Public comments on the draft report to the Los Angeles County Board of Supervisors regarding the possible creation of a health agency

Public comments on the draft report received after March 30, 2015 are included here. The letters/e-mails are ordered by date. Names have been redacted for those individuals who wish to remain anonymous. Personal contact information (e.g., personal e-mails) have also been redacted. Attachments/appendices to letters are not included here, but may be viewed on the Health Integration website at http://priorities.lacounty.gov/health-stakeholders/ under the sending organization. Additional information, including stakeholder lists, meetings, and additional letters received prior to the draft report, can be found on the Health Integration website.

Josie Plascencia

From: [redacted]>
Sent: Wednesday, April 01, 2015 12:38 PM
To: CEO Health Integration
Subject: Agency Merger proposal

Categories: Red Category

Hi—

I am a clinical psychologist [redacted] with DMH. Before that I worked in a community MH clinic in a private/non-profit agenc[redacted]

I have only brief feedback to offer.

First, based on my experiences of mergers. That community MH agency that I worked for merged with another larger private/non-profit after I had been there for 9 years. It was a disaster in the opinion of many, including myself. The staff was miserable from both agencies and turnover was monumental. Many outstanding, experienced staff were lost in the process, and the agency became "hollow", lacking both history and a future direction/vision. Morale plummeted. Service delivery suffered. Revenues suffered, and so more staff were summarily let go in order to balance budgets. Morale got even worse. Service delivery got worse. Chaos ensued. It has taken several years for the agency to begin to regain some sense of stability.

So, I do not feel that merging into one large agency will be beneficial. It will likely be destabilizing, disorienting, and top-heavy with new Admin structures. Money will be wasted that could go to service delivery (or better wages!). I am sorry, but people "at the top", along with various intellectuals and experts tend to want to reify themselves, and so dream-up plans that add more folks like themselves who are theoretically going to whip things into shape. My experience with such schemes is that it is not effective, and winds up being very costly and disruptive to the entire process of what the agencies are seeking to provide. The work-force suffers, as do the target populations.

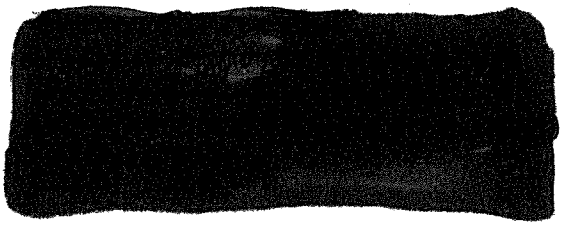
However, there are clearly advantages to ending the silo-ization of the different agencies. Health and Mental Health are an obviously-related pair of variables that are highly dependent upon each other. It would be beneficial to have a more smooth interplay between the two types of services, that sounds quite advantageous. This would be of clear benefit in the area of substance use treatment, in particular, where Health and MH overlap in a major way. Homelessness is also another population where this is also true. TAY populations also need coordinated services during the vulnerable years that they are in that age range.

To some extent, such exchange programs already exist, such as how the HUB medical centers provide care for the kids in DCFS. Also, DMH has had co-located units in the DCFS offices for several years now under the Katie A provisions. We also have had DSS workers co-located here and that was also helpful.

My suggestion would be to utilize the already-proven Co-Location model so that service providers can cross-influence, cross-train, and refer to each other. There would need to be some sort of multi-disciplinary Dept or panel that would design and oversee this process, but it does not need to be a superordinate agency or have a special CEO or anything like that. I would keep it "close to the ground" and keep the bureaucracy to a minimum. If they try to make the agency bigger or unitary it will wind up to be cumbersome and wasteful and redundant. ***I think collaboration, coordination, communication, and cross-influence—and ultimately a higher standard of care--could be achieved without changing the fundamental structures of the agencies or creating new bureaucratic strata.***

My opinion is that DMH, in general, needs more clinical staff and more funding. I have heard the MH typically gets only 6% of all health funding, and that is clearly the wrong proportion!!!
We need to get more services to more people, and we need to have the Medi-cal or other coverage situation be much more streamlined and efficient for consumers!!!

OK, that is my considered personal and professional opinion on this matter. Thanks for the very excellent study that was made available for review and thought. I hope that my input is of some value to this process.



Josie Plascencia

From: [redacted]
Sent: Wednesday, April 01, 2015 1:19 PM
To: CEO Health Integration
Subject: Response to the Creation of a Health Agency

Categories: Red Category

As a current employee of LA County Department of Mental Health, I believe that that the creation of a Health Agency would greatly benefit the client's I serve. I have been a Substance Abuse Counselor for 6 years, I came to DMH just over [redacted] from the private sector. Before coming to DMH I have always worked in person centered treatment. The department's commitment through the Health Agency to enhance the services we provide to our clients is much needed. Currently, substance abuse counselors have no specialty supervisors to assist in their professional development and growth. There are no set evidence based practices or curriculum to use in our groups. I have brought in all of my own to use in the clinic including providing curriculum for the Wellness Center substance abuse groups . Rio Hondo has worked with me to develop my role and to define it, it has been an ongoing journey to do so. I am a well-trained, certified experienced substance abuse counselor, who is educated in the special needs of mental health clients. I feel that I would benefit as well as my clients from the changes Los Angeles County is proposing in the creation of a Health Agency. Right now is an exciting time to be a substance abuse counselor with LA County Department of Mental Health.

Thank you,

[redacted]

Josie Plascencia

From: Trinh Le <TrLe@dmh.lacounty.gov>
Sent: Wednesday, April 01, 2015 1:26 PM
To: CEO Health Integration
Subject: Creating a Health Agency

Categories: Green Category

To whom it might concern,

My strong position on this idea is Please KEEP IT SIMPLE. Why do we want to create another level of complexity. These 3 departments are already under the umbrella of LA County. If we want to streamline the data flow for patient information we should just do that. Let the departments do their best in their specialty to serve the communities and not adding another layer of management structure to tie their hands and restrict them from doing their jobs which are to provide the best health services for the people of LA County.

Thank you,
Trinh

Trinh Le
Los Angeles County
Department of Mental Health
Chief Information Office Bureau
Office: 213.480.3656

Josie Plascencia

From: Elizabeth "Helm" Marsh <EMarsh@dmh.lacounty.gov>
Sent: Wednesday, April 01, 2015 4:05 PM
To: CEO Health Integration
Subject: umbrella agency

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Board of Supervisors,
I am against the proposed umbrella agency overseeing the Departments of Public Health, Health Services and Mental Health. My concern is that just as in San Francisco, there will cease being a Mental Health Department. We have been joined together in the past, and I believe that rather than recreating that again, that you should more thoroughly review the reasons for the original split. This seems to me to be a way for the Department of Health Services to try to grab some of the Mental Health Service Act funds. It seems to be obvious, that having just another layer of upper management in addition to those we currently have is foolish. We need more line staff in the Department of Mental Health**, not more administrators.**

Sincerely,

Elizabeth Marsh

HW

HOUSING WORKS creating housing options

April 13, 2015

Office of Health Integration
Kenneth Hahn Hall of Administration
500 W. Temple Street, Room 726
Los Angeles, CA 90012

RE: COMMENTS REGARDING THE CREATION OF ONE HEALTH AGENCY

Housing Works is a non-profit, 501c3 agency committed to moving homeless people off the street and into permanent supportive housing. We use housing first strategies- providing the housing without barriers such as requiring participation in mental health or addiction treatment. The housing first strategy linked to permanent supportive housing is a best practice- proven to successfully house and retain housing for chronically homeless persons.

In Los Angeles County, there is ***extremely limited access*** to mental health or substance abuse treatment for homeless persons. This perpetuates and exacerbates homelessness in our County. The greatest barriers to successfully *retaining* housing for our prior homeless tenants is the ***lack of access*** *to both mental health treatment and substance abuse treatment.* When our tenants are ready and requesting treatment, it can take several months before they have access. Once they become non-compliant with mental health services, largely because of inadequate or inconsistent treatment, their case is terminated- obviously when they most need it.

We believe that merging the three County agencies under the right visionary *leadership* can eliminate this critical barrier to treatment… and often, housing. The County Department of Health Services has proven its commitment to housing their homeless patients *as a health and recovery intervention using healthcare dollars to do it.* Homeless individuals and families who frequent the County hospitals are now given the real possibility of not only clear access to health care, but direct access to permanent supportive housing.

We have the solution. We need accessible, responsive behavioral health treatment closely aligned with medical treatment and the ability to house people as a foundation for their recovery and ability to thrive. Coordinated, cohesive, no wrong door to both treatment and housing is a must. Merging the three County agencies is a way to do it.

Respectfully,

Mollie Lowery

Mollie Lowery, Executive Director

1277 North Wilcox Avenue, Los Angeles, CA 90038 (323)466-0042 (P) (866)941-7859 (F)
www.housingworksca.org

Paper on Consolidation

William Legere

April 14, 2015

In March, the Los Angeles County Board of Supervisors made a motion to consolidate the Department of Health Services (DHS), the Department of Public Health (DPH) and the Department of Mental Health (DMH) into one department. The paper presented four models of integration. We at the Black Los Angeles County Client Coalition (BLACCC) are opposed to the consolidation although some California counties and counties in other states have integrated their health services and some of the states control mental health services. We at BLACCC feel that:

1) Health disparities among African-Americans, especially in regards to mental illness, physical illness and premature death, are great. The consolidation would not address the disparities.
2) African-American clients want supportive employment and to be incubated and to be involved in supportive services. With the consolidation, DMH would cease as an independent agency and the director of the integrated agency may not be sensitive to clients. Proposals would be scaled back.
3) BLACCC wants to help the homeless. DMH has neglected the homeless. The homeless wants services to help them to be housed; housing is a right; to be educated and be employed. Consolidation would create more barriers and stagnation in regards to African-Americans. One shoe doesn't fit all; mental health differs from public health and health services.
4) L.A. County has about 10 million inhabitants, more than many U.S. states! To combine three agencies into one super County agency would make services inefficient and create a monster that could get out of control. Who would head this agency? The director has to know about mental health, health services and public health and that person would be hard to find. How can one health agency serve 10 million people with such a bureaucracy?

On behalf of the Black Los Angeles County Client Coalition, Inc., in response to the L.A. County Board of Supervisors regarding possible creation of a health agency, March 30, 2015 draft report, please adhere to our comments. In hindsight, the past decade, Proposition 63, a course of action is a sequence of perspective acts which are viewed as a unit of action. The acts which comprise the sequence are mutually related as means to the obtainment of ends. A plan is a course of action which can be carried into effect, which can be expected to lead to the attainment of the ends sought and which someone (aka an effectuating organization) intends to carry to affect. (By contrast, a course of action which

couldn't be carried out which would not have the consequences intended or which no one intends to carry out is a "utopian scheme" rather than a plan)

1) In order to insure that the needs of African-American mental health services are being met, Los Angeles County Black mental health stakeholders formed the Black Los Angeles County Client Coalition (BLACCC) in 2006 to advocate for mental health service delivery for the underserved/unserved African-American population.
2) The Los Angeles County Client Coalition proposes to implement a client-driven cross-sector collaborative (CSC) to increase service effectiveness in mental health by proactively and systemically promoting interagency/cross-agency collaborations and assisting mental health consumers to improve client outcomes.
   a) Structured, formal and informal governance/coalitions
   b) Consistency, resources/financial funding and goal orientation
   c) Actions essential to the desired course of action for
   d) Programs assignments/activities; thus, the design of a course of action leading to the obtainment of the end.

Analysis of the situation; past, present and future...Coalition planning framework. Central factors to be taken into account; culture and process factors that many consumers share the need for meaningful programs (CCC partnership). BLACCC seeks the execution of an empowering partnership, real coalition capacity-building and development, mental health services at funding to engage, support, employment and training. BLACCC seeks CBO decisions as well as to include our sister coalitions, workforce pathways in conjunction to improve homelessness.

Service Area 5
Advisory Committee

11303 W. Washington Boulevard, Suite 200
Los Angeles CA 90066

April 27, 2015

To: Dr. Christine Ghaly, LAC CEO's Office
LAC Board of Supervisors
LAC Board of Supervisors Health Deputies
LAC Mental Health Commission
LAC DMH SAAC Co-Chairs

From: SAAC 5 Co-Chairs, Karen Macedonio & Celinda Jungheim
SAAC 5 Steering Committee: Karen Macedonio, Celinda Jungheim, Penny Mehra, Keith Miller, Anna Henderson, Tristan Scremin, Jacquie Wilcoxen, Mariam Nahapetyan, Brenda Palacios

Although the draft report of the response to the Los Angeles County Board of Supervisors regarding possible creation of a health agency has identified the perspectives of many different stakeholders, it misses a critical opportunity; because the report was limited to determining the benefits and risks of a "single, unified health agency," it has not articulated the real questions: what would an ideal system of care look like for Los Angeles—and what will allow us to achieve that vision? Without the guidance of this overarching vision, a system unification runs the danger of creating devastating service interruptions to vulnerable populations and further confusion to already overburdened LA County systems.

Moreover, this draft report misses another key opportunity to build trust and collaboration: it articulates a top-down perspective on agency integration that was created largely in secret and presented as a 'done-deal.' Such a tremendous shift in county structure deserves the time and thoughtful planning required to move the whole county toward achieving a unified vision of a system that works for all Angelenos. Indeed, to quote a paragraph from the draft report: *"Individuals fall through the cracks and fail to get the services they need. Specific groups, often many of the most vulnerable populations within the County and including many that have been historically underserved, experience gaps in services and programs or remain entirely unserved. To address these gaps, the County must focus on building a radically transformed system that provides the highest quality*

health-related programs and services for all LA County residents and examine whether the creation of a health agency advances this goal."

The process would benefit deeply from the substantial empirical data and perspective available from the people and programs currently involved in these systems on a daily basis—the stakeholders, consumers and agencies working under the Department of Mental Health (DMH), the Department of Public Health, and the Department of Health Services. DMH's Service Area Advisory Committees (SAACs), for one, can provide that critical perspective on what's working, what's not and how we can best move to improve these systems for the people who use them.

At our next scheduled meeting on April 28, 2015, SAAC 5, the DMH West Los Angeles Service Area, looks forward to the opportunity to provide Dr Ghaly's office community perspective from the people and programs involved with mental health on a daily basis. This meeting will be held within our community at St. Joseph Center, 204 Hampton Drive, Venice, CA 90291 from 3 to 5 p.m.

The quality of life of the 10 million residents of LA County, and the pain and suffering being experienced by our underserved or unserved residents is dependent on our courage to make the hard choices that need to be made. And the hardest choice is to admit that we need to start from the beginning, and approach this process with transparency that builds trust. Our quality of life does not depend on adding yet another layer of bureaucracy to the system. Our quality of life depends on building collective wisdom and relationships between people and systems.

Los Angeles County Coalition for Women & Health Reform

May 4, 2015

Office of Health Care Integration

The Los Angeles County Coalition for Women and Health Reform (LACCWHR) understands that the LA County Board of Supervisors recently approved in concept the consolidation of the Departments of Health Services (DHS), Public Health (DPH) and Mental Health (DMH) under a single health agency. Each department performs distinct functions that impact the health and safety of the communities we advocate for and serve, and each plays an important role in improving health and wellness.

Integration must enhance care to vulnerable communities that rely on Public Health, Mental Health and Health Services. Women, who are more likely to live in poverty than men, assume most of the responsibility for making the health and medical decisions for their families. LACCWHR is concerned that current services provided by separate departments will be cut or eliminated, leaving women and vulnerable families at risk. Consumers and community stakeholders are also very concerned about possible disruption of services. Whatever the model, effective people and adequate staffing are critical to the continued provision of services that our communities rely on.

While patient interests are the priority in Integration, key prevention programs in Public Health and Mental Health serve entire communities. Any merger must foster improved population health, understanding that patients are not just individuals who enter County clinics and hospitals, but all of the communities outside County doors. Integration should advance a 'Health in All Policies' approach County-wide.

We urge the expanded engagement of stakeholders before changes are made. LACCWHR respectfully requests to become a stakeholder in this process to better understand and highlight the impact this consolidation will have on women's health and to work toward addressing improvements of women's health in LA County on the whole.

We look forward to being formally included in this process as a stakeholder group. Thank you for your consideration of our concerns and requests. Should you have any questions, please do not hesitate to reach us by contacting Marisol Franco via email at Marisol@clrj.org.

Sincerely,

Marisol Franco

Coalition Member
The Los Angeles County Coalition for Women and Health Reform

About The Los Angeles County Coalition for Women and Health Reform (LACCWHR)
The LACCWHR was formed to ensure that the implementation of the Patient Protection and Affordable Care Act (ACA) meets the comprehensive need of women throughout Los Angeles County. Since the Fall of 2010, the coalition has sponsored an annual community dialogue with a diverse coalition of community leaders, providers and health advocates from throughout Los Angeles County to examine how health care reform implementation is impacting women differently based on race, ethnicity, sexuality, class, ability to pay, age, and immigration status.

Department of Mental Health

New Vision Church of Jesus Christ

First African Presbyterian Church

Watts Counseling and Learning Center

Communities taking action to improve depression care in Los Angeles

10920 Wilshire Blvd., Suite 300,
Los Angeles, CA 90024
Tel: (310) 794-3719
Fax: (310) 794-3724

May 6, 2015

Christina Ghaly, MD
Los Angeles County, Chief Executive Office
500 W Temple St
Los Angeles, California 90012

Dear Dr. Ghaly:

The Community Partners in Care (CPIC) Council appreciate the opportunity to respond to the Draft Report. We recommend two themes for inclusion:

1. **Community, patient, and family engagement**
   We appreciate that the report discusses the importance of community, patient, and family engagement into the integrated care of DMH, DHS, and DPH. We would encourage a model that doesn't relegate community members to "advisory positions" but rather moves towards truly engaging the community fully into improving care provided. In addition, we believe that transparency should be a major goal of the new agency. Unfortunately, a legacy of mistrust from the past, such as involuntary sterilization of minority women in Los Angeles County Hospitals in the 1970's and 80's, continues into the present day. Both engaging the community in improving care, and being open and transparent in all areas, will begin to build trust within these communities.

2. **Elimination of racial / ethnic health and healthcare disparities**
   We advocate for a major goal of any structural adjustment should be the elimination of racial/ethnic disparities in health and health care. Frameworks and evidence, such as IOM reports and Surgeon General's reports, offer evidence-based pathways to improving care for underserved, racial and ethnic minorities. In order to achieve this goal for behavioral health, the new agency should make every effort to retain the range and depth of evidence-based mental health program supported by Mental Health Services Act.

National and local policy models and demonstrations supporting recommendations 1 and 2:

Patient, Family, and Community Engagement within healthcare

- Federally Qualified Health Centers (FQHC) are required to have 51% of patients receiving services to be on FQHCs' boards are responsive to their community's needs.
- CMS and various states definitions of community, patient, and family engagement within regulations and waiver applications range from "education and outreach about existing healthcare services and insurance benefits" to having patients and families in an advisory role to offering patients and families receiving services, a meaningful role in the decision-making leadership of health plans and healthcare systems

Accountable Care Communities and Health Homes may provide financing opportunities to address social determinants of health while enhancing quality, safety, outcomes, value, and patient satisfaction of care through care coordination and partnerships between healthcare and non-healthcare sectors

Department of Mental Health

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Improvements in racial / ethnic disparities in health and healthcare outcomes are performance metrics in several state Medicaid waivers (e.g. Illinois, Massachusetts)

Community Partners in Care (CPIC) is an evidence-based community engagement model demonstrated to improve health outcomes for racial / ethnic minorities. CPIC offer features incorporating: 1. Community, family, and patient engagement in all areas, including project leadership; 2. Evidence-based depression care models consistent with national reports; and 3. Offers a healthcare planning and services delivery model consistent with Accountable Care Communities and Medicaid Behavioral Health Homes. At six-month client follow-up, community engaged planning and services implementation, compared to usual technical assistance for depression care significantly improved mental health-related quality of life and physical activity, reduced homelessness risk factors (homelessness, food insecurity, eviction, financial crisis) and behavioral health hospitalizations and shifted outpatient services from specialty medication visits toward primary care, faith-based and park depression services. The 12-month results suggest modest continuing benefit under the community engaged approach in terms of mental health-related quality of life and decreased hospitalizations.

Sincerely,

The CPIC Council Community-Academic co-Chairs

Loretta Jones, M.A.
Founder/CEO, Healthy African American Families II
Community Co- Principal Investigator, CPIC

Kenneth Wells, M.D., M.P.H.
Director, UCLA Center for Health Services & Society
Principal Investigator, CPIC

cc.

Mitchell Katz
Los Angeles County
Department of Health Services

Marvin Southard
Los Angeles County
Department of Mental Health

Cynthia Harding
Los Angeles County
Department of Public Health

Josie Plascencia

From: Melvin Mabale <MMabale@dmh.lacounty.gov>
Sent: Wednesday, May 06, 2015 10:15 AM
To: CEO Health Integration
Subject: Los Angeles Healthcare Integration

To whom it may concern,

My name is Melvin Mabale and I currently work for LAC Mental Health IT bureau (CIOB). Let me give you a little of my background before providing you some feedback and concerns.

For my own healthcare provider through the county benefits, I currently use Kaiser Permanente. I currently hold a bachelor's degree in IT and after 1 year working at DMH, I attended an LVN (Licensed Vocational Nurse) school to broaden my knowledge in the clinical nursing setting for both physical and mental health. I completed my clinical rotations mostly at the Panorama City Kaiser for physical health and Downtown Los Angeles for mental health. I'm knowledgeable in Kaiser's clinical practice, integration and collaboration between the 2 focuses as a clinician and also as a consumer. Although, I lack the knowledge and experience with the overall claiming process.

My role at DMH is to provide support to our clinical staff. My functional role is the Service Catalog Program manager for DMH. The Service Catalog is a central website for DMH staff to request for IT and Administrative services. For example, through the Service Catalog I can request for Facility, Business Supplies, Computers, Cellular Devices, etc. services. Not only we have become paperless for these services, but DMH staff has a central location to request for these services to support their clinics.

To tell you the truth, I love the Kaiser business and clinical models. Below are high level processes that I have either experienced as a Kaiser consumer and clinician.

Clinician – LVN Student
Example – Admission to ER

1. Client/Patient gets admitted to ER.
2. Admitting staff completes a quick pre-assessment of the client/patient.
3. Nursing staff get assigned to clients/patients and confirms/validates pre-assessment.
4. MD exams client/patients and conducts medical diagnosis.
    a. If MD requires a mental health assessment, PET (Psychological Evaluation Team) is assigned to do an evaluation.
        i. If PET requires a 72 hour, 1 week, 1 month, etc. hold on the client/patient, they are transported and admitted to a Kaiser Mental Health in-patient facility for further care.
        ii. Once care is provided to client/patient, they are referred to out-patient programs for continued care.
5. RN completes nursing diagnosis and provides care.
    a. If client/patient completes care before 23 hours and 59 minutes, MD can discharge client/patient.
    b. If client/patient needs additional care after 24 hours in the ER, MD admits client/patient to a hospital floor.
6. All clinical processes are aligned with each clinical focus.
7. All health record data is viewed by all clinicians at Kaiser.

