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June 30, 2015

To: Mayor Michael D. Antonovich
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Supervisor Don Knabe

From: Sachi A. Hamai
Interim Chief Executive Officer

FINAL REPORT ON POSSIBLE CREATION OF A HEALTH AGENCY (ITEM NO. 2, AGENDA OF JANUARY 13, 2015 AND ITEM NO. 2, AGENDA OF MARCH 3, 2015)

On January 13, 2015, the Board directed the Interim Chief Executive Officer, County Counsel and the Department of Human Resources, in conjunction with the Departments of Health Services (DMH), Mental Health (DMH), and Public Health (DPH), to report back in 60 days on the benefits, drawbacks, proposed structure, implementation steps, and timeframe for the creation of a single unified health agency. On March 3, 2015, the Board extended the deadline of the final report on the health agency to June 30, 2015. A draft version of this report was made public on March 30, 2015; formal public comment closed on May 29, 2015. Attached is the final report in response to this Board motion, having been revised based on input received during the public comment period.

While each has a unique mission and set of responsibilities, the ultimate goal of DHS, DMH, and DPH is to improve the health and well-being of all Los Angeles (LA) County residents across physical, behavioral, and population health. If created, a health agency would be responsible for leading, supporting, and promoting integration and enhancement of services and programs between the three Departments. An agency would support the full current scope and spectrum of activities and responsibilities of each Department. An agency is not intended to reduce service levels or programs, cut budgets, lay off staff, or cut contracts with private agencies/providers.

Key opportunities that the agency might assist the County in pursuing include:

- Improving health outcomes and reducing disparities
- Addressing major service gaps for specific vulnerable populations
- Bridging population and personal health
- Integrating services at the point of direct care delivery
- Streamlining access to care
- Using information technology to enable service and programmatic integration

- Improving workforce education and training
- Strengthening the County's influence on health policy issues
- Improving use of space and facility planning
- Improving ancillary and administrative services/functions
- Maximizing revenue generation

An agency structure may have drawbacks. Risks and concerns that have been raised as part of the stakeholder process include the possibility that an agency may:

- Result in cuts to critical population health and mental health programs
- Add an increased degree of bureaucracy resulting in service/operations delays
- Require financial investment that would be funded from Departmental resources
- Lose focus on the full breadth of the Departments' current missions
- Lead to cultural friction that compromises integration efforts
- Place greater focus on the medical model at the expense of the recovery/resiliency model of care
- Disrupt existing programs and well-established client-provider relationships
- Distract County staff and community stakeholders from their ongoing work

The proposed agency structure takes into account the above risks and seeks to mitigate their likelihood of becoming a reality. Importantly, the Board chose to approve in concept an agency model in which each Department preserves a separately appropriated budget that can only be changed by the Board of Supervisors, rather than approving a merged model in which DHS, DMH, and DPH are consolidated into a single department.

To mitigate the risk of bureaucracy and administrative costs, agency staffing should be lean. Functions should not be duplicated between the Departments and agency. Units should be moved to the agency only when there is a clear, demonstrable added value of doing so in terms of service enhancements and efficiency gains. The report includes specific recommendations for units that could be positioned at the agency level over the short-term as well as recommendations for placement of agency-level individuals serving in strategic leadership roles in specific functional areas. Core administrative units, including human resources, information technology, finance, and contracting/procurement, among others, should not be immediately moved to the agency.

Many people felt that an agency was not necessary to achieve the benefits of integration, but rather such benefits could be achieved by the Departments working more collaboratively or through other non-agency structures. A summary of alternative non-agency models suggested by stakeholders include:

- Creation of a separate office, patterned after the Office of Child Protection, to help coordinate and lead integration-focused initiatives
- Realignment of Department functions without creation of an agency
- Creation of an agency focused only on clinical service delivery (i.e., excluding population health)
- Creation of a health and social services agency
- Creation of a health authority

The Board of Supervisors has three general options as to how it may choose to proceed. First, it may decide the current structure and organizational relationships of the Departments should be left unchanged, ceasing consideration of the agency and other models that would alter County organizational structure and Departmental relationships. Second, the Board may choose to proceed with creating an agency involving DHS, DMH, and DPH. Finally, the Board may choose to proceed with study and/or implementation of a different model, including those noted above.

If the Board chooses to proceed with creation of an agency, the County would adopt an ordinance formally approving the agency and specifying the reporting relationships between the agency and Departments. Additional recommended actions that should be taken if an agency is created include the need to:

- Appoint an agency director with the skills and temperament needed to be successful in the role
- Build a transparent, ongoing, and meaningful partnership with internal and external stakeholders
- Promote cultural competency in all health-related activities
- Establish an integrated strategic plan and a set of initial agency priorities
- Ensure accountability and oversight of the agency
- Regularly and publicly report on agency progress and impact
- Publish clear, concise data on Department budgets
- Publicly communicate changes in County organizational structure and programs
- Create opportunities to build relationships and trust among staff

The hope is that through this report, and the extensive internal and external stakeholder process that helped inform it, LA County leadership is well-positioned to determine the best path forward so that it may maximize opportunities for innovation and integration for the benefit of all LA County residents.

If you have any questions, please contact me, or your staff may contact Dr. Christina Ghaly at (213) 974-1160.

SAH:CRG:jp

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Health Services
Human Resources
Mental Health
Public Health

Response to the Los Angeles County Board of Supervisors Regarding Possible Creation of a Health Agency

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June 30, 2015

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Executive Summary

On January 13, 2015, the Los Angeles (LA) County Board of Supervisors unanimously passed a motion approving in concept the creation of a single, integrated health agency with authority over the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH). As requested in the Board motion, this report provides an overview of the types of integration-related opportunities that a health agency might pursue, the potential risks and drawbacks of a health agency, a proposed structure, and suggested implementation steps and timeline. The report was developed with significant input from a broad set of internal and external stakeholders across the health community.

If created, a health agency would be responsible for leading, supporting, and promoting integration and enhancement of services and programs between DHS, DMH, and DPH for the benefit of all LA County residents. An agency would support the full scope and spectrum of activities and responsibilities of the three Departments. It is not intended to reduce service levels or programs, cut budgets, lay off staff, or cut contracts with private agencies/providers. Below are key integration opportunities the County ought to pursue that, if achieved, would yield significant benefits for the residents of LA County. The creation of an agency might assist in the pursuit of these goals.

1. Reduce health disparities by identifying and implementing interventions that address social determinants of health and improve access and utilization.
2. Address gaps in service delivery for at-risk, vulnerable populations, including but not limited to foster children and transitional aged youth, justice-involved populations, homeless individuals, and those in psychiatric crisis.
3. Enhance cross-linkage between population health and direct clinical care services.
4. Integrate direct care services for patients/clients/consumers that need physical, mental, substance abuse, and housing-related services and supports.
5. Streamline access to services and programs provided or funded by the County by creating a unique identifier and aligning referral, financial screening, and registration practices.
6. Use information technology to enhance access to information and coordinate management of shared clients and populations.
7. Educate and train the health care workforce to succeed in an integrated care environment.
8. Increase the County's ability to influence state and federal health policy issues.
9. Improve utilization of owned and leased buildings to enhance service delivery and lower costs.
10. Capture opportunities in pharmacy, ancillary services, contracting, purchasing, and human resources to improve the quality and efficiency of County services and the experience of those interacting with the system.
11. Generate additional revenue by increasing managed care contracts and strategically pursuing other revenue-maximization opportunities.

An agency structure may have drawbacks or disadvantages. Risks and concerns that have been raised as part of the stakeholder process include the possibility that an agency may:

1. Result in service and budget cuts to critical population health and mental health programs.
2. Add layers of bureaucracy that will result in delayed services/operations.
3. Require financial investment that would need to be funded within existing Departmental resources.
4. Prevent Departments from focusing on the full breadth of their current missions and scope of activities, the full set of clients/populations served, and the way in which services/programs are provided.
5. Aggravate cultural differences and distrust between the Departments, compromising efforts to work together.
6. Replace the recovery and resiliency models that are foundational to the community mental health system of care with a focus on a medical model of disease and treatment.
7. Disrupt existing, successful programs and well-established provider/agency relationships.

8. Distract Department staff and community stakeholders from their ongoing work enhancing programs/services.

The proposed agency structure takes into account the above risks and seeks to mitigate their likelihood of becoming a reality. First, the Board chose to approve in concept an agency model in which each Department preserves a separately appropriated budget that can only be changed by the Board of Supervisors, rather than approving a merged Department model in which DHS, DMH, and DPH are consolidated into a single department. Next, to mitigate the risk of bureaucracy and administrative costs, agency staffing should be lean. Functions should not be duplicated between the Departments and agency and units should only be moved to an agency level when there is a clear, demonstrable added value of doing so in terms of service enhancements and efficiency gains. Specific units (in full or in part) recommended for placement at an agency level are: data/planning, capital projects/space planning, government affairs, and consumer affairs/advocacy/ ombudsman; a workforce training function should be considered. Core administrative functions (e.g., IT, HR, contracting, finance) should remain within the Departments. Individuals with strategic leadership positions in the following areas are also recommended: information technology, revenue maximization, service contracting/procurement, and human resources/employee relations; an individual charged with coordinating managed care strategy should be considered.

Many people felt that an agency was not necessary to achieve the benefits of integration, but rather such benefits could be achieved by the Departments working more collaboratively or through other non-agency structures. A summary of alternative non-agency models suggested by stakeholders include: creation of a separate office, patterned after the Office of Child Protection, to help coordinate and lead integration-focused initiatives; realignment of Department functions without creation of an agency; creation of an agency focused only on clinical service delivery (i.e., excluding population health); creation of a health and social services agency; and creation of a health authority.

At the Board's discretion, a health agency could be created by adopting a County ordinance formally approving the agency and specifying the reporting relationships between the agency and Departments. Beyond this, should the Board decide to create an agency, it should be carefully implemented in a way that mitigates the potential risks raised by stakeholders and that supports ongoing transparency and community engagement. Recommended actions include the need to:

1. Appoint an agency director with the skills and temperament needed to be successful in the role.
2. Establish and clearly communicate an integrated strategic plan and a set of initial agency priorities to which the agency director and Department heads are held accountable.
3. Build a transparent, ongoing, and meaningful partnership with internal and external stakeholders in which a broad set of community members, including patients/clients/consumers and their families, provide input into agency priorities/activities and raise ideas and concerns. Such engagement is critical in ensuring ongoing community participation in planning programs and initiatives and restoring trust and confidence among community members.
4. Promote cultural competency in all health-related activities.
5. Ensure accountability and oversight of the agency, potentially through empowerment of the existing Commissions.
6. Regularly and publicly report on agency progress, including indicators related to agency impact, encouraging public statements to be made by Department heads and community stakeholders as well as agency leadership.
7. Publish clear, concise data on Department budgets including sources and uses of various financing streams.
8. Clearly communicate any changes in County organizational structure or programs with the public.
9. Create opportunities to build relationships and trust among staff.

While each has a unique mission and set of responsibilities, the ultimate goal of the health-related Departments is to improve the health and well-being of all LA County residents, enhancing parity and equitable access to care and services across physical, behavioral, and population health. The hope is that through this report, and the extensive internal and external stakeholder process that helped inform it, LA County leadership is well-positioned to determine the best path forward so that it may maximize opportunities for innovation and integration for the benefit of all LA County residents.

Introduction

On January 13, 2015, the Los Angeles (LA) County Board of Supervisors unanimously approved in concept the creation of "a single, integrated agency" encompassing the Departments of Health Services, Mental Health, and Public Health[1], as well as the environmental toxicology bureau functions currently performed by the Agricultural Commissioner. The motion directed the Chief Executive Officer (CEO), County Counsel, and the Department of Human Resources (DHR), in conjunction with the Department of Health Services (DHS), the Department of Mental Health (DMH), the Department of Public Health (DPH), and Agricultural Commission to report back within 60 days on five issues: the benefits and drawbacks of the agency, proposed agency structure, possible implementation steps, and timeframe for achievement of the agency. The motion specifically requested a stakeholder/public participation process for soliciting broad input into the report.[2] Finally, the motion was also amended to include consideration for moving the Sheriff Medical Services Bureau (MSB) into the agency. This document will address issues pertaining to the organizational integration of DHS, DMH, and DPH, collectively referred to as the "Departments" in this report. The environmental toxicology lab was discussed in a separate report to the Board on March 31, 2015; on May 19, 2015, the Board voted unanimously to effectuate its transfer from the Agricultural Commissioner to the Department of Public Health by the end of the current fiscal year. Regarding health services provided to County jail inmates, on June 9, 2015, the Board voted unanimously to approve a single, integrated jail health services organizational structure, including the transition of jail health staff from the Department of Mental Health and Sheriff's Department Medical Services Bureau to the Department of Health Services under the direction of a new Correctional Health Director. Issues pertaining to the environmental toxicology lab and jail health services will not be discussed further in this report.

Each of the three County health Departments strives, via a unique combination of policy, programmatic, regulatory, and direct care activities[3], to enhance and promote the health of LA County residents, with "health" being defined in this report in its broadest, most comprehensive sense, emphasizing the physical, mental, social, and spiritual wellness of individuals and populations. This includes, where relevant, social services and programmatic supports that fall outside traditional definitions of health but that are needed to address social determinants and produce whole person wellness in all realms (e.g., entities focused on education, employment, community development, recreation, etc.). In meeting their common goal of enhancing health, the activities and responsibilities of the Departments are complementary. The specific niche for each Department (within the broad health care milieu) can be found in their mission statements, functional and operational structures, and strategic plans. The different responsibilities, activities, organizational identities, and assets of each should be viewed as the reason for there being so much value in working more closely together to address challenging issues. Beyond their overall focus on health, the Departments also share important similarities, including mission-driven County staff, a wide and complex network of community partnerships, an ethic of service and cultural proficiency, a commitment to evidence-based practices, and a focus on reducing health disparities among disadvantaged populations.

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.[4] The separations allowed each to develop a strong identity and reputation in their fields, to prioritize their work to achieve their missions, and to avoid program cuts that could occur in the setting of financial deficits. Internal and external stakeholders, including both those opposed to and in support of a health agency, applaud the wisdom of these historical separations.

The health-related needs of many individuals are fully met within the organizational structure of the current system. Many individuals receive excellent care and many populations benefit from the activities of each Department, including from successful integrated models of care provided in County-operated programs or as funded by the County. While

[1] Motion included in Appendix I.
[2] The process used to develop this report is included in Appendix II.
[3] Please see an overview of the Departments' responsibilities in Appendix III.
[4] See Appendix IV for additional detail on the history of the Departments.

stakeholders highlighted these "pockets of success", they also pointed to much larger areas where the system and its separate, largely siloed, efforts are not effectively serving individuals and populations. "It's inefficient." "Confusing." "[Pieces of the system are] broken." "We have many piecemeal processes that have failed to produce significant, lasting impact toward social change." Individuals fall through the cracks and fail to get the services they need. Many individuals, including those that have been historically underserved, experience gaps in services and programs or remain entirely unserved, propagating deeply embedded disparities in access to care and health outcomes among specific populations. To address these deficiencies, the County must focus on ensuring that the totality of the County's operated, managed, and/or funded health-related programs and services provide an integrated and high-quality approach to enhancing the health and wellness of all individuals and populations across LA County, not just those who are well-served by the current system. Success will depend on continuing a healthy duality of thinking: that is, the ability to maintain what is working well while instilling new integrated systems and practices to overcome the current gaps and meet the health needs of the most vulnerable populations.

There is broad agreement on the overall need to integrate services and programs across the different aspects of health, including mental, physical, and public health, and on integration as the best, most effective way to improve health outcomes and reduce disparities, particularly for the most disadvantaged and vulnerable County residents. However, there is strong disagreement on the best way to achieve this shared goal, on the question of whether or not organizational/structural changes to the County's health-related Departments would help to advance integration, and, if organizational changes are needed, the form they should take.[5] Those that favor the agency model believe it is the best way to achieve integration while maintaining independent departments and budgets able to fulfill the breadth of their current missions. Those hesitant or opposed to the agency model question whether a health agency is a necessary or even helpful step in the quest for better health outcomes, noting that more attention to cross-boundary collaboration and, in some cases, additional resources may produce the same outcomes. This report will focus primarily on the agency model proposed by the Board but will also note alternative ways that stakeholders felt integration goals could be achieved.

[5] A summary of the structures used to organize health-related departments in other counties is included in Appendix V.

Organizing LA County's Health-Related Departments to Achieve Integration Goals

The US health care system is moving toward integration. The current siloes in which public health, mental health, and physical health operate, taking into account regulatory, financing, information management, and programmatic/service design, produce a fragmented system that fails to optimally serve all segments of the population. Integration is necessary to achieve sustainable and scalable improvements in health outcomes for individuals and populations across all racial, ethnic, cultural, and societal groups. The Affordable Care Act (ACA) is a major instigator of integration, noted to have "sweeping impacts on the provision of care for individuals with behavioral and physical health service needs who receive services in the public sector."[6] Under the ACA and the state's ever-growing shift toward managed care, California has placed responsibility for treating mild to moderate mental illness on the local health plans which provide health services, rather than in the carve-out specialty mental health system. The trend toward managed care has also increased reliance on capitated payment models in which providers are taking on more financial risk while being held to increasingly stringent standards for timely access and quality. We therefore need delivery systems that can effectively and cost-efficiently manage a population that includes a large number of individuals with co-existing mental illness, substance use disorders, and/or multiple physical comorbidities. Federal regulations on mental health and substance abuse parity related to coverage have also raised the question of whether separate delivery systems and financing arrangements for these functions can produce equal outcomes for consumers.

Under managed care, financial incentives place increasing focus on the role of the delivery system in achieving health care's triple aim[7], a goal that requires collaboration and integration across all of health's spheres: across the spectrum of clinical service delivery (e.g., mental health, physical health, substance abuse treatment) and within the components of each of these areas (e.g., community-based services vs. institutional-based services). It also encompasses areas outside of clinical service delivery, including for example the integration of population health and primary care.[8] As one author noted, "a reformed system should integrate personal preventive and therapeutic care with public health and should include population-wide health initiatives. Coordinating personal medical care with population health will require a more structured system than has ever existed in the United States."[9] This emphasis on integration is seen with Section 1115 Medicaid Waiver renewal discussions in California and approved waivers in other states that focus on the importance of integrating physical and behavioral health and on the delivery system's role and responsibility in achieving population health goals. Integration across the breadth of health's arenas is also the subject of numerous grants awarded by the Center for Medicare and Medicaid Innovation and of recently awarded State Innovation Models.

While the County must increase its efforts toward integration, there are several examples of programmatic/service integration initiatives already in place involving the Departments and partner organizations. Following are a few examples as provided by the three Departments:

1. **Center for Community Health (CCH); also known as the Leavey Center:** CCH is a health center that provides integrated primary care, mental health, dental, optometry, and substance use disorder services (via a contract with Homeless Healthcare Los Angeles) to low-income and homeless individuals on Skid Row. Partners include JWCH Institute, DHS, DMH, and DPH. CCH provides approximately 4,500 service encounters per month.[10]

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[6] Croft, B., (2013). "Care Integration in the Patient Protection and Affordable Care Act: Implications for Behavioral Health," Administration *and Policy in Mental Health, 40*(4). 258-63.
[7] The health care triple aim: to improve overall health outcomes and population health; to improve quality and access and, as a result, experience of care; and to increase cost-effectiveness of care.
[8] Institute of Medicine (2012), "Primary care and public health: Exploring integration to improve population health."
[9] Chernichovsky, D, (2010). "Integrating public health and personal care in a reformed US health care system," *American Journal of Public Health, 100*(2). 205-11.
[10] Data obtained from JWCH, June 2015.

2. **Co-Occurring Integrated Care Network (COIN):** The COIN program is a collaboration involving DPH, Probation, DMH, and other County partners and contracted providers to address the needs of Assembly Bill (AB) 109 Post release Supervised Persons (PSPs) who have a SUD, severe and persistent mental illness, and a high risk for relapse. Services offered include integrated SUD and mental health treatment services, medication assisted treatment, co-located probation supervision, and evidenced based programming. PSPs are referred by the Los Angeles County Superior Court, Division 83, for integrated co-occurring disorder services at the Antelope Valley Rehabilitation Center. Since implementation in March 2013, a total of 67 PSPs have enrolled in the COIN program and 65 were discharged, 75% of those with positive compliance (indicating they completed treatment or left treatment with satisfactory progress). Following discharge, COIN clients had a 56% decrease in homelessness and a 52% decrease in physical health problems.[11]

3. **DMH co-locations in DHS facilities:** DHS-DMH co-locations place DMH staff on a full-time basis in DHS outpatient clinics to provide short-term evidenced-based early intervention services for adults suffering from depression and/or anxiety. The initial pilot at El Monte Comprehensive Health Center started in December 2010; seven sites currently have co-located staff. Approximately 175 unique clients across all sites were served each month in FY13-14. Aggregated outcomes for clients completing treatment are as follows for FY 2013-14: 65% positive change for individuals with depression and 57% positive change for individuals with anxiety.[12]

4. **Health Neighborhoods:** The DMH health neighborhood initiative is an effort to bring together regional providers across health, mental health, substance abuse, and community-based services to improve coordination of services in a specific community. Seven pilots are currently active: Boyle Heights, Central Long Beach, El Monte, Lancaster, MLK/Watts/Willowbrook, Pacoima, and Southeast Los Angeles.

5. **Integrated Mobile Health Team (IMHT):** IMHTs are integrated field-based teams led by mental health providers partnered with primary care providers, substance use disorder staff, and housing developers. This program assesses and provides services to homeless individuals with co-morbid mental health and physical health and/or substance use conditions who are chronically homeless and highly vulnerable. The teams have demonstrated improvements in mental health symptoms, use of alcohol, recovery from mental illness, physical health symptoms and signs (e.g., body mass index, blood pressure), and a decline in psychiatric hospitalizations and ED visits. Over the three years of the project, a total of 581 individuals were served by IMHTs.[13]

6. **MLK Psychiatric Urgent Care Center (UCC):** The UCC is a DMH facility that, through collaboration with DHS and DPH, provides primary care, mental health and substance use disorders treatment for frequent hospital emergency department utilizers. DMH contracts to provide urgent and outpatient mental health services. DHS provides primary care services, increasing access for clients with mental illness who prefer to seek medical care in a mental health setting. DPH contracts with Community Assessment Service Centers (CASC) to co-locate substance use disorder (SUD) counselors and provide assessment and referral to SUD treatment services. From July 1, 2014 to April 30, 2015, co-located SUD counselors at the MLK UCC have screened a total of 123 individuals and of those, referred 28 to SUD treatment.[14]

Successful examples of service integration are also often found in the systems of care that support HIV-positive individuals. From the beginning, the HIV community has insisted on providing integrated physical health, mental health, and substance

[11] Data obtained from DPH SAPC, June 2015.
[12] Data obtained from DMH and DHS, June 2015.
[13] Data obtained from DMH, June 2015.
[14] Data obtained from DPH SAPC, June 2015.

use treatment services to HIV-positive clients, a movement that was supported with categorical federal Ryan White Care Act and HIV Prevention funding and through the initiation of the local Ryan White Planning Council and the HIV Prevention Planning Committee, respectively.

These and other integration models are generally focused on small and/or specific populations or are present in only a certain facility, contracted entity, or region. While they should be applauded, they do not represent an integrated system of care for the residents of LA County, nor have these or other collaborative efforts by the Departments addressed striking disparities in health outcomes between different groups, including but not limited to racial and ethnic minorities and the needs of particular vulnerable populations that cross racial, ethnic, gender, and cultural lines. Similarly, the collective efforts of the Departments have failed to tackle or make substantial progress on what are considered major, intractable problems in the County: homelessness, psychiatric crises, health and mental health issues of children in the foster care system, and the needs of justice-involved populations. In both cases, this is because of a relative lack of focused attention on tackling social determinants that lie within the realm of the Departments' scope of work and because of a lack of successful, integrated programs having been implemented at scale across the County.

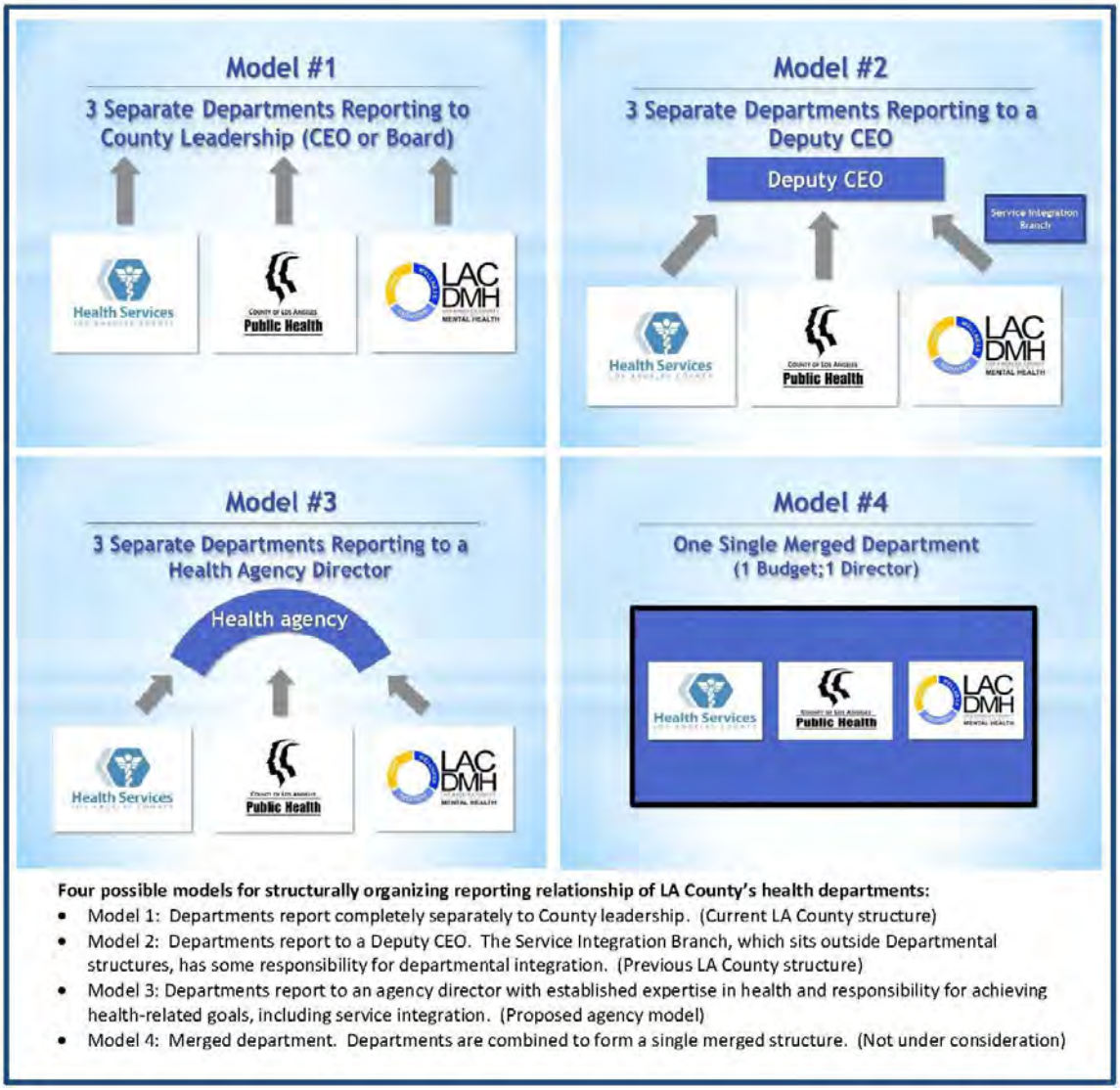
As noted in the introduction, virtually all stakeholders agree with the need to integrate activities (direct clinical services and programs extending beyond care delivery) across the three Departments. While many initially questioned the need for change, highlighting areas of success particularly within the contracted agency/provider community, this sentiment has shifted over the course of the months during which this report was drafted. A vast majority of stakeholders now generally acknowledge the need to make more rapid and robust progress in achieving scalable, sustainable programmatic changes within the broad Los Angeles County public sector system, including those services and programs directly operated by, managed by, or funded by the County. The area of greatest debate is no longer whether change is needed, but rather whether that change requires modification of the current organizational structure and governance in order to be maximally responsive to the evolving, more complex external environment. Further, if modifications are needed, there is debate on the best organizational structure and governance processes to employ in reaching the goals of integration.

