact, the draft report itself compellingly lays out why this fear is real.

¹⁰ Cartwright, S. & Cooper, C. (2012), Managing Merger, Acquisitions and Strategic Alliances: Integrating People and Cultures, Butterworth-Heinemann, Oxford

¹¹ 1) Carleton, I. & Lineberry, C. (2004), Achieving Post-Merger Success: A Stakeholder Guide to Cultural Due Diligence, John Wiley & sons, San Francisco; 2) Field, J & Peck, E. (2003, December), “Mergers and Acquisitions in the Private Sector: What Are the Lessons for Health and Social Services?,” *Social Policy & Administration*, Vol. 37, No. 7, pp. 742-755; 3) Bauer F. & Matzler, K. (2014, February), “Antecedents of M & A Success: The Role of Strategic Complementarity, Cultural Fit, Degree and Speed of Integration,” *Strategic Management Journal*, Vol. 35, No. 2, pp. 269-291.

To quote again from page 42 of the draft report, “[M]any providers in the physical health care system still manage patients first in the medical framework, and then address social, psychosocial, and environmental factors when medical intervention doesn’t yield the expected result. They order diagnostic tests to rule out unlikely but potentially dangerous diagnoses when more obvious social or environmental causes are left unaddressed. They prescribe medications to treat the first sign of disease, without attention to the patient’s other needs or willingness to engage in their own recovery. They manage individuals with chronic diseases with narrow attention to medications and laboratory values rather than emphasizing coping mechanisms and social supports.”

San Francisco Provides Perspective

In an attempt to obtain some further perspective, the Coalition obtained information from the former Director of Community Behavioral Health Services in the San Francisco Department of Public Health led by Dr. Katz, about his experience with regard to integrating Mental Health Services under Health Services in San Francisco, as Los Angeles County is now considering. It should be noted first that an organization chart independently obtained by the Coalition reflects that the Director of the Behavioral Health Division was not one of eleven direct reports to the Director of Health. [See Appendix 8.]

The former Director of Community Behavioral Health Services shared the following caution via email: 1) the unique needs of clients with serious mental illness cannot be managed in most primary care settings; 2) **a “one size fits all” clinic model will not work, where all clients with mental illness, regardless of severity are treated the same, as persons with serious mental illness require greater attention and resources;** 3) **make certain that resources are not diverted away from DMH to cover needs in primary care;** and 4) many clients with severe and persistent substance abuse concerns will need specialized care and resources should not be diverted from such services to cover needs in primary care.

Mental health providers in San Francisco shared similar concerns regarding the role of mental health within the San Francisco healthcare system. Among the comments provided were: 1) mental health was not placed as a priority in planning and there was little collaboration between health and mental health; 2) the structure of healthcare delivery was hierarchical, where behavioral health was simply not a focus in a hospital driven system; and 3) the medical model and medication were seen as the primary treatment model for clients, even those with serious mental illness.

The draft report’s proposed solution to this critically significant problem that the “medical leadership should remain separate between DHS and DMH” is not only inadequate, but is also inconsistent with the proposed agency model implied in the report, which would have the Director of Mental Health reporting to the Director of Health Services in his “dual role” as agency director. [See footnote 6.] Just as importantly, we can get to care integration without this risk of medicalization, and even the specter of “the physical health world’s reliance on medicalization . . . seep[ing] inappropriately into the community mental health model of care,” (page 43) by utilizing the OHE model.

The Draft Report's Attempt to Downplay Agency Model Risks is Incorrect and Ignores the Recent Board of Supervisors' Governance Decision

At page 33 of the draft report, in prefatory language before laying out the health agency model risks, the report declares, "Some of the objections raised by stakeholders would be much more germane if the model were a combined department... As a result, the discussion of these risks is appropriately brief." (Emphasis added.)

The Coalition objects to the dismissive nature of this comment, as we believe the risks are as applicable to the agency model articulated as to an integrated department model, particularly since: 1) in terms of the risks, we are just as concerned about the department heads reporting directly to the agency head and the specter of their concomitant loss of independent voice, autonomy, philosophy, models of service, and ultimately client care, as we are about their budgets and HR-related concerns; and 2) the report doesn't just allow for, but rather leads the way toward the conclusion that the agency director will be in charge of one of the departments (i.e., DHS), which we believe would have the same impact as an integrated department. [See footnote 6.]

The draft report, at page 38, in attempting to respond to stakeholders' serious concerns regarding diminished departments' voice in an agency model tries to mitigate those concerns by pointing out that the Department Heads currently report to the County CEO (and previously reported to the Deputy CEO for the Health Cluster, who reported to the CEO) rather than directly to the Board of Supervisors, and yet have frequent communication with the Board offices and Supervisors.