Client/Patient
Example – Broken Arm with change of mental health status

1. Client/Patient goes to urgent care or ER for a broken arm and change in mental health status.

2. Client/Patient has 1 medical record number for Kaiser staff to look at history or admit them.
3. Medical and nursing diagnosis has been selected and care is provided.
4. Client/Patient needs mental health services and can either setup an appointment onsite or go to a website where I can schedule an appointment.
    a. Referral is already inputted and mental health is expecting that client/patient to setup an appointment.
5. Kaiser staff can retrieve 1 health record at any location.
6. Client/Patient can schedule appointments and message MD's at the Kaiser portal website.

I'm very new to the county and have been only working here for 5 years. I've been working in the private industry in IT for more than 15 years. 5 years ago, during my LAC interview process for both DHS and DMH, I was very surprised to hear how we provided healthcare services and how the healthcare cluster were segregated from each other even though we were all in the LAC umbrella. When I was interviewing for a IT position at DHS, they explained to me that the 3 hospitals (Olive View, LAC-USC, and Rancho) didn't share the same health record. When I finally made the decision to accept the position for DMH, my management explained that the current health record was not shared amongst the different mental health clinics.

With that said, I had concerns about the end to end physical and mental clinical care for LA County consumers. With these practices being departmentalized and the referral process was either nonexistent or delayed, I assumed we would then start to at least share the clinical data between DMH and DHS. As the years went by, DMH purchased their own health record system and DHS followed with another purchase with a different vendor. This strategy was still a concern of mines because both departments would then add an integration layer between the 2 departments, making it less efficient.

I think this healthcare integration is the best idea for providing complete health care for the LA County consumers.

The only concern I have, like many others, is job stability. Will I lose my job through attrition, consolidation and elimination of positions?

I also have a few suggestions/recommendations if you don't have these on your list already.

- Business/Clinical model similar to Kaiser Permanente and Cedar Sinai.
- Please only have 1 medical record system for all 3 departments.
- Consolidation of administrative processes and systems.

I hope this moves forward with either the consolidation of all 3 departments or being 3 separate departments with a caveat of sharing the clinical data and aligning the clinical practices and processes.

Thank you for allowing me to express my feedback and concerns and hopefully this provides some value to your healthcare integration initiatives.

Melvin G. Mabale
Los Angeles County-Department of Mental Health
Chief Information Office Bureau (CIOB)
695 S. Vermont Avenue, 7th Floor
Los Angeles, CA 90005
mmabale@dmh.lacounty.gov

Josie Plascencia

From: Leslie Gilbert-Lurie [redacted]
Sent: Saturday, May 09, 2015 10:59 AM
To: CEO Health Integration
Subject: Health Integration and Dr. Mitch Katz

Dear Supervisors,

I am writing to support the integration of the departments of health services, mental health, and public health.

As a vice chair of the Blue Ribbon Commission on Child Protection and a co-chair of the subsequent Transition Committee, I saw first hand how the silos between county departments have prevented our children from receiving the best care and protection. Combining the departments of health services, mental health, and public health under one agency will, in all likelihood, improve service coordination and care delivery for our foster children, for children living in troubled homes, and for vulnerable populations of all ages throughout the county.

As Co-Chair of the Transition Committee, I worked closely with Dr. Mitch Katz, and I cannot overstate how impressed by him I was. He struck me as precisely the type of highly intelligent, collaborative, passionate and bold leader that the county has attracted too few of in recent years. Beyond all of these traits, Dr. Katz is compassionate and whole-heartedly committed to the health of vulnerable children and adults. Over the months we worked together, he was as concernced with issues of mental health, and substance treatment as he was with the provision of physical health services.

I appreciate that this is a very complicated and critical decision, that there are many fluid pieces that must be taken into consideration, and that any change from the current structure carries a degree of risk. Based on all I know of L.A. County after nearly two decades of service, and all I have come to know of Dr. Katz, I most enthusiastically encourage you to take the risk of creating an integrated health department led by Dr. Katz.

Thank you for considering my opinion.

Sincerely,

Leslie Gilbert-Lurie

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Josie Plascencia

From: Kim Kieu [redacted]
Sent: Saturday, May 09, 2015 11:55 AM
To: CEO Health Integration
Subject: Feedback on The Health Agency Merge

Categories: Green Category

I am a community member of the Los Angeles County, and I am taking time to respond to this merge proposal that the Board of Supervisor has purposed.

Firstly, I am disapproving this merge for many reasons. The fact that a board who is elected by community members like myself would take such a step to suggest a merge without the consultation of it's stake holders is not a board that looks out for the best interest of the community. I feel that the board is over stepping is roles but taking action before public discussions, and I feel disrespectful that you only decided to have public hearings when the community showed up at the board meeting to voice their disapproval for the merge. What is more frustrating is the that community forums has been a joke. The board has already made a decision and pretending that our voices matters is an insult to people like me who have support the board over the year.

Secondly, the fact that the board has not done enough search to show the benefits of the merge is not giving the community an option. To provide a report for community comment that was done in less than month proofs that not enough research was done to either support and deny the merge. And what is more frustrating that when the community have voices that a merge should not occurred that option was taken off the table. If the board is the voice that represent the community than why is our voice not being heard? You have not provided me enough materials to suggest the merge is beneficial to the community that I live and work in.

Thirdly, the process that the board has taken has been one sided. The merge was suggested by the Department of Health Services (DHS), as they feel that it is better that they have all control of the other two department. To put Dr. Galy, who happens to be a long time employee of DHS and a supporter of the merge shows that the board is bias in it's decision making process. Why is the role not open for public discussion?

Lastly, I am not sure why you need to fix something that works. Mental Health has always been an area that requires specialized care and providers. DHS, does not have the experience and specialized staff to provide such services. There health care system does not even support mental health.

What is clear is that DHS is loosing money because of the AHA, since people no longer want to go to a county hospitals for health care. They have other options due to the AHA. When was the last time any of the supervisors received health care at a county hospital? The over crowding, the long wait time and getting treat by interns are not something that I am sure any of you would choose. DHS budget is getting impacted, because they are not getting the funding so this merge has always been about where else we get some of the money.
The sharing of resources as you've trying to tell us is the reason for the merge can be an easy fixed. DHS, DMH and DPH equipments all belongs to the county, the board need to take steps to make it clear that one department cannot tell the other that they cannot use them as no department owns them. They actually belongs to tax payers. Fundings are given to meeting certain needs, money obtain by each department to provide those services needs to be used by those department and cannot be taken and divided as the board or DHS feel fits.

Josie Plascencia

From: elisa.jimenez@californiamhc.org
Sent: Monday, May 11, 2015 11:48 AM
To: CEO Health Integration
Subject: public commet meeting from California Mental Health Connection

Categories: Green Category

Dear Ms. Sachi A Hamai
Interim Chief Executive officer

Re: Health Integration

After a review of the material and the meeting, I would like to make a few comments. Although it appears that steps are being taken to make positive changes in the integration of health care, it is highly unlikely that only one person can effectively oversee 3 departments and integrate services without the assistance of a team consisting of a medical doctor, a substance abuse counselor, a psychologist, and a client advocate. Having only one person with the power of decision is not a new concept. This is how things have always been and this structure dictates that the individual in charge is not only out of reach to the public, but that internal politics will only allow time for meetings with high management and other directors.

Therapists, doctors, substance abuse counselors, advocates and 12 step recovery clients should truly be a team that communicates directly with those making decisions which affect health care.

Thank you for your time.

Sincerely,

Elisa K. Jimenez, Director
California Mental Health Connection
P 626 430 6197 F 626 430 7404
Elisa.jimenez@californiamhc.org

Geneviève M. Clavreul, RN, PH.D
[redacted]
Web: TheNurseUnchained.com

May 14, 2015

Office of Health Integration
Kenneth Hahn Hall of Administration
500 W. Temple St., Room 726
Los Angeles, CA 90012

Via e-Mail - healthintegration@lacounty.gov
Re: Comments regarding the creation of one health agency

Dear Ms. Hamai:

I'm taking this opportunity to provide input regarding the Health Integration Project that's been proposed and was the result of a January 6, 2015 closed session. I think it's important to note that as an open meeting advocate I believe that the Jan. 6th discussion that resulted in the "Health Integration Project" motion was made in violation of our state's open meeting law, The Brown Act. The motion as posted on the January 6th agenda was noticed as "CS-3 Public Employment (Government Code Section 54957) – Consideration of the position of Director of Public Health – no reportable action was taken. (14-5571). Though it is acceptable under the Brown Act to hold discussions such as hiring/firing of personnel for that discussion to move from topic of hiring a Public Health Director to a request to submit a proposal for the integration of the departments of health, mental health and Public Health fails to meet the threshold of a closed session and therefore, should've been moved to an open meeting. Instead these discussions were held in closed session away from public scrutiny and debate. Considering that these three departments have a combined budget of $7 billion dollars, I think it's imperative that a complete and full discussion on this matter is in order. I believe cloaking the initial discussion in closed session was a clear violation of not only the Brown Act and of the public trust, as well. Meanwhile, at the January 13th Board of Supervisors' meeting where the motion was "heard" the Board gave themselves and DHS nearly 2 ½ hours to speak to the motion, while only allocating less then 2 hours to all the members of the public who had come to be heard on this item (each member of the public was given only one minute to speak).

While there have been some stakeholder meetings I believe that the number of meetings have been inadequate when one takes into account that Los Angeles County has a population of approximately 10 million, encompasses over 4,000 square miles and is comprised of 88 incorporated cities (of which only two cities, Long Beach and Pasadena, maintain their own small health departments). In addition, a mere 5 so-called public convening(s) were organized and held. They lacked adequate public notice and in most part seemed to be attended primarily by stakeholders and few if any "at-large" members of the public; which further confirms my belief that there were an inadequate number of public meetings held to vet the proposed integration of the departments of health, mental health and Public Health. The general consensus during these public convening(s) was that the process has lacked true transparency and that the process has yielded more questions than answers. Additionally there were numerous meetings held that were closed to the public and open only to union or County employees.

Los Angeles County has had a poor record and history when it comes to integrating services. For far too long mental health services suffered as a "step child" to the larger mission of the health department. It wasn't until mental health was spun off into its own autonomous department that Los Angeles County residents began to see the mental health needs of their constituents and communities addressed, and much work still remains where the mental health community is concerned. The proposed Health Agency could set back much of the progress that has been made in the arena of mental health. There's also good cause to believe that even the Health Department is showing a degradation of services. I'd like to cite the following two examples: the first being the recent discovery that it takes up to three years for a hernia patient, living in the Antelope Valley, to have the necessary surgery to repair their hernia. This wait is criminal, unacceptably long and reportable to various regulatory agencies; and second is the recent revelation that County+USC Medical Center has been downgraded from a B to a D

rating according to the most recent Leapfrog Group Hospital Safety Score. Both of these are troubling examples of internal problems within the Department of Health Services (DHS). It is my fear that combining these three already huge departments, even under an "umbrella agency" will only make it that much harder to discover problems and discrepancies in services and care.

Many years ago the LA County Board of Supervisors formed a Blue Ribbon Task Force to study alternative options as it related to the DHS. After much research, testimony and public hearings the task forces concluded that LA County should create a Health Authority. The task force also concluded that this Health Authority should include only the Department of Health and that both Public and Mental Health should remain separate entities. The Board of Supervisors chose to reject the Blue Ribbon Task Force's proposal. Later the LA County Civil Grand Jury investigated the option of a Health Authority, engaged an expert to review the data and concluded that LA County should form a Health Authority and once again the Board of Supervisors rejected this recommendation.

I strongly believe this process has suffered from a lack of transparency from the initial discussion which was held under the seal of a closed session when it didn't meet the burden of a closed session, to the original timeline which all but precluded a sufficient number of public meetings which then caused the Board to extend the deadline, the failure of the Office of Health Integration to adequately advertise the five "public convening(s)" that were ultimately scheduled. For example, initially no meeting was scheduled for Antelope Valley (at this meeting that I attended it was asked why Antelope Valley wasn't on the original list, it was stated that they didn't think it might be worth their time to have a meeting there since it was so "far away"). Even though there's a website for the Office of Health Integration this is hardly an adequate mechanism to spread the news far and wide to inform LA County residents about the possibility of creating an overarching Health Agency to "merge" the Departments of Health, Public Health and Mental Health. It's actions such as these that leave this citizen and many others with the feeling that County employees such as Dr. Mitch Katz, Dr. Christina Ghaly, Carol Meyer, Ms. Sachi Haimi and others are simply going through the motions since the Health Agency in their eyes is a fait accompli. The reluctance to provide documents under California's Public Records Act is yet another indication of the lack of willingness to share information (including refusing to give the addresses where the meeting would take place).

In closing, I would urge the Board of Supervisor to reject the formation of a Health Agency; and if not an outright rejection of this proposal then to at least commit to a real public vetting of this motion, via well publicized **public hearings** in multiple locations, with appropriate advertisement of the hearing dates, times and places, as well as hearings offered in the evening hours and weekends, and at the same time include the option of a Health Authority. And though there may be those at the Hall of Administration and the Department of Health Services that feels this is a "done deal" and public sentiment doesn't count. Remember that it isn't over until it's over.

Respectfully Submitted,

Geneviève M. Clavreul, RN, Ph.D.

Josie Plascencia

From: Joyce Dillard [redacted]>
Sent: Friday, May 15, 2015 2:07 PM
To: CEO Health Integration
Subject: Comments LA COUNTY Draft Response Single Unified Health Agency due 5.15.2015

Categories: Green Category

The title of the Motion is:

> *Ensuring Quality Health and Mental Health Care Services in Los Angeles County Custody Facilities*

The goal is implied and that goal is to ***ensure quality health and mental health care services.***

The March 3, 2015 Motion allows for Public Comment:

> *Extend the deadline for submission of the final report on the health agency, as outlined in the motion approved by the Board of Supervisors (Board) on January 13, 2015, to June 30, 2015, including a 45-day open comment period on a draft version of the report*

Public Comment is not allowed for the Response regarding the Agricultural Commission Environmental Toxicology Lab per that Motion:

> *The response to the Board on the movement of the Environmental Toxicology Lab, currently within the Agricultural Commission, to the Department of Public Health should still be governed by the original due date of March 13, 2015*

Environmental Toxicology Lab is responsible for:

> *Environmental testing, sample collection, analytical testing of water, soil, food, and more*

And

> *The lab is accredited by the State Department of Public Health to test drinking water, wastewater, hazardous waste, and agricultural products. The laboratory is also accredited for lead analyses in dust wipes, soil, and paint chips by the American Industrial Hygiene Association.*

Departments involved are:

1. Department of Health Services
2. Department of Mental Health
3. Department of Public Health

4. Agricultural Commissioner (environmental toxicology bureau functions)
5. Sheriff Medical Services Bureau (MSB)

Responsible Parties are:

1. Chief Executive Officer (CEO)
2. County Counsel
3. Department of Human Resources (DHR), in conjunction with the Department of Health Services (DHS)
4. Department of Mental Health (DMH)
5. Department of Public Health (DPH)
6. Agricultural Commission

The Responsible Parties are tasked to determine:

1. benefits and drawbacks of the agency
2. proposed agency structure
3. possible implementation steps
4. timeframe for achievement of the agency

IN THE SECTION entitled *Bridging population and personal health* the direction is a mass marketing technique through the use of the EHR Electronic Health Record.

You fail to mention FACEBOOK or any one of the popular social media. You fail to mention the value of collected medical information in the world market of information technology.

You fail to mention the value to Pharmaceutical Companies for such information.

You also fail to address PRIVACY RIGHTS. You fail to address CHILDREN and their PRIVACY.

You fail to address who controls this information and who has the authority to sell or share this information.

You fail to address who will own the servers or cloud and in what country will they be based.

You fail to address cyber-security issues.

IN THE SECTION entitled *Integrating services at the point of care for those seeking services in the County* sub-section *Examples of service integration models and efforts* the models mentioned are:

- Leavey Center
- MLK Psychiatric Urgent Care Center (UCC)
- Health Neighborhoods
- Co-Occuring Integrated Care Network (COIN)
- DHS-DMH Co-locations

- Integrated Mobile Health Team

Included are pilot programs. No statistics or data is presented to assess the programs. Two departments included in the COIN program are not part of the direction given for this Response. They are:

- Probation Department
- District Attorney
- Public Defender

IN THE SECTION entitled *Integrating services at the point of care for those seeking services in the County* sub-sec *Complex care programs*, five points of similarity are given:

1. A focus on a specific population;
2. Use of specific demographic, clinical, or utilization characteristics to identify the target population;
3. Innovative uses of often non-licensed workforce members;
4. Services provided both within and beyond the four walls of a clinical setting;
5. Lack of dedicated funding streams.

Four synergistic opportunities presented are:

- Program development
- Risk stratification and identification
- Data/analytics
- Training:

You fail to give timeframe in which this identification is derived. You fail to present statistics.

IN THE SECTION entitled *Addressing major service gaps for vulnerable populations,* the Challenging and Vulnerable Groups listed are

- foster care
- transitional age youth
- incarcerated individuals
- re-entry populations
- homeless individuals
- those in crisis.

The following departments listed are not part of the direction given for this Response:

- Department of Children and Family Services
- Department of Public Social Services
- Probation Department
- Sheriff's Department

IN THE SECTION entitled *Streamlining access to care*, non-alignments listed are:

- Screening tools
- Referral criteria, protocols, and tools
- Consents and authorizations
- Patient financial services policies and protocols
- Unique Identifiers
- Registration and check-in procedures
- Preferred points of entry to services

You state:

> *Common or at least consistent referral and financial screening processes and protocols and an ability to share demographic and basic financial information are essential.*

More revealing are the plans in motion:

> *A critical piece of the puzzle is the establishment of either a unique identifier or Enterprise Master Patient Index (EMPI) able to be used across the system; this is already in the development in a way that is compliant with all relevant privacy laws.*

Enterprise Master Patient Index (EMPI) appears to be the goal of this integration.

IN THE SECTION entitled *Using information technology, data, and information exchange to enable service integration*, the conclusion drawn is:

> *Operational efficiency, data quality, and customer experience can be optimized by having all parts of a health care organization use a single, shared EHR.*

Complexities of Electronic Health Records EHR, the requirements of the profession, the requirements of the regulatory process and the technical computer framework are not addressed in relationship to Public contracts.

Instead, Enterprise products presented:

- *Cerner product ORCHID (Online Real-time Centralized Health Information Database)*
- *Netsmart's IBHIS product*

Suggested is the development of an Enterprise Master Patient Index (EMPI) for integration into outside private companies or organizations.

Privacy and Patient Rights are not addressed as to the current laws and regulations and the changes necessary.

Suggested is the development of an Enterprise Master Patient Index (EMPI) for integration into outside private companies or organizations.

Privacy and Patient Rights are not addressed as to the current laws and regulations and the changes necessary.

IN THE SECTION entitled *Improving use of space and facility planning to improve access and reduce costs*, future capital property investment is introduced as a problem:

> *Each Department has several old County-owned buildings which have major deferred maintenance needs and will require substantial capital investment in order to provide safe and efficient work environments. Further, many buildings are not designed in a way that supports current operations and services*

Capital investments include property tax increases or bond issuance. Proposition 218 is not addressed.

No locations are identified nor has replacement costs. Would these properties be considered surplus or would they be privately sold?

Are any properties in the Los Angeles River Revitalization Master Plan area-or the Los Angeles County Metropolitan Transportation Authority's Union Station Master Plan? Is any properties prime for private development opportunities?

IN THE SECTION entitled *Improving ancillary and administrative services and functions*, sub-section *Contracting, Contract Monitoring, and Purchasing*, an aligned and accelerated contracting approach is suggested

Again, bidding processes are streamlined and sole sources are presented as to eliminate competition and opportunities for small business.

You suggest working together through piggyback contracts:

1) Developing future contract solicitations that could be used by any of the three Departments.
2) Consolidating similar contracts if programmatic alignment is strong and services are not tied to restricted dollars (e.g., MHSA). IT contracts are one area that may benefit given the specialized contracting expertise needed.
3) Expanding best practices across the Departments, including pursuing greater flexibility when contracting for proprietary services (e.g., maintenance contracts).
4) Exploring master agreements with similar terms and conditions but with options for different scopes of work and funding caps.

Piggyback contracts have state statute limitations.

IN THE SECTION entitled *Strengthening the County's influence on health policy issues*, influence is addressed:

> *There is also ongoing conversation more locally about the built environment (e.g., parks, neighborhood design) and community development.*

City of Los Angeles, a Chartered City, and other cities have more control over these areas of responsibility.

IN THE SECTION entitled *Aligning resources and programs to reduce health disparities*, a goal is presented other than the one implied in the Motion:

> *to improve the health and well-being of all LA County residents, promoting equity for all and not just for a fortunate few, enhancing parity of access to care and services across physical, behavioral, and population health*

No intention of the language *ensures* exists in this approach.

There is no discussion of the populations involved, the languages involved, the area or boundaries involved, or the miles involved to access services and the transportation available.

Responsibilities around the Public Health issues of Stormwater and Rainwater Harvesting have not been addressed. Guidelines for Harvesting Rainwater, Stormwater and Urban Runoff for Outdoor Potable Uses were approved without a Public Hearing.

Addressed minimally is the regulatory framework. Further detailed analysis is needed on local, state and federal regulatory requirements.

Public Private Partnerships are now involved in the County Health System, yet there was no mention of their role and responsibilities in this Single Unified Health Agency.

In the financial arena, you have No Economic Analysis or Effects on Small Business. There is no discussion of Bonds, their Ratings or another financial structure necessary to execute this integration.

Inspector General is not discussed.

There are no studies or data specific to this region and the facts around the proposal to satisfy execution of an ordinance at this time.

The definition of *Los Angeles County Custody Facilities* is unclear. Does that mean the County Jail only?

Patients themselves, should be addressed especially their Privacy, Rights and Records. The intent of the motion is to ***ensure quality health and mental health care services in Los Angeles County Custody Facilities***.

There is no evidence presented that meets that intent.

[redacted]

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

May 15, 2015

Christina R. Ghaly, MD
Director of Health Integration
County of Los Angeles Chief Executive Office
726 Kenneth Hahn Hall of Administration
500 W. Temple Street
Los Angeles, CA 90012

RE: COMMENTS TO MARCH 30, 2015 DRAFT RESPONSE TO THE LOS ANGELES COUNTY BOARD OF SUPERVISORS REGARDING POSSIBLE CREATION OF A HEALTH AGENCY

Dear Dr. Ghaly:

Once again, we thank you for taking the time to address the Commission on HIV (Commission) directly and providing an opportunity for feedback and recommendations to the County's March 30, 2015 Draft Response to the Los Angeles County Board of Supervisors regarding possible creation of a health agency (Draft Report).