The goal of any organizational change, including an agency as well as any other structural model put in place by the Board, would be to enhance services and programs for individuals and populations, and to increase the total capacity of the County's health-related Departments to serve the residents of LA County in a way that improves quality, customer experience, access to care, and health outcomes. The goal would be to lead and promote service integration where integration would benefit residents of LA County, done in a way that is responsive to the local needs and preferences of the region's diverse communities. Service cuts, staff layoffs, reductions to service contracts, or narrowing the scope of activity of the three Departments is not consistent with these goals and would not be pursued.

An emphasis on integration does not imply that all facets of each Department would benefit from integration-related activities. While the degree of overlap between the Departments is large, certain functions of each Department would not be relevant for integration. Examples include certain health protection programs and regulatory functions within DPH, certain highly specialized tertiary care clinical services within DHS, and the public guardian role within DMH, among others. Those areas that would not benefit from integration should continue to operate and evolve in their current Department. Similarly, any effort by the County to enhance focus on integration does not mean that the Departments should limit their scope of activities or center all of their energy and resources on those areas where their target populations overlap. To be successful, each Department must maintain a vibrant, strong presence across its full scope and spectrum of services. Whatever organizational structure is put in place should fully support the current responsibilities and activities of each Department.

An agency as an organizational structure

In its January 13th motion, the Board put forward a specific organizational model, a health agency, for further investigation and consideration. An agency is one of four general models the County could use to structure reporting relationships for its three health-related Departments, without making changes to the mission, scope of activity, or spectrum of services that each Department currently provides. Model #3, as seen in the box below, is the proposed agency model. Additional models proposed by stakeholders that would either a) implement a new structure without changing Departments' reporting relationships, b) change the composition of the Departments themselves, or c) change relationships with other County departments or the Board of Supervisors, are included in the "Non-agency alternatives" section below.



Four possible models for structurally organizing reporting relationship of LA County's health departments:

- Model 1: Departments report completely separately to County leadership. (Current LA County structure)
- Model 2: Departments report to a Deputy CEO. The Service Integration Branch, which sits outside Departmental structures, has some responsibility for departmental integration. (Previous LA County structure)
- Model 3: Departments report to an agency director with established expertise in health and responsibility for achieving health-related goals, including service integration. (Proposed agency model)
- Model 4: Merged department. Departments are combined to form a single merged structure. (Not under consideration)

Agencies are common in government at all levels and domains. They are characterized by direct reporting relationships between the agency and its component departments, with those departments maintaining their unique structure, mission, priorities, and appropriated budgets. The agency often serves as the strategic apex and central point of accountability for a set of organizations that occupy the same domain (e.g., health). Agencies characterize the structure and reporting relationship of both the State of California and the US government. With respect to California, the Department of Health

Care Services[15] and the Department of Public Health both report, among other health and social service-related departments, to the California Secretary for Health and Human Services in an agency structure. Similarly, on the federal level, the Centers for Medicare and Medicaid Services and the Centers for Disease Control both report, among other health and social service-related departments, to the US Secretary for Health and Human Services in an agency structure.

Those who support an agency see organizational structure as an important enabler of integration and an agency as the right degree of organizational change, able to provide a cohesive and efficient means of building an organized and integrated approach to health and wellness that benefits all LA County residents while still empowering the Departments to focus on their unique roles and responsibilities. They believe that the County will be more likely to achieve the goals of integration if the Departments are led together than if they are led separately. They believe that without an accountable leader helping to set the vision, strategic priorities, policies, and performance objectives related to integration, ensuring coordination and alignment of individuals and groups related to each Department, and working through numerous operational obstacles in reaching scalable and sustainable solutions, most integration opportunities will not practically be achieved.

Notably, creation of an agency is not a merger in which three Departments would be combined into a single department with a single budget. The combination of DHS, DMH, and DPH in 1972 was a merger, with the now three Departments consolidated into one single department. The County has not previously employed an agency model in the organization of its health Departments. This is not a trivial distinction. First, departments have separately and individually appropriated budgets, with the Board of Supervisors having the sole power to increase or decrease department budgets. This serves as an important safeguard for ensuring that funds for mental health, public health, and physical health remain dedicated to those purposes. Second, while providing a structure to help people focus on a common set of priorities, attention and funding can be preserved for other issues. An agency focuses on areas of opportunity, on those places where there is potential for synergy that is not currently being realized. Finally, while cultural friction may naturally arise when inter-departmental teams begin working together in new ways (as it would under any structure/relationship in which a desire for greater integration brings together individuals and systems not accustomed to working together), the Departments and Department leadership are still in place, operating as a self-contained organization, and can maintain their unique identity and culture as long as the agency is not dominated by the agenda of one Department.

Non-agency alternatives

As noted above, a majority of stakeholders agree with the need for integration of services and programs, though they do not necessarily agree with the scope of integration that would be of value or the degree of overlap between the Departments. Despite a common support for service and programmatic integration, there are widely divergent views on whether or not structural changes are needed to achieve the opportunities for integration and, if they are, what type of structural change would be best.

Internal and external stakeholders often asserted that an agency is not needed to achieve integration-related goals, frequently stating “you don’t need an agency to do that.” On several occasions, they suggested alternative ways in which the County could support the goal of integration across the three Departments. Individuals supporting non-agency alternatives often believe that the County’s lack of progress on achieving integration opportunities is best attributed to a lack of available financial resources, rather than to more operational and strategic concerns, arguing that if only additional funds were available, the Departments would not be faced with the challenges they have in terms of service gaps, vulnerable populations, and lack of scaled and sustainable integration initiatives.

[15] The Department of Health Care Services includes physical health, mental health, and substance abuse services in a merged department structure.

Regarding non-agency alternatives, several individuals believe that the current structure, Model 1 above, is optimal and that changes are not needed to the current organization of the County or its health Departments. They feel that integration goals can be achieved simply through greater collaborative effort by the Department heads. "The Departments can establish priorities and work together to achieve them." Some suggest that this collaborative effort could be enhanced if the Board of Supervisors set specific priorities for the Departments for which Department heads are held accountable.

Beyond the four general models in which the County could organize reporting relationships among its three health Departments, stakeholders often expressed a preference for an alternative structure. Provided below is a brief description of the main ideas raised during stakeholder discussions.

1. ***Create a separate entity outside of the Departments charged with interdepartmental coordination and integration.*** Several stakeholders suggested a model in which a separate office would be created, accountable directly to the Board of Supervisors, which would help to set strategic priorities and promote Departmental collaboration to achieve specific integration goals. The leader of this office and his/her team would not be directly responsible for Departmental functions or operations and would not have a direct reporting relationship with the Department heads. The leader's role would be one of coordination, alignment, and consensus-building. The proposed "Office for Healthcare Enhancement" follows this model, patterning itself after the County's Office of Child Protection (OCP) an entity under development in response to recommendations of the Blue Ribbon Commission on Child Protection (BRCCP). The OCP is charged with enhancing child safety across different County domains, in this case public safety (Probation), health (DHS, DMH, DPH), social services (DPSS), community services (Parks and Recreation, Public Library), etc. In a variant of this model, some individuals described a preference for a council leadership approach, rather than preferring a single appointed leader of the coordinating body. This council could be comprised of each of the three Department heads as well as other individuals, such as possibly Commission chairs, clients/consumers/patients, providers, labor, etc.

2. ***Change scope and alignment of current Departmental functions without creating an agency.*** A few stakeholders suggested fundamentally restructuring the Departments, including administrative, financial, and clinical elements. One proposal suggested the County should restructure the Departments into three new entities: one focusing on institutional care (hospitals, locked psychiatric beds, etc.), one focusing on community- and office-based clinical services (both behavioral and physical health), and one focusing on population health. A second proposal suggested the County should realign certain components of the current Departments, moving substance abuse treatment (with or without prevention), public health clinics, and non-clinic/community-based mental health responsibilities (i.e., mental health locked and unlocked placements) to DHS, leaving non-clinical service delivery public health functions within DPH and community-based mental health services within DMH. An agency would not be created in this arrangement.

3. ***Create agency focused on clinical service delivery only.*** Many stakeholders agreed with the concept of an agency that would bring together mental health, health services, substance abuse treatment (with or without prevention), and possibly DPH clinics/personal care services, but thought there was less value from including population health functions of DPH. They viewed the continued separation of core population health functions from a health agency as important to ensuring resources and attention continue to be dedicated to these activities and to recruiting population health experts to leadership roles, including notably the currently vacant DPH Director position. Some individuals felt there was a significant value to integrating those population health functions closely linked to clinical service delivery and suggested a variant in which those programmatic components (e.g., chronic disease prevention, maternal/child health, emergency preparedness, HIV/STD programs, etc.) also join the agency, leaving other areas of population health (e.g., environmental health, community education, regulatory activities) in a non-agency public health department. Some suggested that there could be a phased approach to realigning DPH

programs with an agency over time. The typical suggestion was starting with substance abuse treatment, moving to personal care/clinic services, and finally incorporating population health aspects of public health closely linked to physical or mental health services. In this model, all of DHS and DMH, in addition to portions of DPH, would move into an agency structure.

4. ***Create agency but expand to include social services in addition to health functions.*** Some stakeholders felt the creation of a health agency missed an opportunity to better coordinate and align all health and human/social service functions within the County. They questioned why the County was not considering inclusion of the Department of Public Social Services (DPSS), the Department of Children and Family Services (DCFS), Community and Senior Services (CSS), and homelessness programs located within the CEO.

5. ***Create health authority.*** Finally, several stakeholders suggested that rather than, or in addition to, a health agency, the County should consider establishing a health authority. A health authority is a public entity that has an autonomous or semi-autonomous governance structure to help achieve greater flexibility in such administrative tasks as contracting, procurement, hiring, etc. It operates to some extent independently from local government and associated regulations, being governed instead by a separate board, though often with some involvement of local government. A health authority model has been periodically considered by the County, most recently in 2004-05 but was ultimately rejected and has not been seriously considered since. There are multiple ways of structuring health authorities. Some contain only hospitals and/or clinics (e.g., Alameda Alliance for Health, New York Health and Hospitals Corporation) whereas some incorporate a broader set of health-related functions, including County roles in public health, mental health, and substance abuse in addition to hospital/clinic functions (e.g., Jackson Health Trust in Miami-Dade County, Denver Health).

Each of the options listed above, including the four organizational reporting models and the alternative models suggested by stakeholders, has potential risks, benefits, and ability to effect change under various circumstances and settings. Stakeholders however, do not agree about the specific risks and benefits of the agency and any particular non-agency alternative. They hold divergent views on the likelihood that a given model will be able to effectively establish and achieve a vision of integrated services, support collaboration, innovative problem-solving, and decision-making, or will have the capacity to work through operational issues to make progress on specific integration opportunities. Stakeholders further disagree on the extent to which any given model would be disruptive to existing Departmental operations, is inherently bureaucratic or hierarchical, is likely to produce greater or lesser non-value added forms of County process, and the degree to which cultural friction would result, among other factors.

The strategic choice before the Board regarding structure and governance is important and challenging given the lack of clear consensus among stakeholders. The question the Board must ultimately address is which model will be most effective in supporting the programmatic and operational changes required to build the County's capacity for integrated action. Regardless of the ultimate decision by the Board, the three Departments and relevant stakeholders must commit to making the structure work, specifically committing to a grass-roots, "bottom-up" approach to program/service design in a way that is responsive to the needs and preferences of unique populations and communities.

Integration Opportunities

This section will highlight major areas of opportunity for integration between DHS, DMH, and DPH and examples of specific projects that could be pursued within each area. The opportunities included here are broadly applicable across multiple populations but certainly must be tailored to meet the individual needs of the population served by a particular intervention. Progress in these areas would yield significant benefit for those served by the County. This section will not specify an operational or implementation plan for achieving each goal; this is the work that would be done through an agency over time and in active partnership with clients/consumers/patients, staff, and community stakeholders who have detailed knowledge of specific service gaps and local population needs. While the focus here is on work that could be done to improve services and programs to LA County's ten million residents, it should not be taken as a denial that good work has already taken place within and between the three Departments. Many individuals are well-served by the County and its contractors. Areas that are functioning well and meet the needs of individuals and populations should remain unchanged and would not be the focus of integration activities. Rather, the focus would be on those areas where there are gaps, where there are opportunities to improve, where individuals and populations are not well served.

Opportunities for service integration are classified into the following groups.

1. Aligning resources and programs to improve health outcomes and reduce disparities
2. Addressing major service gaps for vulnerable populations
3. Bridging population and personal health
4. Integrating services at the point of care for those seeking care within the County
5. Streamlining access to care
6. Using information technology, data, and information exchange to enable service integration
7. Improving workforce education and training
8. Strengthening the County's influence on health policy issues
9. Improving use of space and facility planning to improve access and reduce costs
10. Improving ancillary and administrative services and functions
11. Maximizing revenue generation

Aligning resources and programs to improve health outcomes and reduce disparities

Ethnic minorities have higher rates of chronic disease[16] and mental distress,[17] a higher incidence rate of HIV infection,[18] and have more difficulty accessing mental and physical health services[19] than their white compatriots. They experience higher infant mortality and a shorter overall life expectancy.[20] Data among Lesbian, Gay, Bisexual, Transgender, Queer and/or

[16] a) Ogden CL, et al., (2014). "Prevalence of Childhood and Adult Obesity in the United States, 2011-2012." *JAMA, 311*(8), 806-814. b) CDC (2014). National Diabetes Statistics Report. c) Thom, T., et al., (2006). "Heart Disease and Stroke Statistics—2006 Update," *Circulation, 113*(6), e85–e151.
[17] Blumberg SJ, et al., (2015). "Racial and ethnic disparities in men's use of mental health treatments." *NCHS data brief 206.* Hyattsville, MD: National Center for Health Statistics.
[18] a) CDC, (2012). "Estimated HIV incidence among adults and adolescents in the United States, 2007–2010." *HIV Surveillance Supplemental Repot, 17*(4). b) CDC NCHS (2014). "Health, United States."
[19] a) Benjamin, LC, et al., (2015). "The Costs and Benefits of Reducing Racial-Ethnic Disparities in Mental Health Care." *Psychiatric Services, 66*(4), 389-396. b) Cohen RA et al., (2014). "Health insurance coverage: early release of estimates from the national health interview survey." CDC. c) AHRQ (2015), "2014 National Healthcare Quality and Disparities Report." d) The Commonwealth Fund (2006). "Health Care Quality Survey." e) NIH NIAAA,(2013). "Alcohol and the Hispanic Community."
[20] AHRQ (2015), "2014 National Healthcare Quality and Disparities Report."

Questioning (LGBTQ) point toward similar disparities in health risk factors and outcomes.[21] The ultimate goal of the County's health-related Departments is to improve the health and well-being of all LA County residents, promoting equity for all individuals and populations regardless of a person's socio-economic status, background, beliefs, or disabilities, and enhancing parity of access to care and services across physical, behavioral, and population health. Accelerating progress toward these goals will help address the health disparities that unfortunately exist among many segments of LA County, including under-represented ethnic populations, LGBTQ individuals, and other culturally, medically, and socially diverse groups.

As an organizational structure, the agency can raise visibility into the unmet need of particular populations and identify interventions that will help to address gaps in care more effectively than any of the three Departments would be able to do alone. To be successful in achieving this, the County must focus on providing culturally and linguistically competent care in all its domains and must emphasize cross-discipline, integrated interventions that help to highlight and, when feasible, address the social determinants of health that are at the root of many of the evident disparities. An agency could play a strong role in spreading the lessons and practices of areas that perform well in this regard within each Department and foster the greater degree of programmatic collaboration needed within and across County departments and with external partners. This will need to bring the active involvement of external stakeholders who can quickly point out gaps in care and can provide early and objective notice of populations not benefiting from Department programs.

A variety of factors, many of which are mutable, contribute to health disparities: variable coverage for and access to services, the stigma of certain medical conditions, disjointed care delivery systems, inadequate or ineffective public messages, cultural and linguistic barriers, and a lack of attention to the social determinants of health which include enabling resources such as transportation, food, housing and education/job training. DPH has made significant progress in drawing attention to these issues through their work with other departments and their data briefs on these issues, e.g., DPH currently provides information and analysis about cross-over disparities (e.g., food or transportation access) and disparity "hot spots" in the County.[22] DMH has also worked with a variety of community partners to advance the goal of addressing social determinants through the Health Neighborhood initiative. Still, more unified leadership could help better prioritize programmatic activities and guide investment by the local, state, and federal philanthropic community to help to advance achievements in addressing these factors.

In regards to stigma amelioration, service integration can help to reduce the impact of stigma of mental illness and substance abuse by providing individuals with more choices as to where they access needed services. An aligned approach can also more strategically connect public health awareness and prevention messaging to care delivery environments. Disparities are in part driven by the paradigm that has long separated components of health when the actual experience of the person who has needs in more than one health area is whole or unseparated. As one stakeholder said, under an integrated model, "LA County might become a leader in addressing health disparities and creating an effective bridge between what happens in the communities, in families, and what happens in the more intimate service settings." It can also help to drive the County toward a consistent and robust approach to cultural competency that focuses not simply on language and ethnicity, but rather recognizing the unique aspects of different cultures and how they relate to and engage with health services and programs.

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[21] a) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, Board on the Health of Select Populations, Institute of Medicine of the National Academies. The health of lesbian, gay, bi- sexual, and transgender people: building a foundation for better understanding. Washington, DC: National Academies Press; 2011. https://www.ncbi.nlm.nih.gov/books/NBK64806. b) Boehmer U, et al., (2007). "Overweight and obesity in sexual-minority women: evidence from population-based data." *Am J Public Health,97*(6), 1134-40.

[22] These are accessible online through LA HealthDataNow! (https://dqs.publichealth.lacounty.gov/), the DPH Health Viewer (http://publichealth.lacounty.gov/epi/HealthViewer.htm), and through posted reports.

Addressing major service gaps for specific vulnerable populations

A key driver toward change is awareness that the County is not making sufficient progress in tackling some of the most important health issues for at-risk populations. These issues are rooted in the social and physical environments in which people live and cross racial, ethnic, cultural, and social lines. Addressing them requires a concerted effort with internal and external partners. Whereas many individuals have found excellent services and support from County-provided or funded programs, this success has not penetrated some of the more challenging and vulnerable groups: children in foster care, transitional age youth, children with serious emotion disturbances, incarcerated individuals, re-entry populations, individuals facing incarceration who may be candidates for diversion, homeless individuals, and those in crisis.

There are many reasons why it is challenging to effectively address the needs of these populations. First, solutions must involve not only DHS, DMH and DPH but at least one, and many times more than one, other County departments (e.g., DCFS, DPSS, Probation, Sheriff), and often require client/consumer/patient hand-offs between Departments. Since the agency will not organizationally encompass these other non-health departments, it will need to dedicate attention to making these partnerships effective. Second, financial investments and programs are often designed by Departments based on available categorical funding streams, each with established restrictions, without attention to other Departments' funding and activities. When collaborative and integrated service planning and provision do occur, they attempt to "fix" the problem with additional downstream interventions, seldom capitalizing on opportunities to alter upstream funding issues or affect initial program design. More funding, while always helpful, is often not essential to making improvements. Often, funds can be shifted, over time, from high-acuity, resource-intensive areas (e.g., locked inpatient psychiatric beds, incarceration) and used to support a greater, more client-centered, volume of lower acuity services (e.g., permanent supportive housing, crisis residential facilities) that are both lower cost and more clinically appropriate given an individual's long-term needs. Better integration across Departments would allow the County to approach these challenges as a broader health system issue rather than from the vantage point of independent Departments each focusing on their piece of the picture. This broad systems approach can allow for a different set of interventions and strategies to emerge that may prove more fruitful than the status quo. Success in this regard would have a spill-down effect across the County, including for populations that are not these highest risk groups. "Focus on the most difficult problems. If you solve system problems for the most disadvantaged, you end up helping everyone."

<u>Children in Foster Care and Transitional Aged Youth (TAY)</u>

On any given day, LA County has 18,000 children in the foster care system and 13,000 being investigated for physical abuse, sexual abuse, or neglect. Although the Department of Children and Family Services (DCFS) is the lead agency, DHS, DMH and DPH also have roles in serving these children and their families. Studies of the recent deaths of children in the County reveal cracks that exist between investigative and support/care services. Deaths have often involved a breakdown in communication between the involved Departments and a lack of connection between what is happening in the child's home or community and the findings by providers in medical or mental health settings. The recent activities of the Blue Ribbon Commission have brought together many County departments to refine and redeploy resources around how public health nurses assess and refer children vulnerable to child abuse, how more seamless and continuous care can be provided to children in foster care, and how we support children who are difficult to place in safe and appropriate foster care because of age, medical, or behavioral health conditions. Particularly with the creation of the Office of Child Protection, a health agency can be a tremendous force in helping to coordinate the three health-related Departments in their activities related to child protection and foster children.

An additional opportunity under the agency model is in the implementation of whole person care for DCFS-involved children and youth. Despite improvements in services with the implementation of the Katie A. settlement agreement and

the Medical Hub Clinics, mental health and physical health services for children and youth in foster care, as well as non-health services such as employment/vocational training, educational and recreational supports, housing, etc., still operate on parallel tracks and are not well coordinated, leading to delays in care, poorer health outcomes, and unnecessary duplication of services. For example, DMH-contracted Multidisciplinary Assessment Team (MAT) providers conducting comprehensive assessments of newly detained children operate separately from the Medical Hub system, with minimal or no sharing of information between the systems despite that fact that it is permissible for such information to be shared. In addition, foster parents and relative caregivers are often challenged by the need to navigate different systems of care and by the sheer number of agencies and appointments to which they must bring children in their care. Providing greater opportunities for one-stop services and care coordination can help reduce the stresses on foster and relative caregivers and families.

TAY (often defined as those 16-25 years old, including but not limited to those who age out of the LA County child welfare and juvenile probation systems) face numerous challenges in attaining self-sufficiency and have been shown to have poorer outcomes than their peers in educational attainment, employment, housing stability, and mental health. Crossover youth with experience in both the child welfare and juvenile probation systems are at particularly high risk for incarceration, poverty, and high reliance on public benefits and services. County departments have developed goals and programs aimed at increasing TAY self-sufficiency; however, services are still fragmented. DHS, DMH and DPH each provide services that are highly relevant for this age group, including sexually transmitted infection and SUD prevention and treatment, care for chronic and acute medical conditions, mental health outpatient treatment and crisis intervention, and transitional and permanent supportive housing. There is a need for greater coordination of these services, improved information sharing, and much-needed consolidated care coordination/case management services, particularly for high-risk subgroups such as crossover youth and LGBTQ youth.

Re-entry and incarcerated populations

The re-entry population is a diverse group that includes those coming from the State prison system and the County jails. The former group is largely people returning to LA County after years of being away. The latter includes a wide spectrum, ranging from those who quickly cycle through jail to those who have served multi-year sentences. The diversity and unpredictability of when and from where (court, jail or a prison) people are released is a primary driver of the complexity of re-entry services: it is difficult to plan services for an individual when his/her re-entry date, time, and location are unknown and/or unreliable. This challenge is multiplied because the re-entry population has a need for services from all three of the County's health Departments as well as other County departments such as Probation and the Sheriff's Department. While difficult, intervening in this group is critical: people leaving jail and prison have a 12-fold higher likelihood of dying in the first two weeks following release than someone in the general population.[23] The County should be held accountable for narrowing this disparity. A shared approach to addressing the health needs of the re-entry population could enhance pre-release planning, making it easier for this at-risk population to access services without gaps or duplication.

One relative success in integrating care among re-entry populations has been the County's Assembly Bill (AB) 109 experience. Under the AB 109 effort, many County departments have come together to serve an at-risk and vulnerable re-entry population. With CEO support, the Departments have co-located staff, allowing them to work together and share responsibility in creating a system that coordinates care and ensures timely access for re-entry individuals, often able to successfully trouble-shoot very difficult cases. Although there is more work to do under the AB 109 program, such as a need to enhance housing and supportive services beyond the current 90-day transitional housing options available, the Departments have demonstrated the potential impact of working together to assist difficult populations.

[23] Binswanger, IA, et al, (2007). "Release from prison – a high risk of death for former inmates." *NEJM, 356*(2), 157-65.

Under a shared 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. Stakeholders identified many opportunities to bring services together and provide more seamless service provision. As examples, DMH has a program targeting the mental health needs of formerly incarcerated women that would benefit from augmentation of onsite medical services. DHS is planning a transitions clinic at the MLK medical campus to link the sickest of the re-entry population coming out of the County jail system with continuity health services; existing campus mental health and substance abuse services are being leveraged to serve this population. More such programs could be created. Stakeholders also discussed the opportunity to create and use assessment and care coordination tools. Other potential areas of focus of a re-entry service planning effort include: developing shared metrics and jointly reporting progress toward these metrics, as has been done with AB 109, prioritizing greater in-reach of community mental health providers to work with inmates while in jail, and ensuring discharge of individuals with substance use disorders into treatment programs. Under the ACA, the largely male, low income re-entry population has gone from being majority uninsured to having near universal eligibility for coverage through Medicaid expansion. Given the federal funding that now follows these individuals, coordinated, integrated re-entry programs can be more easily prioritized and developed.

While a separate memo explores major issues in health services within the jails[24], it is worth noting here that stakeholders agreed that improving jail health services, particularly at the point of release, would have immense benefit when it comes to planning for re-entry services. Nurse and provider assessments, diagnostic studies, medication lists, labs, and problem lists should follow the individual into the community so their re-entry care plan can be appropriately informed. For example, if a person receives an MRI study in jail, the result should be shared with community providers thereby obviating the need for another study and improving the timeliness of getting the individual to the appropriate next step in care.

Jail Diversion

Over the past twenty years the number of people with mental illness and substance abuse incarcerated in jails has grown. In Los Angeles County's Twin Towers Correctional Facility, for example, the high observation housing (HOH) unit designated for inmates with serious mental illness or those actively suicidal had approximately 250 inmates two to three years ago; today, there are 500 to 550 inmates. The increase is due to a variety of trends, including societal and judicial considerations as well as a loss of community-based placements over the past two to three decades. Loss of these placements has meant more and more individuals with mental illness and/or substance abuse remain without treatment and support, often homeless and alone on the streets. Arrests and jail time for minor, non-public safety offenses (e.g., petty theft, public urination, public inebriation, trespassing, vandalism) have become commonplace for this population as law enforcement officers do not have alternative drop-off locations for such offenders.

Today in LA County's jail system, of the roughly 17,500 inmates, 20% have a serious mental illness, nearly all of whom have a co-occurring substance use disorder. A staggering 80% of the total inmate population is estimated to have a substance use disorder. Jails and prisons have replaced treatment programs and community placements. However, jails are an inadequate replacement: they are expensive and destabilizing environments for people with mental illness. They lack sufficient capacity and space to provide mental health and substance use treatment, leaving most inmates to cope with unaddressed mental health and substance use issues. Unsurprisingly, most of these issues fail to improve and often worsen rather than improve while in jail. While the County must work to simultaneously improve jail mental health and substance use services, there is a clear motivation to prevent offenders with serious mental illness or substance abuse issues who are

[24] http://file.lacounty.gov/bc/q2_2015/cms1_229439.pdf#search="APPROVAL OF PROPOSED JAIL HEALTH SERVICES STRUCTURE"

not considered public safety risks from ending up in jail in the first place. These programs should, as much as possible, live in the community.