At the same time, the draft report provides stakeholder feedback that responds to this attempt at mitigation. To quote also from page 38, "Despite Department-Board communication that exists, some felt that the Deputy CEOs and CEO hampered those open lines of communication with the Board and that the communications would have been more robust had there been a direct reporting relationship to the Board, while maintaining and respecting Brown Act requirements." **More importantly, however, as discussed below, it isn't just the stakeholders that have been concerned about this level of communication and relationship, but the Supervisors' themselves.**

Board of Supervisors' Recent Approval of Revised Governance Structure

On February 24th, the Board of Supervisors unanimously approved a Board motion by Supervisors Antonovich and Kuehl to restructure County government back to the way it was run prior to the adoption of the interim governance structure in 2007, when the County Department Heads reported directly and independently to the Board. [See Appendix 9.] Of course, this action taken, alone, speaks volumes; but the Board motion language for the action taken is also quite instructional.

To quote: "Recent changes in County leadership and the CEO management structure, including the reassignment of Deputy CEOs, represent an improvement over the 2007 structure by removing an unnecessary layer of management. **Moreover, an unintended consequence of the interim governance was in increased distance between departments and the Board of Supervisors thereby reducing accountability. The**

Board of Supervisors has an opportunity to formally update the County governance structure and provide stability in County government in a manner that retains departmental collaboration and interdepartmental communication, but reduces bureaucracy.” (Emphasis added.)

Accordingly, the buffer that the draft report is now recommending between the Board of Supervisors and the Department Heads in the form of a Health Agency Director (see the attempted defense of this buffer on page 47, top) is parallel to the CEO buffer that the Supervisors just recently rejected in going back to the County’s old governance structure and a CAO model. So even though under the 2007 interim county governance structure the Department Heads had the ability to directly communicate to the Board of Supervisors, as the report argues, the Supervisors decided to eliminate that model as ineffective and lacking accountability.

On the other hand, the Coalition’s proposed OHE model is 100 percent consistent with the Board’s focus in the passage of this Board motion on “retain[ing] departmental collaboration and interdepartmental communication but reduc[ing] bureaucracy,” which is reflected in its establishment of the Office of Child Protection as well. By adopting the OHE model, the Board will ensure that DMH and DPH are not the only two of the more than 30 Departments in the County run by non-elected officials who’s Department Heads would not be reporting directly to the Board of Supervisors.

Conclusion: An Office of Healthcare Enhancement Model Is the Best Vehicle for Delivering Healthcare Integration Benefits without the Health Agency Model Risks

- 1) Based on the Office of Child Protection model, an alternate model to a new health agency – an Office of Healthcare Enhancement – should be created by the Board of Supervisors to better integrate healthcare in the County through the development and implementation of a Strategic Plan for Integrated Care. While DHS, DMH, and DPH would report directly to the Board of Supervisors rather than an agency director, the Supervisors would imbue the OHE Director with the clear authority over those areas of overlap of client care responsibilities that promote service integration.
- 2) The Coalition disagrees with the fundamental premise of the Draft Report that organizational integration is the most effect pathway to service integration and improved healthcare. Rather than focusing on integrated governance and the development of a new health agency, the County should be focusing specifically on replicating and expanding already successful models of integrated care that work.
- 3) The Coalition rejects the notion that the health agency model’s “radically transformed system” is necessary, offering instead, through its proposed OHE model, the ability to enhance currently successful models of integration while working to remove those barriers that will allow for their expansion, leaving alone the significant scope of departmental work that is currently working.

- 4) The Coalition believes that the Draft Report's focus on the "Opportunities" of a proposed health agency, as opposed to benefits, is based on the fact that the majority of the arguments made are aspirational or impractical, as opposed to real benefits; and that a large portion of the arguments are generally related to the benefits of integrated care rather than specifically supporting a health agency model.
- 5) Not only does the Draft Report's justification for a health agency model fail to make the case, but it cannot respond to stakeholders' significant concerns regarding an agency's transitional disruption (referenced as a potential "transitional quagmire lasting years"), given the fact that its proposed "dual role" staff operational model simply won't work.
- 6) The Draft Report also fails to dispel the very serious risks associated with a health agency model, including: a) the risk of reduced visibility and autonomy, with concomitant muted voice and reduced attention for the Departments of Health, Mental Health, and Public Health; b) the risk that departmental cultural differences will result in failed integration efforts, leading to unnecessary disruption; c) the risk of the medicalization of community-based mental health; and d) the risk that Public Health's loss of visibility and independence will lead to serious negative consequences for the public at large with respect to the County's ability to address growing public health threats and growing threats of new infectious diseases.
- 7) A health agency model, where the Department Heads would be reporting to the Agency Director, would, as spelled out in the February 24, 2015 Board of Supervisors' motion (see Appendix 9), result in "increased distance between [these] departments and the Board of Supervisors[,] thereby reducing accountability." Alternatively, by adopting the OHE model, the Supervisors would ensure that DMH and DPH continue to be recognized as equals with the other County Departments both in terms of accountability and direct reporting to the Board.