After thorough review and significant discussion of the March 30, 2015 Draft Report, the Commission respectfully requests consideration be given to strengthen language throughout the report to specifically delineate where persons living with HIV are mentioned with greater specificity. Moreover, the Commission respectfully requests that the key concepts behind most suggested edits and additions be stated in the following two main recommendations and incorporated into the Draft Report:

Recommendation No. 1: Creation of an Independent Community Integrated Health Advisory Commission

The Draft Report contemplates the creation of an advisory body that would inform and contribute to the effective development and operation of a health agency. But as consumers and providers have learned with experience over time, advice is often not enough to ensure responsiveness from government.

The Ryan White Care Act was a unique and brilliant piece of legislation that sought to ensure local government was responsive, and most importantly, *accountable*, to the community and consumers. Accountability was established by requiring local government to delegate the power of priority setting for services and allocation of resources for those services directly to the community through the mechanism of a community planning council. The Los Angeles County Board of Supervisors (BOS) enhanced this mechanism by delegating further oversight to its own local planning council for STD planning and prevention services and elevated the body to a full county commission. The Commission has played a critical role in assisting the BOS vet critical issues and provide clarity when complex issues needed a robust community engagement mechanism before policy determinations.

Establishing an independent community planning body, similar in scope and composition to the Commission, accountable directly to the BOS, is a key mechanism to ensure the establishment of a health agency meets the internal and external needs of consumers seeking effective, integrated services throughout Los Angeles County.

Recommendation No. 2: Assess and Incorporate the Role of Community Partners in Health Integration as Indispensable Components of County Service Delivery

The Draft Report is primarily an internally focused document. An opportunity exists however, to ensure the success of integration efforts by incorporating the critical assumption that County departmental services are, to a great extent, provided through and in conjunction with, community partners such as community clinics, community based organizations and other contracted providers.

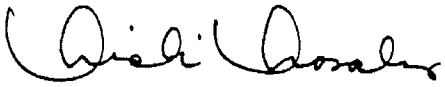
Post ACA, County has continued to enhance its role as a provider of specialty care, inherently reliant on the provision of primary care through FHQC partners. FQHCs are the entry point for many Los Angeles County residents seeking services within the contemplated fully integrated continuum of care. Efforts at integration on one side of any balanced system of care must be matched by the allowance and ability to integrate on the other. External integration will be critical to the success of the creation of health agency to fully integrate service delivery.

Community Partners have long advocated for this integration of service delivery. However, conflicting programmatic requirements, multiple and often redundant oversight functions, human resource allocation limited to one funding source alone, despite obvious administrative duplication, and consistent barriers to efficiency, effective service delivery create additional barriers to access for consumers. External integration for community partners will relieve administrative burden and improve/enhance the skills and efficacy of the delivery workforce where access occurs. This external integration will further enhance community partners' long history of effective consumer engagement for recruitment and retention in care.

Thank you once again for your time and effort to include the Commission in your planning process. We look forward to continued partnership with your office in creating an integrated delivery of care in Los Angeles County.

Sincerely,

Michael J. Johnson, Esq., Co-Chair
Los Angeles County Commission on HIV



Ricky Rosales, Co-Chair
Los Angeles County Commission on HIV

c: Board of Supervisors
Commission on HIV
Division of HIV and STD Programs (DHSP)

Proposed Health Services Consolidation

Background

I, Victoria Ann Sofro, am privileged to have served as a member of LA County's Mental Health Commission for more than 30 years, appointed and reappointed ever since by Supervisor Antonovich, most recently in January of this year. I currently serve on the Commission's Executive Committee, and was previously its Vice-Chair. Just last year I was deeply honored to receive a Lifetime Achievement Award for my contributions to the vastly improved services available to our mental health community throughout the County.

During my entire tenure as Commissioner I've chosen to focus on the delivery of employment/educational services, believing strongly in the ultimate recovery these services enable for our consumers. Fortunately for all, Dr. Southard also shares this belief.

Under Dr. Southard's dedicated leadership, DMH has immensely expanded this opportunity to our consumers. The extraordinary success of these efforts is celebrated each year at our "Connections for Life" educational conference, held annually to inspire and inform our countywide community. "Connections" is now approaching its 10th Anniversary, It is witness to the power of 'Hope, Wellness, & Recovery', made real for the hundreds and hundreds who participate each year.

Recommendations

The original consolidation proposal to the Board of Supervisors envisioned merger into a single department. But upon further input the Board concluded an agency model might provide a superior basis from which to proceed, and ordered evaluation of the merits and risks of an agency approach.

Dr. Christina Ghaly is leading this evaluation, gathering input from stakeholders throughout the County and preparing a formal report to the Board. During this time I have come to greatly respect her abilities. In particular I view her as an admirable communicator - ready to listen and willing to learn - and at the same time a strong, yet collaborative leader.

IF the Board adopts an agency model, I recommend Dr. Ghaly be given the opportunity to continue leading the all-important planning and initial startup phases of this major undertaking as Interim Director of the new Agency. From her recent role, Dr. Ghaly is likely the most currently and broadly informed. I believe her demonstrated skills would provide a powerful catalyst for the essential team-building ahead. Department Directors should remain in place - both to ensure continuity of consumer services within each Department and to serve as informed advocates for the special needs of each during the creation of a "more perfect union", all under Dr. Ghaly's leadership.

Finally, as to a permanent Agency Director, let us first look for that leader to emerge in the course of the work ahead. I believe Dr. Ghaly should be considered for inclusion in the list of potential candidates.

With kind regards,

Victoria Ann Sofro May 17th 2015

Victoria Ann Sofro, Commissioner

cc: MHC, Supv. Antonovich

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

CULTURAL COMPETENCY COMMITTEE

Feedback on the Possible Creation of a Health Agency Draft Report
May 18, 2015

Who is the Cultural Competency Committee?

The Cultural Competency Committee (CCC) promotes cultural awareness and sensitivity in The Department's response to the needs of diverse and underserved populations. It is a countywide committee, comprised by LACDMH staff, contracted providers, Under-Represented Ethnic Population Subcommittees, non-profit organizations, faith-based organizations, consumers, and family members, who represent the culturally diverse populations of the county and are committed to promote progress in the provision of culturally and linguistically competent services within the Department.

I. Questions, recommendations, and concerns about consolidation* of the three Departments under one health agency:

1) The CCC and UREP subcommittees strongly advocated for the continuation of community involvement in determining how culturally and linguistically appropriate services need to be delivered. The draft report mentions the term "cultural competency" only twice and it is mentioned for the first time on page 50.

   The final report needs to define cultural competency and on how each of the three Departments has operationalized/ implemented culturally competent practices, trainings and activities at large to have an positive affect on the quality and longevity of culturally diverse communities, (e.g. taking into consideration the whole

person and PIESs domains--physical, intellectual, emotional, spiritual, and social, as well as environmental and occupational factors)

2) What are the three Departments' practices, activities, and methodology to ensure the delivery of culturally and linguistically appropriate services that are relevant internally and externally to meet the holistic needs of the people being served throughout Los Angeles County health systems (DHS, DMH and DPH)?

3) How are the three Departments implementing and funding these practices, activities, and methods such as training, specialized services, community engagement, including stakeholder processes, community input, decision processes, as well as staffing to meet the needs of the people being served?

4) Regarding the "Opportunities under a health agency" section of the report [p. 6], bullet 2, add the following wording after "... vulnerable populations, including Under-Represented Ethnic Populations (UREP), LGBTQ and other culturally diverse groups."

5) Regarding the "Streaming access to care" section of the report [p. 22], provide examples and outcomes of integrated models that the three independent Departments have piloted to reduce barriers, improve continuity of quality care, and increase collaborative coordination to meet the needs of the people being served in the Los Angeles County public health systems.

6) Regarding the "Aligning of resources and programs to reduce health disparities" section of the report [p. 32], how are the three Departments addressing, investing and identifying the social determinants of health, risk factors, and disparities that can have a negative impact on a person's healthcare, mental health conditions and the quality of life in underserved, unserved and inappropriately served communities and neighborhoods?

7) The Cultural Competency Committee and UREP subcommittees collectively expressed specific areas of concern about the consolidation of the three Departments under one health agency. Below is the feedback provided to Dr. Ghaly on February 11, 2015. The report needs to include a clear and precise "pro" and "con" chart that reflects the

verbatim comments of the community, which includes UREP populations, providers, people receiving services, stakeholders and agencies.

- The UREP subcommittees and CCC do not support the consolidation of the three Departments under one health agency
- The plans for consolidation have lacked transparency and the decision making has taken place without input from the community and the three Departments
- The consumer groups have been left out. Their feedback regarding the consolidation must be sought out and included
- The consolidation will not include the Stakeholders and System Leadership Team processes implemented by DMH
- The consolidation will add layers of additional bureaucracy and administrative cost, which will ultimately take away services from our underserved, unserved, and inappropriately served communities
- A bureaucratic management design is not favorable to the elimination of mental health disparities
- The documentation regarding the consolidation (e.g. planning principles and operation parameters) failed to include cultural competency as related to the community, consumers and providers
- The consolidation will operate based on the medical model which has historically lacked the cultural sensitivity as well as linguistic competency in service delivery
- The philosophy of the medical model will replace the recovery model, which is the framework for DMH's service planning and delivery
- DMH's current efforts for service integration, elimination of stigma, and reduction of mental health disparities will vanish
- Different aspects of cultural competency such as spirituality and collaborations with community partners will also vanish
- The proposed consolidation model will regress DMH's progress and success in engaging and serving underserved communities with culturally and linguistically appropriate services, and in promoting stakeholder involvement
- The DHS's lack of experience in community involvement and partnering with community stakeholders will result in the needs of underserved groups being neglected and ignored
- The consolidation will result in a managed care system and that will eradicate DMHs effort to provide client-driven and culture driven services

- The Mental Health Services Act (MHSA) funding for underserved populations to access services, reduce stigma, and fund innovative programs that incorporate community-design approaches will be negatively impacted by the consolidation
- The consolidation of the three Departments will affect the community negatively as there will be a greater need to build a cultural and linguistic competent workforce. This will result in greater gaps in the cultural and linguistic competency of the "consolidated" workforce
- The consolidation will take away the right of the consumer to choose services that are available
- An alternate "Council" model was suggested, in which Deputies, Supervisors, and UREP representatives would strategize and plan changes collaboratively.
- DMH is already testing and implementing the integration of services. The DMH Community-Designed Integrated Service Management Model was given as an example
- The consolidation timeline is rushed, not well thought out and will not allow sufficient time for a thorough Stakeholder process
- Research on the organizational consolidation of multiple Departments has found that consolidations have been ineffective due to incompatibilities of the systems involved
- The proposed structure of one director reporting directly to the Board of Supervisors will result in an additional layer of bureaucracy. This will generate barriers for the three Departments to express their unique needs.

8) What is the rationale for "one" Director to oversee "three" other Directors who are currently managing Departments that provide unique/specialty services to meet the healthcare and preventive needs of the people served in Los Angeles County---an approximate population of 10 million people?

9) How will Los Angeles County residents and communities receive information to participate in the restructuring of three major Departments to meet the holistic health care and wellness needs of the people being served?

10) How will this information be disseminated to underserved, unserved, and inappropriately served communities that have been historically misrepresented, that have caused bias, institutional racism, discrimination and ineffective community integration in civic engagement and processes?

11) How will a single health agency adapt the concept of a multi-cultural and integrated public health system of care as related to developing a culturally and linguistically competent workforce, increasing parity, identifying social determinants of health, and increasing equity in healthcare outcomes, regardless of a person's social position, culture, education, ethnicity, disability or economic status?

12) Despite of the community and stakeholders concerns about funding and having reported during Public Hearings that each Department would keep its own funding, the draft report makes suggestions to "centralize" services and "braid" funds under the proposed "health agency." On p. 21, the report clearly states: "Under an agency model, it might be possible for funds to be more easily braided..."

II. Recommendations for the implementation of a health agency model or alternate model:

1) Plans/proposals for the implementation of a health agency model or an alternate model need to be made available to stakeholders, consumers and the community with ample time for review and feedback gathering. The community stakeholders, consumers and providers shall provide input **before and throughout** any structural changes [related to the motion] take place.

2) There needs to be a Cultural Competency Unit and Cultural Competency Committee across the three Departments.

3) It is recommended that all County agencies/Departments that have Cultural Competency Units form an alliance to develop a common framework for understanding and delivering culturally competent care.

4) It is recommended that the Board of Supervisors (BOS) and its change leaders/experts utilize and incorporate strategies from the California Reducing Disparities Project (CRDP) strategies as recommended by the community with specific focus on cross-cutting practices/strategies that will serve culturally diverse populations.

5) It is recommended that the BOS/Change leadership build on the lessons learned from the LACDMH Integrated Service Management Model (ISM) projects regarding outreach and engagement activities, as well as holistic and wellness activities proven successful in serving culturally diverse communities.

6) It is recommended that the BOS/Change leadership incorporate emergent opportunities articulated in health neighborhoods concepts to address the social determinants of health aimed at addressing population health.

7) It is recommended county agencies, stakeholders and citizens are united in understanding around cultural and linguistic competency through the development and implement of a multi-cultural conference to ensure all parities achieve consensus on strategies and processes before implementing health integration, should the motion go forth.

8) Suggestive of given health integration goes forth, it is imperative that residents are informed and become participants in the restructuring of the health agency to ensure ownership of the process in a multicultural system of care.

9) How will the three departments implement the aforementioned and include community input in decision-making, etc., To meet population health needs?

LATCO
Latino Mental
Health Council

Maternal and Child
Health Access

MENTAL HEALTH
ADVOCACY
SERVICES

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:

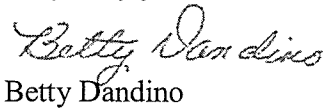
The Los Angeles County Coalition for an Office of Healthcare Enhancement consists of over 135 organizations and agencies representing persons with mental illness and substance use disorders, family members, and providers serving those persons and their families, as well as public health, advocacy services,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

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.

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.

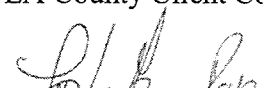
Thank you for your ongoing support for the highest quality healthcare possible for Los Angeles County's residents and for your consideration of our proposed alternative County healthcare model.

Very truly yours,

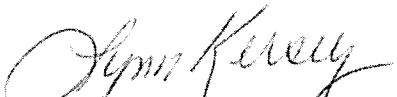

Betty Dandino
LA County Client Coalition

Guyton Colantuono
Project Return: The Next Step

Brittney Weissman
NAMI LA County Council

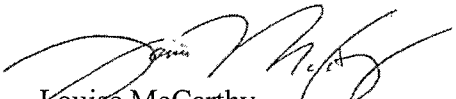

Luis Garcia
Latino Mental Health Council

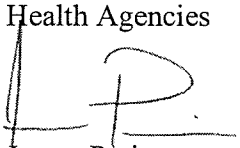
Debra Fong
Asian Pacific Policy & Planning Council


Lynn Kersey
Maternal & Child Health Access

Bruce Saltzer
Assn of Community Mental Health Agencies

Albert Senella
California Assn of Alcohol & Drug Program Executives


Louise McCarthy
Community Clinic Assn of Los Angeles County


James Preis
Mental Health Advocacy Services

c: Health and Mental Health Deputies
Mitchell Katz, MD
Marvin Southard, DSW
Cynthia Harding, MPH
Christina Ghaly, MD
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healthintegration@lacounty.gov
Members of the LA County Coalition for an Office of Healthcare Enhancement

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

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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. Hillsides
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 (SCHARP)
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 that 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.]

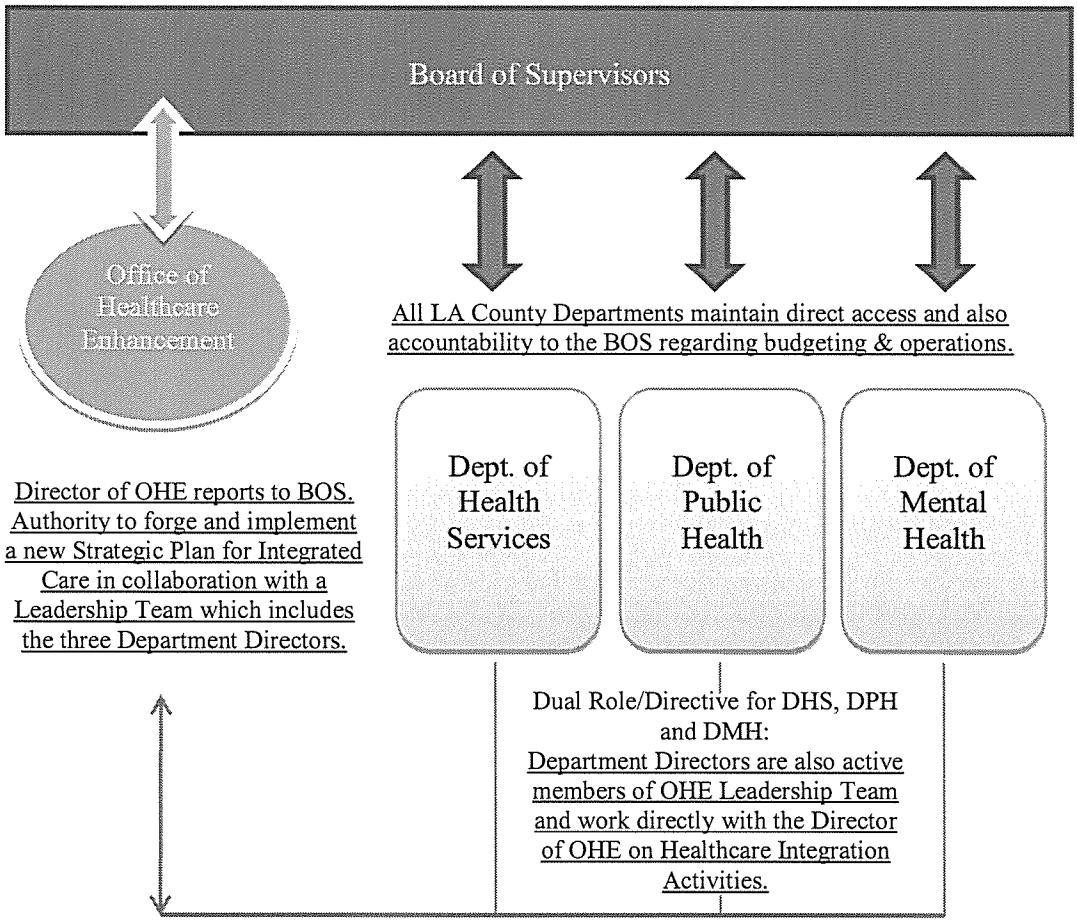
The Summary Description Position also makes the following important points pertinent to the Coalition's position: 1) the Director of the OCP, who would report directly to the Board of Supervisors, would be supported by a small but very talented staff; 2) the operating agencies working with the new Director 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 that 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 though an Office of Healthcare Enhancement makes much more sense that 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.

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[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.

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[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.

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[7] Kramer, M. & and 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.

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[10] Cartwright, S. & Cooper, C. (2012), Managing Merger, Acquisitions and Strategic Alliances: Integrating People and Cultures, Batterworth-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 our 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.

Appendices available online at
http://priorities.lacounty.gov/health-stakeholders/
under Association Community Human Services
Agency (ACHSA)

Josie Plascencia

From: CEO Health Integration
Subject: FW: Health Integration Motion

On May 21, 2015, at 4:56 PM, [redacted]

Hi, Dr. Ghaly:

Regarding the proposed integration of DHS/DPH/DMH, I would like to state that as an American Indian in recovery from substance abuse and mental health issues and living with HIV, the Board of Supervisors should be commended for recognizing that individuals are people and not diagnoses. We experience a multitude of needs that can and should be addressed through a 'no wrong door' approach. Removing a siloed approach to providing services, especially with regard to providing housing and screening for co-morbid conditions, is especially important if we are to assist individuals in Los Angeles in accessing assistance and getting housed. This plan is a step in the right direction.

Regards and best to you,

Josie Plascencia

From: [redacted]
Sent: Friday, May 22, 2015 5:44 PM
To: CEO Health Integration
Subject: Comment on Draft of Report on Creating New Health Agency

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: Yellow Category, Red Category

Hello,

Please do not make my comments public, but please share them. I wish to remain anonymous.

My comment consists of the following questions:

1. The vision of integrated care that offers a spectrum of services to our communities is ideal. However, in some buildings, we already have co-location, such as Glendale Health Center. DPH clients who are uninsured cannot access primary care services provided by the DHS clinic on site, even though they are within the same small building. The DHS clients can access some of the DPH services, but it is much harder the other way around. The only entry option for uninsured DPH clients to receive DHS primary care services is to enter through an urgent care clinic. For Glendale, they would have to go to Olive View Medical Center and wait potentially long periods in the urgent care/emergency room; many times the needs are not emergency in nature but no primary care settings were accessible. How will the agency ensure that co-location results in "more", not less accessible services for those who are not insured or do not belong to the DHS clinic managed care panel ?

2. How will the Board ensure that each department's decision makers possess equal authority over key decisions made by the agency, and no one department dominates decisions? For example, how will the agency ensure that co-location is not motivated by a battle over building space, with DHS having the greater demand for space?

3. Could the agency first develop several model centers, such as Glendale Health Center, with a fully integrated spectrum of services hosted by DHS, DPH and DMH? With this pilot, many of the challenges and risks listed in the report should be addressed on a small scale, before investing much labor, money and time.

Service Area Advisory Committee 4

550 S. Vermont Ave.,

Los Angeles, California

RESPONSE TO DRAFT REPORT from SAAC 4

FOR CREATION OF POSSIBLE HEALTH AGENCY

The Service Area Advisory Committee 4 has reviewed the "response to the Los Angeles County Board of Supervisor's regarding possible creation of a health agency" and listened to a summary of the report presented to the SAAC 4 at April 16, 2015 by Carol Meyer of the Office of Health Integration. The following is a response to the report:

1. Neither the report nor the presentation addresses how "cultural competency" will be included, maintained and enhanced in the three departments under the authority of the new proposed health agency. For example, throughout this process information or presentations were not made available to ensure stakeholders who speak a language other than English, particularly Spanish could participate. While language is not the only cultural component it serves as one gage of cultural competency.
2. The report speaks to the proposed health agency having a leadership team. How will the leadership be chosen? Is there one "leader" of the health agency or a "leadership team"?
3. The report references keeping the "integrity" of the three different departments, once "integration" occurs is it really feasible to maintain the integrity of each distinct department. These appear to be contradictory ideals.
4. The report did not adequately address where and in what area "mergers" will occur or the desired outcomes of the "merged" areas. Will these areas be enhanced, have more services or maintain themselves as they are but talk to each other?
5. It is not clear from the report what is the proposed "outcomes" for the "vision" for the "health agency." Couldn't the current structure have proposed measureable joint outcomes that could be overseen by the Board of Supervisors with clear directions from Executive Staff and do the same thing?
6. The presentation speaks to "opportunities" to increase funding, where would the increased funding come from?
7. Timelines for the proposed changes appear too fast given the important and substantial "goal" that is being suggested, shouldn't there be more time taken

to really work through what the goals and possible outcomes are before launching the proposed "health agency".