In a growing movement around the country, municipalities have looked for opportunities to divert non-violent mentally ill and substance abusing offenders into community-based programs where they can receive appropriate care in a therapeutic rather than destabilizing environment. LA County has begun to explore how jail diversion – both pre- and post-booking– can best be accomplished. DMH, DPH's Substance Abuse Prevention and Control (SAPC), and LASD have been developing a diversion plan over the last year under the leadership of the County's District Attorney. As this larger County diversion plan is being developed, meaningful efforts to divert offenders are beginning. An example of a pre-booking diversion project being developed is the use of DMH-contracted psychiatric UCCs to accept more people directly from law enforcement in lieu of bringing them to jails or the emergency room. An example of a post-booking diversion strategy is the effort between LASD, DMH and the courts to place misdemeanants incompetent to stand trial (MIST) offenders in community mental health placements rather than keep them in jail.

A whole-person approach is needed to accelerate the pace of progress toward a comprehensive and thoughtful jail diversion plan across LA County. The health-related Departments must be at the forefront of developing and implementing diversion strategies, working in partnership with social and public safety focused departments. The Departments have a key role in determining which sites are appropriate for diversion services, considering both community-based treatment programs as well as locked and unlocked placements. The diversion programs must continue to bring together the mental health treatment services, medical and counseling-based substance abuse interventions, and supportive housing services in a single location. Joint program planning, service integration, and funding prioritization among the health Departments, law enforcement, and the courts, is the only way diversion approaches will grow and have the large scale impact seen in other parts of the country. Although many diversion programs can be created today within our existing environment by building relationships and programs between departments, this build-as-you-can strategy may not lead to the comprehensive set of collaborative, integrated programs required to make the meaningful change within the jail population so that non-violent, mentally ill persons are no longer incarcerated. Coordinated action and leadership is needed to draw the best ideas from the collective Departments, identify ripe opportunities for both space and funding to create the programs and allow for more straightforward and streamlined partnership with the custody and court-related partners who must all ultimately work together to develop innovative diversion programs while preserving public safety.

Homelessness

There are over 40,000 homeless people in LA County, 25% of whom describe having a substance use disorder, nearly 30% describe having mental illness, nearly 20% who describe having a physical disability, and 10% who are under age 18. At least 2,000 chronically homeless individuals live within a 54 square block area in downtown Los Angeles known as Skid Row, the nation's largest concentration of unsheltered homeless individuals. Each of LA County's eight SPAs experienced a higher rate of homelessness in 2015 than in 2013.[25] A much larger number of individuals, 373,000 in 2011, report being homeless or marginally housed at some time in the past five years, with rates higher among African-American's (14.8%) and Latinos (5.2%) than among whites (4.1%).[26] These individuals are frequent users of emergency services, ricocheting through County and private EDs, psychiatric EDs, medical and psychiatric inpatient units, the street, jails, residential substance abuse treatment, homeless shelters, and recuperative centers. Study after study in Los Angeles and the rest of the nation

[25] Above data is according to the Los Angeles County Homeless Services Authority biannual count of homeless individuals, there were 44,359 homeless individuals in LA County in January 2015. Full data available at www.lahsa.org.
[26] Los Angeles County Health Survey, 2011. Reflects those who reported being homeless or not having their own place to live or sleep in the past five years. Note the report documented a rate of 1.8% among Asian/Pacific Islanders but noted the value was not statistically significant.

indicate that greater coordination among health care providers and other systems can change this harmful and costly pattern of care.

To a large extent, persistent homelessness in LA County and the rest of the nation stems from lack of affordable housing and poor integration of critical services that homeless and low-income people need to lift themselves out of poverty. Health care plays a critical role given the clear connection between poor health and poverty. In looking at neighborhoods with high rates of homelessness, such as Skid Row, the evidence is overwhelming that the safety net has failed homeless people. Multiple health-related services are needed to effectively assist homeless people who are often struggling with complex and overlapping health issues. More common than not, homeless people have unmet physical health, mental health, and substance abuse treatment needs. For homeless people, treating the "whole person" is a critical component of their path toward survival, recovery, and residential stability.

Notwithstanding many efforts to provide greater coordination among the health Departments on the ground, the physical health, mental health, and substance treatment services remain largely distinct. While there is some coordination, successful programs benefit only a handful of patients each. Many community members are confused as to how to access health and housing services and how to interpret or use the myriads of forms each Department uses. It is common to hear "I don't know how to get somebody into primary care" or "no matter what I've tried, I can't access mental health services for my patient" in a way they want to receive care, or "there is no housing for people who are currently using substances". This dysfunction has real consequences for people desperately trying to make a change in their lives. The fact that a case manager working with a homeless person has no clear path to assemble needed services across the spectrum of health programs, keeps that person homeless and revolving through the hospitals, jails, and streets, at great cost to that person's health and the public's finances. Given the natural dynamics of three separate health Departments in terms of philosophy, funding rules, accountability, program design, and housing-related priorities, it remains difficult to bring all the resources together that are necessary to make meaningful and course-changing interventions in the lives of homeless people.

Ending chronic homelessness starts with engaging people on the street and at the point of discharge from institutional care (e.g., hospitals, mental health facilities, jail). In order to be effective, outreach staff need to have a broad range of tangible resources at their disposal including access to detox and other substance abuse treatment services; crisis and on-going mental health services; urgent and primary care; and interim and permanent housing. This should also include supportive housing, which is widely viewed as key intervention for homeless people (and other populations exiting institutions such as jails, inpatient psychiatric facilities, and residential treatment). Supportive housing strives to provide a "whatever it takes" approach to helping residents recover and thrive, including access to a wide range of medical, social, and logistical supports. The three Departments hold the keys to all of these different types of housing services and resources. However, the reality is that the right combination of services is rarely available at the moment they are needed, or in the way that the individual prefers to receive them.

Many stakeholders commented that they felt existing funds could be better leveraged in an integrated model to solve this problem. A full spectrum of physical and behavioral health (including substance abuse) and housing services should be available to homeless individuals, implementing a true "no wrong door" approach in which chronically homeless individuals can be housed regardless of where or how they present. This would require finance staff to piece together full funding for services using a diverse set of different sources. As one example, individuals who require specialty mental health care are not able to access housing options, including permanent supportive housing with wrap-around case management services, 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. This common problem could be addressed in a two general ways: by creating new ways for people to engage in mental health care (e.g., via primary care co-locations) before they are housed in a way that may be acceptable to the patient, and by creating less restrictive shared housing and service entry criteria that rely on different mechanisms to verify an ability to use certain funding streams or by actually pooling funding behind the scenes.

The ACA, through for example expansion of the Drug Medi-Cal benefit and treatment of mild to moderate mental illness, presents a fresh opportunity to approach this problem in new ways, but opportunities exist to better integrate services even without these new funds.

Psychiatric emergency services

Overcrowding of psychiatric emergency service (PES) facilities is a longstanding problem, adversely affecting public and private hospitals and the individuals and families they serve. Beyond the human cost for the person in crisis, PES overcrowding also results in a greater risk of violence toward patients and staff and extended wait times for ambulances and law enforcement when ED staff members are not able to safely transfer individuals to ED care immediately after arrival. But more than this, it is a canary in the coal mine, reflective of deep societal problems, challenges in the health system's ability to fully meet the demand for health and often social services, and problems moving people efficiently between varying levels of care. It is often assumed that EDs and PESs, as well as LPS-designated[27] urgent care facilities, are filled past capacity because of a shortage of inpatient mental health beds in the County. While this is true on occasion, particularly for individuals with characteristics that make them difficult to accommodate, such as registered sex offenders, children, adolescents, pregnant women, individuals with comorbid medical issues, etc., it is not generally the case. On any given day, over half of DHS' 132 staffed inpatient psychiatric beds are filled with individuals who no longer require acute inpatient admission but for whom a placement deemed appropriate by the discharging physician is not available. A similar situation is prevalent in private EDs and inpatient psychiatric units. The cost of operating these inpatient beds is far higher than the cost of operating lower level of care placement options. Thus, the primary challenge is not a lack of funding but lack of an organized vision, and execution against this vision, for managing placement options across the full spectrum of an individual's acuity and clinical need.

Although the PES challenges are often thought of as an adult problem, the most challenging situations in the PES involve long stays for children or adolescents. The complexities of finding appropriate and available placements for children is a problem that impacts the entire County system of care, particularly given it involves a wider range of partners, including Regional Centers, DCFS, in addition to DHS, DMH, and private hospitals. For children with Serious Emotional Disturbances (SED), the many successful community-based services and the entire Children's System of Care efforts led by DMH in LA County can be augmented with more available crisis and acute services and better coordination among partners. Fairly recent changes in AB 3632, the erosion of Regional Center resources, as well as the lack of foster care placements capable of meeting the needs of children with SED has created a nexus of factors that leave children to cope with an acute crisis without many appropriate options. In many cases, these children can only find care in surrounding counties and only after waiting several days in County or private hospital EDs. Under a more coordinated, collaborative effort, the Departments could arrange for the necessary placements within the boundaries of LA County and also develop a strong legislative agenda to ensure future policy decisions enhance rather than further erode our ability to care for these children. The power garnered from working together on system design, legislative advocacy, and policy setting has potential to create new options and opportunities for children with SED and their families.

Multiple collaborative efforts have attempted to address the PES crisis for adults and children over the years. DMH has long co-located case workers in DHS inpatient psychiatric units in an effort to assist with discharge planning and placement options immediately after admission, freeing up beds for those in the PES. Still struggling with discharge delays, DHS and DMH have partnered more recently on an "all hands on deck" discharge approach which has yielded dramatic point-in-time results but has not proven sustainable. 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

[27] LPS (Lanterman Petris Short) designation refers to the ability of a facility to accept patients on psychiatric holds.

additional urgent care facilities able to serve as alternative destinations for a portion of individuals who would otherwise be transported to the PES. DHS has also partnered to expand the capabilities of one such urgent care facility. DMH's new urgent care center in Sylmar opened in 2011 as a non-LPS designated facility and, as a result, was unable to play a role in decompressing the chronically overcrowded Olive View PES located down the street. After several years of discussing various possible solutions to this problem, DHS and DMH have agreed for DHS to assume responsibility for operating and staffing the locked portion of the urgent care center, a move which will allow the facility to begin serving people on involuntary holds 24/7. Despite these and other initiatives, the census in the three County PESs has remained at twice or even three times the facilities' physical capacity for years.

Much more can and should be done to accelerate the movement of patients through the continuum of care while maintaining activities and resources that serve a vital role in stabilizing the PES system (e.g., PMRT teams, allocation of IMD beds to private hospitals). Below are examples of steps that could be taken to address challenges in meeting the needs of individuals in psychiatric emergencies. In many cases, efforts in these areas are ongoing, but a renewed effort and innovative approaches in these areas could yield benefits.

1. DHS and DMH must develop a collective vision for managing psychiatric emergencies, focused on getting people to the right level of care at the right time. Individuals should not have to experience long waits in County or non-County facilities for acute services and, similarly, those ready for community-based placements should not be slated for or kept in more restrictive types of care. This philosophy should apply County-wide, to both public and private hospitals.
2. The resources and budgets of each Department's investment into acute services, as well as those outpatient services that support discharges from the acute system, should be made more transparent.
3. The Departments should continuously evaluate whether or not available resources are maximally matched by federal funds (via the Waiver and other mechanisms) and flexible enough to purchase services or placements which are new and innovative in their function and approach, such as greater use of acute diversion units and crisis residential beds.
4. The County should continuously engage with private facilities on new strategies to support acute psychiatric services. This includes making sure County investments in psychiatric services in non-County facilities are strategic and maximize the benefit for all those served by the County.
5. The County should improve audits of IMD utilization to determine whether there is an opportunity to reduce length of stay and thus reduce wait times for patients in inpatient psychiatric units.

Bridging population and personal health

The field of public health began to differentiate itself from clinical medicine in the early 20th century due in large part to the rise of the biomedical model of disease and a resulting devaluation of other approaches such as health education, community mobilization, and regulation. Underfunding and misaligned financial incentives also began to increasingly impair a close linkage between public health and clinical service delivery as they resulted in payment structures designed to reward treatment of disease rather than prevention of it, paying for volume rather than outcomes, and incentivizing specialty care and procedural interventions over primary care, preventive care, and health promotion activities. Despite this history, public health and direct clinical services have complementary functions and share a common goal of improving a population's health, though the former defines "population" to include persons who do not seek or receive clinical care.

While the medicalization of physical health care was critical to progress in diagnosing and treating disease, the devaluation of social determinants of health during that same period was to the detriment of individuals and the achievement of population health goals. When society began to again recognize the critical importance of social determinants in the late

20th century, it happened in the context of largely siloed public health and primary care expertise and infrastructure, limiting the feasibility of a coordinated and collaborative response. This is unfortunate. Most of the major challenges facing primary care providers involve factors that are not present in the clinic setting. According to a commonly cited statistic, only 10% of an individual's health is attributable to the care they receive, the remainder being determined by genetics, social circumstances, environmental exposure, and behavioral patterns.[28] Rising health care costs also underscore the importance of re-integration, given the important role of public health activities in achieving sustainable and cost-effective improvements in a population's health.

Public health and primary care integration efforts have shown to benefit individuals and populations. While DPH's activities should not be limited to those served within DHS and DMH, improved integration of direct clinical care and public health could enhance the capacity of both Departments to carry out their respective missions. This would be done by combining knowledge, resources, and skills, including leveraging DPH's strong ties at the community level to link those served in County facilities to community-based organizations and resources in areas such as prevention, health promotion, health education and management of chronic disease. Giving providers population-based information relevant to their practices could enhance their capacity to address behaviors and underlying causes of illness. At a very practical level, greater linkages could also ensure that individuals who screen positive to risk factors or disease in the community could have streamlined linkage to primary care, obstetric, behavioral health, or other appropriate clinical access points within a delivery system if they do not have an existing provider.

Increased access to health information technology (IT) serves as a powerful tool in linking public health and clinical service delivery. If desired, DPH could use the recent Electronic Health Record (EHR) implementations in DHS and DMH to monitor and learn about diseases or risk factors that cluster in low-income or vulnerable populations seen within the County, including but not limited to obesity, tobacco use, substance abuse, food security, prescription drug/opiate abuse, etc. Greater cross-linkage between public health and the mental and physical health delivery system could also help the County play a greater role in setting a vision for the County's overall health care delivery system, improving coordination and collaboration across providers of all types, and understanding gaps that specific entities, including both public and private providers, may be well-suited to fill. On a similar note, the County could play a stronger role in engaging with private health care organizations in reviewing policy and operational issues that affect the entire County.

Integration efforts might also promote the seamless and strategic linkage of patients in the delivery system to community-based services. As one stakeholder put it "the days where patients receive their health care within the walls of a clinic building or doctor's office are over. The community is an important army for health care service delivery that needs a deeper tie into primary, specialty, mental health and other care." This point is more and more recognized in the personal health realm as evidenced by the evolution of the patient-centered medical home (PCMH) model. The most evolved PCMH models have seamlessly linked individuals with community-based services (i.e., cooking courses, exercise opportunities, food and transportation access, health empowerment and self-efficacy programs, weight loss interventions, etc.), providing important connections that can address the root causes of disease.

Tighter integration between physical and public health also creates unique opportunities to strengthen programs that rely on both strong public health programs and clinic-based services. Needle exchange is one example. High rates of substance abuse threaten not just the health and well-being of those addicted, but also many who surround them. Needle and syringe exchange programs are one important mechanism for reducing the unnecessary spread of infectious diseases, with benefits for population health and a reduction in unnecessary utilization of costly health services. Through closer integration, individuals being served in County-operated or funded clinics who could benefit from needle exchange could be seamlessly referred and connected (e.g., via warm hand-offs or other mechanisms) with such services in the community.

[28] Schroeder, S (2007). "We can do better – Improving the health of the American people." *NEJM, 357*(12), 1221-1228. Adapted from McGinnis, JM, et al, (2002). "The case for more active policy attention to health promotion." *Health Affairs, 21*(2), 78-93.

Similarly, those who visit community-based needle exchange sites could be connected with clinical services and resources they need to enhance their overall health, including SUD treatment services.

While people support the linkage between primary care and population health in theory, many wondered whether greater integration between DHS, DMH, and DPH would hamper collaborative efforts between public health and health care providers outside of the County's directly operated network. There is no reason why this must be the case. If created, an agency's proper focus and mission should not be on the individuals served by DHS or DMH, but on the ten million residents in LA County. To the extent that greater partnership between the County's health-related Departments helps to inform and improve the population health activities within DPH, this would benefit providers and individuals across the County. Also, while partnerships should not be limited to DHS and DMH, collaborations between DHS, DMH, and DPH are critical precisely because they focus on underserved, disadvantaged populations: safety net beneficiaries are one of the groups most affected by the social determinants that many DPH programs rightly seek to address.

Integrating services at the point of care for those seeking care within the County

A commonly shared goal of all stakeholders, both internal and external, is that clinical services should be more completely and consistently integrated at the point of direct care delivery for individuals, including both children and adults, cared for within (or in clinics funded by) one or more County departments. This section focuses on how best to optimize care for this set of individuals, a challenge complicated by the fact that Medi-Cal and safety net providers for specialty mental health services are encompassed in one provider network whereas primary care services are provided by DHS, Federally Qualified Health Centers (FQHCs) and other independent practice groups and plans.

A frequently cited 2013 data analysis revealed that only ten percent of the total active DMH outpatient client population was empaneled to DHS directly-operated primary care clinics. People have suggested that this means there is relatively little overlap between the DHS and DMH population and thus little need to create a mechanism to prioritize clinical service integration activities across the Departments. This conclusion, however, is inaccurate. First, the 10% figure underestimates the overlap between DHS' empaneled population and DMH's active client base.[29] Second, the true population of overlap between DHS and DMH that is relevant for service integration extends far beyond the cross-over between DHS-empaneled patients and active DMH clients. It should also include: a) Active DMH clients who use any clinical service (e.g., inpatient, specialty care, substance abuse services, personal care public health services) provided or funded by DHS or DPH; many of these individuals enter the County system via community-based primary care services (through either the County-funded My Health LA Program[30] or by non-contracted community-based primary care providers) b) Active DMH clients with no stable source of primary care, many of whom rely on County or private EDs, psychiatric EDs, urgent care centers, and inpatient units for their comprehensive health-related needs c) Individuals with a serious mental illness or serious emotional disturbance who are seen within County or private hospitals/clinics but who are not actively engaged in the DMH system. All of these individuals may benefit from a connection with a resource able to provide integrated health services, obtained through either County or community-based resources, or a combination thereof. Certainly there are many active DMH clients with a stable source of high-quality physical and behavioral health care in private clinics and who do not use DHS or DPH direct clinical services; this should not be used as an argument to deprioritize the needs of often vulnerable individuals who are not so well-connected.

[29] Reasons for the underestimate include: 1) Data was pulled early in DHS' empanelment process. In 2013, ~ 250,000 patients were empaneled to DHS primary care clinics; today the figure is ~500,000. 2) The data match process is prone to error: since the Departments do not share a unique identifier, data matches are highly error-prone and tend to underestimate the true shared population.
[30] My Health LA funds primary care at contracted community clinics for up to 150,000 uninsured LA County residents.

Given high rates of mental illness and SUD among Medicaid populations[31], the total population of individuals who could benefit from integrated health services across DHS, DMH, and DPH is likely high. Attention to these groups is important because those served within the County and in clinics funded by the County are some of the most disadvantaged, underserved, and overlooked populations in LA County. They are disproportionately low-income and may not be eligible for public insurance. They are members of underrepresented minorities or groups who have long suffered health disparities, discrimination, with poor (or no) access to care. Some portions of this population come to the attention of mainstream society only when they are in crisis, when they present a personal and public safety risk, when they over-use emergency services, or when they are identified as imposing high societal costs. They may be part of particularly vulnerable segments of society: recently incarcerated, children and transitional age youth, disabled, and/or homeless. There are many individuals within the County who would likely benefit from coordinated mental health, physical health, and often substance abuse treatment services. A failure by the County to well-serve these populations propagates and even risks increasing health disparities in LA County.

Much has been written about the different models through which care can be integrated in different populations. Integration activities range in intensity from simple care linkages to more complex care models utilizing a diversified and highly-trained workforce.[32] Co-location, while often a core component of the model, is not in and of itself sufficient to bring about true service integration. The target population (including children and adults, specific ethnic/racial groups, those with various medical or psychiatric diagnoses, etc.), design, and health-related outcomes of these models vary substantially. Rather than summarizing this excellent body of literature[33], this section will focus on the overall opportunities and benefits for clients/consumers/patients in LA County. The specific opportunities to be pursued should depend on a number of factors including the needs and preferences of individuals, communities, and populations served, their degree of connectedness to the current system, comorbidities, etc. Local community place-based initiatives, including those operated by the County as well as community-based models developed and led by contracted agencies and providers, that have demonstrated success in serving the needs of a diverse set of individuals and populations, and evidence-based models of service delivery that support a range of different communities and that can be adapted in response to the voice and culture of individuals and their communities, should be prioritized for implementation, particularly if they can be brought to scale in a sustainable manner.

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[31] Rates of mental illness in Medicaid populations are over twice the rate as in the general population; among disabled Medicaid patients, mental illness prevalence is estimated to be approximately 50%. (Kronick, M (2009). "The faces of Medicaid III: Refining the portrait of people with multiple chronic conditions." *Center for Health Care Strategies, Inc.)*

Substance use disorders are estimated to affect approximately 13.6% of those newly eligible for Medicaid and approximately 11.9% of those previously eligible; (vs. a rate in the general population of 10.3%). (Mark, TL. et al. (2015). "National estimates of behavioral health conditions and their treatment among adults newly insured under the ACA." *Psychiatric Services*, 66(4), 426-429.)

[32] Throughout this report, "workforce" refers to both County and non-County staff at private and/or contracted agencies and providers.

[33] While numerous publications exist, the following provide overviews of integration models, frameworks, and key success factors:

a) Agency for Healthcare Research and Quality, "Integration of mental health/substance abuse and primary care," No 173, 2008.
b) Institute for Healthcare Improvement and the Lewin Group, "Approaches to integrating physical health services into behavioral health organizations: a guide to resources, promising practices, and tools," prepared for CMS, 2012.
c) The Kaiser Commission on Medicaid and the Uninsured, "Integrating physical and behavioral health care, promising Medicaid models," 2014.
d) Millbank Memorial Fund, "Evolving models of behavioral health integration in primary care," 2010.
e) National Council for Community Behavioral Healthcare," Behavioral health/primary care integration models, competencies, and infrastructure," 2003.
f) National Council for Community Behavioral Healthcare, "Behavioral health/primary care integration and the person-centered healthcare home," 2009.
g) SAMHSA-HRSA, Center for Integrated Health Solutions, "A standard framework for levels of integrated healthcare," 2013. SAMHSA-HRSA, Center for Integrated Health Solutions, "Advancing behavioral health integration within NCQA-recognized patient-centered medical homes," 2014.

Bi-directional co-location and integration of primary care and mental health services to enhance access to care

To the greatest extent possible, individuals should have the option to receive integrated primary care and mental health services, including both specialty and non-specialty services, in the location where they are most comfortable. There are two general forms this could take: co-locating and integrating primary care services in mental health settings and co-locating and integrating mental health services in primary care settings. Both models can apply equally to directly-operated and contracted clinic sites, though the implementation steps for each will obviously vary.

In co-located, integrated models, physical health services would be provided by nursing and/or provider-level staff who can tailor treatment approaches based on the individual's risk factors for physical illness, medical history, and readiness to engage with the health system. On the mental health side, the individual's level of impairment and scope of need for specialty vs. non-specialty mental health services will determine whether these services should be provided by members of the primary care medical team itself, with education and consultation provided by mental health staff, or by mental health staff directly. This co-location of services should not be limited to manage those with only mild to moderate mental illness. Primary care clinics across LA County are frequently used by those with serious mental illness and serious emotional disturbances, just as specialty mental health providers are used by those with physical health conditions. The goal is to effectively manage a full spectrum of services in a way that is responsive to the needs of the individual client. One summary of how this division of responsibility could work is provided in "Revised Four Quadrant Clinical Integration Model" as described by the Second Supervisorial District Empowerment Congress Mental Health Committee.[34] It presents a six-box matrix for how integrated services would be provided depending on an individual's physical health risk (high/low) and mental health risk (high/moderate/low), advocating that individuals at mild and moderate mental health risk can be successfully served in physical health settings by a combination of mental and physical health staff, in addition to mental health settings as is the commonly accepted practice. Despite the appeal of co-location, there is a sizeable gap between individual demand and what the system is currently able to provide.[35]

***Primary care services co-located and integrated into mental health settings*:** For over a decade, those with co-occurring serious mental illness have been known to die more than 25 years earlier than people without mental illness, with the majority of the excess mortality stemming from largely preventable and/or treatable medical conditions.[36] There are multiple explanations for this finding. First, individuals with mental illness have higher rates of clinical (e.g., smoking, obesity) and social (e.g., poverty, homelessness) factors than the general population. Second, individuals with mental illness may be uncomfortable or unwelcome in traditional medical settings, including primary care clinics. Individuals may also be fearful of new situations or may have had negative experiences in physical health clinics previously, in part due to the stigma associated with mental illness, because clients believe primary care providers look down on them, or because primary care providers do not have time to manage the concerns of mental health clients. Also, those with mental illness are frequently under-diagnosed and under-referred to primary care or specialty care services, despite their high risk for disease and the known physical effects of psychotropic medications. In the words of one stakeholder: "primary care just doesn't work for many [mental health] clients". Outcomes among children are equally disturbing.[37] Given the high stakes, taking time to strengthen and evolve the availability of primary care in mental health settings should be a high County priority. The operationalization of a sophisticated primary care-mental health integration model will take time to develop

[34] Second Supervisorial District Empowerment Congress Mental Health Committee, "Los Angeles County Mental Health Services 2014 White Paper," 2012.
[35] Blue Shield of California Foundation, "Exploring low-income Californians' needs and preferences for behavioral health care," 2015.
[36] Parks J, et al, (2006). *"Morbidity and mortality in people with serious mental illness."* National Assoc. of State Mental Health Directors.
[37] SED youth have higher rates of pregnancy and STDs, including HIV, than the general population, and experience higher rates of SUD and suicide. Youth with SED are also at higher risk for not graduating from high school, homelessness, illness, poverty, future unemployment, dependence on public systems, and arrest, many of which are associated with chronic diseases and premature mortality. (Davis, M., Vander Stoep, A. (1997). "The transition to adulthood among adolescents who have serious emotional disturbance." *Journal of Mental Health Administration, 24*(4), 400-427.

but is an important venture if we hope to reverse the decades-long trend of premature morbidity and mortality among those with mental illness.

***Mental health services co-located and integrated into primary care settings*:** Partly due to the intense stigma of mental illness, many of those seen in the physical health system "fly under the radar" and don't receive necessary mental health or substance abuse services, engaging only in the primary care (or other physical health) system where their less stigmatized medical illnesses are addressed but where their behavioral health issues are often undertreated. Even when an individual would accept treatment for mental illness, there are additional challenges in connecting them to care, both because of a failure by primary care providers to screen and refer both children and adults to mental health and failure of the system to translate that referral to a timely visit. Many 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 in identification, diagnosis, and treatment techniques, including use of recovery-based approaches. For other individuals, treatment by a mental health professional may be required, but could often still be performed in the physical health setting, enhancing access to and retention in care. These actions are currently being undertaken by DHS and DMH to some extent but could be accelerated.

DHS and DMH have attempted to address this need previously with a basic co-location model in which DMH placed a psychiatric social worker in certain DHS adult primary care sites, while recognizing that successful co-locations between DMH and community clinics and among pediatric populations should also be supported. While several sites have been in place for over three years, the volume of referrals has been lower than the suspected need in each clinic and providers have criticized the actual impact on access and linkage to care. There are many reasons for this, including a cumbersome referral system, resistance from primary care leadership and/or slow adoption by primary care providers in certain sites, and sub-optimal mechanisms for ensuring joint consultation and follow-up between providers. Some stakeholders pointed to successful examples of these DHS-DMH co-location efforts as evidence of what could be accomplished without an agency. Others argued that the challenges support the need for a new model to promote service integration.

Co-location can offer particular benefits to those with complex medical problems and disabilities. These individuals often require a broad mix of services including substance use treatment and mental health care but face unique challenges in navigating a complex array of physically separated services. One example where greater collaboration and integration could be specifically helpful is in meeting the needs of Traumatic Brain Injury (TBI) patients. TBI patients have a high prevalence and incidence of mental illness and substance use disorders, both prior to and following their injury.[38,39,40] Given the nature of this group's behavior, proper facilities and integrated models of care are needed to help manage their complex rehabilitative needs.

While critical, physical co-location is only one aspect of care integration. Clinics, including both directly-operated and contracted partners, could also be assisted in helping to evolve partnerships in a deeper and more deliberate way, such as the development of shared care plans, merged care management functions, etc.

[38] Model Systems Knowledge Translation Center abstract: "TBI Model System Collaborative Study of Amantadine for Post TBI Irritability and Aggression." Accessed March 23, 2015 at: http://www.msktc.org/projects/detail/1059.
[39] Kolakowsky-Hayner, SA (1999). "Pre-injury substance abuse among persons with brain injury and persons with spinal cord injury." *Brain Injury, 13*(8), 571–581.
[40] Ohio Valley Center for Brain Injury Prevention and Rehabilitation. (1997). "Substance use and abuse after brain injury; A programmer's guide."

Improved access to substance use services

Approximately 8.2% (21.6 million) of US residents aged 12 or older suffered from a SUD in the past year.[41] These individuals tend to be heavy utilizers of health services, incurring between two and three times the total medical expenses as those without SUDs.[42] Similar to the statistics for individuals with a mental health condition, individuals with a SUD die on average 26 years earlier than the general population due to modifiable risk factors and physical health problems related to their long-term substance use.[43] Also, despite frequent use of public and private EDs, psychiatric emergency services, urgent care clinics, and mental health facilities, very few admissions to SUD facilities result from referral from other health professionals[44], evidence of a disconnection between the health care system and the SUD delivery system. As a result, individuals with SUD fail to receive the well-documented benefits of SUD treatments, receive physical health care in isolation from their medical risk factors, and the County fails to achieve the cost savings that accrue when SUD services are effectively integrated or coordinated with other health care settings.

Recent legislative changes under the ACA and its renewed focus on the importance of parity present an unprecedented opportunity to end the past forty years of separate and unequal resources for the treatment of SUDs. Currently, the Substance Abuse and Mental Health Service Administration (SAMHSA) is considering changes to federal substance abuse confidentiality rules, in part due to their acknowledgment that the strict consent requirement of the Federal Substance Abuse law, commonly referred to as Part Two, makes it difficult for programs to participate in care coordination initiatives that facilitate the sharing of health information. These legislative efforts, combined with new knowledge from basic, clinical, and health services research over the past two decades, have set the stage for a new public health-oriented approach to managing SUDs with the same insurance options, healthcare team composition, clinical goals, and clinical methods analogous to those used to manage other chronic illnesses such as diabetes, asthma, or chronic pain.

Changes in SUD treatment models are much needed. Recent advancements in understanding the biopsychosocial basis of addiction has led to new models for treating SUD, including medical assisted therapies. However, these new models have not been widely incorporated into SUD treatment. For the most part, existing treatments for addiction are "program-centered" rather than "person-centered" – everyone gets the same care regardless of the type of addiction or coexisting medical and/or social problems. Because everyone essentially receives the same care, there has not been a movement to evaluate other influences including issues related to employment, legal or family issues, and medical/psychiatric problems that could affect the course of recovery. Previously, health coverage linked to SUD programmatic care has been time- or session-limited, and the financial limitations of health coverage have restricted the range of treatment components (tests, medications, therapies, family support services, etc.) available within any treatment program.

With the augmentation of the Drug Medi-Cal (DMC) benefit and the need to reestablish and augment the DMC provider network, the County should specifically explore opportunities to expand DHS' and DMH's clinic and workforce capacity to provide substance abuse services. A recent Medi-Cal managed care requirement for primary care providers to offer alcohol Screening, Brief Intervention, and Referral to Treatment (SBIRT) has drawn attention to substance abuse, but has not extended to actual treatment capacity. Currently, outpatient substance abuse services are primarily contracted out. DHS and DPH need to explore how substance abuse screening, counseling, and treatment might be offered within existing DHS primary care clinics or DMH mental health clinics, alongside contracted partners. This may be done through training DHS staff in how to manage SUD patients by employing more focused workforce models such as greater reliance on certified

[41] SAMHSA. Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings. http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf
[42] Thomas, MR, et al, (2005). "Prevalence of psychiatric disorders and costs of care among adult enrollees in a Medicaid HMO." *Psychiatric Services, 56*(11), 1394-1401.
[43] Oregon Dept. of Human Services, Addiction and Mental Health Division (2008). "Measuring premature mortality among Oregonians."
[44] According to an analysis of Los Angeles County Participant Reporting System (LACPRS) data in FY 13-14, only 1.4% % of admissions came directly from a health professional referral.

substance abuse counselors as DMH has been doing for a number of years. In this instance, the integration of certified SUD counselors into DHS clinics, as is already the case in DMH clinics, would complement the professionalization of the SUD workforce to create a healthcare workforce that is more similar across systems of care and whose training reflects the individualized needs of whole-person care.

While the role of psychosocial interventions and more recovery-focused approaches should be strengthened, advances in pharmacotherapy have also led to an increasingly medicalized model for delivering substance abuse treatment, including office-based pharmacologic treatment interventions such as Buprenorphine (Suboxone) for opiate addiction and Naltrexone for alcohol use disorder. These changes in the substance abuse field require a diversification of the SUD workforce to include more highly trained individuals, such as physicians, nurses, psychologists, and social workers. Greater use of these professionals within mental health and physical health settings would complement the services provided by SUD counselors and allow for the development of a system of care for substance abuse that can more comprehensively and efficiently meet the needs of persons with SUD. In the transition toward more integrated systems of care, the agency model will play an important role in ensuring that the level of professionals in substance abuse mirror those in physical and mental health in order to allow for more effective coordination and communication. As it expands capacity to provide substance abuse services, the County should pursue possible certification of DHS and DMH clinics as DMC providers. This would not only improve care for individuals using the County's delivery system, but would also help to support the overall success of the expanded DMC benefit in LA County by increasing access and network coverage. DMC certification would also allow the County to be reimbursed via DMC for office-based pharmacologic interventions and other services for which a dedicated revenue stream does not currently exist.

Improved access to quality substance abuse treatment will have positive downstream effects on overall population health goals, including both physical and mental health: just as it is difficult to remain healthy while hungry or homeless, managing disease and becoming healthy is near impossible while addicted. In addition, individualized approaches to illness management for individuals suffering from alcohol and other addictions will require close coordination across the Departments to sustain self-managed recovery – specifically, sobriety, personal health, and good social function. Transitioning individuals through a system of care that is coordinated with all other aspects of their health will allow providers to anticipate challenges and intervene promptly to help patients prevent relapses, reduce ED visits and hospitalizations, and improve health outcomes.

An additional advantage of having DHS and DMH provide directly operated SUD services is that the County becomes directly familiar with the practice, approaches and operational realities of delivering these services. This firsthand experience allows the County to be more knowledgeable and discerning purchasers of substance abuse contracted services and enhance the ability to design more accessible and integrated programs with its existing contractors as has been DMH's historical experience.

Beyond SUD network expansion, another potential benefit of greater linkage between substance abuse and primary care is a more coordinated strategy for managing prescription drug abuse. With the expansion of Medi-Cal, it is paramount for direct service providers such as DHS to remain vigilant around opiate diversion, misuse, and abuse. Bringing DPH contractor expertise and energy together with DHS providers might allow the County to improve approaches to preventing and managing opiate abuse and diversion. In turn, these improvements could be shared and adopted in contracted clinics.

Finally, greater collaboration could help to identify opportunities and mobilize resources to expand access to inpatient rehabilitation or residential services, particularly important with the expansion of the DMC benefit under the ACA. The Departments may also choose to prioritize creation of more novel approaches to detox, such as integrated sobering centers supported by physical and mental health, housing, and other social services. One program that could serve as an example for the County is the Restoration Center in San Antonio, TX. The Restoration Center is a detox and substance abuse treatment center that provides assistance to homeless individuals struggling with alcohol and drugs and those with severe

mental illness. The Restoration Center provides 48-hour inpatient psychiatric unit, residential detoxification, a sobering facility, injured prisoner programs, outpatient substance abuse treatment including intensive outpatient substance abuse counseling services, in-house recovery programs, linkage to housing, and job training. More than 18,000 people pass through the Restoration Center each year. The Center has saved the city of San Antonio more than $10 million annually, largely from reducing the inappropriate use of emergency rooms, unnecessary hospitalization, and detention in jails and mental health facilities.[45] Other benefits include increased support for homeless populations and greater efficiency in the use of law enforcement.

The County should also leverage opportunities to influence Medicaid coverage regulations and design of opportunities in the upcoming Section 1115 Waiver (e.g., inclusion of sobering center services for uninsured individuals in the proposal for a merged Disproportionate Share Hospital / Safety Net Care Pool fund). The approval of California's DMC waiver, which would shift DMC financing to a per user per month capitated payment would also help to further incentivize novel approaches to managing this chronic disease and the high associated health and social costs.

While stakeholders voiced mixed views of the agency model itself, they were nearly unanimous in supporting any changes in the County that could improve support for a full continuum of SUD services based on medical need. Citing extremely low penetration rates at less than 20%[46], stakeholders commonly commented that "it certainly couldn't get any worse." Stakeholders cited the need for treatment on demand and simultaneous access to multidisciplinary services as "the only things that are proven to make a difference for real people in crisis." They pointed to screening and early intervention for both alcohol and other drugs, such as through use of SBIRT, as offering the best hope for changing the course of disease. "We treat substance abuse, a chronic brain disease, episodically in EDs, psychiatric EDs, and in jails, and then we wonder why it isn't working." As with the integration of mental and physical health, the County needs to develop an organized system of care for the management of SUD, a model that offers interventions for individuals across acuity levels and at different stages of willingness to engage in their recovery. Integrating all three service spheres - mental health, physical health, and substance abuse - into the same site would help each Department better connect individuals to the right service, at the right time, in the right place in a way that is efficient and person-centered. This does not imply that all individuals prefer to receive all of their health-related services at a single site; they do not. Individuals who prefer to maintain separate locations or providers for their disparate health services should continue to have this option available to them. As with all efforts to integrate and streamline access to services, the goal is to provide clients/consumers/patients with greater, and not more limited, degree of choice as to how they access programs.

Complex care programs

One of the most important opportunities could be to better align programs currently underway in each Department to help support and manage the most complex individuals within each service area. Although each Department's programs are distinct, they often share similar elements. These include: a) a focus on a specific population; b) use of specific demographic, clinical, or utilization characteristics to identify the target population; c) innovative uses of often non-licensed workforce members; d) services provided both within and beyond the four walls of a clinical setting; and e) often have complex financing sources that must be navigated.

Individuals with complex chronic injuries (e.g., spinal cord injuries) and diseases (e.g., HIV infection) may especially benefit from complex care programs provided in an integrated, collaborative manner. For example, individuals with HIV require a unique and complex set of services from a variety of health providers. Accessing such care is particularly complicated given

[45] http://www.chcsbc.org/innovation/restoration-center/; http://kaiserhealthnews.org/news/san-antonio-model-mental-health-system/
[46] Los Angeles County Participant Reporting System data, 2013. Los Angeles County DPH, Substance Abuse Prevention and Control.

the complexity of payer sources that individuals and their providers must navigate in providing this care, including services covered under Ryan White Care Act, the AIDS Drug Assistance Program, SAMHSA, and CDC-funded programs. These complicated payer sources are compounded by a fragmented provider system and the acute need for preventive and non-medical community-based interventions to address ongoing disparities in HIV incidence, access, and outcomes among specific populations (e.g., communities of color).

There are a variety of synergistic opportunities to align certain aspects of these programs:

1. ***Program development:*** A critical way in which to support the development of complex care management approaches is to lead the Departments to adopt a joint program design and implementation approach, including non-County partners and providers when appropriate to do so. The experience of Project 50, which DMH facilitated in 2007 with a goal of permanently housing fifty of Skid Row's most chronically homeless individuals, is a concrete example of a project that successfully engaged health and social service County departments for the benefit of individuals and the community. While a good example of integration, it will be important to build programs such as these to a much larger scale, a goal that takes substantial energy and coordination.

2. ***Risk stratification and identification:*** Currently each Department determines its own eligibility criteria for complex patient and high-utilizer programs, usually based on requirements of associated funding streams. Because the criteria are often similar but not overlapping, certain high-cost, high-need patients may qualify for a program with a certain set of benefits in one Department but not for a program with separate benefits in another. This makes it difficult and confusing for providers, inside and outside the County, to know how best to connect individuals with the services and programs they need. Departments should consider jointly determining where the overlap is in their respective populations and how to structure eligibility so the benefit is to the most complex individuals possible at the County, rather than Department, level without incurring fiscal liabilities and audit issues.

3. ***Data/analytics:*** These programs are often resource-intensive and thus require heightened scrutiny as to their performance and value. The Departments should synchronize their approaches to measurement and analysis (where there are opportunities to do so), reducing duplication of analytic activities, facilitating response to the varying needs of funders, and allowing for more robust program analysis which can inform which programs should be further supported and which may require alteration.

4. ***Training:*** Given high use of non-licensed clinical (e.g., community health workers) and non-clinical (e.g., analysts, epidemiologists) staff and the need for constant recruitment due to staff turnover, it could be valuable to centralize scarce but critical expertise and adopt a coordinated, efficient way for the Departments to train and educate the workforce. This may mean, for example, jointly partnering with labor- and community-based agencies expert in the use and training of certain personnel. In doing so, opportunities for those with lived experience should be maintained and expanded.

Apart from the needs of highly complex populations, individuals who use services in more than one Department would benefit from greater commonality in Departmental forms and electronic documentation tools (e.g., forms for registration, consent, and care planning, population registries, screening and discharge planning tools). Greater alignment in tools would allow for development of more efficient and transparent care management approaches, shared assessments of clinical quality, and would help County departments and community-based organizations to more consistently interact around specific individuals they share in common. Aligned documentation tools could also facilitate greater use and effectiveness of multi-disciplinary team meetings for high-risk populations including youth in foster care, re-entry populations, homeless individuals, and fragile elderly.

Integrated children's services

A majority of the content in this report applies equally to adults and children. Still, a number of stakeholders requested discussion of integration opportunities that are specific to children. There is no doubt that children across the County would benefit from a coordinated effort to integrate services and programs. While many integration opportunities apply to both adult and youth populations, opportunities for children are different in a few important ways: a) they must place greater focus on prevention and early intervention efforts alongside more traditional direct services; b) they must be collaborative with entities focused on children, particularly DCFS, the LA County Office of Education, and schools; and c) they must promote a broader agenda that prioritizes policy and legislative changes to promote overall child safety and well-being.

Many of the current successful children's services provided by the Departments can be enhanced through integration. For example, integration can promote service augmentation and close gaps for unique populations such as children and youth in foster care (CYiFC), TAY, youth in the juvenile justice system, children with serious emotional disturbances, children with co-occurring mental and physical health issues including some children in the California Children's Services (CCS) program, and children cared for by guardians without strong social supports and who themselves have multiple comorbidities and use multiple County services. Integration can also improve the coordination of the many preventative and early intervention services targeting children and their families around violence prevention, trauma avoidance (e.g., promoting bike helmets), obesity prevention, substance use prevention, and communicable disease prevention, to name a few.

The County has over 2.3 million children between 0-18 years of age.[47] The County's direct services touch the most vulnerable of these children while the prevention, protection, and safety messages touch a much larger number. In regards to direct services, the health-related Departments are uniquely positioned to provide comprehensive, convenient, and effective care to the most vulnerable children in LA County, either in traditional clinics or alternative settings such as school-based clinics, other community sites, or using home-based visit models. By joining forces, the Departments might provide a state-of-the-art model of trauma-informed health home services ideal for those in the foster care or juvenile detention systems. Most of the children touched by DCFS and/or juvenile detention come through the doors of DHS and DMH at some point. However, the disconnect between the DHS medical Hubs and the DMH-led mental health assessment and services programs represents a missed opportunity. By virtue of the recent Board of Supervisors-supported Hub augmentation promoted through the Blue Ribbon Commission on Child Protection, wherein DHS partnered with DCFS and DMH to augment existing medical services with co-located mental health and case management services, the County is beginning to put together this more comprehensive, continuity model for CYiFC. The Hub system, through its planned case management enhancements, hopes to build on its current capabilities to stretch into communities and schools that are vital to the success of these children.

For youth in the juvenile justice system, the recent effort to create a more scripted and robust aftercare planning process for youth in the juvenile camps can be leveraged to create a functional re-entry system for youth returning to their families and communities. For many youth, their time in the camps provides an opportunity to make certain life improvements and changes but consolidating these gains when they return to their communities can only occur with a more concerted, integrated, and coordinated effort. To do this well will require DHS, DMH, and DPH to work together to not only provide thoughtful, targeted aftercare planning but also to ensure seamless and coordinated implementation of these aftercare programs. A youth exiting a camp with diabetes and substance abuse problems, for example, should find services provided by DHS or a community-based provider connected to and coordinated with a SAPC-contracted provider. The chance to actually change the arc of this youth's life depends on services that are convenient, family-centered, and that work together, rather than in silos.

[47] US Census Bureau, 2013.

Over the past five years, the science of how trauma impacts overall development as well as mental and physical health has rapidly developed. We know that exposure to early trauma in the home or community creates hormonal surges that are unusually high in childhood, create abnormal neural white matter connections that are hard to interrupt and ultimately become a root cause of challenging behaviors and illness throughout life. These behaviors and illness put affected children at a distinct disadvantage in coping with life stressors and compromise their chances of succeeding in society. The frequent result is children who have difficulty in school, poor acquisition of life skills such as reading and basic arithmetic, high truancy rates, difficulty forming strong peer and adult relationships and, ultimately, missed educational opportunities to improve their life chances. DHS, DMH, and DPH should be among the leaders in working to turn the tide on the prevalence and the impact of childhood trauma and in the provision of trauma-informed care.[48] This will take many forms, such as violence prevention initiatives, identification of child abuse and neglect, efforts to reduce the rapid rise in opiate abuse among children, enhanced roles for school-based health centers, and collaboration with schools to ensure individualized education plans (IEPs) have the requisite behavioral and physical health services needed to support children and family, to name a few. The specific learning and expertise that the Departments have developed in trauma-informed care should be spread across one another in design of services for children. The Departments should become a visible and vocal County leader in determining not only how to integrate services currently siloed within DHS, DMH or DPH but to also ensure trauma-informed practices are implemented within these integrated services. The Departments should work with the County's Office of Child Protection, the broad LA County funding community, First 5 LA, as well as the rich array of community-based providers working hard, day-in and day-out for these children and families, to set a clear and strategic agenda that supports children already exposed to trauma and to lessen the future exposure to trauma so more children can develop into healthy and productive young adults free of the poisonous impact of surrounding stressors.

Although many other parts of this report relate to children, it is appropriate to mention a few that are most relevant to promoting health and wellness, especially for the most vulnerable. This includes the importance of information sharing across the Departments; figuring out how to efficiently share this information while maintaining compliance with all relevant regulatory safeguards will be key to the success of any service integration effort. Similarly, reducing the maze of interactions required for non-County entities to partner with the Departments will promote collaboration and effective program development so children and families can use their energy to become stronger rather than on navigating our currently disjointed system. The technology enhancements potentially available in a more integrated health system will certainly improve efforts to reduce duplication and ensure timeliness of care to the most vulnerable children and youth who move between institutions and placements and suffer the inefficiencies of poor coordination.

Expansion of the recovery and resiliency model into physical health care settings

The recovery model emphasizes an individual's capacity to change and gain control and meaning in their life through empowerment, hope, community, and attention to the whole person. Among children with SED, the resiliency model also emphasizes integrated systems of care (e.g., involving family, school, community agencies, etc.) to enhance a child's future opportunities. Both models rely on care being client-directed and incorporate a strong family focus where relevant. DMH's community mental health programs are centered around the concept of recovery and resilience, rather than on a "medical" model for treating mental illness. While often used in the mental health context, an emphasis on recovery and resilience should not be reserved only for specialty mental health populations. Housing programs (e.g., DHS' Housing for Health program), care models for those with uncurable chronic medical conditions, and many approaches to substance abuse treatment often employ a recovery philosophy with good results. Despite wide and growing recognition of the value of recovery-based approaches, use of the model could be expanded. For example, DHS could increase use of recovery

[48] It should be noted that DMH has already gained approval to devote $91million to the furtherance of trauma-informed care through the Health Neighborhood Initiative using MHSA Innovations funds.

philosophies in managing individuals with chronic pain or chronic conditions, particularly those not well-served with available medical interventions. Individuals with diabetes, chronic pelvic or abdominal pain, arthritis, or headaches could benefit from a greater emphasis on recovery. An agency could help spread these practices across the Departments, making available additional treatment options based on an individual's level of commitment to engage and change.

Greater linkage to care by embedding primary care in DPH direct service clinics

When DPH became a separate department in 2006, it retained responsibility for operating direct clinical services such as STD screening and treatment, TB control, and immunization clinics. Both DHS and DPH acknowledge there was little coordination between these services and primary care prior to the separation. By embedding primary care in DPH clinics, LA County residents who rely on DPH clinics for certain focused services could have the option of accessing more comprehensive services at the time of their visit. Although STD, immunization, or family planning services might be the initial draw, co-locating a nurse or provider would help identify those with or at risk for chronic medical conditions, substance use disorders, domestic violence, or other potentially mutable conditions that benefit from early intervention.

For childhood immunization services, offering, but not requiring, well-child services could increase the number of school aged children who receive necessary anticipatory guidance, are screened for common chronic diseases prevalent in childhood, and are assessed for developmental or behavioral issues that can impede school success and achievement. Beyond the benefits in access and care quality, an additional advantage of this approach is the opportunity to enhance the system's funding by assisting with eligibility determination and enrollment for Medicaid, with linkage to the person's provider of choice either within or outside of DHS. Finally, there is an opportunity to better integrate mental health screening tools into both DHS and DPH pediatric clinics, actions that could help make important early interventions for at-risk children. Literature shows that most serious mental disorders begin early in life (50% by age 14 and 75% by age 24[49]) but, unfortunately, less than half of children with such disorders receive treatment appropriate for their condition.[50] County clinics serve a number of children who are at high risk for behavioral health problems and who could qualify for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits through Medi-Cal but whom are not routinely and systematically screened. Implementation of standardized screening tools for mental illness could be an important way to identify and link individuals with the mental health services they need and are entitled to.

Tuberculosis (TB) services

Due to prompt intervention and intense case management by DPH's TB control program, TB rates are declining in the County. However, there are still a number of individuals undergoing community-based treatment for TB or who require ongoing surveillance by DPH. Inpatient and highly specialized outpatient care (e.g., pulmonary procedures) are provided by DHS as well as non-County hospitals and clinics, but providers in the different Departments are unable to easily and quickly exchange health information for care and treatment purposes. Advances in achieving a unique patient identifier, common medical record (or linked systems) would help, as would a greater level of joint care planning. DHS and DPH could also rely on one another's ancillary services (e.g., radiology) based on availability in certain locations with resulting cost-savings. Bringing together the housing efforts within DHS and DMH with the TB housing efforts of DPH might allow LA County to better serve homeless TB patients. Finally, better coordination between DPH's surveillance and control of TB within the jail

[49] Kessler RC, et al, (2005). "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication." *Archives of General Psychiatry, 62*(6), 593-602

[50] Costello JV, et al, (2014). "Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey – Adolescent." *Psychiatry Services, 65*(3), 359-366.

and DHS' inmate specialty health services could allow for a more efficient approach to the management of possible jail TB, including fewer unnecessary admissions to rule out TB, a costly evaluation in a hospital setting.

Streamlining access to care

While the clinical care in County facilities is often excellent, the process of getting connected to that care can be challenging. In many stakeholder sessions, individuals came forward describing satisfaction with the care they receive in the County and their anxiety or fear that the agency would disrupt the services they have come to rely on. Yet in listening to these stories, they frequently started with a description of how difficult it was for the individual to get established in care in the first place. They described weeks, months, and in some cases years, of being referred from place to place, both within the County system and between private and County providers, of having to fill out an overwhelming amount of paperwork, of having appointments cancelled without notice, of having their information not available when they went to the next site of care.

A great deal of time is spent discussing a "no wrong door" approach to accessing care and services. Despite the attention the topic receives, there are still a variety of doors to access County services/programs, many of them "wrong" or at least ineffective at linking people to the services they need in a client-centered, efficient manner. The redundancy and waste in the system is striking, as is the impact on customer satisfaction, retention in care, timely access to services, service coordination/rationalization, reimbursement, and ultimately, quality. While people acknowledge this current state and support the development of a coordinated, rational way for individuals to access the system, the operational barriers to making true headway on the issue are sizeable. "No one knows what services are available across the whole continuum, much less how to get your patients to access them. It's a black hole."

Screening tools; referral criteria, protocols, and tools; consents and authorizations; patient financial services policies and protocols; unique identifiers; registration and check-in procedures; and preferred points of entry to services are not aligned across Departments. Even if hypothetically consistent, which they are not, the duplication in these processes is tremendous, in large part because the Departments do not share a common identifier between one another so cannot tell in real-time when someone is known in another part of the County. DMH has access to the services provided in its network of care, but may have trouble matching those with DHS provider records. "You have no idea the number of times I had to fill out paperwork asking the same questions. Everywhere you go it's the same thing. I have to start from scratch every time. Doesn't anyone talk to each other?" Contracted service providers outside of mental health also lack a common identifier and often cannot easily refer individuals to one another. Despite being well-established in one Departments' system, that Department must first send them, either physically or virtually, for referral processing, or force individuals to start over by telling them to dial a 1-800 number to access mental health services or to go to emergency or walk-in sites to access physical health care. This creates unnecessary delays in care and is a source of immense aggravation for individuals.

The solution lies in streamlining and rationalizing the multiple different processes, beginning with identifying a particular need for a particular person and ending with an encounter appropriate to that person's need. Common or at least consistent referral and financial screening processes and protocols and an ability to share demographic and basic financial information are essential. 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. Without this, it will not be possible to fully capture opportunities in streamlining access to care. While it sounds straightforward, achieving this degree of alignment is immensely complicated, requiring numerous changes in IT systems, staff roles and workflows, and clinical practices. Some believe that because of the complexity of the

work required, without a single entity prioritizing the end goal, it will not be realistic for the County to accomplish the necessary steps.

Using information technology, data, and information exchange to enable service integration

Information technology (IT) is a key enabler of overall service integration goals and of efforts to enhance system access. The shared benefits of IT integration include the ability to enhance providers' access to information on individuals using services across Departments (thus improving service delivery and care coordination), eliminate redundant processes for those receiving services from more than one Department, and increase the ability of Departments to perform population-based analyses for program planning and evaluation.