8. What is SEIU's involvement in the proposed health agency? That is not clear.
9. Do DHS and DPH have stakeholders' groups, consumers, families, and community agencies, community members who participate and give input into this process?

Josie Plascencia

From: Bill Resnick <drbill@g.ucla.edu>
Sent: Friday, May 22, 2015 10:48 AM
To: CEO Health Integration
Subject: Support for integrating mental health, substance treatment and physical health care

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: Green Category

Dear Supervisors:

As a board-certified psychiatrist who has worked in a variety of patient-care settings I know the importance of integrating mental health with substance treatment and physical health care. The most vulnerable people in our county--the homeless, those with mental health problems in the jail, those in psychiatric emergency services or in patient wards, children in group homes in our foster care system--suffer from a combination of problems that can only be handled by addressing all three areas holistically. No one would create de novo a health care system with physical health in one department, mental health in another department, and substance abuse treatment in a third department, and expect that clients would go from one department to another to gain the services they need, especially when they themselves may be unclear which area can best help them.

Having trained in county mental health facilities, I can assert the challenge of not having reasonable access to medical services for psychiatric patients. The current system makes it difficult for psychiatrists to have access to medical workups for their patients, which is crucial in ruling out potentially reversible causes of mental illness. Currently, as chair of the board of a large nonprofit substance abuse treatment facility, I see how illogical it is to separate out substance abuse treatment from mental health care, when there is so much obvious overlap. What often happens is that substance abusers see county psychiatrists who aren't well trained in identifying and treatment patients with substance use disorders, and prescribe medications for patients whose psychiatric symptoms are mainly a result of their drug or alcohol abuse. For example, I've encountered numerous cases of patients diagnosed with bipolar disorder who have never had a clear period of mood disturbance outside of their drug or alcohol use and have been prescribed multiple medications which have been unhelpful.

For these reasons, I support the creation of a health agency so that the services our most vulnerable residents need can all be under one umbrella and connected by a modern information system that allows the clinicians to have the necessary information for helping them.

Thank you for your consideration.

Sincerely,

William Resnick, MD, MBA
Assistant Clinical Professor, UCLA

Josie Plascencia

From: Celinda Jungheim <[redacted]>
Sent: Monday, May 25, 2015 9:11 AM
To: CEO Health Integration
Subject: Support for the Los Angeles County Coalition for an Office of Healthcare Enhancement

Follow Up Flag: Follow up
Flag Status: Flagged

Dr. Ghaly and Honorable Members of the Board of Supervisors:

I have reviewed the original proposal for combining the Department of Health Services, Department of Public Health and the Department of Mental Health and also the alternate proposal to develop an Office of Healthcare Enhancement and I strongly favor the Office of Healthcare Enhancement model. This will allow for the most inclusionary and integrated process with the least disruption of services and will develop a truly integrated model.

I have been active in the mental health system of Los Angeles County since the 1960s when I started receiving services and I have seen many changes over the years. The last 10 years of work done by the Department of Mental Health focusing on a Recovery Model of support and a focus on the whole person is, in my opinion, the only model that works. Of course, not perfect but one should never be satisfied with the status quo and The Department of Mental Health has continually improved services.

Again, I strongly urge supporting the idea of an Office of Healthcare Enhancement.

Sincerely,

Celinda Jungheim

Celinda Jungheim
Board Chair Emeritus, Recovery International
Co-Chair SAAC 5
[redacted]

UCLA
FIELDING
SCHOOL OF
PUBLIC HEALTH

Health Policy and Management

May 26, 2015

Honorable Supervisors,

As your Health Officer and Director of Public Health for 16 years before retiring last September, I was honored to have your support as Los Angeles County developed one of nation's best public health departments. Together we built a much stronger capacity to protect and improve the health of all 10 million residents of our great County. I remain dedicated to continuing our progress by helping to prepare our next generation of public health leaders.

I have been closely following the discussion of possible reorganization of the health departments, have provided my input to the individual developing the final report for your Board, and have closely studied the content and recommendations in the draft report.

I write to you with great urgency now because I believe the current recommendations in the draft report will directly jeopardize the safety and health of County residents. By developing a health service dominated umbrella agency, public health will be returned to the difficult situation I encountered when I entered County service in 1998.

I was recruited to lead a struggling and demoralized public health department housed within the Department of Health Services (DHS). Due to its location in the organizational structure, one small part of a large department with an important but different mission, the ability of public health to protect the public and improve our collective health had been terribly compromised. Placing the Department of Public Health (DPH) under an umbrella health agency will again relegate it to inferior status under an individual whose primary responsibility and accountability is to fulfill a clinical mission focused on individual health care services.

Los Angeles County is by far the largest county in the country. DPH protects the health of all residents with approximately 4,000 employees working in 39 divisions. The only jurisdiction of comparable size is New York City and there, as here currently, public health is a separate independent department. New York Health and Hospitals has the primary responsibility for that city's clinical services. Today, in the largest jurisdictions of the nation, the different missions of public health and clinical care are recognized through entirely independent public health departments.

I understand and agree with your important objective of improving coordination between the three county health departments to streamline access to direct services and remove unnecessary barriers for clients. There are at least two better alternatives to achieve your objective than the approach recommended in the recent report:

UCLA Jonathan and Karin Fielding School of Public Health

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1. Appoint a seasoned manager with a broad view of health improvement opportunities through health services, mental health and public health as Health Care Services Coordinator under the Chief Executive's Office (CEO). This individual's charge would be to improve coordination in the provision of clinical services among the three departments. This action would parallel your recent decision to appoint an Interim Director for the LAC Office of Child Protection. It would accomplish your goal of improved service coordination consistent with your priorities.

2. Immediately use your power and authority to direct the three Departments to achieve 3-5 high priority goals that improve service integration within defined timelines and hold your leaders accountable for their individual and collective contributions toward success. This approach could also enhance the County's responsiveness to the multi-faceted challenges of health services reform.

I had hoped the draft report would identify the priority service delivery problems to be solved in the short term, yet it does not. The risks of an umbrella agency led by the same person running the largest of the three departments are clear in the draft report. I was disappointed, but not surprised, that the report concluded that the rapid implementation of an agency structure is the **only** solution (and the only option studied) for improving clinical service integration in LAC.

The entire process was not constructed to be objective. The author of the report was put in an impossible position to remain objective. She has worked for the putative agency head as a deputy director since 2011, was only temporarily assigned to the CEO to write this report, and has been clear with myself and other stakeholders that she will return to DHS after the Board votes on the agency, presumably to report to the same individual. Given this situation, I am not surprised that the report first oversimplified complex ideas to justify the predictable conclusion that an umbrella agency should be created. Nor am I surprised that the report dismisses dissenting views and legitimate concerns from local stakeholders including those with extensive public health leadership experience. Despite this lack of objectivity, the author still had to admit within the report that "most, if not all opportunities, could technically be achieved under any organizational structure."[1] But this alternative is quickly discarded. Further the report inadequately articulates the specific integration problems to be addressed, so the overarching solutions don't inspire confidence that the actual needs will be met.

The report also neglects to provide any oversight for the clinical care system more broadly. It fails to clearly articulate the integration priorities, the standards of metrics by which success will be measured, or how the shift to this structure will tangibly advance the missions of all three departments beyond clinical services. By taking an exclusively clinical approach, the report also totally ignores the critical population-wide needs for improving the health of LAC residents by improving the conditions in which people live and reducing their health threats.

Each of these failures can jeopardize the health of your constituents.

I am so passionate about the misdirection of the draft report recommendations because I served 8 years when Public Health was only a division of DHS. Our work during those years was seriously impeded by being a small part of a large bureaucracy. Our budget suffered. We were always last in getting

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[1] Page 6 - *Response to the Los Angeles County Board of Supervisors Regarding Possible Creation of a Health Agency* issued from the LAC CEO on March 30, 2015.

human resources help, which contributed to unhealthy high vacancy rates. We had minimal assistance getting and monitoring key contracts and our efforts to focus on the broad opportunities for improving the health of all were subordinated to clinical health service priorities. The accomplishments of the 8 years since DPH became a stand-alone department testify to the benefits of independence.

Some of the accomplishments include:

- Built a nationally acclaimed chronic disease prevention division that teamed with many communities and other stakeholders to change the trajectory of major health and disease trends for the better. Life expectancy in LAC increased and death rates declined by double digits for coronary heart disease, stroke, lung cancer and infant mortality.
- Opened a new state of the art public health laboratory that serves as a critical reference laboratory for all Southern California, novel biological agents capable of causing epidemics.
- Advised Los Angeles Unified School District on policies to improve the nutritional quality of food served in cafeterias and eliminated junk food and sugar sweetened beverages.
- Played a pivotal role in obtaining state legislation to require menu nutritional labeling in fast food restaurants.
- Partnered with First 5, WIC and other organizations to stop and start reversing the increase in obesity in preschool children.
- Recruited a senior epidemiologist with a national reputation as the first Chief Public Health Science Officer.
- Reduced opiate overprescribing and over dose deaths by working with the Los Angeles County Medical Association and increasing use of drugs that can reverse an overdose.
- Led efforts to effectively reduce tobacco use to 13% with multipronged efforts including working with cities to pass over 120 local tobacco control policies.
- Developed an effective bioterrorism and all-hazards capability within DPH and trained every employee to be a public health responder using an incident command structure with first in the nation agreement and partnership with the Federal Bureau of Investigation.
- Mounted the largest ever public health mobilization response, to H1N1 influenza, establishing vaccination sites throughout LAC to administer over 230,000 doses of vaccine and efficiently allocating more than 4 million additional vaccine doses to private sector providers.
- Established an economic analysis unit to assess the cost-benefit and cost-effectiveness of novel public health initiatives.
- Published a first of its kind book that summarizes key activities, lessons learned and best practices that have emerged from DPH programs.
- Established a major public health communication capability that provided accurate information in a timely fashion on key public health threats and issues, which effectively raised the visibility of the County Health Officer as the public's doctor.

I was disturbed, therefore, that there was minimal acknowledgement within the report of the risks of eroding DPH's ability to fulfill its mission by returning to a structure that did just that. Nor did the report sufficiently address valid concerns about the appropriate recruitment of a DPH Director[2]. Make no mistake, if the proposed agency model is implemented, the County will fail to attract a nationally recognized Public Health leader to innovate and push DPH to its full potential, which the largest local

[2] Pg. 52 - *Response to the Los Angeles County Board of Supervisors Regarding Possible Creation of a Health Agency* issued from the LAC CEO on March 30, 2015.

public health jurisdiction in the country deserves. The brief paragraph in the report about the Health Officer[3] indicates there will be a dotted reporting line to the Board, yet it omits any safeguards the agency will establish to assure the Health Officer's ability to produce and enforce orders that may be inconsistent with the opinion of the agency director. The proposed organizational structure makes a public health director subservient to a medical care system, not an equal partner in improving health. It is a badly outdated model for improving the health and wellbeing for all 10 million residents.

The narrow perspective of the report is seen in the description of human resource needs. It raises human resources as an area for the agency to support improved recruitment of staff tied to health care delivery, yet many of the staffing needs for public health require non-healthcare background, skills and knowledge (e.g. policy analysis, economic evaluation, urban planning, inspection, environmental assessment, epidemiology, and spatial analysis). It is unclear how the agency plans to prioritize and ensure that critical, non-clinical staff will be recruited and retained. Nor is it clear that when subordinated in the bureaucracy that DPH would command the authority to accomplish its mission. The wide range of expertise public health needs to employ was neither understood nor supported by human resources when DPH was only a division of DHS, and I am greatly concerned with the narrow view of staffing needs presented in the report. The always-compelling demands for clinical services for individuals has historically trumped the need for less visible but more impactful preventive public health activities; the proposed agency is likely to exacerbate this problem.

The report asserts that bringing successful integration to scale across the County will require significant work and costs at the operational level to make progress[4]. At the same time, the report claims that by creating a lean structure, with individuals performing dual roles complementary to their current assignments[5], costs will be essentially negligible. It does not sufficiently address the real world concerns of stakeholders that anticipate the dual staffing model will erode the departments' abilities to meet their existing commitments, that the agency will be disproportionately staffed by employees of one department, or that over time there will be additional funding requests to finance agency operations. The report indicates that the Chief Executive Officer does not support an agency structure that requires additional County investment[6]. At minimum, a thorough cost analysis should be completed prior to your final decision on the implementation of the health agency. Failure to codify what specific changes are needed and how they can be achieved makes it impossible to assess what the financial impacts are likely to be, but they are likely to be substantial. Moreover, the greatest savings to the clinical care system are likely to come from population health interventions, yet the importance and value of pursuing these is not considered.

Evidence-based preventive interventions delivered broadly to the population before individuals need to access clinical services, is the County's greatest advantage in reducing overall healthcare expenditures in LAC. An agency designed to focus on the integration of clinical services falls short of its potential to truly benefit the health of people in LAC. The report did not provide a forward thinking argument for

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[3] Pg. 51 - *Response to the Los Angeles County Board of Supervisors Regarding Possible Creation of a Health Agency* issued from the LAC CEO on March 30, 2015.

[4] Pg. 45 - *Response to the Los Angeles County Board of Supervisors Regarding Possible Creation of a Health Agency* issued from the LAC CEO on March 30, 2015.

[5] Pg. 39 - *Response to the Los Angeles County Board of Supervisors Regarding Possible Creation of a Health Agency* issued from the LAC CEO on March 30, 2015.

[6] Pg. 39 - *Response to the Los Angeles County Board of Supervisors Regarding Possible Creation of a Health Agency* issued from the LAC CEO on March 30, 2015.

how the agency will specifically improve health. What essentially boils down to an improved referral system, shared clinical files, and potentially more full-service options at some County venues does not solve the bigger health issues our communities face: poverty, low educational attainment, low wages, limited job opportunities, unhealthy environmental exposures, stigma, high rates of incarceration, institutional discrimination and a fragmented clinical care system.

Without a strong and innovative public health presence in LAC, which is inconsistent with the agency model in the currently projected structure agency model, DPH's current capacity to serve as an honest, and independent, broker on major underlying determinants of health will be diminished. I am concerned that the report does not adequately inform you of the potential drawbacks, and that it overstates the benefits of an agency with bias. It takes strong senior-level leadership to stand up for the health of the public. DPH funding is largely categorical which means it has deep expertise in specific areas, but it needs more depth in the future-oriented population health mission which is recognized as essential to continue progress towards better health for all. Individual clinical services are one important tool to improve health but it is recognized, in the Affordable Care Act, the Triple Aim, and elsewhere, that future improved health requires a great and strong concentration on population health, the primary mission of DPH.

I want to emphasize that my concerns are related to the proposed structure and predetermined leadership arrangement, not with the very competent current leadership of DHS which has made remarkable progress in improving the County's important clinical health services function.

In summary, we all want improved services for residents seeking care at County facilities, yet the agency structure is not the only viable path to consider. To make a truly informed decision about how you would like to structure the County's overall health systems governance for the foreseeable future, greater consideration should be given to practical alternative models with similar potential to provide the results you want. A decision to accept the blatantly biased report will lead to a severely weakened public health capacity without the independent innovation, leadership and voice you deserve to hear.

I would be pleased to meet with any of you to discuss this further at your convenience.

Sincerely,

Jonathan E. Fielding, MD, MPH, MBA
Distinguished Professor of Health Policy, Management and Pediatrics, UCLA

cc: Ms. Sachi Hamai
Mitchell H. Katz, MD
Christina Ghaly, MD

LOS ANGELES COUNTY
HOSPITALS AND HEALTHCARE DELIVERY COMMISSION
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May 26, 2015

Office of Health Integration
c/o Sachi A. Hamai and Christina Ghaly, M.D.
Kenneth Hahn Hall of Administration
500 W. Temple Street, Room 726
Los Angeles, CA 90012
healthintegration@lacounty.gov

Re: Proposed Creation of a Health Agency

Dear Ms. Hamai and Dr. Ghaly,

The Hospital and Health Care Delivery Commission ("Hospital Commission") is grateful for the opportunity to submit its comments to you regarding the proposed creation of a health agency that would encompass the Departments of Health Services (DHS), Public Health (DPH), and Mental Health (DMH). After consideration of the Draft Report dated March 30, 2015, entitled "Response to the Los Angeles County Board of Supervisors regarding possible creation of a health agency," (the "Draft Report") and the remarks of Dr. Ghaly and other stakeholders at the Hospital Commission's public meetings on February 5, 2015, and May 7, 2015; the Hospital Commission has decided to support the concept of a health agency.

Before the County implements this concept, the Hospital Commission requests that the County conduct further analysis on the following issues, including further study of whether there are other options for integrating the work of these departments:

Should all DPH programs be included in the health agency?

Though all of the departments relate to "health" in a broad sense, the shared focus of the DHS and DMH on individual health is distinct from the DPH's focus on population health. The DPH's functions – restaurant inspections, water quality assurance, and emergency preparedness, to name a few – have little overlap with those of the DHS and DMH.

On the other hand, the DPH houses programs like the Substance Abuse Prevention and Control program (SAPC) which are centered on individual health care delivery and may already work hand-in-hand with physical and mental health providers. It may be advantageous to join the DHS, DMH, and programs like the SAPC while keeping other DPH programs separated.

Accordingly, the County must evaluate the utility of including the entirety of the DPH in a health agency. The County must similarly evaluate whether a health agency should incorporate other programs in- and outside of these departments unrelated to individual health care delivery (e.g., Sheriff's Medical Services Bureau).

Are there alternatives to a health agency model for exchanging data among these departments?

The DHS, DPH, and DMH will undoubtedly find value in one another's data. However, other means of sharing such data may be available outside of a health agency model which may require fewer resources and/or less structural change. The County must explore the feasibility of each of these alternatives prior to choosing a health agency model to facilitate the departments' exchange of data.

How will the divergence in the culture of care between the DHS and the DMH be reconciled in a health agency model?

The comments above do not assume that the DHS and DMH operate in lock-step with one another on every issue. To the contrary, the Hospital Commission is aware that the culture of care between the DHS and DMH often diverge, notably on the DHS' application of the medical home model and the DMH's application of the recovery model. Moreover, the Hospital Commission was informed that the DHS receives an annual budget of approximately $4 billion, which is about $1 billion more than the annual budget of the DPH and DMH combined.

The Hospital Commission is uncertain how the dynamics between these departments would change under a health agency, and most importantly, how patient outcomes could be expected to improve as a result. The County must identify and strive to preserve the things that work well in each department before imposing a structural change that may set each department back.

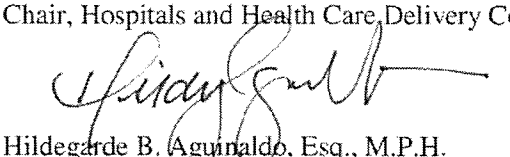
Will integration into a single health agency result in cost savings to the County of Los Angeles?

In our meetings with Dr. Ghaly and our review of the Draft Report, there was little, if any, consideration of how combing three large health agencies into one super-agency would result in cost savings to the County of Los Angeles or the taxpayers. In fact, at the Hospital Commission's May 7 meeting, Dr. Ghaly reported that cost savings were specifically not part of the analysis of the agency combination. As referenced above, the County spends approximately $7 billion on the three agencies. Certainly, there must be some redundancies in the administration of these agencies and/or economies of scale that can be recognized if three agencies are combined into one. The Hospital Commission's strong recommendation is that the County analyzes the potential cost savings and efficiencies that could result from an integrated agency.

We are hopeful that the County will thoroughly consider these comments and those of our colleague stakeholders in diligently evaluating the creation of a health agency. We look forward to continued dialogue with you on this issue.

Very truly yours,

Stacy Rummel Bratcher, Esq.
Chair, Hospitals and Health Care Delivery Commission



Hildegarde B. Aguinaldo, Esq., M.P.H.
Member, Hospitals and Health Care Delivery Commission
Chair, Ad Hoc Committee on Health Agency Integration

Health Services
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

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LOS ANGELES COUNTY

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

Health Services
www.ladhs.org

May 27, 2015

TO: Mitchell H. Katz, MD
Director, Department of Health Services

Nina J. Park, MD
Chief Executive Officer and Chief Medical Officer, ACN

Christina Ghaly, MD
Director of Health Care Integration, CEO

FROM: Sheila Shima
Chair, ACN Advisory Board

Enrique Peralta
Vice Chair, ACN Advisory Board

SUBJECT: **INTEGRATED HEALTH AGENCY PROPOSAL – ACN ADVISORY BOARD RECOMMENDATIONS**

At our May 19, 2015 meeting, the Department of Health Services (DHS) Ambulatory Care Network (ACN) Advisory Board adopted recommendations regarding the draft report on the proposed new County Health Agency, developed by the Interim Chief Executive Officer's (CEO) Office of Health Care Integration. We are submitting our written comments and recommendations for consideration in accordance with the public comment period ending May 29, 2015.

We on the ACN Advisory Board thank both Dr. Ghaly and Carol Meyer for meeting with us to discuss the pending proposal, both prior to the development of the draft report and again after the release of the report for public comment. This proposal would have a potentially significant impact on the provision of medical and behavioral health ambulatory care services for County residents, and we appreciate the opportunities to share our comments and recommendations about the proposed change.

We commend the writers of the draft report for capturing the extensive amount of information from the various stakeholder groups in the document, including the list of issues submitted to the Interim CEO's Office of Health Integration after our ACN Advisory Board's March 26, 2015 meeting.

However, we are concerned that many community members, including patients receiving services from County Departments, will continue to have difficulty in understanding the proposed creation of a health agency, despite the Executive Summary which was prepared to help the general public understand the key issues and recommendations in the report.

The ACN Advisory Board members have adopted the following recommendations:

1) We continue to strongly support the goal of improving care coordination and ensuring better integration of services. The critical role of the DHS Ambulatory Care Network, as DHS primary care providers, should be more clearly referenced in the draft report. The report should also reference the opportunities to improve care coordination within DHS itself between ACN outpatient, hospital outpatient and hospital inpatient services.

2) It is critical to provide adequate resources for the proposed new Health Agency and the departments in order to achieve the goal of improving integrated care coordination.

    a. We are concerned about comments in the report that no additional resources would be provided.

    b. New resources may only be needed for a limited time to allow the new Agency to achieve longer-term savings.

3) It is critical to clearly define the mission, purpose and responsibilities of the new Agency and to establish measurable outcomes the Agency should achieve in improving care coordination.

    a. We recommend that the metrics be developed before the decision is made to create the new Health Agency to ensure a shared understanding of the Agency's purpose and expected outcomes.

    b. If the Agency is created, parameters should be developed for evaluating Agency success at achieving outcomes and to determine whether changes to the Agency structure and/or operations are needed.

4) The report to the Board of Supervisors should reference the need to address, with or without new resources, the logistical issues of establishing and staffing the new Health Agency as a separate and distinct entity from the three County Departments.

5) The report should reference how the new Health Agency could participate in opportunities for innovation and integration for improving the health and lives of all County residents, many of whom may be served by non-County primary care providers.

    a. What is the agency's role in engaging with private, non-County entities in discussing policy changes and strategic issues in the larger healthcare arena? This is especially critical with the expanding roles of behavioral health, long-term care and social determinants in affecting individual health outcomes.

6) The new Agency should be responsive, on a continuing and more proactive basis, not only to the Board of Supervisors, the Departments and other County agencies, but also to the various stakeholder groups and community advocates who support the departments and to the patients/clients receiving County services. The Agency should ensure appropriate transparency at all times and that all communications appear in major languages represented in the County's ethnic communities.

    a. A process should be developed to ensure input from patients on operational changes the Agency and/or Departments are considering, prior to implementation of the changes, which would have an impact on patient access to care.

    b. It is critical to seek community input, particularly from consumers, in all parts of the County.

    c. It is also critical that community involvement reflect an understanding of differing needs and perspectives of ethnic populations.

We on the ACN Advisory Board look forward to continuing our involvement in issues, such as this proposal, which affect the health care outcomes for DHS ambulatory care patients and other Los Angeles County residents.

SS

c: ACN Advisory Board Members
Carol Meyer, RN, BSN, MPA, Community Outreach Coordinator, CEO
Board Health Deputies
Board Mental Health Deputies
Board Public Health Deputies

Terry and Tilda De Wolfe
1142 Kenton Dr.
Monterey Park, CA 91755
[redacted]
May 27, 2015

To: Office of Health Integration
Kenneth Hahn Hall of Administration
500 W. Temple Street, Room 726
Los Angeles, CA 90012

We are family members of and advocates for persons with mental illnesses. We do not approve of the proposed Umbrella agency creation.

We ask WHY do this?

We concur in the integrated delivery of health services, but do not feel the creation of an umbrella agency is necessary to produce cooperation between the three existing departments. It causes concerns that you would be creating another level of bureaucracy that would take funding better used in the delivery of necessary services for the three existing departments.

A committee of leadership from the three existing departments could effectively and efficiently handle sharing of resources and information.

Most Sincerely,

Terry De Wolfe Tilda De Wolfe

[redacted]

Provider Questions and Feedback from May 27th DMH Child Providers Meeting

Bryan Mershon Introductory Remarks

On January 13, 2015, the Board of Supervisors directed the Chief Executive Office, County Counsel and the Department of Human Resources, in conjunction with the Departments of Health Services, Public Health, and Mental Health to report back on the benefits, drawbacks, proposed structure, implementation steps, and timeframe for the creation of a single unified health agency. Carol Meyer and Dr. Ghaly from the CEO are not able to be here today to participate in the discussion. The purpose of today's discussion is to gather input regarding the CEO's draft report. Feedback received from this meeting will be sent to the CEO. Carol Meyer and Dr. Ghaly have attended the Mental Health Commission, Service Area Advisory Committee meetings, and SLT meetings to receive feedback.

We provided you the two page executive summary report of the CEO's draft report to the Board of Supervisors regarding integration, and we provided the link to the full draft report. We need to send our meeting discussion summary to the CEO by May 30, 2015. Are there any comments or questions you would like to discuss on the draft report or the executive summary?

Provider Comments

- Has the management team at your various organizations received the proposal for the Office of Health Care Enhancement? It's a very extensive document developed by a community coalition that discusses point by point critical issues as an alternative to the merger. ACHSA sent out the document to the CEO. It should have been posted on the health care integration website but has not yet been posted. It was submitted May 19.
- The most concerning thing is that the 78 page draft report only has one page that talks about children's services. This little feedback is very concerning which makes me think "is children's services not part of the integration?"
- I attended SLT meetings, and they didn't talk about TAY or children's services. We were told it's ultimately the Board of Supervisors' decision.
- Look at what happened at the state level. I'm afraid where children's services are going to end up if DMH goes down.
- Just an FYI, in San Francisco, children's services are in a separate entity from adult services.

Bryan: Any other questions regarding the proposed Health Care Integration?

No response.

Thank you for your feedback.

May 27, 2015

Mental Health Committee

C/O: Community Partners
1000 N. Alameda Street, Suite 240, Los Angeles California 90012
(213) 346-3247

To: Office of Health Integration

Regarding: Input to the Response to the Los Angeles County Board of Supervisors Regarding the Possible Creation of a Health Agency - Draft Report

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The Mental Health Committee of the Second Supervisorial Empowerment Congress* is submitting comments regarding the proposed creation of a Health Agency as presented to the Board of Supervisors in a draft report dated March 30, 2015. The input of the Mental Health Committee is decidedly skewed in the direction of mental health services. Recalled is the Committee's drafting of a White Paper dated July 2, 2012, which established the critical importance of mental health services and the contribution to one's physical, social and emotional well-being (see attached).

During its last three meetings the Committee members have been deeply involved in discussing the Report's contents. In addition to its critical review of the Report several Committee members have participated in other forums across the County to hear the voices of fellow stakeholders.

Our appreciation is expressed to Dr. Christina Ghaly who offered to attend the Committee's May 7th meeting. A series of questions developed by a Committee workgroup were posed to Dr. Ghaly whose responsiveness was very helpful in filling in some gaps. Included was Dr. Ghaly's illustrating of the proposed Agency structure and listing of proposed functions.

Of particular concern to the Mental Health Committee members is the change to the Department of Mental Health, to be subsumed under the Agency Model. The representation that the three departments will remain distinct with their own missions, budgets/revenue and contracts seems belied by the hierarchal Agency entity to which they would report.

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* Empowerment Congress Mental Health Committee: Formed in 2006 by then Assembly Member Mark Ridley-Thomas, this monthly forum, which today serves the Second District, ensures that constituents are apprised of and can give voice to mental health issues of concern. Included are mental health providers, allied public and nonprofit organizations, consumers, family members, advocates, concerned citizens and others to discuss and share ideas which address mental health-related issues and advance policy and other important initiatives.

Since the Committee's inception much effort has been devoted to educating participants about Proposition 63 – the Mental Health Services Act – and how constituents can benefit. The Committee has served as a nexus for coalition-building on behalf of increasing services to those who are homeless and mentally ill. In 2012 the Committee completed a White Paper which focused on the design of mental health services in concert with health care reform. More recently, the emphasis has been on diverting mentally ill inmates from the local jail.

While several integration structures are cited from other California counties there is no information as to how mental health consumers have been made better off. A cautionary tale is the dissolution of the State Department of Mental Health and its functions being subsumed by the State Department of Health Services. We see no evidence that mental health has fared well. In fact, attracting highly qualified leadership to the mental health director position has been very challenging. Diminution of mental health services is experienced on multiple fronts.

Whatever entity is established by the Board of Supervisors, we believe its primary responsibility is coordinating and using public assets to their highest and best value. The Agency must demonstrate the ability to create a climate which supports and effectively engages the three departments in undertaking collective initiatives. While cited in the Report is the knowledge and experience that an Agency director candidate should demonstrate in the three department domains, importantly, the Agency director should have a deep resume in strategic and collaborative planning and a demonstrated commitment to stakeholder engagement.

For the Mental Health Committee members the matter of stakeholder involvement warrants special focus. Los Angeles County Department Mental Health has distinguished itself from other mental health departments by the extent to which it engages mental health consumers and other key stakeholders beginning at the Department leadership team and evidenced throughout the Department's day to day operations. When a separate State Department of Mental Health existed, we could document the multiple avenues by which stakeholders provided their knowledge and "lived" experiences toward shaping the policies and operations of the Department. This kind of dynamic engagement is no longer experienced since the State Department of Mental Health was taken over by the State Department of Health Services, hence, a loss of a valuable resource to informing public policy. Whether the Agency Model or some other entity is put in place the critical importance of leadership having a prominent track record in stakeholder engagement, including the involvement of mental health consumers, is considered an important credential.

Going forward, apart from the Board of Supervisor's decision as to how to proceed related to the Agency Model, the Mental Health Committee's White Paper offers a means by which to integrate primary care and mental health services with the knowledge that coordination of care can be achieved by a proposed three tier matrix (which is outlined in the White Paper). Collaborative efforts can be immediately undertaken by the three departments using a team approach which regards each department as an equity partner. Lessons learned from other large public health systems, for example, the use of universal screening tools to determine which tier a given patient/consumer should be directed, is an example of an immediate initiative.

The Mental Health Committee of the Second Supervisorial Empowerment Congress appreciates the opportunity to provide its input and welcomes the opportunity to dialogue with elected officials, department partners and others that may be interested in the foundational work it has undertaken by way of its White Paper and other policy work.

Attachment is available online at
http://priorities.lacounty.gov/health-stakeholders/
under Empowerment Congress

Josie Plascencia

From: Jonathan Sherin <[redacted]>
Sent: Wednesday, May 27, 2015 3:10 AM
To: CEO Health Integration
Subject: YES to health integration

Categories: Green Category

Dear Supervisors:

I have worked as a psychiatrist, educator, scientist and administrator focused on the wellbeing of Veterans in Los Angeles and beyond for the last 15 years. In my work with Veterans I have seen how important it is to break down silos in order to provide integrated services. I support the creation of a unified health agency because it is the best way to coordinate mental health, housing, substance abuse, and health services in an integrated way. I believe this perspective to be true not only for Veteran's but for other vulnerable populations such as the homeless, the incarcerated and those in crisis.

Sincerely yours,

Jon

Jonathan E. Sherin, MD/PhD
Executive VP, Military Communities
Chief Medical Officer
Volunteers of America, Inc
(310) 266-8391

Date: May 28, 2015

To: Office of Health Integration

From: Asian Pacific Policy and Planning Council (A3PCON), Mental Health Committee

Regarding: Input to the Response to the Los Angeles County Board of Supervisors regarding the possible creation of a health agency

I. Overview:

A3PCON supports the need for service integration of health and behavioral services on selective fronts. We do not feel that the health agency model is the most effective way to achieve the needed levels of integration. The draft report (dated 3/30/15) continues to clearly subsume the entirety of DMH, DPH and DHS under the Health Agency and a hierarchical bureaucratic organizational structure that is to be directed by the current director of DHS. This as we noted in our meeting is unacceptable since the bias of DHS in setting health agency priorities is virtually unavoidable.

As we had noted in our meeting with Dr. Ghaly, we proposed a model of collaboration, equity and accountability among the three entities to define and execute shared integration goals. At the same time we support a model that maintains the independent operational responsibilities and budgetary authority of DMH, DPH and DHS and their direct reporting authority to the Board of Supervisors.

The draft report (dated 3/30/15) points out a number of areas where the opportunity for service integration exists but the proposed model does not take into account the many areas where services are working well and should be left alone. The draft report in our view simply "brainstorms" all possible ideas of integration initiatives yet fails to assess what is realistically possible given the enormity of the challenges facing each department separately. What is clearly necessary as a next step is the creation of a strategic plan that balances the separate work of each department with the collaborative work that is necessary to achieve the shared integration goals.

To insure that the distinctive work of each of the departments can occur unimpeded we disagree with Dr. Ghaly that it is necessary for each entity to be subsumed under the health agency. In our meeting with Dr. Ghaly (4/15/15) we proposed a model where each department carries a dual role as ordered by the Board of Supervisors: independently responsible to the Board for their respective separate missions, budgets and operations and through a CEO level office of healthcare enhancement, responsible for collaboratively creating and executing a strategic plan for healthcare integration activities.

A3PCON feels that the work of advocating, creating and delivering community based culturally competent services will be adversely affected by the Health Agency. Our work is an example of the many non-health services and health and behavioral health integration programs of DMH of which is grounded in a unique community based, stakeholder and consumer driven process. We have been particularly

effective in addressing mental health disparities in our communities. The draft report does not include any planning for this essential principle of operation. The need for outreach, engagement and education to overcome disparity for underserved communities is not treated as a requirement but instead identified as one of many well intentioned priorities. Cultural competency has to be woven into the fabric of any agency and we are proud of our work to imbed it into the culture of DMH. It is not just linguistic access; it is sensitivity to the diversity of the ethnic and cultural communities in Los Angeles and focusing on approaches and strategies that address these individually.

II. **Specific Concerns:**

1. We are particularly struck that concerns from community based agencies and consumers about an inclusive approach if under a health agency model is labeled as a "general anxiety" about new leadership and change in your report. Our concerns are real, based on past experiences.

2. The clash in organizational cultures between the three entities (DMH, DPH, DHS) is extraordinary as we noted in our meeting with Dr. Ghaly (4/15/15) and that subsuming DMH in particular under a health agency significantly threatens to mute or de-prioritize our work amidst a multitude of competing priorities. We noted for example the real possibility of DMH being eclipsed by DHS. We think that can be avoided by a model that maintains the continued independent operating authority of DMH while at the same time establishing a Board ordered CEO level Office of Healthcare Enhancement that is ordered to create and execute a strategic plan for healthcare integration. Dr. Ghaly's critique that this alternative would not have sufficient authority to execute is misplaced. In the County of Los Angeles the Board of Supervisors is the ultimate authority who can in-turn delegate executive level authority to CEO level executives and department directors. In this instance the chain of command is straightforward: the Board of Supervisors directs/orders the CEO level director and the three department heads to collaboratively create and execute a strategic plan for integration. This is how historically the "hands-on" County Board of Supervisors has managed successfully.

3. The draft report does not adequately reflect the many areas mandated by public funding that cannot be integrated nor a clear value added benefit for consumers achieved through integration. There is no justification why such areas should be placed under the control of the health agency and its director unless the ultimate intent of this proposal is to ultimately control the direction and resources of all three entities.

4. Many services do not have a need for service integration and the draft report does not explore these. These are principally areas that are not health-focused and or successful programs where integration is indeed working as your report acknowledges. While the draft report continues to state that the new health agency would not focus on these areas where there is no benefit we question why it is necessary that all these efforts be placed under the health agency. What is achieved by this added level of bureaucracy? In our opinion, the creation of a health agency as

proposed will add another layer of bureaucracy that will further prevent those in need from accessing needed behavioral health services.

5. The draft report does not adequately take into account the level of disruption that will occur when an under-resourced and understaffed integration plan is implemented without needs assessment, stakeholder input to determine priorities and a well thought out timeline. There is not a clear assessment of how a health agency will be balanced against the current workload of each department.

6. We strongly believe in the continued independence of DMH to pursue its mission and to be able to directly report to the Board of Supervisors.

    - The integrity of the Department's internal decision-making process should be left alone.
    - The integrity of the stakeholder process used so effectively by DMH should not be lessened in any degree. If there is a new structure for integration of services, it must include such a model to set priorities for the integration of services.
    - DMH should be held directly accountable to the Board for its distinctive mission, goals and services.

III. Our Support for an alternative Model of Health Care Enhancement.

We are disappointed that after two lengthy meetings with you (UREP and A3PCON) that our extensive comments and recommendations have made little more impact than a mere recording of stakeholder comments and concerns. We are troubled that an extensive process of stakeholder involvement that has been carried out over the past three months has had no impact on the proposed structural realignment of the Health Agency that subsumes the entirety of DMH, DPH and DHS under this umbrella.

We believe the public health, health and mental health system can do much better than propose an outdated hierarchical model to solve challenging contemporary problems of integrated services. As concerned stakeholders we have joined with over 135 agencies, consumer groups and community leaders representing mental health, public health and health to propose an alternative plan for healthcare enhancement. This 31-page plan for an "**Office of Healthcare Enhancement**" has been formally submitted on 5/19/15 to the Board of Supervisors and widely distributed. Our model embraces leadership through collaboration to define and achieve shared integrative goals. This Board ordered model holds the executive leadership of all three departments equally accountable to achieve specific integrative goals which would be developed collaboratively with the new CEO level Director (also Board authorized). In addition our model maintains each department as independently accountable for their separate department based goals and requires direct access to the Board. 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.

HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA®

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Los Angeles, California 90071-3300
213.538.0700 Fax 213.629.HASC (4272)

May 28, 2015

Sachi A. Hamai
Interim Chief Executive Officer
Chief Executive Office – Office of Integration
County of Los Angeles
Kenneth Hahn Hall of Administration
500 W. Temple Street, Room 726
Los Angeles, CA 90012

Dear Ms. Hamai,

The Hospital Association of Southern California (HASC) which represents over 85 hospitals in Los Angeles County wishes to provide comment on the document titled: **Response to the Los Angeles County Board of Supervisors Regarding Creation of a Health Agency**. HASC wishes to express its appreciation to the Los Angeles County - Office of Integration for meeting with key stakeholders and incorporating those initial comments into the draft plan.

A plan to integrate Health Services, Mental Health and Public Health is a significant undertaking that requires careful analysis on its anticipated impact on County beneficiaries / clients; countywide residents; and underserved populations served by private hospitals. The breadth of services offered by Health Services, Mental Health and Public Health require that risks be properly mitigated before moving forward on a proposal that will impact as many as 10 million residents.

The plan cites a need to co-locate services and development of a consistent referral and financial screening process as reasons to pursue an integrated model. However, the report did not clearly highlight specific gaps in the transitions of care and associated metrics for how success will be measured. It is also unclear how Mental Health and Public Health programs and services provided directly to private hospitals (non-county) will be impacted. HASC, with hospital input, identified the following issues that must be addressed in the final report.

Mental Health: Areas of Concern

- **Identified Gap:** A need to fully identify within the continuum of care specific gaps that necessitate integration with clear metrics for measuring, monitoring and reporting success.
- **Psychiatric Mobile Response Teams (PMRT):** Private non-LPS hospitals rely on PMRT to perform psychiatric assessments of individuals placed on a 5150-Hold. The report does

not address how this resource will be affected under a health agency model as it pertains to private non-LPS hospitals.

- **Institutions for Mental Disease (IMD) Beds:** IMD access and placement is exclusively managed by the Department of Mental Health for county and non-county hospitals. The report is silent on whether IMD access by private hospitals will change under a health care agency. Patient referral to an IMD must be managed without regard to whether a patient is from a county or a non-county hospital. The current wait-time for an IMD bed is estimated to be about 14-months.
- **Specialty Mental Health:** Mental health carve-out requires that the Department of Mental Health continue to provide specialty mental health access and treatment to adults with serious and persistent mental illness. Also, the plan needs to address how services for children and adolescents for whom inpatient placement is very limited will be improved.
- **Appointment Access:** Need to preserve the 15-day appointment standard for mental health outpatient appointments regardless of whether a patient is discharged from a County or non-County hospital.

Public Health: Areas of Concern

- **Identified Gap:** A need to identify within the continuum of care specific gaps that necessitate integration with clear metrics for measuring, monitoring and reporting success.
- **Surveillance and Control:** Concern that integration could detract from Public Health's core mission and undermine countywide prevention efforts, community health initiatives and disease surveillance. Steps must be taken to preserve staffing associated with the division of Emergency Preparedness & Response and Public Health Laboratory. Finally, mission driven services and staff expertise can be lost to clinical demands that potentially undermine unique partnerships with local, state and federal agencies.
- **Role of Health Officer:** Report notes that the Health Officer will have a dotted reporting relation to the Board of Supervisors - this preserves the Health Officer's visibility and credibility on emergent issues. However, it is unclear in the report if the Health Officer will continue to lead a countywide disaster coordination and response effort, as well as issue health officer orders that are timely and independent.
- **External Countywide Needs vs. Internal County Needs:** A need to ensure that health initiative prioritization reflects countywide needs due to competing priorities outside the public health arena. There must be continued focus on addressing underlying social determinants of health, addressing health disparities, and protecting the general public from outbreaks and communicable diseases.

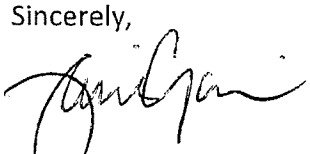
- **Nimble, Timely and Effective:** The plan does not offer metrics related to improving the County's response to public health threats; and does not address the role of private providers / county partners within the integrated model. Also, need to preserve the Hospital Outreach Unit which allows Public Health and private hospitals to partner together on initiatives that include rapid disease and outbreak reporting.
- **Licensing and Certification:** It is unclear how the process will change given net-county costs and ongoing negotiations between the State and the County.

Moving Forward

In the absence of clear objectives and corresponding metrics it remains unclear whether a health agency that integrates Health Services, Mental Health and Public Health will improve coordination and efficiency across the continuum of care. HASC, while it remains neutral on the issue of integration, encourages the County to continue its stakeholder engagement in order to properly mitigate concerns and unintended consequences. This recommendation is necessitated by the complexity, size and unique scope of service that each department provides. More importantly, this process will enable the County to build on the unique successes that its stand-alone departments achieved.

HASC appreciates the opportunity to provide comment and looks forward to continuing its dialogue with the Office of Integration on addressing the above concerns.

Sincerely,



JAIME GARCIA
Regional Vice President – Los Angeles Region

Josie Plascencia

Subject: FW: Feedback on the Draft Report for a health agency

From: Mariko Kahn
Sent: Thursday, May 28, 2015 5:13 PM
To: healtintegration@lacounty.gov
Cc: Mariko Kahn
Subject: Feedback on the Draft Report for a health agency

Dear Dr. Ghaly,
Although I have given verbal feedback at several venues on the draft report regarding a Health Agency, I wanted to also submit my written comments because I strongly feel that the proposed structure for the health agency does not fully address the concerns and issues raised. Your staff and you have done your best to represent the multitude of opinions that were expressed but based on my attendance at these feedback sessions, I felt several key points were not included.

Here are my major concerns:

1. There is a significant lack of consideration for the inclusion of cultural competency in the health agency. The overwhelming disparity to access and utilize services especially in the highly diverse Asian and Pacific Islander communities is not included in the draft report. Cultural competency must be woven into the fabric of a department or agency, not just given lip service. Without a unified yet culturally sensitive approach that includes outreach, education and engagement of underserved populations, disparity and stigma will continue. DMH has taken a lead role in making cultural competency a principle that guides funding, program implementation and client satisfaction. The fact that it is not addressed in the draft report causes great concern.
2. A structure that does provide equity and parity among the three departments with significant stakeholder input will create an agency that promotes the medical model over others such as client recovery. The health agency has the three department heads working under one person which implies if there are differences, the health agency director presents to the Board of Supervisors what the "recommendation" or "decision" are from the health agency. Even though each department has been promised direct access to the Board of Supervisors as well as a separate budget, the result is that as a member of the health agency, each department a priori is seen as agreeing with the priorities and decisions of the health agency. That is what will be presented to the Supervisors.
3. As a contracted provider for DMH as well as a very active agency in the API communities, I noted that the draft report does not include community based organizations (CBOs) in the vision and scope of the health agency. There is no described mechanism to incorporate their needs, priorities and strengths into the health agency. CBOs tend to be cost efficient, embedded in their communities and knowledgeable about underserved populations. It is important that they be more fully included in the discussion.
4. Integrating services seems to be everyone's priority. PACS has integrated mental, medical and substance abuse services as well as non-traditional and spiritual practices under the Integrated Service Management (ISM) Model for Cambodians. It has been a highly successful program with very good outcomes. We know, as do many of the other agencies funded under Innovation, the challenges and strategies to best provide integrated services. This was done without having to form a health agency. I hope the final report will include some of the rich data that these learning models have produced. One thing was clear from our work over three years, having a centralized health record is simply not attainable until Federal laws change.
5. The creation of a health agency will be highly disruptive, create delays, add another layer of bureaucracy and entail more expenses. Strategically, it would be better to identify the priority areas for integration through a stakeholders process, determine what is achievable since many of the siloed funding or services are dictated by Federal or State requirements, and work on them cooperatively. Focus on the key areas for integration rather than on the formation of another agency.