Electronic Health Record (EHR) and Information Sharing: Many people have asserted that the optimal solution for LA County would be a single shared EHR using one unique identifier; operational efficiency, data quality, and customer experience can be optimized by having all parts of an organization use a single, shared EHR if the necessary functionality is there for all involved user organizations. However, there is not agreement that this is the only or best solution for LA County. A single EHR solution should only be considered if it can be established that the EHR can meet the differing needs of directly-operated sites and programs without compromising different documentation, reporting, and care delivery methods. Contracted providers would almost certainly not be users of the single EHR because most, if not all, have or will have their own EHRs; their data and operations will need to be integrated electronically. There is no scenario under which all data for all clients/consumers/patients seen in clinics operated or funded by the County will originate in a single EHR as long as there are contracted service providers as part of the County's health care delivery network.

There is consensus on the value of a single comprehensive longitudinal health record for LA County clients/consumers/ patients. There is no consensus, however, regarding how this goal is best achieved. A great deal can be done without moving all of LA County health service delivery to a single EHR by using the data integration capabilities of existing County systems. By pursuing that less disruptive course as the starting place to build the comprehensive consumer health record, benefits are achieved in a shorter time and the County can then allow for very careful analysis of the functionality of the available EHR options and their ability to meet the needs of all Departments.

If the Departments do choose to progress to the use of a single system, patient/client privacy and security can be preserved: modern EHRs are architected in a manner that allows for tight control over privacy and security of Protected Health Information (PHI), segmenting data so it can only be accessed by an appropriate resource. Modern EHRs also maintain audit trails of all records accessed as well as the specific information viewed.

Each Department is at a different place in its own EHR process.

- **DHS:** DHS has completed implementation of its integrated enterprise EHR, a Cerner product (Millennium) referred to as ORCHID (Online Real-time Centralized Health Information Database) at three IT cluster sites representing over 75% of clinical volume within DHS. The remaining three sites are projected to be live by early 2016. Both Sheriff Medical Services Bureau and the Juvenile Court Health Services also use a version of Cerner Millennium that is customized for the custody environment. Cerner Hub, a tool that facilitates information sharing between Cerner systems, will be live and able to begin linking the Sheriff, Probation, and DHS systems by fall 2015.

- **DMH:** DMH has implemented the Netsmart Avatar behavioral health EHR at 122 of 143 directly-operated sites and four contracted sites. Netsmart is a niche mental health product, capable of performing clinical documentation

and claims/authorization functions required to fulfill DMH's role as the Medi-Cal Local Plan Administrator for specialty mental health, serving contracted legal entity providers and providers in the Fee-for-Service Medi-Cal network. DMH will soon pilot use of Netsmart's Care Connect module that exchanges referral information and continuity of care documents between participating systems, including those not using Netsmart products. These steps can enhance care coordination over what is in place in LA County today, but they are not the only available integration solutions for managing shared clients/consumers/patients. Netsmart has expressed a willingness to work with Cerner to integrate Avatar with the Cerner Hub so that clinical data, not just static documents, can be exchanged electronically between the two systems.

- **DPH:** DPH has been working with DHS since 2014 to explore the feasibility of adopting ORCHID as the EHR for its fourteen Public Health clinics, leveraging the County's contract with Cerner that was specifically written to facilitate the addition of additional County departments at the same preferred pricing level available to DHS. Due diligence performed to date has not identified any significant gaps that would prevent adoption of the ORCHID platform for clinical services. The Departments are working to resolve several technical and operational/design issues before finalizing a contract.

Despite the potential advantages of being on a shared EHR, given where DHS and DMH are in their respective implementations, it would not be prudent to disrupt either's ongoing implementation. The consequences of changing course would be expensive, and possibly hugely damaging to programs, services, client/consumer/patient confidence, and the good will of the County's contracted providers. If a diligent investigation into the advantages and disadvantages of converting to a single shared EHR confirms such a move is in the best interests of the County and its consumers, the transition would take several years to implement.[51]

While a single EHR solution capable of meeting each Department's clinical and administrative needs may be the best solution for directly-operated clinics, this would not directly address the need for information exchange with contracted community-based providers, each of whom have their own EHRs as noted above. To better integrate services for those who receive care outside of directly-operated County clinics, the County must continue its support for LANES (Los Angeles Network for Enhanced Services), the organization implementing a Health Information Exchange (HIE) collaboration between LA County stakeholders including the Community Clinic Association of Los Angeles County, LA Care Health Plan, and the Hospital Association of Southern California. The County must also continue development of an Enterprise Master Patient Index (EMPI) which can reconcile multiple unique identifiers used for the same individual and help ensure the correct person is identified regardless of how or where they receive services within the County. Progress on the EMPI and LANES initiatives is ongoing and should continue, regardless of the ultimate decision concerning the creation of an agency and shift to a single, integrated EHR. As important as they are, though, neither LANES nor a County EMPI would offer the County comparable functionality as would a single EHR. Beyond the potential for a single or linked EHR and single identifier, there are additional opportunities to leverage IT in a way that could enhance departmental operations, improve service levels, and reduce costs.

Applications (outside of the EHR): The three Departments currently use many different systems for a variety of common functions. The Departments could evaluate their collective library of applications to identify opportunities to consolidate currently unlike systems, with resulting cost reductions and improved alignment of processes, data, and reporting capabilities. Examples of areas to investigate include physician credentialing/master provider database, pharmacy benefit management, health care claims clearinghouses, referral management systems, active directory, and Picture Archiving and Communication Systems (PACS) that facilitate the movement of radiological studies across clinical environments. As longer

[51] Per a Board motion approved on April 7, 2015, the CEO, CIO, County Counsel, and Departments are currently developing a report on the feasibility and potential impact of shifting to a single, integrated EHR. This report is due to the Board July 7th.

term opportunities, the Departments could consider an aligned approach to Personal Health Records, allowing individuals to utilize the same system for accessing personal health information across Departments. They could also consider a coordinated strategy for billing and cost-accounting systems. The Departments also each use several IT applications that are unique to the functions of their Department and would not be appropriate for convergence. These individual applications should continue to be supported regardless of work on shared tools.

Data Governance and Repositories: If DHS, DMH, and DPH are to effectively coordinate care and improve service delivery, there must be agreement on the meaning of data used across Departments; this is achieved through a process known as data governance. A joint data governance approach would lay the foundation for more effective use of data to meet County goals. There would also be significant value to the County of the Departments having a single health care data warehouse. Both DHS and DMH have invested in their respective data warehouse/repositories to address the much broader range of data becoming available with the implementation of their EHRs. DPH does not have a data warehouse or data analytic infrastructure but could establish data feeds into DHS' repository and build a Public Health data mart to expand its data reporting and analytic capabilities. Making these investments by leveraging existing infrastructure would be more cost-effective than making de novo investments. As with EHRs, data repositories can be structured to properly safeguard data privacy and security. If shared data repositories are developed, DHS, DMH and DPH will need to work with County Counsel to examine consent and data use guidelines to ensure compliance with all regulatory requirements.

Improving workforce education and training

A wonderful strength of the County health system is its rich and talented workforce. Some believe that through the direct actions taken by an agency and the indirect effects of an agency's effort to integrate care, an agency can support workforce education and training in ways that build staff capabilities, increase workforce satisfaction, and enhance recruitment and retention. Innovation in clinical service delivery and population health will not be successful without workforce education. Best or expected practices in workforce education could be established across the three Departments. Performance and quality improvement programs should be commonplace. Developing shared approaches and tools for improving performance on new or existing initiatives will help the County to efficiently alter programs, approaches, and front-line practices.[52] In some cases, expanded roles or the creation of new/broader classifications may be needed, helping to diversify the workforce, support job ladders and create promotional opportunities. These in turn might help invigorate the County's workforce, with benefit for both those served and employed by the County. Finally, classifications that are currently underutilized within the County might find greater use if programs and duties were planned and structured in a coordinated way.

Workforce education opportunities can be increased with minimal investment simply by better leveraging the unique strengths and expertise already available in each Department. As an example, DMH could provide de-escalation training to some DHS and DPH staff. In other areas, new investments may need to be made, but doing so across all three Departments would be a more efficient use of available resources. For example, the County could benefit from potentially creating a County-wide Community Health Worker (CHW) institute that would support both County and community-based CHW efforts. Also, each Department is involved in customer-service training initiatives for front-line staff. While the services may be disparate, the intended customer (the public, client, consumer, patient) may be interacting with more than one Department. A common approach to basic customer service would enhance the consumer experience and likely lead to efficiencies in training resources over time.

[52] Although the nature of the process improvement work across Departments may differ, the approaches may be similar and done in an integrated manner. Care should be taken, however, not to eliminate important differences between Departmental approaches.

Strengthening the County's influence on health policy issues

Due to its sheer size, LA County has a very visible role in shaping state and federal policy. However, efforts are often poorly aligned because the three Departments approach advocacy and policy differently. Policy and advocacy priorities should be set and advanced together. The stories of front line experience can be complimented by broader, population-focused data and trends. As one public health leader said, "we [DPH] would benefit by having DHS or DMH by our side when we are talking to city councils about an issue in their community because our sister Departments can tell the real life stories about patients who might be impacted by the areas we discuss."

At this moment in time, there are some obvious areas where collective action on a joint policy and advocacy agenda and approach would be applied. The current drug Medi-Cal provider certification process is being developed by the State; LA County has much to gain or lose depending on the direction the State takes. There is also ongoing conversation more locally about the built environment (e.g., parks, neighborhood design) and community development. Finally, a policy agency could include advocacy to rationalize the various financial incentives and financing streams that are often a barrier to greater service integration. In any of these instances, a louder and cohesive voice from the County's health agency could be more effective than DHS, DMH or DPH moving forward alone. A joint approach to policy and advocacy must still prioritize issues of importance to each Department, rather than solely focusing on those issues that are of concern across multiple areas.

Improving use of space and facility planning to improve access and reduce costs

As described in greater detail above, one important way in which services can be integrated at the point of care is through co-location. Co-location may have several advantages:

- It may offer individuals more choice in terms of where they receive care, allowing people to attend the type of facility or clinic in which they are most comfortable, expanding access to care and retention in care.
- If it is designed in a way that improves geographic access, this can result in improved customer experience and improved geographic coverage for managed care contracts.
- If a portion of clinical (e.g., nursing attendant, substance abuse counselor) or support staff (e.g., front desk staff, security) are shared, it can reduce administrative costs.
- It may provide an opportunity to diminish the stigma associated with the provision of mental health services - if the culture and service delivery provided by health facilities is embracing of those with mental illness.

Better integration of services, whether through co-location or other solutions, presents an opportunity to more effectively manage the County's inventory of County-owned and leased facilities, including clinical, administrative, and warehouse buildings. Each of the Departments currently faces several challenges with respect to their facilities. All three face capacity constraints and are looking to expand services in specific geographies. 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. By managing space jointly at the agency level, the County could be more strategic in how it uses space, where it chooses to buy or lease new buildings, helping the County to avoid additional capital investments in new infrastructure. In thinking through specific space-related opportunities, it is important to keep in mind the different ways each Department conducts its business, unique regulatory requirements (e.g., OSHPD or Cal-OSHA) that must be met, the role of field-based staff, ADA accessibility, and the availability of parking, public transportation and support infrastructure.

Improving ancillary and administrative services and functions

Greater efficiencies in ancillary and administrative areas can improve service quality and an individual's experience with the system. Further, by reducing duplication and producing economies of scale, efficiencies in these areas can reduce costs over the long-term. While such potential cost savings are not the primary goal of an agency, they should be captured over time in order to allow funds to be redirected to clinical and population health programs. Considered briefly here are opportunities in pharmacy and non-pharmacy ancillaries (e.g., radiology), contracting/purchasing, and human resources.

Pharmacy and non-pharmacy ancillaries

There are several potential opportunities to improve integration of pharmacy services. The first is related to enhanced pharmacy access by allowing DMH uninsured clients to access DHS pharmacies. This may also result in savings since the DHS cost to refill a prescription is less than the fee paid to DMH's contracted pharmacies. Additionally, individuals seen at both DMH and DPH could potentially receive prescription refills by mail using DHS' Central Fill location.

Second, the Departments could benefit from implementation of an evidence-based unified drug formulary and prescribing protocols/practices. This would provide individuals with a more consistent experience and would reduce costs by increasing the use of generic medications and consolidating use on a smaller number of pharmaceuticals. DMH conforms its indigent formulary to the Medicaid formulary to prevent dual levels of care between insured and indigent clients. However, there may be savings possible by adopting different formulary practices; typical savings from such moves are 10-20% of non-reimbursed annual pharmacy expenditure.

Third, it may be possible to extend 340B pharmaceutical pricing to DMH's directly-operated clinics, typically accessing such pricing through DHS facilities' covered entity status. DHS hospitals and DPH clinics have access to 340B pricing already. It is not advisable to attempt to extend 340B pricing to contracted clinics given that it would require substantial disruption to existing service patterns. While there are several ways in which DMH's clinics may gain access to 340B pricing[53], it would be a long-term process, would require substantial administrative restructuring of DMH facilities and regulatory approvals, and would possibly impose new risks to DHS as the covered entity responsible for oversight and audit of the 340B program. The County should carefully investigate the estimated financial savings (currently estimated at $2-3 million annually) and operational impact before embarking on this path.

Adopting a single or at least coordinated strategy for ancillary clinical and operational services outside of pharmacy can benefit clients/consumers/patients by improving service quality and helping to realize operational efficiencies and financial savings. Such efforts could be applied to clinical laboratory services, radiology, durable medical equipment, employee health services, home health services, and medical transportation. As an example, DPH currently provides a small amount of radiology professional services through a contract radiologist. DHS, with its larger radiology practices, may be able to provide this service for the same or lower cost and with fewer service interruptions. Also, DMH processes labs collected within its directly operated clinics at contract, non-County labs. Given the highly automated nature of most laboratory test processing, a DHS or DPH lab could provide the same processing at a net County savings.

[53] Four models for extending DMH 340B pricing: 1) Merged Location: DMH clinics and staff must be fully merged with and physically located within the "four walls" of a registered 340B hospital. 2) Child Site: Covered entities add "child site" locations (outpatient facilities located outside the four walls of the covered entity, subject to geographical limitations on distance between facilities). 3) Referral Relationship: A DHS hospital refers 340B-eligible patients, as needed, to DMH clinics for mental health treatment. The covered entity retains responsibility for the overall care of the referred patient and use of any 340B drugs dispensed. 4) FQHC Look-alike Status: FQHC "Look-Alikes" are eligible for 340b pricing but must meet federal regulatory requirements under Section 330 of Public Health Law, including the need to have a governing board made up of individuals currently being served by the health center.

Contracting, contract monitoring, and purchasing

In stakeholder sessions, some external entities who contract with multiple Departments shared hope that an agency would be able to reduce unnecessary duplication of auditing, reporting, and contract monitoring practices and better align currently conflicting programmatic requirements. Challenges in both of these areas contribute to confusion and unnecessary costs on the part of consumers and can serve as obstacles to delivery of efficient, high-quality services for consumers. Several of the County's current contracted partners expressed a desire for an aligned and accelerated contracting approach which took into account the full breadth of services purchased. As one contractor put it, "If the agency's only achievement was a single, coordinated RFP, reporting, and audit process for each of the three Departments, it would be worth it just for that." Other ways the Departments could work together include: 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.

Changes should be made with caution to avoid unexpected adverse effects. As one contractor put it "From my perspective, things are fine. I've figured out how to navigate County ways. There may be advantages to the County of doing this, I don't know, but please don't let the agency make things worse for us."

Contract monitoring and program audits may also benefit from greater collaboration, for example by having contract monitors or program auditors assigned to administrative/insurance compliance for shared contractors across the agency. An in-depth review would highlight what agreements may benefit from shared monitoring functions and which may require specialized knowledge or skill sets to ensure compliance. Given that each Department raised concern about an inadequacy of resources for contract monitoring, moves to streamline contracting activities would help to make good use of scarce resources and may reduce the need to add additional contract auditor staff in the future.

Given the different state of each Department in their eCAPS roll-out and the different manner eCAPS is used to meet their organization's procurement needs, it would not be advisable to consolidate the Departments' purchasing functions at this time. There are opportunities, however, to optimize purchasing practices, such as by fully capturing manufacturer rebates and other cost saving mechanisms, extending use of University Health System Consortium (UHC) Novation Agreements[54], and sharing warehouse space and supply distribution infrastructure. The County also has the opportunity to leverage better pricing and standardized support through an enterprise approach to IT purchasing and contracting. Where the three Departments utilize common products or services, there is an opportunity to establish master or joint agreements that could be leveraged by each.

Human Resources (HR)

Creation of an agency could help improve HR operations and enhance consistency in several ways:

Exam planning and development: DHS, DMH and DPH utilize a number of the same or similar classifications where exam planning and administration is delegated to the Department-level. At present, collaboration is limited to requests to use an eligible list that resulted from another Department's exam. An integrated approach to exam administration for common

[54] UHC is a national healthcare consortium that competitively solicits bids for goods and services to leverage volume purchases to achieve low pricing and rebates to customers for future UHC purchases. DHS currently uses UHC for medical equipment and supply purchases. DPH indicates they currently use UHC only for certain medical commodities. DMH does not utilize UHC.

classifications could result in better exam planning and recruitment outreach and more efficient use of subject matter expertise and HR analysts, though this may not be appropriate for all classifications. For example, an agency could seek delegated authority from DHR to run exams for County-wide classifications (e.g., IT positions) for all three Departments, tailored to the specialized needs of health-related departments, while still coordinating with DHR on all master calendar exams. More broadly, an agency would be strategically positioned to develop classifications and job specifications closely tied to health care delivery. As an alternative view, some felt greater coordination on exams could result in worse outcomes for individual Departments (e.g., longer planning period, inability to attract appropriate staff, etc.).

Employee relations and risk management: There is significant overlap among staff classifications at DHS, DMH, and DPH. Consequently, the three Departments interact with many of the same unions via labor-management committees at the Department and County levels. Strategy-setting and engagement at the agency level would enhance each Department's ability to manage issues related to commonly represented classifications, employees, and functions. For instance, an agency initiative to engage represented employees in working to the top of clinical license would have greater impact than each Department pursuing separate strategies in union engagement.

Following are some additional examples of areas where greater collaboration would yield benefit on staff-related issues:

- DHS is adopting Safe and Just Culture principles to improve operations, risk management and performance management and could be scaled to include DMH and DPH.
- Departments could better align in how they manage performance improvement initiatives, including mechanisms for engaging front-line staff, middle-management and labor colleagues.
- Departmental approaches to employee wellness could be jointly pursued such as those exemplified by DPH.
- An agency might create greater opportunity to investigate and, when appropriate, advocate for a solution to classification-compensation issues, such as pay discrepancies between similar classes.
- DHS and DPH might implement a Staff Advisory Committee in the manner that DMH has done.

Maximizing revenue generation

There may be opportunities to generate additional revenue through more collaborative and integrated efforts between the three Departments. Following is a summary of potential opportunities for maximizing revenue. Each of these would need to be further evaluated before a definitive decision could be made as to the magnitude of the net benefit that could be achieved and the timeline over which each opportunity could be pursued.

Managed care contracting and billing: Managed care revenue contracting is in its infancy in the County outside of DMH's status as the Medi-Cal specialty mental health (SMH) plan under California's carve-out for SMH services in which it has responsibility for adult Medi-Cal clients with SMI or children with SED. In fulfilling this responsibility, DMH both contracts for and directly operates clinics providing the required services and also maintains a contract to provide SMH services to all plans participating in Cal Medi-Connect serving those who are dually eligible for both Medicare and Medi-Cal. Clients with mild to moderate mental illness (i.e., non-specialty mental health [NSMH] services) are managed through Medi-Cal's managed care two-plan model in LA County or through fee-for-service (FFS) Medi-Cal. DMH is beginning to consider developing contracts outside of the scope of the SMH carve-out, investigating opportunities to execute Medi-Cal contracts to provide treatment for NSMH services and for treatment of SMI/SED for non-Medi-Cal/non-indigent individuals. DHS holds two contracts with Medicaid managed care plans and eighteen contracts with other health plans, independent physician associations (IPAs), hospitals, and pharmacy benefits management companies, with one more in progress. At present, DPH's SAPC program provides services to behavioral health affiliates, LA Care, Health Net, and Molina, through its memorandum of understanding (MOU) with Care 1st and its agent Beacon Health Strategies. SUD services are provided to

these managed care plan participants that qualify and SUD services are reimbursed through the Drug Medi-Cal program. At present, DPH bills Medi-Cal for immunizations and is in the process of billing for TB Directly Observed Therapy (DOT), along with a pilot for public health nurse Targeted Case Management.

In the nearer term, while all three Departments bill private providers to different extents, opportunities remain to further support revenue generation through billing. While DPH has tried to utilize DHS billing infrastructure in the past, DHS was unable to provide immediate support at that time given the simultaneous changes in the organization and infrastructure of its billing systems. A renewed collaborative between the Departments could facilitate DPH's ability to contract with the health plans and providers and then claim for TB and other clinical services, such as STD care. For example, DPH is developing a platform off the SAPC-based Medi-Cal claiming translator to bill for DOT services. Other counties have leveraged their ability to bill Medi-Cal for DOT to contract with and bill private providers (e.g., a commercial health plan such as Kaiser) for public health services that otherwise would not receive any reimbursement. Ventura County DPH also has a contract with Kaiser to bill for its services. As another example, the County could build off of DMH's contract to provide eConsult psychiatrist services by offering both additional eConsult services available within DHS and also offering DMH's eConsult services through DHS' contracts with other health plans and/or their contracted providers.

Over the longer-term, bigger opportunities exist. The County has a large potential to increase the depth and breadth of managed care contracts with health plans and IPAs, particularly if it is able to market an integrated model of care. The County's efforts to attract and retain revenue-generating individuals will be critical to the future competitiveness and financial viability of the County's health Departments and its ability to fulfill its Section 17000 responsibilities without infusion of additional revenue. While the Departments are exploring ways to expand managed care contracts for their respective services, pursuing these arrangements within a highly integrated model of care that includes a full spectrum of mental health (mild to severe), physical health, substance abuse, and select public health services, could be more attractive to individuals and plans alike. This type of service offering might be particularly attractive to plans if it targets known high-utilizers or particularly complex (clinically and socially) or vulnerable populations that the County has a unique ability to serve and that private providers may not want to see. An agency could build a model to serve these people by combining the health offerings of the three Departments into one package, supplemented by social services available in other County departments. Integrating safety net services offered by these Departments would give the County greater expertise in handling more acute patients with multiple diagnoses and social issues, a benefit that could be leveraged to negotiate higher reimbursement rates.

Some stakeholders felt that such opportunities for greater managed care contracting were speculative at best. They pointed to DHS' history of losing market share among obstetric patients to community Medi-Cal providers in the 1990s and continued challenges in attracting large numbers of non-high-risk obstetric patients to the County. They also commented that the competitive challenges in the current Los Angeles health care marketplace were not taken into account and might make these managed care goals difficult to achieve. Finally, there is the danger that a health plan may be interested in only purchasing part but not all of the services offered.

Over time, the County may decide to enter into novel financing arrangements which would give the County greater flexibility in funding services and programs that currently have no available revenue stream. As an example, the County may wish to enter into risk-sharing relationships with the State and health plans in which it assumes full responsibility for the comprehensive provision of health services, including physical and behavioral health, by directing funds for SMH, SUD, and physical health services into a single capitated payment, although state law changes and federal approval would likely be required if Medi-Cal beneficiaries are to be involved. This type of financial integration would be an added support for clinical and service integration initiatives. While these opportunities are being pursued, it will be important to not disrupt existing strong relationships between plans and the County. For example, one health plan indicated that its relationship with DMH for referral of SMH services is "a model for the entire state." The County should strive to preserve these

relationships as it considers implementing or shifting to consolidated contracting arrangements. Prior to considering a consolidated contract with health plans to cover physical, mental, and specialized public health services, the County would need to consult with the State Department of Managed Health Care to determine if a full Knox-Keene health plan license is needed, and, if it is, would need to assess the organizational and operational implications of maintaining licensure.

Supplemental Medi-Cal managed care payments: For the last several years, DHS has been able to receive supplemental payments from Medi-Cal managed care plans using intergovernmental transfers (IGTs) to fund the non-federal share of increased capitation payments to the managed care plans, which then pass the money on to DHS. DHS cannot presently access all of the supplemental revenue that can be created through IGTs. It may be possible for DMH or DPH also to receive payment from Medi-Cal managed care plans using IGTs, as long as they can provide non-administrative services of benefit to the plans. Ideas for such services include immunization and STD care through DPH, or enhanced case coordination/case management service for those mentally ill individuals that shift between moderate and SMH care during the course of their illness. Implementation of such initiatives will require the approval of both the State and CMS. Given that there is a capped amount of supplemental Medi-Cal managed care revenue that can be IGT-funded, the County should help assure that each Department gets access to an appropriate share of these funds.

Cost-Based Reimbursement Clinics (CBRC) revenue for Public Health clinics: The County should evaluate the feasibility of obtaining CBRC revenue (a special Medi-Cal payment program that provides full cost reimbursement for outpatient services in DHS) for certain public health services, such as immunizations, STD testing, and women's health. Under current rules, CBRC is not available for specialty mental health services or for services in clinics which provide predominantly public health services. However, public health services could be eligible for CBRC if they were incorporated more fully into DHS clinics. Certain public health functions, such as Targeted Case Management (TCM) and Medicaid Administrative Activities (MAA) are already receiving partial Medi-Cal reimbursement through MAA and TCM programs. Careful analysis would need to be done to ensure that CBRC revenue would be superior to other revenue streams currently available to DPH for TCM and MAA programs. Analysis should also ensure that an appropriate mix and type of services are moved to DHS sites, considering geographic access, space/renovation needs to accommodate specific clinical conditions (e.g., TB), and impact on DPH clinics' designation as Essential Service Providers (ESP) under Covered California.

Patient Financial Services (PFS) reimbursement: DHS employs PFS workers to take Medi-Cal applications from patients and bills for and receives offsetting Medi-Cal administrative revenue of about $15 million per year. Under an MOU with the State, these DHS employees assist with application completion, data entry, and make a preliminary eligibility determination which is confirmed by DPSS. DMH PFS/Eligibility Workers (EWs) assist clients with Medi-Cal applications but rely on DPSS staff to complete the eligibility process and thus do not receive administrative reimbursement. DPH does not employ EWs because it does not currently bill Medi-Cal, but is actively engaged in developing processes to bill for certain services. If that is successful, it may be appropriate for DPH to employ EWs to help with identifying and accessing coverage by third-party payers. The County may also be able to extend DMH and DPH access to the current MOU with the State, expanding funding for enhanced Medi-Cal eligibility activities.

Hospital Presumptive Eligibility (HPE): DHS is currently processing applications at its hospital locations for Medi-Cal HPE, which is a program providing full-scope Medi-Cal benefits for a short period of time to allow an ordinary Medi-Cal application to be taken and processed. DHS is evaluating ways to extend HPE to its outpatient clinics using hospital staff and could potentially extend this to DMH and DPH sites, though doing so would be operationally complex and would require substantial coordination across Departments. There are certain advantages of obtaining short-term Medi-Cal coverage in higher cost hospital and clinic settings. While it may not be beneficial to the County to extend HPE to all County sites, use of HPE at some DMH and DPH sites would help additional individuals enroll in Medi-Cal and could provide a temporary revenue source for certain individuals. This issue should be evaluated more fully before implementation begins.

Drawbacks and Risks of the Agency Model

In soliciting input on this report, many stakeholders were openly critical of the Board motion and the lack of public discussion before the item was placed on the agenda. Individuals described feeling "violated", "ignored", "offended", "blindsided." Stakeholders often commented that the County had "betrayed their trust," and made it difficult for them to engage in a full discussion of the agency. This sentiment can only be addressed over time, by establishing transparent processes and maintaining open communication with stakeholders, including subsequent to the point at which this report is submitted to the Board.