6. From a countywide perspective, it is significant that Probation, DCFS, Juvenile Justice and other departments and divisions are not included in the health agency model. All of these serve individuals and families with medical, mental and substance abuse issues. If there is to be integrated services, they need to be part of the process and decision-making.

I am in favor of integrated services; I am not convinced that the health agency model is the most effective or constructive model to implement. I hope the Board of Supervisors will consider how this type of change will impact our clients and their families. There is already a great deal of concern that it will be more difficult to get help and that funding will be cut.

Thank you for your consideration.

Sincerely,
Mariko Kahn, LMFT
Pacific Asian Counseling Services
8616 La Tijera Blvd., Ste. 200
Los Angeles, CA 90045
(310) 337-1550 ext. 2018
www.pacsla.org

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Los Angeles County
Mental Health Commission
"Advocacy, Accountability and Oversight in Action"

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May 28, 2015

Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
Los Angeles, California 90012

Dear Supervisors:

The Los Angeles County Mental Health Commission strongly supports the Board's desire to provide quality, integrated healthcare services to the people living in Los Angeles County. We recognize that integrating mental health, substance abuse and physical healthcare services is the vanguard that will ultimately transform our current healthcare delivery system into one that provides much needed whole person care. As we move forward with this integrated healthcare service delivery initiative, the Commission offers the following recommendations which we feel better represent and respond to the broad consensus that we have heard from our mental health community (includes underrepresented populations) and stakeholders, including the Service Area Advisory Committees, the National Alliance for the Mentally Ill and other client coalitions, and the System Leadership Team of the Department of Mental Health:

- Board of Supervisors postpone the creation of a Health Agency and first establish a leadership team, including the Directors of Health Services, Mental Health, Public Health, and their perspective Commissions (Hospital and Health Commission, Mental Health Commission, and Public Health Commission) charged with the responsibility and authority to develop a strategic plan for integrated healthcare services. This strategic planning process should be facilitated by an unbiased, outside, experienced consultant.
- The outcome of this strategic planning process will result in a shared vision of integrated healthcare services, core values, and clear outcomes or performance indicators. This strategic plan will set a clear vision for where we want to be in terms of an integrated healthcare service delivery system.
- The strategic planning process should come before any decisions are made on how we are going to implement this plan (i.e. Health Agency or a different governance model). Specifically, it is out of order to implement an Agency Model without a clear plan. Another more effective model may emerge once the planning process has been completed.
- The Board of Supervisors separate out the strategic planning process (where we want to be) from any particular integration models (how we are going to get there) and allow adequate time for the strategic planning process. We believe that investing time at the front end will maximize the success of whatever integration model is eventually implemented.

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Email: mentalhealthcommission@dmh.lacounty.gov
Website: http://wcmprd1.its.lacounty.gov:10039/wps/portal/dmh/about_dmh/mhc

- Utilize the strategic plan to determine the most effective way to integrate healthcare services in Los Angeles County. It is premature to move forward with the creation of a Health Agency without having a clearly defined vision, core values and performance indicators.

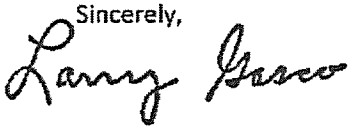
While focusing on what is required for effective service integration and improved healthcare, the strategic plan should plan for and ensure minimal transitional disruption to current services and programs and only that which is required to implement it. It should maintain, enhance, expand and replicate currently successful models of integrated care by and among the three Departments that work and work then to identify and remove those specific organizational structural and governance barriers that will allow for their expansion.

Integrated services and improved healthcare for children and youth and their families across the three Departments must be considered and addressed. The draft report fails to address improvement of children with serious emotional disturbances and their families, which accounts for more than one-half of the County mental health system's budget. We should coordinate and integrate the recommendations and proposals that arise as the three Departments are engaged with Office of Child Protection in its mission and joint strategic planning process to improve child safety County-wide.

Throughout this process, we need to ensure that the Departments of Mental Health, Public Health and Health Services continue to be recognized as equals, along with the other County Departments, in terms of accountability and direct reporting to the Board of Supervisors.

We appreciate your consideration and look forward to working together to integrate Los Angeles County's healthcare services.

Sincerely,



Larry Gasco, PhD, LCSW
Chairman

c: Cynthia A. Harding, MPH, Interim Director, Department of Public Health
Mitchell H. Katz, MD, Director, Department of Health Services
Marvin J. Southard, DSW, Director, Department of Mental Health
Christina R. Ghaly, MD, Director of Health Care Integration, CEO
Public Health Commission
Hospital and Health Commission

Dear Los Angeles County Board of Supervisors,

We are the Presidents of three unions representing Los Angeles County health care/mental health workers: AFSCME Local 2712 (Association of Psychiatric Social Workers of Los Angeles County), AFSCME Local 3511 (Supervising Psychiatric Social Workers), and the Union of American Physicians and Dentists, AFSCME Local 206 (Physicians, Psychiatrists, and Dentists). On behalf of the workers we represent, we want to express our support for bringing the Department of Health Services (DHS), Department of Mental Health (DMH), Department of Public Health (DPH), and the Sheriff's Department medical services under a single agency.

When we talk to the workers we represent, we have found a high level of support for integrated services. Having an overarching structure that unites these departments will allow County workers to better coordinate care for the people we serve. Our members support the notion of a single medical record that can be viewed by all providers. We want an accessible, streamlined, and coordinated system for making appointments, so we can help people connect with the spectrum of care they need in a timely fashion. We want the tools to provide the best possible service, and we believe that creating one agency for health/mental health care will make significant progress in that direction.

Providing comprehensive health care at a single point of entry is not only better for County workers and the people we care for, it is cost-effective. Right now, every time a patient moves from one department to another, extra costs are incurred. Additionally, many fall through the cracks during this process, frequently resulting in a more acute phase of illness requiring a higher level of care. When inefficiencies are eliminated, the savings can be used for more important things, like improving patient services and keeping worker pay and benefits competitive.

Lastly, we would like to express our belief that Dr. Mitchell Katz is the best person to run the new health care agency. As head of DHS, Dr. Katz has a history of dealing fairly with workers and making intelligent improvements to the department. We think the whole system would benefit if he is given a chance to lead it.

However, regardless of who is appointed to run it, our support of the Agency Model is contingent upon the inclusion, from the beginning, of a robust Joint Labor-Management process, including the leadership of our three unions. This would help ensure that functional processes are put in place that would outlast the tenure of a competent leader such as Dr. Katz.

Signed,

Stuart Bussey, MD, JD

Stuart A. Bussey, M.D., J.D.
President, UAPD

Theodorah McKenna, LCSW

Theodorah McKenna, MSW, LCSW
President, AFSCME Local 2712

Marina Martin, LCSW

Marina Martin, MSW, LCSW
President, AFSCME Local 3511

COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY

Member Driven. Patient Focused.

Dr. Christina Ghaly
Office of Health Integration
Kenneth Hahn Hall of Administration
500 W. Temple Street, Room 726
Los Angeles, CA 90012

Dear Dr. Ghaly:

On behalf of the Community Clinic Association of LA County (CCALAC) and the 55 non-profit community clinics and health centers we represent, I am writing to submit comments on the LA County CEO's Office Draft Report on the Potential Creation of a Health Agency (Draft Report). We appreciate the opportunity to review the report and comment on it.

In February of 2015, CCALAC Membership approved Principles for the Integration of LA County Mental Health, Health Services and Public Health. Our attached comments examine how the Draft Report addresses these principles, citing areas of agreement, concern, and areas where we feel more information is needed. While the report states the creation of a health agency could present many opportunities, we also agree that such an undertaking would bring many challenges that will require close partnership between agency leadership and stakeholders who have been working achieve the goal of improved integration for decades.

While CCALAC worked to provide comments on the Draft Report, others, such as the Coalition for an Office of Healthcare Enhancement, also approached us with ideas on how to improve the overall health of LA County residents. CCALAC reviewed these ideas as well against our principles. We are supportive of any effort that achieves those outcomes our Members prioritized. Because there is often more than one way to reach a desired outcome, we are in support of many different approaches to improve integration in LA County. We do not view our support of any one approach as exclusive and seek to be productive partners in all integration efforts.

We look forward to continued partnership with LA County to improve health in the region, particularly among the uninsured, underserved and most vulnerable. Please do not hesitate to contact me should you wish to further discuss our comments.

Best,

Louise McCarthy, MPP
President & CEO

Encl: CCALAC Response to the LA County CEO's Draft Report on the Possible Creation of a Health Agency

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COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY

Member Driven. Patient Focused.

Response to the LA County CEO's Draft Report on the Possible Creation of a Health Agency

The Community Clinic Association of LA County (CCALAC) reviewed the LA County CEO's Draft Report on the Possible Creation of a Health Agency (Draft Report) to the Los Angeles County Board of Supervisors regarding possible creation of a health agency in detail. In February 2015 CCALAC's membership approved Principles for the Integration of LA County Mental Health, Health Services and Public Health. In addition, CCALAC solicited comments and feedback from our members, including CEOs, providers and operations leaders. Our comments, below, examine the LA County CEO's Draft Report against these principles, citing areas of agreement, concern, and areas where we feel more information is needed.

CCALAC appreciates the opportunity to comment on the Draft Report and is proud of our partnership with LA County for over two decades. We continue to be eager to partner with LA County in addressing the many challenges that LA County residents face through innovation and collaboration.

Many Possibilities, Little Detail

While a health agency may, indeed, promote many opportunities for improved integration of services and coordination of care for the most vulnerable in LA County, the endeavor also carries a significant risk of destabilizing current systems of care. While the Draft Report attempts to address various concerns in this regard, details remain elusive on how such a significant shift would happen successfully.

Improved Integration as Primary Goal: Improved integration of services and coordination of care for clients of *all three departments* and their partner agencies should be the primary goal of this endeavor. Parity among the three departments must be considered throughout the process.

Service Integration: Any action to consolidate or integrate services must demonstrate that it will improve and enhance service delivery, quality of care and consumer satisfaction for all three departments.

- While the report certainly points out many opportunities for integration improvement, the document lacks detail on how a broader vision of overall integration might be achieved.
- There needs to be better integration *within* the Departments themselves before moving to the agency model. The report addresses improvement for the homeless population in stating, "In order to be effective, outreach staff need to have a broad range of tangible resources ate their disposal including...urgent and primary care" (p. 20). Unfortunately, County policies with regard to the My Health LA (MHLA) program have made it more difficult to ensure this population receives the primary care they need. Another is the "no wrong-door" approach touted in the proposal. LA County has been very clear that there are wrong doors when it comes to enrollment in the MHLA program.
- The report discusses the promise of colocation. Colocation can be a first step to providing integrated services, yet much more must be done to ensure service are truly integrated in a meaningful way. To be successful, the physician, behavioral health provider and others must work together in delivering patient-centered care. There are significant barriers to collocate services effectively.
- In many places, the report calls for IT improvements to promote integration. These efforts are complicated and would be long-term in nature as many have attempted to overcome these issues in the past with little success.
- The report makes suggestions of how lessons learned by County agencies can help to inform its partners (e.g. prescription drug abuse, p. 14). CCALAC Members have utilized a number of approaches to address the issue. CCALAC participates in Kaiser Permanente's Opioid Task Force which has identified emergency rooms as the first

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priority of focus. Perhaps County agencies could also learn lessons from those contracted clinics that have expertise in the area. The document is lean on opportunities for true *partnership* with the proposed agency.

Administrative Integration: Any action to consolidate or integrate planning, business, and administrative functions must also demonstrate that it adds clear value (meaningful savings and improvement in services) to each of the departments and their partner agencies.

- The Draft Report outlined many opportunities for administrative integration and simplification. As noted in services integration, there needs to be better administrative integration *within* the Departments themselves before moving to the agency model. Investments into communications, internal change management and internal coordination must be made before any moves to externally integrate with other departments. The County CEO states "Individuals who use services in more than one Department would benefit from greater commonality in departmental forms and electronic documentation tools" (p. 16). CCALAC has long advocated for simpler processes for patients but these suggestions have often been rebuffed in favor of duplication and a desire to avoid the true integration of systems for County patients (e.g. specialty care under Healthy Way LA). This is a difficult proposition for an agency when single departments continue to struggle here.
- The County's report also mentions the detrimental effect that bureaucratic delays have had on individuals. "While delays may harm individuals who use County services, they are especially detrimental to disadvantaged populations who are already challenged with accessing the system and thus exacerbate health disparities" (p. 37). The very clinic sites that patients access are often put at risk with delays of this nature, particularly regarding payment. Contract provisions not thoughtfully considered have, in fact, resulted in clinics closing their doors. The report fails to explain how an agency model might improve circumstances in this regard.
- CCALAC Members open their doors to often duplicative County audits several times a year, disrupting productivity and taking time that could be better used for discussion on the improvement of patient care and innovation. These administrative layers and barriers are areas where CCALAC hopes any future consolidation effort would have significant impact.

Thoughtful and Measured Approach: Any plan to consolidate should not be rushed to meet an artificial deadline. Further, continued implementation of health reform and other critical initiatives currently underway should not take a back seat to the consolidation/integration efforts due to time or resource constraints.

Planning: LA County should allow sufficient time to not only engage stakeholders, but to also investigate appropriate models of integration and to ensure that any legal and operational issues are sufficiently addressed prior to implementation.

The Report fails to deeply investigate other appropriate models of integration and provides little detail on how any legal and operational issues are sufficiently addressed prior to implementation. The report references a high level of anxiety felt by many stakeholders on the establishment of an agency. "Once established, the agency can reduce this level of anxiety by establishing relationships with external partners, clearly communicating the agency's priorities and commitment to not disrupt existing services that are serving individuals well" (p. 43). Is it reasonable to believe that agency leadership would dedicate enough time to establishing the meaningful relationships with such a wide range of stakeholders?

Implementation: CCALAC maintains that thoughtful planning and rollout can save the County from avoidable problems further down the line. The County should consider phasing in any proposed consolidations to ensure the smoothest transition possible.

The timeline proposed in the County CEO's report is very ambitious, with the possible establishment of a health agency by October 1, 2015. CCALAC was disappointed that the Report did not provide more detail on a stakeholder process that might occur during formation of an agency. The County should provide additional detail on how agency creation could be structured and how they will ensure that stakeholder engagement during the creation is done in a meaningful way.

Ongoing Monitoring: Any plan to consolidate should have clearly defined objectives, along with a plan to evaluate and monitor progress toward those objectives.
The report contains a lengthy discussion of possible measures and metrics to monitor agency initiatives and significantly weaves stakeholder engagement into the discussion. While this is promising, these discussions can become complicated, with much disagreement on what measures are appropriate for various initiatives. CCALAC would hope that any agency created commits substantial energy to ensuring that monitoring progress occurs *with stakeholders* and that solutions to improve poor outcomes are reached collectively.

Transparency & Stakeholder Engagement: Any consolidation must involve a robust public stakeholder process, including community mental health agencies, community clinics and health centers and other contracted community partners. Stakeholders must remain engaged throughout planning, implementation and ongoing monitoring.

The report dedicates significant discussion to the continued engagement of stakeholders. The report states, "If an agency is created, several steps should be taken to reduce risks, establish safeguards, and build trust and reduce fear" (p. 54). The report goes on to describe several ways to build that trust by ensuring community participation, gathering feedback on various initiatives, creating metrics and establishing a forum to express concerns. However, what is the CEO's vision and perspective when it comes to stakeholders? There is much in the way of engaging stakeholders but how would the agency view them? As partners in the creation of initiatives or simply as external entities affected by health agency initiatives? The Report lacks a bidirectional sense of tone when it references stakeholder relationships and CCALAC looks forward to improvement on this in the future.

When it comes to engaging in the planning, implementation and ongoing monitoring of a health agency, CCALAC's Members have stated that the importance of this element calls for the building of stakeholders into the actual structure of the agency. Stakeholder engagement should first have a formal structure and the agency must clearly document the function of any stakeholder forum. While CCALAC understands that it is not appropriate for any stakeholder forum to participate in all agency functions, it should play a key role in shaping the direction of the agency and act as a real partner with leadership and staff to create the best possible health system for LA County. Some areas that stakeholders should be engaged in include:

- Creation of Stakeholder Forum or Fora
- Strategic Planning
- Integrating Services at Point of Care
- Information Technology and Data
- Addressing Service Gaps for Vulnerable Populations
- Workforce Issues
- Streamlining Access

CCALAC looks forward to participation in a stakeholder process and working with many other partners to improve the overall health of LA County residents.

ECONOMIC ROUNDTABLE

@EconomicRT
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economicrt.org
315 West Ninth Street, Suite 502
Los Angeles, CA 90015

May 29, 2015

Dr. Christina R. Ghaly
Office of Health Integration
Kenneth Hahn hall of Administration
500 W. Temple Street, Rm 726
Los Angeles, CA 90012
healthintegration@lacounty.gov
Sent via electronic mail

Subject: Comments on Draft Report – Creation of a Health Agency

Dear Dr. Christina Ghaly:

On behalf of the Economic Roundtable, we thank you for the opportunity to comment on LA County's proposed creation of a health agency. The Economic Roundtable is a nonprofit public policy research organization based in Los Angeles. The Economic Roundtable has developed the only tool for prioritizing the needs of homeless individuals, based upon cost data for the 10 percent of homeless patients with the highest public and hospital costs in Los Angeles County.

Below, we offer specific recommendations for strengthening your concepts to address **integrated 'whole person care' for both homeless and re-entry/justice involved populations.**

- **Utilize research data conducted by the Economic Roundtable in the development of the Crisis Triage Tool,** designed to identify homeless individuals in LA County's 10th highest decile of public and hospital costs with similar research conducted in Santa Clara County.

- **LA County should adopt and bring to scale the 10th Decile Project,** a Social Innovation Fund Initiative of the Corporation for National and Community Service. This project was awarded to CSH in a national initiative, and implemented by a team of safety net agencies led by the Economic Roundtable in Los Angeles County (one of four national sites). This five year demonstration project uses a triage tool developed by the Economic Roundtable to screen for high cost, high need homeless individuals, then wraparound, intensive service integration is provided by integrated mobile health teams operated by homeless

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Los Angeles, CA 90015

service organizations toward the establishment of health homes, linked to supportive housing.

We appreciate the opportunity to comment and hope this information is useful to LA County in its efforts to adopt a promising model for care integration to address the comprehensive needs of the most vulnerable, costly and complex populations.

Sincerely,

Daniel Flaming, PhD
President

Deborah Maddis, MPH
Consultant

Attachment is available online at
http://priorities.lacounty.gov/health-stakeholders/
under Economic Roundtable

inner city industry

"Inspire and prepare children, youth and families to reach their full human potential through social, emotional and professional development while encouraging academic excellence"

1909 W. Imperial Hwy~ Los Angeles, CA. 90047
(323) 364-2015

May 29, 2015

To: Los Angeles County Board of Supervisors
Re: Health Integration Draft Report

As President/CEO of Inner City Industry and current co-chair of the department of mental health cultural competency committee and in accordance with multiple community-based organizations, we whole-heartedly support the integration of mental health, public health and health service systems of care into a single unit agency. It has become crucial to better population health outcomes as trauma has been defined as the issue of our time. Pursuit of a patient-centered system of care represents the unique opportunity to initiate dialogue across government agencies, contract providers and community stakeholders to communicate a clear pathway to reduce racial/ethnic social determinate of health disparity.

In 1998, I discovered students with behavioral issues were being diagnosed with mental illnesses. The system error resulted in countless youth being inappropriately labeled and one of several reasons the word "mental health" is stigmatized beyond repair. Since, I have gained expertise in whole-system transformational change and currently represent both the African African American and Latino Underrepresented Ethnic Populations (UREP) subcommittees. In assessing community needs, each of the five state funded California Reducing Disparities Project (CRDP) reports confirmed a common theme. Stigma associated with mental health is the most prevalent barrier to citizen understanding the significance of mental health and accessing services. Health integration presents the opportunity to rebrand direct care services as "behavioral health care" and build growth capacity instituting prevention and early intervention (PEI) services within a continuum of systems framework. Branding PEI as "behavioral health learning supports" will systemically eliminate mental health stigma among future generations.

Concerns expressed in the CEO's Draft Report as well as during convening's hosted throughout the public comment period questioned the agency structure, culture and lack of community engagement. While each area of concern is valid, many of the identified risk and challenges may be mitigated through coordinated communication amongst select system administrators, contract providers and community-based stakeholders groups. There are multiple research theory's and practices applicable to restructuring the core support and work processes of each system while developing supportive policy. A fully integrated system of care will achieve mental health parity per Affordable Care Act law. Integration is crucial to bettering population health outcomes, which one system cannot accomplish alone. To achieve the triple aim established by the Center for Medicare and Medicaid services, health integration transformation ought to include the departments of child and family services, probation and office of education to congruently reduce disparities across systems.

We encourage the board of supervisors to embrace Schumpeterian theory which suggest the creative destruction and innovative reconstruction as a core principal of health integration to establish a culturally responsive and equitable system of care. We recommend the board of supervisor's commission white papers by consultants that address concerns identified in the CEO's final report by delineating a vision, processes and timeline to integrate multiple systems. In advance, please consider adhering to the summary points below to increase knowledge acquisition as a non-threating approach to engaging all aforementioned stakeholders in further dialogue.

inner city industry

"Inspire and prepare children, youth and families to reach their full human potential through social, emotional and professional development while encouraging academic excellence"

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- As primary and essential to reducing racial/ethnic disparity, cultural competency must be embedded and considered in all aspect of decision making and delivery of services to strengthen the quality of care. An advantageous next step, consider convening each county department cultural competency committee, unit and/or processes to initiate and share dialogue related to policy and practices implementing cultural competency. This internal system process will prepare agency leadership in principal on the necessity of embracing cultural competency in advance of health integration.

- Given trauma has been described as the issue of our time. Review and embrace strategies and program recommendations within the California Reducing Disparities Project (CRDP) reports as baseline data acknowledging community voice, need and desires. Each CRDP profile report will aid in developing a culturally responsive system of care based on recent and relevant community stakeholder input. This report will mirror data presented in the department of mental health's 2008 population report which identified vulnerable communities within Los Angeles County.

- Identify revenue streams in which resources are held in a wellness trust to reimburse prevention and early intervention services. This approach requires an improved and sustainable reimbursement model to facilitate delivery of integrated care within a continuum of systems approach. As example, Best Start communities rely on proposition 10 funding. Several additional tax-payer proposition's 30, 47 and 63 are also designated to better individual and population health outcomes. Withstanding legal restrictions, consider pooling resources to equitably distribute and manage tax-payer resources to strengthen the safety-net of services simplified by community-based providers.