Beyond extreme displeasure with the technical process, stakeholders raised a number of specific risks they felt could result from implementation of an agency model. Every organizational structure has potential risks, both perceived and real. It is important to understand these risks and their likelihood of coming to fruition, and to consider how they might be mitigated through both the structural design of an organization and through its careful implementation. With this in mind, this section describes ten categories of risk as expressed by stakeholders, offers thoughts on each area's particular relevance to an agency model (vs. likelihood of coming to reality with any organizational change that would promote integration), and makes suggestions on how the County may be able to mitigate each risk, if it chooses to implement an agency, so that the County can maximize the benefit for LA County residents. The recommendations included in the "Proposed Structure" and "Implementation Steps" sections also are intentionally developed to include safeguards, checks and balances, and processes that can help reduce the likelihood that these risks would come to bear.

1. Concern regarding potential legal risks
2. Concern regarding potential human resource risks
3. Risk of history repeating itself: Fear of service/budget cuts and deprioritization of County functions
4. Risk of increased degree of bureaucracy
5. Risk that an agency may require financial investment for administrative positions
6. Risk that Departments may lose focus on the full breadth of their current missions
7. Risk that cultural differences may compromise integration efforts
8. Risk of medicalization of community-based mental health
9. Risk of disrupting existing service models and the staffing structures and partnerships they rely on
10. Risk agency planning may detract from the work of integration

Concern regarding potential legal risks

County Counsel reviewed potential legal risks associated with the agency model and did not identify any legal impediments. They did, however, raise several issues that will need to be monitored should the Board move forward with creating an agency.

- The Director of Health Services (which is interchangeable under the Charter and County Code with the Director of Hospitals), the Director of Mental Health, the Director of Public Health and the Health Officer are all positions to be appointed by the Board, in accordance with qualifications and requirements set forth in California law and the County Charter. However, nothing precludes these positions from being included within the agency structure.
- At this time, no reduction, closure, or elimination of medical services is expected such that the Beilenson hearing process would be triggered. As agency priorities are set and integration activities accelerate, the agency will need to work closely with County Counsel to monitor the applicability of the Beilenson hearing process if medical services are realigned or relocated.

- The implementation of an agency structure does not threaten the reimbursement each Department receives. While some funding is necessarily restricted by operation of law or agreements with funding agencies, such as certain mental health funds and public health-related grants, or requires the contribution of a match or maintenance of effort, as long as those restrictions are honored, no legal impediments based on revenue and reimbursement should exist. As stated previously, the proposed agency will preserve the existing budgets and funding streams of each Department.
- As previously discussed, the County has the potential to negotiate a consolidated contract with health plans to cover the provision of physical health (both physician and hospital cost components), mental health, and specialized public health services, such as directly-observed therapy for TB patients. County Counsel and Departmental representatives will need to consult with the State Department of Managed Health Care (SDMHC) to determine if full Knox Keene health plan licensure is needed as a prerequisite to the County participating in this kind of contractual arrangement. As the Board may be aware, DHS is in the process of converting its Knox Keene license to a restricted license as the result of winding down the Community Health Plan. If a plan license is required, the agency will have the ability, through a request for a material modification to SDMHC, to request the restricted license be expanded to a full license. The agency would have to take into consideration the organization and composition of the agency and the concomitant implications on maintenance of financial records, the performance of audits and such other aspects to ensure compliance with SDMHC's legal and regulatory requirements.
- DPH currently must audit and/or provide program oversight functions for Public Health-funded services provided by DHS and DMH (e.g., services funded by Children's Medical Services and Division of HIV and STD Programs). Creation of an agency model can be achieved without compromising DPH's role. Where there may be a perceived conflict, an audit division can be maintained separately from the programs that will be subject to audit. Thus, staff that are responsible for program implementation would not be vested with auditing that function.

Concern regarding potential human resource risks

The Department of Human Resources, CEO Classification/Compensation, and CEO Employee Relations (ER) did not identify any direct risks of creating a health agency. However, some County staff were apprehensive that the very act of creating an agency and appointing an agency director would have direct consequences on classification, compensation, and ER issues. Staff also felt unsure about how an agency would affect their work assignments and roles. Specific questions raised are included below.

- Will the creation of an agency result in layoffs or staffing reductions?
    - Creation of an agency would not impact Departmental budget appropriations so would not lead to staff layoffs. The agency's goal is to improve and enhance services and programs across all three Departments; budgetary or staffing reductions are not consistent with this goal.
- How will the agency affect roles and responsibilities of specific positions, geographic assignment, scope of practice, and team structure?
    - The creation of the agency itself will not immediately affect any of these issues. However, as integration progresses, the agency and Departments will need to communicate openly with staff and organized labor about ways in which job responsibilities and workflows/processes may be affected. If initiatives or program changes would affect wages, hours, or working conditions, they would be the subject of formal consultation with organized labor.

- Will the County be required to reconcile differences in HR and ER-related issues affecting employees of the same or similar classifications (e.g., pay differentials, differences in MOUs with labor unions, etc.)?
    - Where differences exist, they are based on differences in employee roles, responsibilities, or working conditions. The creation of an agency will not force these differences to be reconciled. Based on current case law, the County will be required to review differences if the agency has an impact on wages, hours or working conditions for any impacted classification. If there is no direct impact on wages, hours or working conditions, the County would only address these differences during MOU negotiations as needed. However, the agency could create a forum for better understanding the reasons for these differences and, when appropriate, advocate for a proper resolution.
- Will the creation of a new "agency director" item lead to the automatic downgrade of positions or affect the depth or number of unclassified positions in each Department?
    - The positions within each Department would continue as they are today. If the Board chooses to create an agency director position, it would not automatically downgrade roles in the County. The three levels of unclassified positions within each Department can also be maintained per language in the County Charter.
- Will the agency affect seniority pool as used, for example, to determine vacations?
    - The concept of "seniority" applies mainly to labor-represented classifications. MOUs that contain vacation scheduling provisions would still apply under an agency as would other standard practices for scheduling vacations. Other uses of seniority would also not be expected to change.
- If a reduction in positions within one Department were to become necessary, would this trigger a cascade in staff re-assignments across the agency to remain consistent with County seniority rules?
    - Cascades are typically handled within the department having the budgetary issues necessitating the workforce reduction. If not able to be managed within the department, the cascade is managed at the County level, including all departments with like items. This would remain the case under an agency model. Position reductions, while rare, have virtually always been able to be accommodated by filling vacant like items. These activities would be coordinated by the involved Department(s) and the Department of Human Resources in accordance with existing civil service rules, MOU provisions, and/or Board Policies.

Risk of history repeating itself: Fear of service/budget cuts and deprioritization of County functions

When the Department of Mental Health was merged into a single Department of Health Services, along with the Department of Public Health, in 1972, it ushered in six challenging years before DMH was split out again in 1978. Some of the funds that were supposed to be dedicated to mental health were directed to urgent or emergent needs in the hospitals. Leadership gaps and a geographic operating model further complicated the single department's operations and contributed to the eventual separation. In the 1990s and 2000s, DHS, which was then made up of separate divisions of public health and hospital/clinic care faced financial deficits and went through a series of budget cuts. While the cuts were distributed across the Department they also included cuts to important population health programs. Population health advocates and some DPH staff who lived through these years perceived this as a cannibalization of public health's budget. These budgetary concerns and the distinct missions of the public health and hospital/clinic arms of the Department were major reasons behind the split of DHS into two separate departments, DHS and DPH, in 2006.

Many people raised concern that creating an agency would be asking for history to repeat itself. As one stakeholder asked "If it didn't work in 1972 and it didn't work in the 2000s, why would it work now?" While not the exclusive focus, concern was often centered on preservation of Proposition 63 Mental Health Services Act (MHSA) dollars made possible by victory

in a hard-fought 2004 ballot initiative. MHSA funds form the foundation of numerous mental health programs and services for clients across the County, including funds for prevention and early intervention, services, and infrastructure, including technology and training, and are rightfully protected by mental health advocates. Some stakeholders commented that despite the safeguards that protect the use of MHSA funds for mental health programs, they worry that an agency would lead to the gradual diversion of funds for non-intended uses. Many people pointed to the DHS' budget as the likely target of such funds, dominated by hospitals with large fixed costs and with an industry known for acute/emergent problems. While many stakeholders were not aware of DHS' current fiscal surplus, even those that were aware expressed concern of money being taken from DMH (or DPH) to fund DHS if its fiscal outlook worsens in the future. One population health advocate voiced, "Clinical imperatives always trump public health. The urgency of 'now' trumps long-term benefits."

Cuts to a Department's budget are not possible in an agency structure without Board approval. Cuts to mental health in the 1970s and to public health in the early 2000s were perceived as possible without Board approval because of the organizational structure in place at the time of a single merged department. Department heads have the authority to recommend the movement of funds within their Department, but ultimately, all changes between Department budget units must be approved by the Board of Supervisors. Because the agency model preserves the structure of the three separate Departments, it would further highlight any budgetary shifts between Departments. If a situation arose in the future in which one Department faced a financial shortfall, the agency director would not have authority to cut funds or programs in another Department to fill the deficit.

While the dollars matter, stakeholders were also concerned that public health and mental health would be deprioritized and under-recognized in an agency model, similar to their perceived experience in a merged department. Several individuals pointed toward the merger of the California Department of Mental Health into the California Department of Health Care Services (DHCS) in 2011 as an appropriate parallel, calling mental health issues "functionally forgotten" at the State level and citing a dearth of communication with DHCS and senior Health and Human Services leaders.[55] Stakeholders expressed fear that an agency would similarly detract from attention paid to population health or mental health activities and goals. "The mental health client took a back seat for many years and now they are actually sometimes in the driver's seat. It would be a shame to lose that progress." Another commented, "Mental health gets steam-rolled by the other Departments already; won't that get worse?" "We'll be the ugly step-child," said one population health stakeholder. A DMH consumer expressed concern over "loss of focus and funding for mental health, even to the point that our coalition groups will be disbanded." "Mental health and population health will be swallowed up by health services." Others took a more personal view of the risk. "Change is scary when you are the most vulnerable, disadvantaged person in the room; you are scared you will be left behind." This concern of deprioritization and a perceived loss of standing also manifested in people being concerned the Departments would be unable to recruit talented leaders who are well-established experts in their field. This is particularly the case for DPH which has lacked a permanent director since September 2014. The suspected dominant agency was most frequently thought to be DHS, a fact attributed to its size, the acute and costly nature of hospital-based crises, and concerns the DHS director may concurrently hold the role of agency director. However, several stakeholders also expressed concern about how substance abuse would be impacted in an agency, particularly if it is moved from DPH to DMH. Many people stated they feared that SAPC would be subsumed by mental health or "overrun by mental health professionals not appropriately trained to treat addiction."

[55] This view of the State's merger of mental health and physical health was not unanimously shared. Several stakeholders commented that major progress on mental health and substance abuse issues would not have been made without the merger, such as the expansion of treatment for mild to moderate mental health disorders. A similar sentiment was shared regarding the movement of the Department of Alcohol and Drug Programs into DHCS in 2013; this shift was thought to be a primary factor in support for the expansion of the Drug Medi-Cal benefit and Drug Medi-Cal waiver design. Those who supported the State's reorganization viewed antagonism to the mergers as based on people's perception and experience of engagement in, for example, various State advisory groups, and not as reflective of actual attention to mental health and substance abuse issues at the policy level.

The concern that an agency may result in deprioritization or undervaluation of each Department's mission and activities was often also expressed in the context of concern about who would be selected to lead the agency. "Our director is an incredible ally; we don't trust that the person that comes next will be the same." "We fear we will be led by someone who doesn't understand us and won't listen to us." Stakeholders often focused on a specific concern that one of the three Department heads may be appointed to serve concurrently as the agency director. This idea was met with intense criticism by a number of stakeholders based on an assumption that it would lead the agency director to favor and focus disproportionately on his/her own Department, prioritize initiatives related to that Department, and siphon resources in a way that would benefit that Department, risking the neglect of critical County functions. Even if the individual was able to focus on the breadth of activity across the system, some feared this would come at the price of neglecting focus on his/her home Department. "[Having a department head also serve as the agency director] would be an absolute show-stopper." "It's not three Departments on equal footing. If there are disagreements, it's no question who would win. The agency director wouldn't be able to be a fair arbiter if they are also a Department head." As one way of addressing this concern, the Board could consider conducting an open, competitive recruitment for the agency director position, considering various candidates rather than immediately appointing a permanent agency director from among the current Department heads.

In contrast, others felt an agency structure would be best able to draw attention to a complex and comprehensive set of health-related activities. They felt that while not perfect, society and health leaders today had a far greater and more nuanced understanding of the critical role of population health and mental health activities than was the case in the 1970s, or even in the late 1990s and early 2000s. There is broad recognition of evidence that early investment can yield long-term savings: substance abuse and mental health treatment has been shown to save up to seven dollars for every dollar spent due to averted medical and societal costs (e.g., avoided incarceration).[56] There is also ample evidence of the effectiveness of health promotion activities, including those that target clinical, social, and behavioral interventions.[57] This acceptance may reduce the likelihood that an agency would lead to a deprioritization of a broad and diverse set of health-related activities.

Practical steps that can help build confidence that the needs of each Department will not be deprioritized or defunded in an agency include the following:

- ***Select an agency director with experience in all three areas.*** Selecting an agency director who has leadership experience in all three fields: mental health, public health, and physical health, can help to establish credibility, build trust, and decrease the likelihood that the agency will narrowly advocate on a limited set of issues.

- ***Increase transparency into Department budgets.*** Each County Department's budget is shared publicly, but its style and length make it challenging for people to understand. The development of clear, concise, Department-specific budget summaries, demonstrating the size of different funding streams and their uses, with historical comparisons, would be a valuable source of information to the public where not already available and could help to increase the practical level of transparency into County budget processes, reducing the likelihood that individuals or groups feel Department funding is being inappropriately diverted.

- ***Clearly communicate any administrative savings from implementation of an agency structure.*** Over time, The County may choose to move certain administrative functions to an agency level when doing so would

[56] Substance abuse: Ettner, SL, et al, (2006). "Benefit-cost in the California treatment outcome project: does substance abuse treatment 'pay for itself'?" Health Services Research, 41(1): 192-213. Mental health: Cutler, D, et al, (2003). "Your Money or Your Life: Strong Medicine for America's Health Care System." *Oxford University Press.* "Best Return on Investment (ROI): Mental Health and Substance Abuse Treatment." *National Alliance on Mental Illness. (2009).*

[57] Smedley, BD and Syme, SL, eds. (2000). "Promoting health: Intervention strategies from social and behavioral research." *Institute of Medicine.*

demonstrably improve service levels and help to reduce costs. The amount of total savings and uses of these funds should be clearly summarized and shared with the public.

Risk of increased degree of bureaucracy

One of the most commonly cited potential drawbacks of an agency is increased County bureaucracy, additional layers, "big government". Many stakeholders criticized the agency for being a "hierarchical" structure, with "hierarchy" associated with increased bureaucracy (i.e., "red tape" generated by those in the hierarchy), a loss of control and power, and a lack of voice. Department personnel described a fear of "losing control" and having "diminished influence" within an agency, particularly if critical functions moved to an agency level, and of having "to work through yet one more layer of County bureaucracy for everything from ordering a pen to executing a contract for critical services." As anyone who works in or with the County knows, the effect of too many layers and bureaucratic processes is delayed services and increased costs. While delays may harm any individual who use County services, they are especially detrimental to disadvantaged populations who are already challenged with accessing the system.

Stakeholder concern about the creation of an agency leading to additional bureaucracy stems from three assumptions: 1) That an agency would indiscriminately place key administrative and operational units (e.g., finance, contracting, human resources, IT) at the agency level, rather than leaving them within the Departments where they would be close to their programmatic and executive leadership. 2) That placing any units at the agency level would automatically increase the unwieldiness of operations, rather than improve efficiency and timeliness. 3) That the agency director would take a dictatorial, non-collaborative style and would micro-manage department operations, putting in place multiple process steps to be completed before departmental actions would be allowed to proceed. While hypothetically possible under an agency (or other structure), it is possible to implement an agency that does not produce this result. As one stakeholder phrased it "view the health agency role as a communication/coordination hub and not as a hierarchical overseer."

An organization's structure does not by itself generate bureaucracy; any organization and any organizational structure can be bureaucratic or not. Bureaucracy is rather a reflection of how an organization operates and makes decisions. Similarly, an organization is not "hierarchical" simply because of its structure and reporting relationships; it may not necessarily depend on its hierarchical structure in day-to-day communication and decision-making. For instance, each Department has a Department head (and often but not always a Chief Deputy Director) who directly supervise the senior leadership within the Department; despite this reporting relationship, stakeholders often described these same departments as "non-hierarchical" and "non-bureaucratic." This sentiment more accurately reflects hierarchy and bureaucracy as a function of an organization's policies and procedures and the governance style of its leadership as being either dictatorial or collaborative, including the willingness of leadership to empower managers and staff further down in the hierarchy and/or use team-based or cross-functional team approaches. One stakeholder, critical of this section in the draft report, commented "an agency isn't bureaucratic if it can get things done. You want to see bureaucracy? Look at each of those three Departments, each with their own separate procedures, protocols, rules, and committees for dealing with problems and people. That's bureaucracy."

Taking a view that bureaucracy is dependent on both how an organization approaches decision-making and governance as well as its structure, the following characteristics may help to mitigate the risk that the agency would introduce more bureaucracy into the system.

- ***Place administrative functions at the agency level only when there are clear net benefits of doing so.*** There was broad agreement that functions should only move to an agency level if there was a clear and demonstrable benefit of doing so, taking into account both impact on services/programs and also administrative efficiencies and cost-

savings. Stakeholders agreed that dual placement of functions at both the Department and agency (e.g., retain HR exams unit within the Department structure but also add an exams unit at the agency level) would increase bureaucracy, cost, and would hamper operational efforts. Similarly, movement of an entire organizational unit (e.g., finance, contracting, HR) could risk destabilization of critical program support functions and should be done only after careful study. This report recommends that core administrative functions such as notably human resources, information technology, contracting/procurement, and finance, in addition to others initially, remain at the Department level and not be moved to or duplicated at the agency.

- ***Maintain a flat/horizontal organizational chart at the agency level.*** Multiple reporting layers can contribute to administrative costs, redundancy, and bureaucracy, and reduce the degree to which management is actively involved in decisions and operations. To avoid these risks, the agency should minimize multiple reporting layers within the agency.

- ***Carefully select an agency director with the style and temperament needed to implement programs and achieve strategic goals in collaboration with internal and external stakeholders.*** Additional detail is provided on desired characteristics of an agency director in the "Implementation Steps" section.

Many stakeholders were also concerned that the agency structure would diminish a Departments' voice with the Board of Supervisors. This does not need to and should not be the case under an agency model. It was commonly assumed that the Department heads currently report directly to the Board, rather than to the County Chief Executive Officer and, until very recently, to the Deputy Chief Executive Officer for the Health Cluster who then reported to the County CEO.[58] Despite this lack of a direct reporting relationship to the Board, all three Departments have frequent and direct communications with individual Board offices and the Supervisors themselves. This open communication reflects both the importance of health-related issues in the County and also the ability of Department personnel to develop strong relationships with Board offices. Despite strong Department-Board communication, 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.

Often individual units, facilities, or programs within each Department also enjoy similar relationships with Board offices without communications being funneled through the Department head. It would be neither feasible nor productive for a Department head to interfere with those relationships; a similar fact holds true for an agency director. Access to the Board is not solely a reflection of one's position and reporting structure. Open and direct lines of communication are a reflection of relationships built over time, the Board's level of trust and confidence with the involved staff, and the importance of the issues at hand. As one concrete way to support and encourage continuation of direct lines of communication between Department heads and the Board, the Board could request regular public hearings on progress in implementing the agency in which Department directors, and not just the agency director, are requested to speak before the Board. Additionally, if an agency is created, the Board should openly encourage Department heads to discuss in private and publicly testify before the Board on issues within their Department that are of importance to the County, particularly those areas not currently being prioritized as a focus for the agency. Finally, it should be noted that constituents would still have the same access to the Board under an agency as they do under the current County structure. Members of the public, including clients/consumers/patients, family members, contracted agencies/providers, organized labor, and others should be encouraged to approach Board offices with their concerns and expectations under any organizational structure.

[58] The Deputy CEO/cluster lead position was functionally removed from the County CEO structure in December 2014.

Risk that an agency may require financial investment for administrative positions

A number of stakeholders felt that if an agency is created, the actual cost and budget of the agency and the way in which these funding needs would be met should be identified in advance, based on an expectation that the agency's administrative structure would need resources to be effective. The degree to which an agency would require funding for administrative positions would depend to a large extent on the structure of the agency. A large central agency with multiple new administrative positions and layers would both increase bureaucracy (see section above) and increase costs to the County with concerns that these costs would be covered by cutting services for already underserved communities.

If approved, a health agency can be designed in a way to minimize new costs. First, integration of administrative units should proceed only if such moves are cost-neutral or cost-saving. Second, care should be taking in adding leadership positions to the agency level. One economical approach to agency management would involve creation of a lean structure in which a handful of individuals would support coordination and strategic direction. This could be accomplished by either adding a small number of new personnel items to the agency[59] to reside at the agency level or by identifying individuals who would perform dual roles that are complementary of current assignments to help lead integration activities in a specific field (e.g., IT, finance). The benefit of the dual-role model would be to minimize administrative costs and build off of the strength and experience of each Department and its personnel. However, several stakeholders criticized it as unrealistic or likely to compromise 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 likely to erode Departments' ability to meet their existing commitments or result in an agency disproportionately staffed with people from one Department. They viewed an agency-level role as being a full-time job even if there were sizeable synergies with the person's Department-level role. They also thought that this model would prove ineffective and that, over time, the agency would need to ask for additional funding from the County or would need to take funding from the Departments' individual budgets to fund agency functions. One suggestion for making this model more feasible included having the assignments to dual-roles be time-limited and/or rotating but, even with this suggestion, a number of stakeholders opposed the concept.

Regardless of whether they are selected from within Departments to serve in a dual-role or are brought onto new positions, individuals filling positions within an agency should be selected because they have the appropriate mix of experience, expertise, broad knowledge of work in the three Departments, professional strengths, and leadership style to be effective in a strategic/coordinating role. If new positions are added to create the agency, new County funding should be allocated in a transparent manner and should be subject to Board approval.

Risk that Departments may lose focus on the full breadth of their current missions

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. A health agency would naturally focus on those areas where there is synergy in working more closely together and would not focus on those areas where there is no benefit from greater collaboration. Stakeholders raised concerns that in doing so, the time, energy, and resources of each Department may be shifted away from critical activities that are not the focus of the agency. An agency that focused only on the area of overlap between the three Departments, to the neglect of initiatives and priorities with other County departments, would be "an epic failure," as one stakeholder put it. These concerns exist on a number of levels and would need to be handled carefully under an agency structure.

[59] This could be accomplished in budget neutral manner by using available items, adding and deleting items, or filling unlike items; alternatively, it could be accomplished through new financial investment by the County.

- ***Impact on constituent base of each Department:*** Beyond specific programs, population health stakeholders called attention to the different scope of the three Departments with DPH's mission encompassing all ten million LA County residents rather than any single subset. DPH's responsibility in population health extends beyond the subset of individuals that are receiving care in DHS' or DMH's delivery system. If too closely aligned with either Department, DPH may be distracted from its broader mission or may create an impression that it will support DHS or DMH in achieving population health goals more than it supports other healthcare delivery systems in the County. Stakeholders questioned whether DPH would be able to practically continue programs serving all LA County residents rather than those who use DHS and/or DMH for clinical care. They saw this as a major reason to question whether there were sufficient benefits to public health in joining the agency. "I understand the clinical problem we are trying to solve for DMH and DHS, and perhaps for the personal care side of DPH. Services at the point of care operate in isolation, are inefficient, impossible to navigate, and leave crater-sized cracks for people to fall into. I don't, however, see the problem we are solving in bringing population health along for the ride."

- ***Impact on roles and programs not involved in integration efforts:*** An agency risks de-prioritizing areas that are not natural areas for interdepartmental integration such as DPH's work on restaurant inspections, childhood lead poisoning programs, etc.

- ***Impact on collaboration with other County Departments:*** DHS, DMH, and DPH work collaboratively with other non-health County departments on a variety of issues. Stakeholders questioned whether this high degree of interaction and collaboration would take a backseat to integration efforts that focus solely on DHS, DMH, and DPH. As an example, mental health staff mentioned that the vast majority of DMH's work that crossed over with other County departments did not involve either DHS or DPH, specifically citing programs involving the Probation Department, Sheriff's Department, DCFS, DPSS, and CSS. DHS and DPH both are similarly involved in a number of collaborative activities with other County departments.

- ***Impact on contracted providers and agencies:*** Stakeholders questioned whether a health agency would focus disproportionately on directly-operated clinics at the expense of community agency partners. The Departments provide a different mix of services through contracted provider arrangements. While the agency would be comprehensively responsible for all services provided, regardless of whether they are directly operated or contracted out, many individuals and private provider groups felt there may be tendency to favor the needs of directly-operated sites.

The risk of narrowed focus depends in large part on who is selected to be the agency director. An agency has a greater risk of narrowing the focus of each Department if the individual selected to lead the agency does not have robust experience, knowledge, and appreciation of the issues central to each Department. An individual with experience in only one area may be most likely to focus efforts within an agency on those areas where he/she is most comfortable. The success of other local governments that utilize an agency structure but still have strong component departments was often attributed to the credentials of the agency director. For example, the New York City Department of Health and Mental Hygiene which operates as a merged Department combining mental health and public health, was noted by some stakeholders to be as strong as it is in part because of the national prominence of its prior Commissioner in the field of public health. Several stakeholders commented that an open, competitive process for selecting the agency director would help to ensure the County appoints the person best suited for the position. An agency should not be developed for one person's talents and charisma.

Implementation of an agency structure, in which the three Departments maintain Department status, helps to mitigate the above concerns, as opposed to a structure in which two Departments move under a third and lose their department status.

As Departments, DHS, DMH, and DPH would be expected to fulfill the entirety of their mission, establish strategic priorities and goals to accomplish that mission, and set budgets accordingly. The agency would help to ensure that goals affecting the entire County are prioritized alongside these activities, but not in place of them.

While most stakeholders expressed concern that the agency may limit the scope of each Department, some held the opposite opinion. They felt that, rather than hampering efforts to achieve Department-specific goals, an agency could help Departments focus additional time and energy on the areas that are uniquely theirs. Adding new energy and perspectives to tough, long-standing County problems related to health integration could free up time within Departments to focus on their unique scope of services.

Risk that cultural differences may compromise integration efforts

Naturally, the three separate Departments have three distinct cultures, though often there is a diversity of cultures within each Department as well. The culture of each Department is apparent in everything from its organizational structure, how administrative tasks such as HR and contracting are performed, approaches to collaboration and decision-making, the degree of centralization vs. regionalization, and methods for ensuring the cultural fit of their services and programmatic mix. Cultural differences are not limited to only County or contract staff; they also apply to differences in the ways in which services are designed and provided to clients/consumers/patients and the way in which individuals receiving services interact with the system. These characteristics are an important part of what has led to the successes of each Department.

Often, stakeholder sessions revealed that those working both inside and outside the County have much to learn about the culture and strengths of each Department, often relaying perspectives of other Departments that were based on a single experience or on historical reputation. Fear of the unknown and of how the agency would engage with clients/consumers/patients and external community partners also emerged as a strong driver of concerns over cultural friction. "I'm afraid the agency won't give us a voice in the way that this Department does. The leadership here listens to and values our concerns." "I worry the other Departments don't work collaboratively with communities of color." "The voice of the family and consumer is not strong even here; I fear it will get worse in an agency."

The proposed agency model is explicitly not a merger. Unlike a merger, creation of an agency would maintain the Department structure and many core administrative functions as they currently exist. Given this fundamentally different structure, lessons drawn from mergers and acquisitions may not apply to an agency. Still, if created, an agency would seek to accelerate the rate of integration and, in doing so, differences in Departmental practices and norms may result in staff tension and friction. This is a natural tendency and will occur under any structural model, agency or otherwise, that is able to promote and support integration. Still, it will be critical for such differences and tensions to be openly and proactively addressed, rather than leaving them to languish and risk compromising integration efforts over the long-term.

The cultural differences between DHS, DMH and DPH should not be underestimated, but should also not be considered an insurmountable barrier. It is in part because of the differences between the Departments that there is so much benefit from greater integration and collaboration. One of the greatest challenges but also richest opportunities of any integration effort will be to promote integration while maintaining the positive attributes of each Department's culture, building understanding of others' strengths, and supporting the development of new sub-cultures so that staff can be fully engaged in integration activities. Cultural friction may arise and must be addressed. Cultural differences must be respected but can also be identified and leveraged to increase the capacity for integrated action. "By really looking at the differences between the Departments, the County may fuel the creation of a wider range of services and programs."

Some stakeholders pointed to challenges in the creation of the Department of Homeland Security in 2002 as a potentially relevant case study regarding how to address cultural tension. Its creation represented the largest restructuring of the federal government, bringing together under one Department twenty-two different agencies that were formerly subordinate to eight different federal departments. Since that time, the Department of Homeland Security has faced a large number of departures from high-level staff blamed on clashing departmental cultures, an increase in lucrative private sector security jobs, and a high degree of pressure from elected officials and the media. To address the culture-related portion of these challenges, the Homeland Security Advisory Council's Homeland Security Culture Task Force generated a set of specific recommendations.[60] They noted the importance of clearly defining the new Department's role in establishing the vision, policies, strategies, and performance objectives needed to protect the United States, facilitating coordination between units, and empowering divisions to execute their respective goals rather than having primarily an operational role that duplicated the focus of the component organizations. The report suggested several steps to reduce cultural friction, including the need to build trust between component parts over time, to strive for a "blended" rather than single organizational culture that retains the strength of each and identifies with the shared mission, ethic, and vision of the agency, the importance of empowering front-line staff, and the need to be a good partner to external organizations through communication and collaboration. These recommendations are equally applicable to an LA County health agency or other structural model put in place.

Risk of medicalization of community-based mental health

The community mental health system as led by DMH is rooted in a recovery-based model of care among adults that emphasizes personal empowerment and resilience, social support, community connectedness, wellness, and the pursuit of hope and meaning in one's life as a means of reaching one's potential in life, and a resiliency-based model of care for children emphasizing integrated services, family and community involvement, etc. This is in comparison to a medical approach to mental illness that defined the field in previous decades, relying on diagnosis of disease, identification and treatment of symptoms and signs, and heavy use of medication and diagnostic testing. The recovery model is rightfully favored by mental health providers, clients, and advocates, many of whom fear that closer integration with DHS in particular will result in a shift away from recovery toward medicalization of mental health treatment. For the many individuals who have experienced first-hand the benefits of a recovery approach, and for the providers and advocates who serve them, this is a frightening possibility.

While the term "recovery" is not widely used in the physical health realm, the concepts underlying the model are not foreign to many physical health providers. Many clinicians acknowledge the failure of the medical model to address the root issues affecting their patient's health and life, particularly among low-income and other vulnerable populations, and believe in an approach that emphasizes individual empowerment, provision of culturally and linguistically competent care, and social determinants of disease. Issues of poverty, homelessness, unemployment, community violence, lack of access to healthy food and parks, social and spiritual isolation, and lack of purpose are large drivers of symptoms that land individuals in emergency departments and outpatient clinics and must be addressed. Despite this recognition in the physical health community, particularly among safety net providers, many physical health providers still manage patients first in the medical framework, and then address social, psychosocial, and environmental factors when medical interventions do not yield the expected result. They often order diagnostic tests to rule out unlikely but potentially dangerous diagnoses when more obvious social or environmental causes are left unaddressed. They often 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 often

[60] Homeland Security Advisory Council, (2007). "Report on the Homeland Security Culture Task Force." Accessed March 23, 2015 at: http://www.dhs.gov/xlibrary/assets/hsac_ctfreport_200701.pdf

manage individuals with chronic diseases with narrow attention to medications and laboratory values rather than emphasizing coping mechanisms and social supports.

There is much that the physical health community can learn from the mental health community about empowerment, hope, wellness, and recovery. In the best of worlds, this exchange of information would be facilitated through education about recovery, integration of recovery models into primary care and even emergency or specialty care settings. But while this learning is happening, it will be important to ensure that the physical health world's reliance on medicalization doesn't seep inappropriately into the community mental health model of care. To help prevent this from happening, clinical leadership should remain separate between DHS, DMH, and DPH and the agency should maintain strong roles for external coalitions and groups that emphasize recovery models. Staff and others well-versed in the recovery and/or resiliency models should play a key role in the design of integrated care models, so that the principles and concrete elements of these philosophies can be built into the fabric of service enhancement and expansion.

Risk of disrupting existing service models and the staffing structures and partnerships they rely on

Many stakeholders were concerned that agency leadership would establish different expectations for engagement with external partners and contractors with adverse effects on the individuals who benefit from these services and the providers/partners who appreciate the structure and tenor of current County relationships. Stakeholders voiced anxiety about how and where individuals would access care, fearing that individuals would be forced to change where they receive services, disrupting delicate and long-standing therapeutic relationships. They feared that any changes made would not be clearly communicated to the public. In particular, contracted providers doubted that a new agency director would be as supportive of existing external relationships and contract terms as the current Department leadership. Questions posed by external stakeholders focused both on whether or not services would be cut but also whether or not contracts would be changed even if service levels were held constant. In one exchange with a contracted provider: Provider: "Are there going to be reductions to service contracts?" CEO staff: "No, service levels will be maintained." Provider: "I don't mean if services in general will be maintained. I mean are you going to cut *my* contract for providing those services." On a few occasions, stakeholders compared the agency to the roll-out of the State's Coordinated Care Initiative, anxious over whether or not the agency would continue to keep them "in network" with implications for both provider reimbursement and continuity of care.

This issue is not reserved for contracted direct service providers. Similar sentiments were shared by private organizations that provide non-patient/client care services (e.g., family support, administrative support, and ancillary services). "Some bureaucrat I've never met is going to say 'we don't need [organization] anymore'." In some cases, the feedback is connected to specific individuals. "My organization has a great relationship with [Department leader]; I don't want things to change once the buck doesn't stop there."

Similar to the note regarding cultural friction above, these sentiments are not specific to an agency model; they would be equally relevant to any new/evolving leadership, organizational structure, or process through which the County might foster integration and change. If 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. When changes are considered, they should be done in an open and transparent manner, fully engaging external partners throughout the process.

While many stakeholders expressed concerns about how their role might be reduced, others saw the agency as an opportunity to expand their reach, helping to forge new connections with populations that could use their services or with

Departments who should be aware of their capabilities and programs. While some external organizations have well-established relationships with two or three Departments, many have very strong ties to only one, despite offering services that could benefit a broader set of individuals. Examples include community clinics able, or potentially able, to offer primary care, mental health, and substance abuse services; family support organizations; and consumer advocacy groups. Time spent building relationships, developing partnerships, and forging strategic alliances could help to bridge these gaps, benefiting the individuals served and the external entity through increased reach.

Risk agency planning may detract from the work of integration

Many individuals describe an atmosphere of distrust and suspicion of the process for evaluating the agency model and its goals, particularly given the absence of a stakeholder process before the item was brought for discussion by the Board. Some questioned whether or not an agency could recover, begin to build trust with these stakeholders, and focus time and attention on the work to be done. If efforts are not taken to ameliorate this distrust and fear, they could complicate the real work of the agency in integrating care. Given this, if implemented, it will be important for the agency director and other Department leadership to have the necessary skills, experience, and temperament to build trust-based relationships with stakeholders over time.

Additionally, some stakeholders raised the practical concern that focus on planning an agency would distract from the real work of integration that should be the primary focus for the Departments. One stakeholder commented: "Let the Board's answer be a simple yes or no; a lukewarm 'let's study it for a while' would be a terrible waste of everyone's time." Others felt a long planning period was necessary before the County "jumped into something it didn't want." "We've been married before and it didn't work; we should spend more than 60 days deciding if we want to get married again." If an agency is created, there is also concern about how the process of designing and establishing the agency will affect services. They described being fearful that energy would be spent investigating the feasibility and return on investment from various administrative restructures (e.g., HR, finance), rather than focusing on service-oriented initiatives. "The process of building an agency is a distraction from the real work; it could be a transitional quagmire lasting years."

Certainly the real work of an agency is in integrating services by establishing and achieving shared goals. The goal is not the creation of a complex organizational structure. This is an additional reason, beyond the concerns of bureaucracy noted above, why the agency should be structured in a lean and simple manner and why functions should only be moved to the agency level if there is a clear value-add of doing so. If executed in this way, design and implementation of the agency structure itself would be minimal so that staff may focus on the real work of integration.

Proposed Structure

As requested in the January 13th Board motion, this section describes an initial potential structure for a health agency that could be implemented if the Board chooses to proceed with the agency's creation.

Before discussing specific responsibilities that could be placed within an agency, it is helpful to note the approach taken with stakeholder recommendations to revise the location of programmatic divisions within and between Departments. Stakeholders volunteered several suggestions about shifts or "trades" in the placement of specific programmatic divisions that they thought should be made simultaneously with the creation of an agency. Some of the more commonly raised examples include: a) moving Emergency Medical Services from DHS to DPH, b) moving personal health services such as TB control, immunization clinics, and STD services from DPH to DHS, c) moving prevention and early intervention activities from DMH to DPH, and most commonly, d) moving substance abuse control (with or without the prevention component of SAPC) to DMH , DHS, or allowing it to have its own new Department "on equal footing" with DMH and DHS. Shifts of this nature are more operationally and organizationally complicated than the creation of an agency itself, given the impact on administrative support functions (e.g., HR, finance, IT) and the resulting separation from other clinical initiatives within the home department. As a result, this report recommends that if an agency is created, all Department programmatic divisions should be kept at least initially where they currently reside. Over time, agency and Department leadership should carefully assess the benefits and risks of these or other possible shifts and make adjustments where appropriate.

Placement of specific responsibilities and functions within a health agency

One defining role of an agency is that it can host certain administrative functions as a means of helping to streamline operations and reduce duplication. Programmatic and service delivery functions should not be moved to the agency level; they should be retained within the Departments with the agency working to coordinate and align strategy and operational implementations. Re-location and integration of administrative functions isn't the primary goal of an agency but such shifts can be an important catalyst for service integration, if done correctly, and can help to enhance operational efficiency and reduce costs over time. If done indiscriminately, however, such moves can be disruptive and harmful to ongoing Departmental activities. In considering whether and when an agency might place specific administrative functions at an agency level, several points emerged: the need to progress slowly, avoid duplication, stay lean, and respect Departmental expertise and culture.

Progress slowly: One benefit of an agency is its ability to streamline administrative functions, reduce duplication, and dedicate more funds to services of direct benefit to individuals and populations. While the possibility for efficiencies and cost-savings exist, these are long-term opportunities that must be carefully considered and planned for in order to avoid disrupting ongoing operations and services that rely on these support functions. Rather than rushing into a series of potentially disruptive changes, functions should only be moved when there is a clear strategic or operational advantage, economy of scale/efficiency to be gained, or when circumstances arise that present opportunities for change (e.g., personnel changes). Even when the possibility of savings exists, functions should only be moved to an agency level when there is demonstrable evidence that doing so will create a value-add in terms of improving service levels, enhancing departmental operations, and achieving economies of scale. Organizations are fluid; they need to be allowed to evolve over time based on the opportunities and challenges of the moment. As one stakeholder commented, "the natural inclination would be to move things right away in order to save money but this would be very disruptive. These shifts, if done right, would take years."

Avoid duplication: To avoid redundancy and bureaucracy, and to ensure that an agency either decreases administrative costs or is cost-neutral, an agency should be careful not to duplicate units or functions. Using HR as an example, it would not be wise to have each Department retain a full HR unit and also create an HR unit at the agency level. This would raise costs and increase the number of steps required to accomplish tasks within the County, ultimately leading to delays in downstream services and programs.

Stay lean: In order to keep costs and bureaucracy low, it is best to structure the agency as a lean body. A lean agency would imply very few management-level positions and could involve the use of strategic leads in different functional areas (e.g., IT, finance) in which a single individual is appointed to take on a strategic role at the agency level. These strategic leads would have a matrix reporting line with the corresponding Departmental lead for specific areas. These strategic leads must understand the functions and operational frameworks of each Department to ensure that the agency-level strategy takes into account the unique needs and requirements of each Department while advancing a cohesive vision to support agency objectives. It is possible to achieve these positions in a cost-neutral manner as described in the "Risks" section above. If, over time, certain functions move to the agency level, this would obviously increase the number of staff reporting to the agency (vs. the Departments). However units would only be moved to the agency when there is a clear value-add in terms of Departmental operations and if doing so would yield net financial savings.

In some cases, rather than appointing a specific individual to coordinate work on a topic at the agency level, a particular unit or team could be designated as the lead for the agency for those areas while remaining within their Department. In this center of excellence model, divisions with particular expertise on a given topic could support other Departments without having to relocate to the agency. As examples, DPH may be well-suited to provide a leadership role for the agency in grants solicitation, accounting, and fiscal management or employee wellness; DMH in providing instruction on use of the recovery model in clinical practice; and DHS in revenue maximization.

Respect Departmental expertise and culture: Small differences can have big impact on operations and on an organization's culture and strength. Moving functions to an agency level without attention to these nuances could compromise critical technical functions by reducing content knowledge of the division. The risks of moving the finance unit from the Division of HIV and STD Programs to an agency finance unit is one example raised given the specialized knowledge and expertise required to perform Ryan White-related finance services. These moves could also weaken the overall fabric of an organization if such a unit were a core part of the Department's identity. Some stakeholders raised concern that if DMH's family/advocacy unit were moved to an agency level, in an effort to spread best practices to both DHS and DPH, that DMH would lose connection with a unit critical to its core identity.

With these guidelines in mind, below are the CEO's recommendations on the placement of specific functions and roles at the agency level. Prior to decisions regarding these moves being finalized and executed, the agency and Departments should spend a reasonable period of time in a focused planning phase, working out operational and implementation details.

<u>Recommendations for creation and/or reassignment of units (in full or in part) to an agency level</u>

1. ***Data/planning group:*** The agency model may facilitate the sharing of certain data and information for care and treatment purposes as well as for statistical analysis and planning. As to care and treatment purposes, it should be noted that each Department currently maintains separate privacy practices as well as authorizations for the release of information and consent forms. Even within Departments, these may be replicated or refined at a division or facility level. Thus, the County system of care currently is a complex and sometimes overlapping process and often does not engender an environment conducive to coordinated care.

   To address these needs, the agency should create a small data/planning unit made up of individuals reassigned from each Department (and/or acting in a Department liaison role) that would have responsibility for performing

analyses needed for planning and program design activities. Examples of specific roles would include: performing data matches in a manner that preserves information privacy and security, leading agency-wide data governance activities, developing business intelligence functions including development of performance metrics and indicators, performing geographic analyses, leveraging available data and analytic resources, and assisting in the data-based design of programmatic initiatives, such as high-utilizer programs and coordinated case management functions.

In developing this report, County Counsel was asked to explore the feasibility and legal issues related to this concept. Regarding improvement of information management for care and treatment purposes, Counsel concluded that the agency model would facilitate the Departments in adopting joint privacy practices and a universal authorization for the release of information. Counsel surveyed the agency models used in other jurisdictions and learned that they have a wide array of authorizations and consents to enable the sharing of client- or patient-specific information. Likewise, they have privacy practices that are implemented at the agency level so that they encompass all departments that comprise the agency. Counsel does not foresee significant legal obstacles to establishing similar policies and procedures in LA County. The agency must be cognizant that federal and State laws still provide heightened protections for certain information, such as that pertaining to substance abuse, mental health and STDs and, as a result, the agency will require authorization from the individual to share this sensitive information. However, several other counties that have moved to an agency model have followed this protocol, facilitating improved care coordination for individuals served by multiple departments.

As to information sharing at the agency level for statistical or planning purposes, an agency unit would be akin to the function currently implemented by the Service Integration Branch (SIB) of the CEO to support multiple County departments. Essentially, the agency would be interchangeable legally with the CEO's SIB in this arrangement. While DHS, DMH and DPH would still participate in SIB activities as needed for relationships with non-health departments, they would separately engage in data sharing projects at the agency level.

2. ***Capital projects and space planning group:*** As described in greater detail above, one advantage of an agency is the ability to better coordinate and plan use of County-owned and leased properties. Each Department has a unique inventory of facilities but also has several unmet needs including deferred maintenance issues, aging infrastructure, greater geographic access for clinical services, suboptimal floorplans and locations for current operations/services, etc. By having the agency take on a role in overall space planning, including management of capital projects, the County would be better positioned to create economies of scale, reduce cost, and improve the degree to which County-owned and leased buildings meet the needs of each Department as long as these activities replace rather than duplicate similar activities undertaken currently by CEO. In this structure, staff shifted from the Departments to the agency would still need to be dedicated to Department-specific projects. This function would not include actual facility management. These activities should remain in the Departments, closely aligned with clinical programs.

3. ***Government affairs:*** To ensure alignment in the County's policies on certain issues and create a stronger advocacy arm for health-related issues, the agency should have a unit dedicated to government and legislative affairs. This unit would not replace the policy units within each Department nor would it replace the role of Intergovernmental Relations in the CEO. Rather, it would be responsible for developing and/or consolidating, supporting, and advocating for positions that would be of benefit to any or all of the involved Departments. Positions recommended to the government entities would continue to be developed based on analyses and input from subject matter experts within each Department.

4. ***Consumer affairs/advocacy/ombudsman:*** Navigating the services provided in each of the three Departments can be challenging. A central unit could help individuals and external entities access services, find clear answers to questions that are not Department-specific, and facilitate open dialog with individuals and community stakeholders. This unit would be in addition to the existing consumer affairs/advocacy/ombudsman units that each Department currently operates; these Department units should continue operating. As suggested by Neighborhood Legal Services of Los Angeles County (NLSLA), such a program could also hold the following responsibilities with respect to consumer advocacy:[61]
    - Enumerate the powers of the agency to investigate and resolve consumer complaints at both the intra- and inter-departmental level and ensure consistent handling of issues.
    - Hold the agency accountable for tracking and reporting the incidence and outcomes of consumer complaints.
    - Specify a timeline for investigation and resolution of complaints.
    - Ensure that client/consumer/patient protection organizations are able to work collaboratively with the agency to advocate on behalf of their clients and can escalate concerns when needed.

Several stakeholders also suggested that there would be substantial value to the County if the agency also had a specialized unit focused on workforce training. The goal of this unit would be to foster staff engagement and development and to promote a culture of continuous improvement well-versed in models of care that support service integration. The unit would help design and implement education and training on, for example, new care models and practices, techniques to identify and solve problems, consumer engagement, and cultural competency. Further discussions should be had among Departmental leadership to assess whether there is support for creation of this or similarly-focused units at the agency level and how such units would be staffed and structured given the different ways in which these functions are currently fulfilled in each Department.

A number of stakeholders specifically recommended that IT be immediately moved to the agency level as a shared function. While such a move might result in better aligned strategy, coordinated activities, and economies of scale with respect to IT support, etc., there are also sizeable risks of such a move. First is the concern that the agency would divert time and energy away from critical Public Health IT needs including those of Environmental Health, Disease Surveillance and Control and Emergency Preparedness and Response. Second is the concern that IT staff would be devoted to the implementation of the agency structure rather than the achievement of the desired clinical or operational objectives. Clinical service integration objectives may best be met by having IT entirely at the agency level over the longer-term, but progress can still be made by appointing an individual to be responsible for ensuring the strategic alignment of IT initiatives in each Department. For this reason, IT is included below as a strategy role and is not recommended to be completely shifted to the agency.

Over time, the Departments and agency should continue to examine whether a particular function would be best positioned at an agency rather than a Department level.

<u>Recommendations for strategic roles within the agency, each filled by a single individual</u>

It would not be prudent to immediately move most core administrative functions from the Departments to the agency level. Still it would be advantageous for the agency to be able to coordinate and align policy, strategy, and operations in key areas. The purpose of agency strategy roles is to help facilitate synergistic and coordinated strategic and operational decisions. Individuals in these roles could serve as a dotted-line supervisor for each Department's lead on a specific content area in a matrix reporting structure. The positions listed below would each be filled by a single individual. These positions

[61] Adapted from NLSLA's letter providing comments on the draft document; full letter available in Appendix VII.

are not primarily operational in nature, but will have a strong role in helping to align operational activities in each Department and remove obstacles that may impede success on particular initiatives. Single individuals are recommended by the CEO to fill strategic roles at the agency level in the following areas:

1. ***IT strategy:*** While each Department should maintain responsibility for their own IT operations, it will be critical for the agency to align IT strategy and prioritize certain IT initiatives if it is to make progress integrating services. A single individual at the agency level focused on IT strategy would ensure decisions made are complementary or at least not antagonistic, would identify opportunities to leverage economies of scale, and would help to support priority service integration goals, while making sure Department-specific projects are not compromised.

2. ***Revenue maximization:*** All three Departments could benefit from having a single individual whose role is to understand the revenue streams within each Department and recognize opportunities to draw down additional State or federal funds. Part of this individual's responsibility would also be to clearly communicate the sources and uses of different revenue streams as a means of increasing confidence that the agency is preserving the intended use of different funds.

3. ***Service contracting and procurement strategy:*** Movement of contracting and purchasing functions to the agency level would risk severing a critical link between contract development and program business owners and is not recommended in this report. However, there are opportunities to better align contracting/purchasing strategy, such as through improved coordination on use of master agreements, RFP development, contract monitoring tools and protocols, etc. An individual serving as the strategic lead for contracting and procurement could help to capture these or other opportunities without risking significant disruption to these core functions.

4. ***Human Resource (HR) /Employee Relations (ER) strategy:*** Without detracting from the role of the CEO and DHR with respect to HR and ER functions, there would be advantages to having a single individual focused on HR/ER issues at the agency level, especially if they are focused on highly specialized content areas unique to health-related fields or the needs of certain health programs shared by the three Departments but not generally shared by those outside of DHS, DMH, and DPH.

One additional central strategy role that could be considered by the agency over time is a role coordinating managed care strategy. As each Department further develops its health plan and managed care relationships, it will be increasingly important for the agency to have a holistic view of the scope of activity and contracts being developed. A managed care lead could also identify and help implement joint contracting approaches as opportunities arise.

Beyond the recommendations above, the HR workgroup chaired by DHR further recommended that a Chief Strategic Officer position be created at the agency level to oversee agency-level individuals and help achieve the strategic/operational objectives of the agency. While this recommendation is in line with the structure of many County departments, it would be preferable to defer a decision about a Chief Strategic Officer position, or other deputy-level agency positions, to the permanent agency director once he/she is selected by the Board.

In summary, the proposed agency structure would include the following specific individuals/units reporting directly to an agency director:

- ***Three Department heads:*** Directors of DHS, DMH, and DPH.
- ***Four agency-level units:*** Data/planning, capital projects/space use, government affairs, and consumer affairs/advocacy/ombudsman. To be clear, this report recommends that core administrative functions including IT, finance, HR, contracting, purchasing, etc., all remain in their current Department location and should not be duplicated with an equivalent agency-level unit.

- ***Four individuals serving in a strategy/coordinating role in the following areas:*** IT, revenue maximization, service contracting and procurement, and HR/ER.

The role of the Health Officer

The Health Officer plays a critical role in a County health system and has specific statutory roles and responsibilities. It is critical that the County ensure the Health Officer is able to take immediate and necessary action, even if such action conflicts with the views of the DPH Director[62] and/or agency director, can act autonomously from the agency director and his/her staff, and is strategically positioned to work collaboratively with each Department. The Health Officer will continue to be an unclassified position within DPH and will continue to hold all current responsibilities, including the responsibility to lead a County-wide disaster coordination and response effort, issuing orders to the general public and to health care facilities, etc. To preserve the autonomy and public accountability of the role, the Health Officer should also have a dotted reporting line directly to the Board of Supervisors.

[62] In the case that the Health Officer is not held simultaneously by the DPH Director.

Possible Implementation Steps and Timeframe for Achievement of an Agency

The January 13th Board motion included a directive to report back on "possible implementation steps" with respect to creating a health agency. While the Board must first decide whether or not to move forward with creation of an agency, if it does wish to proceed, the following steps are recommended. These steps are those required from a legal/technical perspective, particularly as it relates to amendment of the County ordinance, and strategic/operational steps that, while not legally required, are recommended for consideration by the Board.

Several stakeholders, including the Mental Health Commission and Public Health Commission, have developed planning and/or integration principles to guide discussions and development of a new organizational structure. Many of these principles are relevant for a discussion of agency implementation and are included in Appendix VI.

Legal and technical steps required to create an agency

Currently, the three Departments are each created under separate ordinances contained in Title 2 of the Los Angeles County Code. Nothing in those ordinances is inconsistent with creation of an agency. The County's Charter requires the Board to provide by ordinance for the creation of offices not required by law. Therefore, at the Board's discretion, it could adopt an ordinance formally approving the creation of the agency. Such action is within the Board's authority under the police powers granted by the California Constitution. The agency ordinance would bring those separate Department ordinances under the umbrella of the agency structure by reference, with reporting lines from the Department heads to the agency director built into the agency ordinance. The position and authority of the agency director also would be created and defined in the agency ordinance itself. The authority of the Board to appoint the agency director, as it does for the directors of DHS, DMH and DPH, would also be part of the agency ordinance as provided in the County's Charter. The agency director position may be filled by any individual inside or outside the County as the Board chooses.

If necessary, the ordinance will also amend discrete provisions contained in each Department's ordinance if roles under the agency structure need to be clarified or modified. To the extent salaries or job titles must be modified to implement the agency, certain provisions of Title 6 may also require amendments. This could be accomplished using the ordinance that creates the agency and its director. These amendments can also be made over time as the agency structure evolves.

As with the majority of ordinances, the agency ordinance must have two readings at a Board meeting. The agency ordinance would be placed on the agenda for introduction, then return for adoption at a later meeting, which is typically the following week. The agency ordinance would then take effect thirty days after adoption. The agency ordinance must be effective before the agency structure can formally exist. Should the Board wish to direct County Counsel to prepare an ordinance to create the agency, that work could be completed within sixty days of the Board's direction to do so.

Strategic/operational steps related to implementation of an agency

Organizational change of any kind can be challenging and must be carefully implemented and managed. If an agency is created, steps should be taken to restore stakeholder trust in an ongoing and transparent public process and reduce the possible risks of an agency. As some stakeholders put it, "we love the concept; the devil is in the details of its execution."

Appoint an agency director with the necessary skill and temperament to be successful

Stakeholders raised a number of concerns about who would be selected as an agency director. Several individuals and groups inquired about the process the Board of Supervisors would use in appointing an individual to lead an agency, particularly preferring that the Board choose to appoint an interim director while the County conducts a formal, open, competitive search for a permanent director. Several stakeholders stated a preference that a Department head not be permitted to concurrently serve as the agency director. Finally, others suggested that the agency director position should be filled by each Department head on a rotating basis (e.g., for two years each).