- Strategically increase opportunities for community input. Health integration of this magnitude at minimum is a five year process produced in multiple phases. Imperative to success is an effective social marketing strategy directed at community integration to gain legitimacy among county residents. Social marketing commences with mapping and analyzing resources, appointing transformation leadership, reaching common ground among stakeholders, developing policy, implementing recommendations, evaluating processes, scaling changes and making continuous improvements.

Bear in mind, whole-system transformational change suggest, changing one part of a system requires changing the whole system. Piecemeal processes and administrative repositioning fail to have lasting impact and causes greater damage to the external ecosystem. Such a proposed shift in thinking requires an upstream approach to social change. Essential to reducing the range of health, education and economic disparities, residents must be intimately involved in reconstructing the system of care to develop an ownership mindset and acceptance of changes.

We commend the Board of Supervisors for issuing this motion. Health integration presents the opportunity to exhibit Angelino unity and pride in leading the transformation of health and human services throughout Los Angele County.

Thank you for your consideration.

Bruce M. Wheatley
Bruce M. Wheatley

Los Angeles
HOUSING+COMMUNITY
Investment Department

Eric Garcetti, Mayor
Rushmore D. Cervantes, General Manager

Strategic Planning & Policy Division
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May 29, 2015

Office of Health Integration
Kenneth Hahn Hall of Administration
500 W. Temple St., Room 726
Los Angeles, CA 90012

Re: Draft Report to the Board of Supervisors regarding possible creation of a health agency

Thank you for a well-written, thoughtful response to various issues raised about the proposed health agency integration. Topics that received scant attention in the draft report include:

- The potential impacts – positive and negative - of the integration on partners and stakeholders outside of the existing County agency and contractor 'infrastructure', including the 88 cities within Los Angeles County, community health and housing advocates and non-profit agencies.
- Housing problems and their relationship to health concerns of many County residents (e.g. asthma).

I would like to draw your attention to Issue Number Two of *Social Determinants of Health* which was published in February 2015 by the Department of Public Health, entitled 'Housing and Health in Los Angeles County'. Its recommendations have implications for the proposed health agency integration, and include:

General Recommendation:
- Increase collaboration across government agencies at all levels and between stakeholders from community groups, public health agencies and private groups (e.g. employers) to ensure a coordinated approach to housing as a determinant of health and health disparities.

Housing Quality Recommendations:
- Improve and enforce current federal, state and local housing codes and guidelines to reflect current knowledge regarding hazards within the home environment.
- Use national, state and local public campaigns and programs to educate and empower private-and public-sector housing providers, owners and tenants about the dangers of unsafe and unhealthy housing and about their rights and responsibilities.
- Increase resources and expand the role of public health agencies in housing education, inspections and enforcement at the local, state and national level.

Local municipalities often have more control over a variety of housing issues and code enforcement than does the County, and cities need to be your partners to achieve improvements in the health of all our residents. Advocates keep all of us focused. Non-profit and business partners have contributions to make as well. Please consider incorporating recommendations from this DPH report into your ongoing health planning efforts.

Sincerely,

Sally Richman
Director, Knowledge Management and Evaluation

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NLSLA

Neighborhood Legal Services
of Los Angeles County

50 years of changing lives and transforming communities

May 29, 2015

Christina R. Ghaly, M.D., Director of Health Care Integration
Carol Meyer, BSN, MPA, Community Outreach Coordinator
County of Los Angeles Chief Executive Office
500 W. Temple St.
Los Angeles, CA 90012

Re: Health Integration Motion

Dear Dr. Ghaly and Ms. Meyer:

Neighborhood Legal Services of Los Angeles County (NLSLA) is one of California's leading public interest law firms, having served Los Angeles' impoverished communities for more than 50 years. NLSLA's innovative Health Consumer Center (HCC) provides direct assistance to tens of thousands of County residents seeking to access health care, educates the community about their rights, and works collaboratively with the community and the County to improve and transform the delivery of health care in Los Angeles. Through these efforts, NLSLA advocates have become experts in comprehensive and effective health services to the County's low-income residents.

Given our extensive experience, we are well-positioned to speak to issues low-income health care consumers would face as a result of the Los Angeles County Board of Supervisors' motion to create a health agency to oversee and integrate certain functions of the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH). We have read the Draft Report on the motion published by the Office of Health Integration of the Chief Executive Office ("CEO") and we offer the following comments for the CEO's and Board's consideration.

NLSLA believes that greater integration of services and implementation of no-wrong-door policies among the Departments holds great promise for low-income Los Angeles County health care consumers. At the same time, like many other community members and organizations, we are also cognizant of certain risks inherent in a re-organization and restructuring effort of this magnitude. We urge the County to consider several key principles that are critical to protecting access to care and ensuring meaningful participation in the integration process by the residents that depend on County services.

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(1) **Meaningful consumer participation.**

(a) Participation before Board vote. NLSLA is concerned that the stakeholder process to date has been insufficient to obtain informed input about the proposal from community members. As a preliminary matter, very little has been done to educate community members through outreach and materials written at an accessible reading level and in threshold languages for limited English proficient residents. The public meetings were inaccessible to a large swath of Los Angeles County given that they were held during workday hours in geographically inaccessible locations.

While the change contemplated at this time is at the County governance level rather than the service delivery level, NLSLA encourages further consumer engagement at this stage to inform the Board's mission and vision for the health agency, and its directives to the agency director regarding the creation of an ongoing stakeholder process and a patient advocacy program. NLSLA recommends targeted focus groups to solicit community feedback. These meetings must be held in accessible community settings throughout the County, with consumers that represent the social, economic, ethnic and geographic diversity of our County, during hours that accommodate typical work schedules, and with provisions made for disability and language access, including translation of outreach materials into the threshold languages.

(b) Mechanism for ongoing stakeholder feedback. NLSLA recommends inclusion of specific provisions for stakeholder input in the CEO's Final Report and in the Board's directive to the agency. Consumers and community based organizations must be afforded the opportunity to provide feedback about how the health agency is created and its performance once implemented.

NLSLA's experience in a variety of health stakeholder groups at both the County and State levels has underscored the vital importance of meaningful dialogue between agencies and stakeholders. We have participated in a number of successful County and community collaborations, such as the Joint Dialogue Department of Public Social Services workgroup and the "Everyone on Board" coalition with DHS. Based on these successful models, we recommend:

- Creation of an advisory group that meets on a regular basis and is open to broad participation of client coalitions and advocacy, education, and outreach groups.
- Collaboration between the agency and stakeholder advisory group in crafting the vision, mission, and principles of the agency.
- Consultation with the stakeholder advisory group to obtain its input at each phase of agency development, from governance to care delivery planning.
- Opportunity for stakeholder feedback on policy and guidance issued to each of the health departments.

- Regular reporting of the stakeholder advisory group to the Board of Supervisors on the progress and challenges of integration.

(2) **Improved services, not cost-savings, is the primary goal.** The new health agency should not be promoted as a cost-saving mechanism. According to the CEO, "there is hope that an agency could yield long-term cost-savings." (Draft Report at 5). NLSLA is concerned that if cost-savings becomes one of the primary goals for the new health agency, service cuts may ultimately result from agency decisions that prioritize savings over improved services. NLSLA advocates that the CEO advise the Supervisors against prioritizing cost-savings as a goal for the new agency, including in their selection of the agency's director.

(3) **Patient Advocacy Program.** NLSLA strongly recommends that the CEO's Final Report endorse creation of a mechanism for patients to resolve issues that arise when accessing services and coordinating care. NLSLA advocates for tens of thousands low-income Los Angeles County residents who confront problems and barriers to care with County health services, Medi-Cal, Covered California, the Coordinated Care Initiative (CCI), and private insurance. Our experience in advocating for Angelenos consistently reinforces how critical patient advocacy programs are, especially when undergoing such major innovations and changes. The Draft Report encourages "[f]urther discussions...among Departmental leadership to assess whether there is support for creation of" an ombudsman program. (Draft Report at 50). Currently, each health department has a radically different mechanism for resolving consumer problems. NLSLA urges the CEO to recommend, and the Supervisors to adopt, provisions and funding for a patient advocacy program that would:

- Enumerate the powers of the agency to investigate and resolve consumer complaints at both the intra- and inter-departmental level and to ensure consistent handling of issues within each department.
- Hold the agency accountable for tracking and reporting the incidence and outcomes of consumer complaints to the Board of Supervisors.
- Specify a timeline for investigation and resolution of urgent and non-urgent complaints.
- Guarantee that patient protection organizations can work collaboratively with the agency to advocate on behalf of their clients and escalate concerns to the agency when appropriate.

Without such a program, many of the patient level goals of integration may go unrealized, and unintended consequences may not be identified. The new health agency must provide an avenue for effective problem-solving by individuals and their advocates.

(4) **Agency structure that advances integration while ensuring departmental parity.** NLSLA was pleased that the CEO recommended an "open, competitive recruitment for the agency director position, considering various candidates rather than immediately appointing an existing Department director as the agency director." (Draft Report at 39). NLSLA believes the CEO's Final Report should go a step further: the director of the new

agency should not concurrently hold the position of DHS, DMH, or DPH department head. The leader of the new agency should be independent of any of the departments to protect each department's interests and to facilitate the director's full-fledged engagement in the complex undertaking of integration.

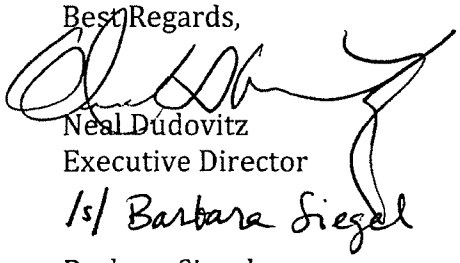
(5) **Regular evaluation and identification of unintended consequences.** The new health agency's successes and failures, based on a variety of metrics produced with stakeholder input, should be transparent. NLSLA endorses the view of the CEO that "Agency and Departmental leadership should ... be expected to report publicly, on a regular basis, on the opportunities being pursued and whether or not risks are being appropriately prevented." (Draft Report at 55). NLSLA urges that an independent consultant perform the evaluations and identify any unintended consequences of the merger.

In conclusion, NLSLA is supportive of many of the goals of integration, such as "integrating services at the point of care for those seeking services," addressing "major service gaps for vulnerable populations,] and "streamlining access to care." (Draft Report at 6). Even the best-laid plans will have consequences for low-income health care consumers, and NLSLA advocates for provisions in the proposal for a health agency to ensure such consequences are promptly identified and remedied.

NLSLA thanks the Office of Health Integration for providing us the opportunity to participate in the stakeholder process. We especially thank Carol Meyer and Dr. Ghaly for meeting with us, and Carol Meyer for presenting the proposal and answering community members' questions at a meeting of the Building Health Communities Boyle Heights.

We look forward to continuing to work with you and the Board of Supervisors to improve the delivery of health services to all County residents.

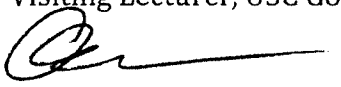
Best Regards,



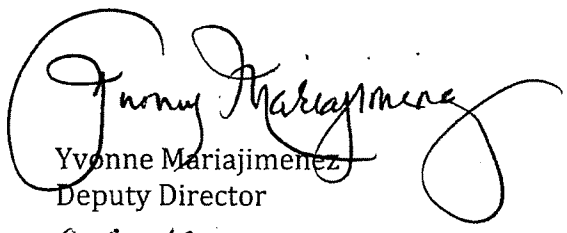
Neal Dudovitz
Executive Director

/s/ Barbara Siegel

Barbara Siegel
Visiting Lecturer, USC Gould School of Law

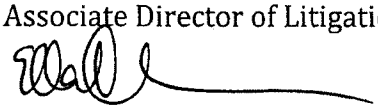


Gerson Sorto
Staff Attorney



Yvonne Mariajimenez
Deputy Director

Cori Racela
Associate Director of Litigation and Policy



Ella Hushagen
Staff Attorney

ESTABLISHED IN 1926

Pacific Clinics
ADVANCING BEHAVIORAL HEALTHCARE

800 S. Santa Anita Ave.
Arcadia, California
91006-3555
626.254.5000
Fax 626.294.1077

May 29, 2015

The Honorable Michael D. Antonovich
Mayor, Los Angeles County
5th Supervisorial District
500 West Temple Street, Room 869
Los Angeles, CA 90012

Dear Mayor Antonovich,

Pacific Clinics is responding to the Chief Executive Office's draft report about the possible creation of a health agency to oversee the Departments of Health Services, Mental Health, and Public Health. Pacific Clinics remains in full support of the Board of Supervisors' overarching goal that Los Angeles County residents need better integrated care, particularly for underserved communities. While the report outlines the potential advantages related to a health agency and briefly acknowledges stakeholder concerns, it fails to dedicate a separate section on children and youth. Los Angeles County is lauded for its rich cultural, linguistic, and ethnic diversity. The CEO's draft report does not include a strategic framework for a vision to offer improved care to underserved and underrepresented communities under the health agency model. Lastly, we are troubled by the few lines dedicated to describing how contracted community-based organizations significantly enhance the county's "network" to provide integrated care to constituents. In the absence of a comprehensive report which includes a consideration of all proposed models, the Board may find it challenging to determine how to proceed. For these reasons, we urge the Board to take as much time as necessary to ensure a deliberative process with full stakeholder engagement.

Pacific Clinics appreciates the opportunity to outline its concerns and recommendations. We look forward to working with the Chief Executive Officer and the Board of Supervisors to ensure that constituents receive improved and timely integrated care services.

Sincerely,

Susan Mandel, Ph.D.
President
SM:ww

C: The Honorable Sheila Kuehl, 3rd District
The Honorable Don Knabe, 4th District
The Honorable Mark Ridley-Thomas, 2nd District
The Honorable Hilda Solis, 1st District

Josie Plascencia

From: [redacted]
Sent: Friday, May 29, 2015 10:28 PM
To: CEO Health Integration
Subject: Comments from Patricia Russell

Follow Up Flag: Follow up
Flag Status: Flagged

My Comments

As a member of the DMH Systems Leadership Team, a Co-chair of Service Area Two, and a member of the Advocasy Committee of Nami LACC, I've had the opportunity to participate in a number of meetings that have addressed the proposed Health Agency and the integration of services to members of the Los Angels Community. My head spins just thinking about it.

At the latest Mental Health Commission Meeting on May 28th, Dr. Katz came to speak to us. I also heard him speak at our System Leadership Team Meeting on May 20th. Dr. Ghaly has also spoken at two Service Area/Mental Health Commission Meetings and other Community Meetings.

At the May 28th meeting I was able to make a public comment and ask a question of Dr. Katz. I shared that from all the meetings and presentations I had participated in, the unanimous feeling was we need more time. As one of the Commissioners said, "We are being asked to get on a plane but we don't know where it's going." I suggested to Dr. Katz that we not have any vote by the Board of Supervisors until representatives from Health Services, The Department of Mental Health, The Department of Public Health, and stakeholders have an opportunity to meet over a long enough period of time to WORK TOGETHER to map out the the steps to be taken that will make it possible to navigate TOGETHER the best way to treat the WHOLE PERSON with INTREATED SERVICES. Dr. Katz's response lead me to believe he thought this was a good idea and doable. After Dr. Katz left, the Mental Health Commission members voted on a letter they have written to the Board of Supervisors. I asked if they could read it so everyone in the audience could hear it. This letter asks for time to work together on the front end to achieve the goals of true integration. I agree with everything in this letter.

My 35 year old son has suffered, and struggles with Co-occurring Disorders: Bipolar Disorder, Obsessive Compulsive Disorder and Poly-substance Dependence for 15 years. I know up close and personal the gaps in services for him because of the silos of the present system. He has almost died in Twin Towers Correctional Facility and on the street many times. It is truly miraculous that he is alive. Many have died and will die because of the system's inability to treat the whole person. Dr. Katz said there is something wrong when the largest facility for those suffering from mental illness is Jail. There is something wrong when we see the wheelchairs, tents, and families on Skid Row. I say we need more time to work together to find the most effective ways to treat the whole person and I also know, as Martin Luther King Jr. said, "THERE IS A FIERCE URGENCY OF NOW."
We can do this if we work together now so the outcome truly treats the whole person. This can happen as a result of our continuous quest to achieve true integration of services.
Lives hang in the balance.
Submitted by
Patricia Russell

Sent from my iPhone

The Honorable Board of Supervisors
Los Angeles County
Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Re: Re: Board of Supervisor's Motion to Consolidate

Dear Board of Supervisors,

As a psychiatrist at Northeast Mental Health Center, I support the integration of the Department of Health Services (DHS), Department of Mental Health (DMH), Department of Public Health (DPH), and the Sheriff's Department medical services into a single agency.

I have spoken to many physicians at Northeast Mental Health Clinic, Hollywood Mental Health Clinic, West Valley Mental Health Clinic, and Arcadia Mental Health Clinic regarding the need for coordinated integration of care in providing optimal health care for our patients. My fellow colleagues shared that they are often put in a position of providing services without access to medical records, including critical laboratory and other medical work up, medications that may cause interactions along with assessments from primary care physicians and specialists that provide for continuity of care. We spend countless hours doing creative detective work to obtain essential information. As you know, many of our patients have comorbid medical, psychiatric and substance related disorders and yet a large percentage of our patients do not have even have a primary care physician, let alone medical specialist care and adequate substance related treatment.

An example of someone that may easily fall out the loop without integrated care is my patient, who suffers from schizophrenia, alcoholism and hepatitis. He asked if I could order the new Hepatitis C medication for him. Since it is not in my scope of practice to order treatment for hepatitis, I called his primary care physician who noted that the approval for the patient's Hepatitis C treatment had expired and agreed to redo the application for his treatment. Patient was very grateful for the call and coordination of services, but the delay in getting treatment already resulted in him having complications of liver failure with episodes of delirium. The challenges that my patient faced could have been prevented if there was an integrated health system where any of his care providers can pick up the phone, look in the same medical record system, speak to any one of the patient's provider to coordinate and provide the best care for him. The sad thing is that I usually do not have the luxury to call my patient's primary care physician.

Yet, coordinated care is more than possible. Having trained in a Department of Health Services residency program, I remember the benefits of such coordinated care where we could speak to our colleagues in a timely matter for a curbside or official consult, ask about getting an appointment for our mutual patient, have easy access to labs and other tests, and obtain general health suggestions on behalf of our patients. Much, much more of the care was done with better efficiency and efficacy under one umbrella.
And, with the resources of all the departments in LA County, the sum will be greater than its of its individual parts.

The physicians at the DMH outpatient clinics and I would like to support the integration of all the departments under the leadership of Dr. Mitchell Katz. In medicine and business, one of the most helpful predictive factors of successful outcome is the history. As head of DHS, Dr. Katz has a history of dealing fairly with workers and making intelligent improvements to the department. We think the whole system would benefit if he is given a chance to lead it.

Sincerely,

[redacted]
Staff Psychiatrist

Petition in Support of Department Integration

To: **The Los Angeles County Board of Supervisors**
From: **DHS, DMH, DPH, and Sheriff's Department Doctors**

We support the integration of the Department of Health Services (DHS), Department of Mental Health (DMH), Department of Public Health (DPH), and the Sheriff's Department medical services into a single agency. Only by pulling together can we create the medical home that County residents need as their foundation for achieving wellness.

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Providing comprehensive health care at a single point of entry is not only better for the people we care for, it is cost-effective. Integration will save money by avoiding the duplication of services that happens when people are passed between multiple departments for their health care, for example.

We know that running a health system is difficult -- the County must control costs, optimize sources of revenue, and compete against many other employers to hire qualified providers. A single, well-managed agency can help the County meet these challenges. We have been impressed by the progress that Dr. Mitch Katz has made at DHS, and we hope that he will continue this work as the head of the new agency. We believe that the new agency should be run by a doctor with strong clinical, financial, and management skills, and that Dr. Katz fits that description.

Signed,

Signature	Printed Name	Department
[illegible]	MD/TAMARA ALOYAN	DMH

Signature | Printed Name | Department

The Honorable Board of Supervisors
Los Angeles County
Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Re: Re: Board of Supervisor's Motion to Consolidate

Dear Board of Supervisors,

As a psychiatrist at Compton Mental Health Center I support the integration of the Department of Health Services (DHS), Department of Mental Health (DMH), Department of Public Health (DPH), and the Sheriff's Department medical services into a single agency for the following reasons:

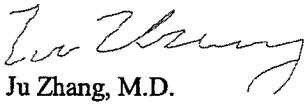
1. There are times when I see a patient who does not have a primary care doctor and there is no coordination to schedule them to see a County DHS provider. 2. When I see new clients who are part of the DHS system, I can't see their medical records electronically. 3. If I believe a patient needs to be seen by a specialist, at DHS there is no coordination between departments except to give them a phone number or ask them to contact their primary care doctor.

As a doctor, I look forward to a day when each person has one medical record that can be viewed by all providers. And a single system for making appointments, so we can help people connect with every type of care they need in a timely fashion. We want the tools to provide the best possible service, and we believe that creating one agency for health care will make significant progress in that direction.

Providing comprehensive health care at a single point of entry is not only better for county doctors and the people they care for, it is cost-effective. Right now, every time a patient moves from one department to another, extra costs are incurred. When inefficiencies are eliminated, the savings can be used for more important things, like improving patient services.

Lastly, we would like to express our belief that Dr. Mitchell Katz is the best person to run the new health care agency. As head of DHS, Dr. Katz has a history of dealing fairly with workers and making intelligent improvements to the department. We think the whole system would benefit if he is given a chance to lead it.

Sincerely,



Ju Zhang, M.D.

Compton Mental Health Center / FSP Program

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A significant portion of the people we see have some combination of physical, mental, and substance abuse issues. Today, the County's disjointed health system makes it difficult to address those needs in a comprehensive fashion. We would prefer to work together to care for County residents within a single, integrated agency. Integration will improve communication between providers, assist us in making appropriate and timely referrals, reduce delays, and increase treatment compliance. In short, integration will lead to better health for our community, as well as a better working environment for doctors.

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We know that running a health system is difficult -- the County must control costs, optimize sources of revenue, and compete against many other employers to hire qualified providers. A single, well-managed agency can help the County meet these challenges. We have been impressed by the progress that Dr. Mitch Katz has made at DHS, and we hope that he will continue this work as the head of the new agency. We believe that the new agency should be run by a doctor with strong clinical, financial, and management skills, and that Dr. Katz fits that description.

Signed,

Signature	Printed Name	Department
	Khatera Ghazanfar, D.O.	DMH
[redacted]		
	Shahin Khashayar	DMH
	Aelred Boyle	DMH
MD	Maria P. Aguilar, MD	DMH

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Signed,

Signature	Printed Name	Department
William Fong	WILLIAM FONG	DENTAL

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Signed,

Signature	Printed Name	Department
M.D.	Alisha Smith	Jail MHS - DMH
	Tuere Memiours	Jail MHS
	Miran Ham	JAIL MHS
	Kim R. Guy	Jail HHS

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Signature	Printed Name	Department
MD	Tejsen Gevorksian	Jail MH service DMH
	Printed Name	Department
	Printed Name	Department
Signature	Diana Mirzoyan	Jail MHS - TTCF
Signature	AUSTIN J ANTHony	Jail MHS
Signature	DIANA BOTEZAN MD	Jail MHS - TTCF
MD	Katherine Smith MD	Jail MHS-TTCF

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Signed,

Signature	Printed Name	Department
[illegible]	Bessy Mashibosyan	M.D. DMHC.

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Signature	Printed Name	Department
[illegible]	John L. KALIVAS	LASD

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Signature	Printed Name	Department
	DR. DOMINIC MARZAN	LASD-MSB-DENTAL

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Signature	Printed Name	Department
E. Gilmanmd	Elena Gilman MD	DMH
C Hathaway MD	Conny Hathaway MD	

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Signature	Printed Name	Department
MD	Paul Bong, MD	DMH
	Karina Shulman MD	DHS
	Anetz Pinco MD	DMH
	Emouzel Nabieva, MD.	DMH
	Lilit Negazaryan MD	DMH

The Honorable Board of Supervisors

Los Angeles County

Kenneth Hahn Hall of Administration

500 West Temple Street

Los Angeles, CA 90012

RE: Board of Supervisor's Motion to Consolidate

Dear Board of Supervisors,

I support the integration of the Department of Health Services, Department of Mental Health, Department of Public Health, and the Sheriff's Department medical services into a single agency.

I had a privilege to work for the DMH for almost 13 years. We have gone through different changes during all these years and finally we are going back to the medical model of integrated health services. I am truly excited to be a part of the new agency.

As a doctor I am used to work in a medical model . In my opinion it ensures a better communication between specialists, faster appointments for the patients and as a result a more comprehensive and better patients' care. I believe if we have the same electronic records system it will certainly benefits the doctors as well as the patients. I also think it will be much more cost effective to have everything in one department.

I look forward for Dr.Mitchell Katz to run the new health agency. He has been a head of DHS and has a history of dealing fairly with workers. I think he should be given a chance to lead a new agency, I strongly support his candidacy.

Sincerely,

Karina Shulman, MD

05/27/2015

Petition in Support of Department Integration

To: The Los Angeles County Board of Supervisors
From: DHS, DMH, DPH, and Sheriff's Department Doctors

We support the integration of the Department of Health Services (DHS), Department of Mental Health (DMH), Department of Public Health (DPH), and the Sheriff's Department medical services into a single agency. Only by pulling together can we create the medical home that County residents need as their foundation for achieving wellness.

A significant portion of the people we see have some combination of physical, mental, and substance abuse issues. Today, the County's disjointed health system makes it difficult to address those needs in a comprehensive fashion. We would prefer to work together to care for County residents within a single, integrated agency. Integration will improve communication between providers, assist us in making appropriate and timely referrals, reduce delays, and increase treatment compliance. In short, integration will lead to better health for our community, as well as a better working environment for doctors.

Providing comprehensive health care at a single point of entry is not only better for the people we care for, it is cost-effective. Integration will save money by avoiding the duplication of services that happens when people are passed between multiple departments for their health care, for example.

We know that running a health system is difficult -- the County must control costs, optimize sources of revenue, and compete against many other employers to hire qualified providers. A single, well-managed agency can help the County meet these challenges. We have been impressed by the progress that Dr. Mitch Katz has made at DHS, and we hope that he will continue this work as the head of the new agency. We believe that the new agency should be run by a doctor with strong clinical, financial, and management skills, and that Dr. Katz fits that description.

Signed,

Signature	Printed Name	Department
[illegible]	FELIPE BAUMAN, DDS	LASD - MSB - Dental Department

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Signed,

Signature	Printed Name	Department
	JOHN G. BISHOP	DENTAL

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Signed,

Signature	Printed Name	Department
Phari M, MD	Phari Tunu	DMH - Psychiatry.

May 28, 2015

The Honorable Board of Supervisors of Los Angeles County
Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

RE: **Board of Supervisor's Motion to Consolidate**

Dear Board of Supervisors,

I, Dr. Phani Tumu, wholeheartedly support the integration of the Department of Health Services (DHS), Department of Mental Health (DMH), Department of Public Health (DPH) and the Sheriff's Department medical services into a single agency.

I am a staff psychiatrist and have been an employee of DMH for the past six years. I have seen DMH mismanagement with my own eyes. DMH has poorly trained management who are incapable of meeting the needs of an ever-growing mentally ill population of Los Angeles County. I have seen first-hand how poorly managed are the funds from Proposition 63. Frankly, it is an embarrassment to work for such a poorly-managed agency. I find light in knowing, however, that my patients are taken care of because of the due diligence put forth by doctors with whom I work.

The integration is the best way forward for our patients in Los Angeles county. The current system makes it difficult for me as a physician to obtain medical records from other providers, even if these other providers are county-employed. As a doctor, I look forward to the day when each person has one medical record that can be viewed by all providers. Additionally, I would like a single system for making appointments so that we can help people connect with every type of care needed in a timely fashion. We want the tools to provide the best possible service, and we believe that creating one agency for health care will make significant progress in that direction. Providing comprehensive health care at a single point of entry is not only better for county doctors and the patients they treat, it is also cost-effective. Right now, every time a patient moves from one department to another, extra costs are incurred. When inefficiencies are eliminated, the savings can be used for more important endeavors, like improvement of patient services.

Lastly, I would like to express my belief that Dr. Mitchell Katz is the best person to run the new health care agency. As head of DHS, Dr. Katz has a history of dealing fairly with workers and making intelligent improvements to his department, unlike the current heads of DMH. I think the whole system would benefit if he was given a chance to lead the integrated agency.

Yours sincerely,

Phani M, MD

Phani M. Tumu, M.D.
Staff Psychiatrist
Santa Clarita Valley Mental Health Clinic
Los Angeles County Department of Mental Health

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Signed,

Signature	Printed Name	Department
5/28/15	Dr. PUNITA OSWAL DDS	LASD - MSB DENTAL

SEIU 721's Position Paper for Creating a Health Agency

A Pathway to Creating Integrated Care in LA County

SEIU 721's Position Paper for Creating a Health Agency
A Pathway to Creating Integrated Care in LA County

Executive Summary:

Our County-operated health system is at a crossroads. While our Public Health Department is charged with protecting all County residents, key elements in the more clinically-based programs must transform to improve access, quality, and cross coordination of care.

After conducting six town hall meetings, surveying our members, meeting with key stakeholders and convening our own internal Integration task force we agree with the Board of Supervisors that there is need to improve the integration and coordination of services between DMH, DHS, DPH and to create a Health Agency governance process to help make sure these outcomes are achieved.

Our members believe that the current system of care is not sufficiently nimble to meet the diverse healthcare needs of clients and communities and that there is a significant need to create more cross coordination.

Our members and our Health Integration Task Force feel it is critical to start working immediately on improving the coordination of care of clients and communities. Our clients need more integrated care now. Our suggestions of how to achieve this outcome begins with identifying and implementing project-based Care Integration Work Groups (CIWGs) overseen by the Care Integration Task Force (CITF) representing key departments and stakeholders. The CITF in partnership with the County's representatives will be charged with breaking down barriers to integrated care. The CITF will make recommendations for the structure and resources needs for a Health Agency in order to deepen care coordination for our clients.

We feel strongly that our approach A Pathway to an Agency Model is realistic based on best practices in the industry to create care coordination. With clear authority of the CITF to make decisions this partnership approach will enable the County to develop in a timely manner the appropriate governance structure and resources needed for the work of a Health Agency that will have the responsibility of ensuring coordinated and high quality care for our clients. The experience of project-based workgroups will provide us with the data to make sure the Pathway to a Health Agency is successful.

Background for Change (principles and goals)

SEIU 721 intends to step up and share responsibilities with management to improve the delivery of high quality services. A successful transformation will require tapping into the critical skills and knowledge possessed by SEIU-represented frontline staff, our union (at both local and national level), and County management. SEIU fully supports the integration, not mere co-location, of services and is committed to identifying ways to work with management to provide residents of Los Angeles County high quality integrated care.

Our front-line healthcare workers pride themselves in their system expertise and know they are experts on how to better break through the care barriers that inhibit the integration of mental, public, and physical health.

As one of the largest counties in the nation, Los Angeles is poised to lead the way in successfully implementing the Affordable Care Act; it is SEIU 721 members who are at the forefront of this groundbreaking task and their insight is invaluable.

Who We Are and Why Structure Matters to Us

On any given day approximately 22,000 public-sector and Private Non Profit Clinics unionized healthcare workers, represented by SEIU 721, provide critical health care services to County residents. They counsel, coach, orient, nurse, test, assess, enroll, plan, and discharge thousands of clients. Others are involved in planning, health education, contract monitoring or first-line investigative or advocacy work. Whether their work is clinical, more supportive, administrative, or investigative, or they are involved in planning and policy roles—SEIU 721 members are frontline advocates for clients, patients, and communities and stand prepared to help make needed changes to better integrate the care of our clients.

Engagement process and results

Since January 2015 SEIU 721 has organized six town hall meetings, dozens of worksite meetings, conducted a survey of our members, and launched an internal Integration Taskforce. Task force members met with Health Deputies from all Supervisorial Districts to share and solicit feedback about how to improve the integration of care for our clients. Although there is skepticism among our membership as to whether and how a "Healthcare Agency" could guarantee better coordination, there is consistent agreement that significant changes are need to ensure that patients, clients, and communities get the services they deserve in consistent manner.

Perspectives from a Survey of Front Line Members

Twenty-eight percent of our members surveyed nearly 1,000 representing a proportionally balanced sample of our members in DMH, DHS, and DPH favored keeping the system 'status quo.' Six out of 10 members surveyed felt that structural barriers (silos) woven into the current system force the public to work too hard for services, yet only a minority (34%) felt confident—at this point in time that placing DMH, DHS, and DPH under an agency umbrella would help clients and patients to better navigate through the system. A third agreed that system change was necessary but expressed concerns with a health agency model resulting in possible unintended consequences. If our health system is to thrive every point of view, including people's concerns and hesitations must be explored and addressed.

Suggested Approach – Getting Results While Designing the Appropriate Structure to Ensure Care Integration

SEIU 721 is committed to working with the management of each of the County's three health departments. We believe the appropriate mechanism to begin is through a transitional approach used **to ensure we create an effective** care integration system. A launch pad - made up of intentional *Care Integration Work Groups* (CIWGs) overseen by a *Care Improvement Task Force* (CITF). *See the attached diagram.* Subject matter experts from labor, management,

community organizations, academia, and policy/research bodies can serve on CIWGs. The CITF will then provide oversight and be responsible for having work groups obtain their deliverables in a timely manner. This group will consist of directors plus representatives from labor and community stakeholders and will have the authority to implement needed changes.

Strategic priorities for care coordination will be defined by CITF as well as outcomes to be achieved. Timelines will be established by the CITF for each of the workgroups (CIWGs). Each work group will have a specific area related to care coordination. Where services touch individuals who are incarcerated, the CITF will solicit input from clinical staff within Sheriff's. Where community groups or agencies may have specific clients or communities impacted, community stakeholders will become members of specific workgroups. Specific work groups will be established between two or three departments due to the particular nature of the area to be coordinated. Each work group will be assigned a quality improvement consultant/facilitator to help keep to the timelines that will be developed. The CITF will determine the staff and union representatives that will be needed from DHS, DMH, DPH, and community organizations. These work groups and the Task Force will provide appropriate resources in order to achieve care coordinated outcomes in a timely manner. These resources include dedicated staff time (including backfill) to work on designing and helping to implement new systems of care coordination processes, staff time to obtain in-put from other staff and subject matter experts, access to research on best practices for creating an integrated care delivery system, and training of workgroups in quality improvement techniques so they can use these tools to assess and then implement new systems of care in a timely manner.

This approach of creating an accelerated change process first and then developing the appropriate governance process (e.g. creating a Pathway to a Health Agency) has been an extremely helpful process for other health care systems that transforming their operations to provide more integrated care and then develop the appropriate governance process. The process being suggested is considered a "best practice" for needed transformation to a coordinated and integrated delivery system.[1]

Summary and Conclusions

SEIU 721 leadership is convinced that there is an urgent need to find ways to improve the coordination of services. We feel that the recent Board item is timely and appropriate in order to find innovative and efficient ways to improve the coordination of services to the communities our members serve.

We agree with the intent of the Board's item to improve the integration of client care. We are suggesting an expedited process to improve care coordination and one that will begin to demonstrate tangible results. Our position is grounded in our engagement process with frontline staff and other key stakeholders.

Our position upholds the belief that in order to achieve healthy communities a strong Health Agency governance structure, with the appropriate resources to redesign services, is crucial to ensure that current care coordination is taking place and new processes are established to deepen these activities. Our research and feedback from members and subject matter experts suggests that the method to achieve these outcomes is an interim process. This process should be driven by actual work to improve the integration of care with extensive frontline staff,

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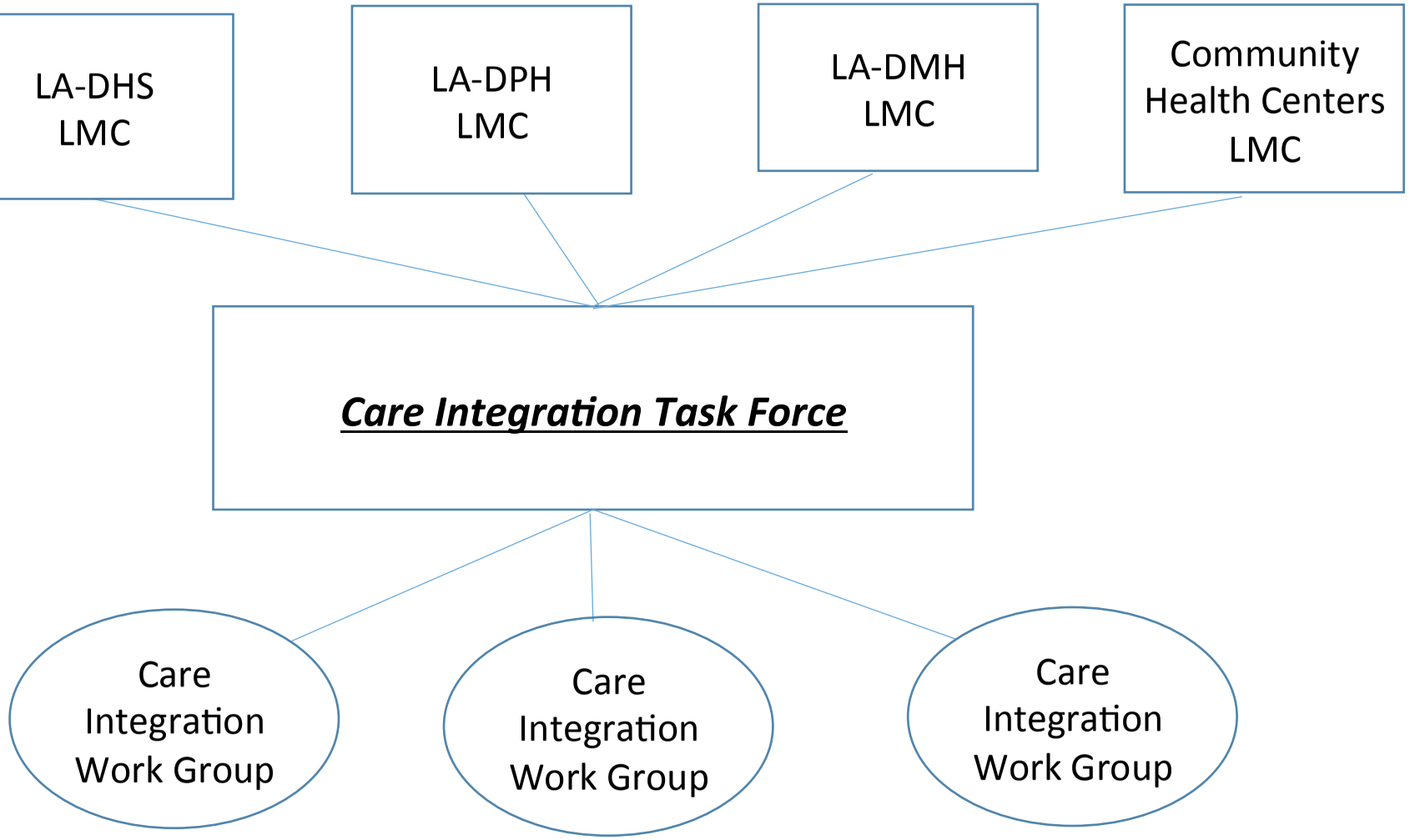
[1] Alegent Health and Fairview Health Services are just two examples of systems that have recently adopted this process.

union, and management involvement. A design phase process must be established (e.g. learning from what really works—the Pathway to a Health Agency) for radical changes to be implemented.

We are eager to share additional details of our approach with you when it is appropriate. We have attached to this position paper SEIU's principles of engagement that we feel should be practices during all phases of work to create more care coordinated activities for our clients, patients, and communities.

Bob Schoonover, President, SEIU Local 721
SEIU 721 Health Integration Task Force

Pathway to Creating Integrated Care in LA County
An Organizational Change Structure for Creating the new Health Agency



Notes:

Agency LMTC – to meet initial for a 2 day retreat and then meet once a quarter

LMCs- to meet once a month

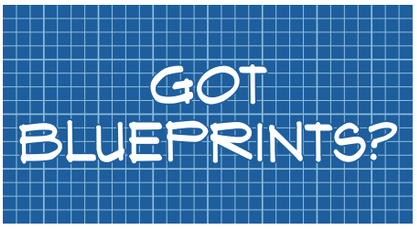
SEIU 721 Health Integration Planning Principles

As the largest union representing healthcare workers in LA County, SEIU 721 members are instrumental to implementing delivery system change. Success of the integrated health agency will only be possible with the participation and input of our members.

Front-line workers must be involved in the design, implementation and ongoing evaluation of any LA County Health Agency model formed.

As the backbone of the county healthcare systems SEIU 721 members hold that:

- ***Communities, patients, and clients first*:** Integration first and foremost must 'do no harm.' It should only happen if it strengthens the safety net and facilitates timely access to appropriate, culturally-competent care of utmost quality.
- ***Fiscal savings re-invested in healthcare services**:* Any cost savings or revenue identified from efficiencies or restructuring must be reinvested in services. Integration must translate into service levels being maintained, but also the continuum of services must be expanded. System financing and budgets must be transparent (and intelligible) and responsible with taxpayer's dollars.
- ***Culturally competent care*:** County health clients, patients, and communities are exceptionally diverse as are their healthcare needs and understanding of wellbeing. Whether care is received in a "behavioral home" or "medical" home, it must address that cultural diversity.
- ***Cohesive services*:** A seamless continuum of care pivots around a cohesive delivery system. Integration must eliminate excessive outsourcing which undermines care cohesion and requires clients, patients, and communities to work harder to obtain services
- ***Integrated services go beyond merely co-located services**:* Clinicians, technicians, financial service workers and others require tools and processes that facilitate timely referrals and information sharing
- ***Mutual respect*:** The important missions of the three health departments cannot be diluted. Respect for institutional knowledge and organizational expertise is paramount. Integration must foster collaboration and equity among departments.
- ***Transparency***: CEO, Health Agency, and Department leadership must fully comply with the Brown Act. Any new structure must not result in an erosion of the public's access to policy decisions, information, and resources.
- ***Process*:** Integration must focus principally on breaking down the barriers inhibiting access to quality care. Operational barriers need to be identified prior to focusing on efficiencies or cost-saving efforts that provide little to no patient benefit.
- ***Incorporate best practices, ongoing assessment and evaluation.*** Planning needs to be grounded in health care best practices. Stakeholder involvement needs to be expanded to include defining metrics of success.



We Can Transform LA County Healthcare From the Ground Up

Los Angeles County's elected Board of Supervisors recently voted to approve "in concept" the consolidation of the services provided by the Departments of Health Service (DHS), Public Health (DPH), and Mental Health (DMH) into a single integrated umbrella Health Agency (Agency Model). The Board's position was that the current system of care may no longer be sufficient to deliver essential services — physical, emotional/behavioral, and community health — in the most integrated manner.

The Board tasked the CEO to work with the impacted departments and others and report back on a 'proposed structure' to accomplish a more integrated system of care. The report would also examine "the benefits as well as any drawbacks" of linking the health departments under an umbrella agency — itself headed by a Health Agency Director. *[The Sheriff's Medical Services Bureau was also included as a **possible** candidate for the Health Agency as well as the Environmental Toxicology services performed under Weights and Measures.]*

As a SEIU 721 member you make up the backbone of our current system of care. You have an important stake in what our system looks like going forward The County Supervisors recognizes that feedback from individuals, agencies and community groups, **and unions** is critical.

Your input on this survey and throughout the engagement process will be vital.

Please take a few minutes to respond to the following questions:

Tell us about yourself. What Department do you work at?

☐ DMH ☐ DHS ☐ DPH ☐ Sheriff ☐ Weights and Measures

What is your county classification?_____

Facility/Program?_____

1. Which of the following best describes your thoughts on the structure of care delivered in LA County

☐ Los Angeles County's current structure is bureaucratic—each Department operates in it's own silo—the public could be better served under a Health Agency model (an umbrella agency integrating services provided by DHS, DMH, DPH)

☐ The current system needs to be changed, but a Health Agency could result in possible unintended consequences.

☐ Our system is working well enough, why fix it?

2. Do you believe a Health Agency provides an opportunity for you to:

- Better coordinate care for patients/clients/the communities you serve ..... ☐ Yes ☐ No ☐ Not Sure
- Provide higher quality services ..... ☐ Yes ☐ No ☐ Not Sure
- Increase the amount of care delivered ..... ☐ Yes ☐ No ☐ Not Sure
- Improve efficiency of services (for example consolidating some services?) ..... ☐ Yes ☐ No ☐ Not Sure
- Help ensure adequate funding for service delivery? ..... ☐ Yes ☐ No ☐ Not Sure

3. In your experience does the current County system require clients, patients, and communities to navigate through too many barriers to receive services?

☐ Yes ☐ No ☐ Not Sure

3b) If yes, do you think integrating services under a Health Agency might help?

☐ Yes ☐ No ☐ Not Sure

4. How might an integrated health agency impact your work or working conditions?

_____

_____

_____

_____

_____

_____

5. Thinking about the work in your specific area/unit/program, how might a change to a Health Agency impact the services you or your colleagues deliver

_____

_____

_____

_____

_____

_____

Do you want to get more involved and share your ideas (town halls, focus group discussions, etc.)?

☐ Yes ☐ No ☐ Not Sure

LOCAL 721 SEIU

www.seiu721.org

seiu721

@seiu721

Contact Information

Name_____Employee #_____

Personal Email Address_____

Home Zip Code_____Cell Phone #_____

☐ Okay to text. SEIU 721 will never charge for mobile messages. Standard data rates may apply. Please check with your cell phone provider.

RM:ds opeiu 537, afl-cio 2/15