Stakeholders additionally weighed in on qualities they would want to see in an agency director. Some of the characteristics mentioned by stakeholders include the following:

- Possesses relevant background and professional experience in physical health, mental health, public health, and substance abuse, including development and implementation of integrated programs across all areas. Of note, several individuals commented that, of the three, a background in public health is the most important because of the breadth of its mandate and because of a desire to see public health exert greater influence over the clinical delivery system given the evolution of morbidity and mortality and the importance of focusing on social determinants. As one of stakeholder put it, "all of what an agency does is really public health at some level."
- Highly values active and ongoing stakeholder participation and community engagement and commits to continued dialog regarding the design, implementation, and ongoing monitoring of integration activities. This includes supporting an active partnership with clients/consumers/patients, organized labor, contracted agencies/providers, the faith-based community, and others. Specifically,
    - The individual should embrace the concept of "nothing about us without us" referring to the empowerment and meaningful partnership with clients/consumers/patients in all aspects of the planning and implementation of programs and services.
    - The individual must highly value labor-management collaboration and the involvement of front-line workers in programmatic reform and continuous performance improvement.
    - The individual must embrace existing relationships with contracted agencies/providers, actively partnering with them to learn from successful programs already in place in community-based sites and to continuously improve services and programs County-wide.
- Explicitly supports robust, direct communication between Departments and the Board of Supervisors.
- Employs a collaborative, consensus-building leadership style that empowers staff, values transparency, and seeks to build trust-based relationships with staff, contractors, and external stakeholders.
- Views health and wellness in its most comprehensive sense, taking into account an individual's physical, mental, social, and spiritual health, and the multiple environmental, occupational, and socio-economic factors that affect it, and embraces an inclusive perspective of the breadth of clinical, non-clinical, and recovery-based interventions that are needed to optimize health.
- Has a strong concern for the needs of vulnerable groups, un-served, underserved, and inappropriately served individuals, and a commitment to reducing health disparities among specific populations (e.g., ethnic/racial groups, LGBTQ, children, and others) by developing programs and services in partnership with local communities in a culturally proficient manner.

Establish and clearly communicate an integrated strategic plan and set of initial agency priorities

If an agency is created, careful attention should be dedicated to defining the agency vision and mission and creating an integrated strategic plan that will guide agency activities and priorities over the coming years. The agency director and the three Department heads will be held accountable for meeting these established agency goals as well as for achieving

Department-specific goals. While a strategic plan will be important to help define the specific activities of the agency, the appointed director should also ensure that the work of integration begins immediately. Early and transparent priority-setting will help to center people's attention on initiatives that will yield concrete benefits for LA County residents and will help to avoid the risk that "thinking about the agency" will create a shared enemy that distracts attention from the true goal.

Over the course of stakeholder discussions during past six months, individuals raised numerous potential issues that might be initial priority areas for an agency. Some of the most commonly raised ideas, or those where there was a high degree of consensus, are included below. Discussion of an agency's specific strategic priorities was not a centerpiece of every discussion, nor were all stakeholders willing to engage in discussion of possible strategic priorities while the Board was still considering the issue of organizational structure and governance. Given that fact, this should not be considered a fully-vetted list of strategic priorities. Additional input from the Board, County leadership and staff, and external stakeholders should be obtained before a formal set of priorities is established for the agency. Of note, some individuals felt that this should happen through a formal strategic planning or needs assessment process that takes place prior to a Board decision about the agency, whereas others felt that such a process would not practically be possible until after the Board provides further direction of its intent with respect to the agency. With this tension in mind, below is a suggested list of initial priorities. While there is work in progress to some degree on all of these initiatives, each would benefit from greater attention and a larger degree of collaborative, coordinated action by the Departments.

- Design and implement a streamlined process through which clients/consumers/patients access care across Departments, including mechanisms to reduce the need for duplicate registration processes, universal consent, single points of access, common patient identification processes, referral mechanisms, etc.
- Develop and implement a comprehensive diversion program for non-felony offenders with mental illness and/or substance use disorders who are deemed to be appropriate candidates for non-jail-based placement/treatment.
- Reduce chronic homelessness among individuals with health-related needs, including a targeted focus on the Skid Row area of downtown Los Angeles.
- Create additional capacity and diversity of placement options, including crisis residential placements, sobering centers, and acute diversion units, that can serve as alternative drop-offs or destinations for individuals facing psychiatric crisis, in an effort to ensure that individuals are cared for in the least restrictive, most therapeutic environment that is appropriate for their clinical condition.
- Reinvigorate a focus on preventing the incidence and adverse outcomes of youth violence and trauma.
- Move toward more timely, comprehensive assessments and ensure ongoing treatment is consistently delivered and having the desired impact on foster children and their social communities (e.g., school, home).

If an agency is created, the director (interim or permanent) should immediately initiate a process to obtain input on priority areas for focus, including but not limited to consideration of the above list. While this strategic planning process is important, strategic planning should not be considered as progress in and of itself; no individuals or populations are well-served by a strategic plan, however well-conceived. The goal of this effort should be to comprehensively, but also relatively rapidly, develop a shared set of priorities so that the agency can initiate the actual work of program design and implementation, in continued partnership with internal and external stakeholders.

<u>Build transparent, ongoing, and meaningful partnership with internal and external stakeholders</u>

"We want a voice." To be successful and responsive to the needs of individuals and populations, an agency should establish mechanisms to ensure ongoing, meaningful dialog and partnership with internal and external stakeholders, including those representing multiple perspectives and constituencies. A broad set of stakeholders, including clients/consumers/patients

and their families, community advocates, private providers, service agencies, and community-based organizations (including but not limited to the Departments' contracted partners), the 88 cities within LA County, organized labor, the faith-based community, and experts/leaders in the field should be actively included. Efforts should include bringing in the voices of mentally ill persons who are in jail or in institutional settings.

The goals of these stakeholder forum and processes include:

- Ensure community/public consultation, participation, and input into ongoing planning and decision-making processes, including but not limited to the development of the agency's strategic plan and the prioritization of integration initiatives.
- Provide feedback on the impact of those initiatives, intended or otherwise.
- Help to create metrics that offer early indications of success or problems and review them on a periodic basis. Additional discussion of the importance of these indicators is included below.
- Establish a forum to express concerns, help to resolve disputes, learn from one another and begin to build trust among groups not accustomed to working together.

The agency should actively seek the involvement of stakeholders with particular insight into the needs of disadvantaged, underserved, and vulnerable populations to provide critical input on areas of unmet need, how program design may affect specific groups, and the design of culturally competent services, and to serve as early warnings for adverse or unintended consequences of an initiative. This will be a critical element in ensuring an agency is successful in its role of helping to reduce health disparities and promoting access and parity across populations and services.

Many people expressed concern as to how the stakeholder process would be set up, fearing a "superficial, check-the-box, stakeholder process" or one that would not support bidirectional communication between stakeholders and the agency. As one step, some stakeholders expressed a preference for having an external facilitator help guide discussion at these fora. While stakeholder input is critical, careful attention would have to be paid to the membership of the group(s) formed to ensure broad representation across stakeholder types while ensuring the size of the group is still amenable to in-depth discussion of issues. Other mechanisms (e.g., focus groups, sub-committees, etc.) could be used as ways to obtain necessary input from a larger set of individuals. As an initial step, the Board could consider immediately establishing an agency advisory group, comprised of, for example individuals appointed by the County Commissions, organized labor and, as appointed by each Department, those representing the views of clients/consumers/patients and their families, community partners (including contracted and non-contracted organizations), community advocates/experts, and others.

Creation of an ongoing agency-level stakeholder process should not replace or supplant existing stakeholder engagement mechanisms and groups already established within each Department. To the contrary, existing groups and ways in which Departments and/or facilities/programs engage in dialog with stakeholders and involve them in program design, priority-setting, and decision-making should continue. These are often well-established groups/fora that serve an important role within their respective Department; their roles and responsibilities should remain unchanged.

<u>Promote cultural competency in all health-related activities</u>

LA County is one of the most ethnically and culturally diverse regions in the nation. Delivering services and programs, as operated, led, or funded by the County health Departments, in a culturally competent manner is critical. By improving access to high-quality health services and programs that are respectful of and responsive to the beliefs, practices, and cultural and linguistic needs of individuals with diverse backgrounds and experiences, the County is better positioned to address health disparities among specific populations and improve overall health outcomes. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to function

effectively to understand the needs of groups accessing health information, programs, and services in an inclusive partnership where the provider and the consumer meet on common ground.

A common thread in many discussions regarding the health agency was the need for greater cultural competency and humility across the breadth of the County's health-related activities. While each Department has operationalized efforts to deliver culturally competent programs and services in different ways, among the three Departments, many stakeholders commented that they viewed DMH as having the strongest foundation and infrastructure in support of cultural competency and recommended that the agency pattern efforts to enhance cultural competency after those taken by DMH. However, even in that Department, stakeholders commented that improvements could be made. These stakeholders expressed concerns that the hard-earned progress made in terms of prioritizing cultural competency may face setbacks under an agency model if the agency did not highly prioritize this area.

If created, an agency should explicitly recognize cultural competency as a foundational principle that should underlie its activities, along with other principles such as commitment to labor-management partnership, ongoing and transparent stakeholder engagement, and others. The agency, in recognition of the challenges presented by the health needs of diverse racial and ethnic communities with their own cultural traits and beliefs, will need to focus on promoting and fostering cultural competency among all workforce members through a variety of educational and human resource initiatives that help to instill the behaviors, attitudes and norms needed to support provision of culturally competent programs/services. This should include support for workforce training, including that of County staff and contracted workforce members, modification of performance management expectations, support for recruitment and retention of diverse workforce, availability of interpretation and translation services into threshold languages by service area, and, critically, design of programs to take into account all recognized domains of culturally competent services, including physical, intellectual, emotional, spiritual, social, environmental, and occupational realms.

With regard to designing services to meet the mental health needs of clients, particular attention should be paid to the recommendations made in the population reports published by the "California Reducing Disparities Project," a project of the California Department of Public Health that commissioned work on how to reduce disparities in mental health services among five priority populations: African Americans, Asians and Pacific Islanders, Latinos, Native Americans, and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ). These reports put forward "population-focused, culturally competent…community-defined, strength-based solutions and strategies"[63] for addressing disparities in accessing mental health care and can be a major source of information to consider in designing culturally responsive initiatives.

<u>Ensure accountability and oversight of the agency</u>

Several individuals raised the need for outside, objective oversight of the agency on an ongoing basis. This would include evaluation of the fiscal, programmatic, workforce, and community-related impact of agency activities and processes. While this could be performed by any outside entity, the existing Commissions could fulfill this role. The relevant Commissions, including the Commission on Alcohol and Other Drugs, HIV Commission, Hospital and Health Care Delivery Commission, Mental Health Commission, and Public Health Commission could each be charged by the Board with assessing agency impact and reporting findings, qualitative and quantitative, to the Board on a regular (e.g., semi-annual) basis. Rather than or in addition to relying on the existing Commission structure, some stakeholders have also suggested that the Board appoint a new, independent Commission which would serve as an oversight and accountability body for the agency overall. Such an entity would, as with other Commissions, be accountable directly to the Board of Supervisors. Some suggested that such a Commission be patterned after the Ryan White Care Act in which a community planning council is delegated

[63] California Reducing Disparities Project, RFP, initially released by the California Department of Mental Health in 2009.

"power of priority setting for services and allocation of resources for those services directly to the community." If appointed, some made a suggestion that the new agency-level commission be comprised of at least 51% active clients/consumers/patients of County services (directly operated or funded). Finally, some stakeholders specifically suggested that a separate entity be developed to focus specifically on review of population health issues as one means of ensuring the agency pays proper attention to this critical public health realm. One suggestion was for a "Community Prevention and Population Health Task Force" that would report on fiscal, operational, and policy issues, delivering reports directly to the Board.

Regularly and publicly report on agency progress, including indicators related to the agency's impact

Many stakeholders were open about their concerns regarding the potential impact of an agency and asked "What will you do to guarantee that these things I fear won't happen?" It is necessary but not sufficient for County and agency leaders to make clear reassurances that the risks of an agency will not become a reality. Leaders should also be expected to report publicly, on a regular basis, on the opportunities being pursued and whether or not risks are being appropriately prevented. Carefully developed and transparently tracked indicators can also be critical in alleviating anxiety, building trust, and establishing a foundation for interactions that can focus on the work of integration. Such indicators would help to highlight whether or not services and operational functions are improving, but also could provide early warnings of adverse consequences of the agency's impact. Metrics will not cover all topics but should be broadly reflective of a variety of domains and functions. With respect to the development of these indicators, the following should be kept in mind:

- Metrics should cover a diverse array of activities, reflecting the full breadth of the Departments' scope. This should include measures that highlight population health, physical health, and mental health services; policy/regulatory functions; community-based interventions; direct clinical services; and administrative practices. Each Department should independently validate that metrics are appropriately reflective of their scope and priorities.
- Metrics should focus on outcomes that are of direct importance to clients/consumers/patients such as access, customer experience, care quality, health outcomes, community responsiveness, as well as administrative processes required to get the work done.
- Metrics should be able to measure progress toward specific established integration priorities.
- Metrics should assess how effectively individuals in specific populations (e.g., underserved or underpenetrated ethnic groups, vulnerable populations) and geographies are able to access and/or be connected to services and health outcomes among these groups. This is critical to reducing health disparities and provides an objective way to judge the appropriateness of resource allocation.
- Measures that are not directly related to public-facing services can also be helpful if they provide information on the administrative and operational health of the agency. Covered areas could include staff satisfaction, HR efficiency, (e.g., time to fill an item), finance functions (e.g., time to process payment), and contracting/procurement functions.
- Measures should take into account work done by both directly-operated as well contracted providers/agencies.
- Measures of the financial impact of agency changes are critical in reassuring the community and building trust. This includes showing trends in and uses of different revenue streams and budget appropriations. It should also include estimated cost savings from administrative efficiencies gained, including ways of tracking the beneficiaries of these additional funds and how these savings are used.

Indicator reports, when routinely measured and publically reported in a clear way, can serve as a powerful method of ensuring accountability and transparency. The development of these indicators will take time and could benefit from the involvement of a wide range of external experts who can be neutral arbiters of what measures would be appropriate

reflections of an agency's possible impact. The role of these external perspectives should not be limited to only metric development. Their continued involvement in the review and interpretation of data and review or audit of external publications would enhance accountability and build public trust.

It would obviously not be appropriate to attribute all change, either positive or negative, to the impact of the agency. The agency would not be implemented in a vacuum; the work of Departments and external factors would continue to influence measured processes or outcomes. This fact should be taken into account both when designing the measures and also when interpreting the results. Reports should allow for qualitative interpretations of data, sharing a broader context and explanation of what is seen in the numbers.

Data and more qualitative points about the impact of the agency should be regularly (e.g., quarterly) shared before the Board of Supervisors. At such hearings, the agency director and each of the Department heads should be expected to report on agency priorities, activities, client/consumer/patient impact, including whether opportunities and risks are being realized. The report should also include a summary of any structural changes made to the agency. Community stakeholders representing a variety of perspectives should be encouraged to attend and speak about the impact of the agency to date.

Develop and publish clear, concise data on Departmental budgets, appropriation, revenue sources, and uses

The issue of clarity into financial data is related to the above discussion of indicators, but deserves specific attention. The single most common concern raised across stakeholder groups was that Department budgets, particularly those of DMH and DPH, would be cut over time to divert resources to other purposes, particularly within DHS. As discussed in the "Risks" section, the very structure of the agency makes it impossible for funds to be moved between Departments without Board approval. Still, stakeholders should be provided with continuous confirmation that Department funds are maintained within the Department and, at a more nuanced level, that more subtle means of manipulating budgets is not taking place.

The County budget process and its communications are dense, filled with technical jargon, and are difficult to understand by those not constantly immersed in the subject. Effectively alleviating stakeholder concerns that the agency will lead to cannibalization of Department budgets will require clear and transparent budget communications. Finance staff working with public communications experts should develop simple charts showing where key funding streams are being spent, including notably MHSA funds and County general fund dollars, and what those funds are buying (e.g., number of visits, days of placement, public service campaigns). The data behind these charts should also be made available to the public.

Clearly communicate changes with the public

External partners, community agencies, and service providers need to know the changes that are being made to Departmental structure and programs so they know where to go to get the information they need. Stakeholders expressed concern that the agency would lead to changes in administrative functions or shifts in roles and responsibilities within the County over time and that they would be left "out of the loop and wondering where to go." The need for clear and frequent communications cannot be overstated and, as several individuals noted, is not a particular strength of the County. Some suggested that those within the Departments with expertise in managing public communications could share best practices across the agency.

Create opportunities to build relationships and trust among staff

Each Department has a strong and unique cultural identity. These differing cultures can be an asset or a liability as the Departments work toward integration, depending on the degree of trust and respect that exists. The creation of an agency could promote opportunities to intermingle the cultures of the Departments in a way that shares best practices and builds off of the strengths and capabilities of one another. One stakeholder described needing to work to increase "the cultural competency [of the Departments] not just for the sake of the individuals we serve, but also in regards to the staff within our Departments." It is possible to create an agency that works effectively together across its distinct parts to improve services to clients/consumers/patients, but doing so will require significant work and focused attention. The importance of this process was strongly emphasized by internal and external stakeholder alike.

To achieve this, front-line staff should be actively engaged in a discussion of agency mission and priorities and must be given opportunities to build relationships over time through real work. Where prior integration activities have succeeded in a sustainable and deep manner, success was attributed to a sense of shared mission and goals and a commitment from those involved working as a team to overcome operational barriers. Some individuals however cautioned that these interactions should not be forced: "Cultures need to simmer and not be immersed instantly; cultural understanding and relationships take time." Trust is built over time through clear and open communications, transparency, and establishment and tracking of performance goals. The agency should be sure to invest in the resources needed to enable staff to do their work and promote a culture built on labor-management collaboration and partnership.

Conclusion

This document has attempted to outline integration opportunities, risks of an agency model, and potential ways in which these risks can be addressed through an agency's structure and implementation. The hope is that through this report, and the extensive internal and external stakeholder process that helped inform it, LA County leadership is well positioned to determine the best path for the County's three health-related Departments so that it may maximize opportunities for innovation and integration and ultimately improve the health and lives of all LA County residents.

The past six months has offered opportunity for numerous stakeholder discussions about a health agency as proposed by the Board of Supervisors. While there is not agreement among all stakeholders about the best path forward with respect to achieving the goals of integration, the Departments and many stakeholders feel that the process to date has solicited the breadth of various perspectives regarding the agency and the need for service and programmatic integration more generally. Certainly some individuals feel that the process should be extended longer, but this is not widely shared.

Having solicited a wide range of opinions, the Board of Supervisors has three general options as to how it may choose to proceed. First, it may decide the current structure and organizational relationships of the Departments within the County should be left unchanged, ceasing consideration of the agency and other models that would alter the County structure and Departmental relationships. Second, the Board may choose to proceed with creating an agency involving DHS, DMH, and DPH. Finally, the Board may choose to proceed with study and/or implementation of a different model, including the alternative models described on pages 12-13 of this report.

If the Board of Supervisors chooses to proceed with creating an agency, the following is a summary of recommended actions that could be taken:

- Direct County Counsel to prepare an ordinance to create the agency, amend the County Code as necessary to ensure consistency with the new agency model, and report back to the Board with the ordinance language within sixty days.[64]
- Appoint an interim or permanent agency director, whose position may be temporarily placed within the CEO's office pending the agency's creation by ordinance, who can begin critical steps related to the agency's creation. Such steps may include:
    - Develop an agency mission and vision statement regarding the agency's role in enhancing and promoting the overall health and wellness of all LA County's residents.
    - Develop and hold agency director and Department heads accountable for achieving an initial set of integration priorities.
    - Begin process of selecting a set of indicators to be routinely tracked and reported to the Board as a means of gauging the agency's effectiveness and impact, including potential adverse consequences. Specific attention should be paid to indicators that can reflect sources and uses of existing Department funding streams.
    - Establish a mechanism for ensuring meaningful ongoing dialog with external stakeholders possibly via the immediate creation of an advisory body comprised of Commission representatives, organized labor, and, as appointed by each Department, representatives of clients/consumers/patients and their families, community-based organizations (contracted and non-contracted), community advocates/experts, and others.
- Establish a regular (e.g., quarterly) formal presentation as a set item before the Board of Supervisors in which the agency director and each of the Department heads report on agency priorities, activities, creation and funding of

[64] As noted in "Implementation Steps" section above, the agency ordinance must have two readings at a Board meeting before being adopted and would take effect thirty days after adoption.

agency-level roles, and whether opportunities and risks are being realized. Community stakeholders should be encouraged to attend and provide public comment about the impact of the agency to date.

- Direct existing relevant County Commissions to assess and report directly to the Board on the agency's impact.

Over the longer-term, the agency director should further investigate, as needed, or pursue specific opportunities to enhance integration between the three Departments. This should include particular attention to service integration activities as well as opportunities for maximizing available revenue/financing streams, ensuring optimal levels of IT integration, and optimizing use of space for both clinical and administrative purposes.

If the Board wishes to take an action other than creating an agency, the CEO is prepared to assist in whatever way is required.

Regardless of the Board's decision as to how best to proceed, the past six months have raised attention to the importance of service and programmatic integration between DHS, DMH, and DPH to improve the health of individuals and populations. This represents an important step forward for the County and, if taken advantage of, will produce lasting benefit for LA County residents.

Appendix I: Board Motion on Health Integration

AGN. NO._____

MOTION BY MAYOR MICHAEL D. ANTONOVICH JANUARY 13, 2015

AMENDMENT TO AGENDA ITEM #2

Historically, the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) operated as a single department within our County. In response to a variety of factors and the need to establish distinct identities, the Board separated the three functions into three separate departments. While the decisions to separate the functions into three departments were appropriate at the time, evolving trends in health care delivery, policy, and reimbursement have changed. In the present and expected future health care environment, it would be better for the County to operate a single unified health ~~department~~ **agency** that encompasses all aspects of population and personal health.

By integrating DHS, DMH, and DPH, the County will be better positioned to provide high quality, comprehensive health-related services and programs to County residents. Additionally, a single combined health ~~department~~ **agency** would be best positioned organizationally to break down the bureaucratic barriers facing the County's patients, identify synergies between programs, streamline operations, optimize finances and align incentives so that all County staff work toward the goal of providing high-quality, patient-centered, cost-effective health services across the full continuum of

MOTION

SOLIS _____

RIDLEY-THOMAS _____

KUEHL _____

KNABE _____

ANTONOVICH _____

DHS DPH DMH Consolidation - Amendment
January 13, 2015
Page 2 of 2

health services. Additionally, consolidating the three departments should result in budgetary savings by sharing capital or administrative expenses, while yielding tangible benefits for patients in terms of service delivery enhancements.

Finally, it makes sense to also consolidate the environmental toxicology bureau functions currently performed by the Department of Agricultural Commissioner/Weights and Measures within the new consolidated health services ~~department~~ **agency**.

I, THEREFORE, MOVE that the Board of Supervisors:

1. Approve in concept the consolidation of DHS, DPH, and DMH into a single integrated ~~department~~ **agency**, including the assumption of the environmental toxicology bureau functions currently performed by the Agricultural Commissioner; and
2. Instruct the Chief Executive Officer, County Counsel and the Department of Human Resources, in conjunction with the Departments of Health Services, **Mental Health, Public Health, and Agricultural Commissioner/Weights and Measures** to report back within 60 days with a proposed structure ~~to~~ **that might** accomplish ~~the~~ **such a** consolidation, as well as ~~proposed~~ **possible** implementation steps, ~~and a~~ time frame for achievement of the ~~consolidation~~ **agency, and the benefits as well as any drawbacks to this action. In addition the CEO should establish a stakeholder/public participation process to ensure that their input is considered in the report.**

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Appendix II: Brief Overview of Process for Developing this Response to the Board

In preparing to respond to the Board's January 13, 2015 motion, a concerted effort was made to obtain input from a broad range of internal and external stakeholders. This included outreach to external entities, including Commissions, advocacy groups, non-profits, and other groups identified by the Departments, with opportunity for presentation and discussion of the Board motion. Over 35 stakeholder meetings were held prior to release of the draft report. A full list of these stakeholders is provided below. Letters received from stakeholders are posted on the health integration website (priorities.lacounty.gov/health), along with other information and documents on the health integration process. Labor unions with members in one or more of the affected Departments were briefed on the issue and offered an opportunity to raise questions or concerns. Each labor union then established their own process for additional engagement with their membership. Finally, executives in large California counties outside of Los Angeles were also interviewed, as were individuals with knowledge of the structure of major US Counties outside of California.

External Stakeholders	
AFL-CIO	Los Angeles County Client Coalition
AFSCME	Los Angeles County Coalition for Women and Health Reform
Alzheimer's Association	Los Angeles Housing + Community Investment Department Maternal & Child Health Access
Ambulatory Care Network Advisory Board	Mental Health Advocacy/Legal Advocates
American Heart Association	Mental Health Consortium – Congresswoman Napolitano, 32nd District
American Indian Community Council	MHS Oversight & Accountability Commission
American Lung Association	National Alliance on Mental Illness
Antelope Valley Partners for Health	National Alliance on Mental Illness Urban LA
Asian Client Coalition	Neighborhood Legal Services of Los Angeles County
Asian Pacific Policy & Planning Council	ONEgeneration
Association Community Human Services Agency	Operating Engineers and Building Trades
Black Los Angeles County Client Coalition	Pacific Clinics
Blue Shield California Foundation	Prevention Institute
California Alliance of Information and Referral Services	Project Return Peer Support Network
California Association of Alcohol and Drug Program Executives	Public Health Alliance of Southern California
California Center for Public Health Advocacy	Roybal Institute/USC
California Community Foundation	Service Area Advisory Committee Chairs (plus 8 Service Areas)
California Endowment	SEIU Local 721
Children's Systems of Care / Transitional Age Youth	Southern California Association of Non-Profit Housing
Committee on Interns and Residents	Southern California Public Health Association
Community Clinic Association	System Leadership Team (SLT)
Community Health Councils	Teamsters Local 911
Community Partners in Care	The Wall Las Memorias Project
Cooperation for Supportive Housing	Union of American Physicians and Dentists
DMH Faith-Based Advocacy Council	UCLA, Fielding School of Public Health
Economic Roundtable	Under-Represented Ethnic Population
Eldorado Community Service Center	UniHealth Foundation
Empowerment Congress	U.S. Department of Health and Human Services Promotoras Initiative Steering Committee
Greater LA Black Infant Health Consortium	USC, Environmental HS Department
Harbor Area Counseling Services Inc.	Western Center on Law & Poverty
Hospital Association of Southern California	
Housing Trust Advisory Group	
Housing Works	**Commissions**
Inner City Industry, Inc.	Commission for Children and Families
Insure the Uninsured Project	Commission on Alcohol and Other Drugs
International Union of Operating Engineers	Commission on HIV
LA Care Health Plan	Commission on the Status of Women
LA Homeless Service Authority	Hospital and Health Delivery Commission
Latino Client Coalition	Mental Health Commission
Local 1083, 36, 2712, 3511 & 1921	Public Health Commission
Long Beach Public Health	

Input was also obtained from County staff through a number of different mechanisms. This included the development of seventeen workgroups (see list of workgroups below) focused on a wide set of clinical, programmatic, and administrative topics, who met to discuss the responses to the Board motion from the vantage point of their content expertise.

Interdepartmental workgroups
Facilities / Space Planning
Finance / Revenue Generation
Housing
Human Resources
IT and Data
Managed Care Contracting
Pharmacy/340B Reimbursement
Purchasing/Contracting
Service Integration: Ancillary Services
Service Integration: Care for Individuals Requiring Physical, Behavioral and Public Health Services
Service Integration: Community-based Interventions, Population Health, and Personal Care
Service Integration: Contracted Clinical Services
Service Integration: Foster Children and Transitional Age Youth
Service Integration: HIV
Service Integration: Re-entry Populations
Service Integration: Response to Public Health Threats
Service Integration: Streaming Access to Care

An initial draft report was prepared by staff from CEO and County Counsel. Leadership from the County CEO (including Employee Relations, Compensation, Budget/Finance, etc.), County Counsel, Department of Human Resources, DPH, DHS, and DMH were each asked to review and directly edit the initial draft for both factual accuracy and also to ensure the full set of perspectives and points were reflected. All efforts were made to ensure their input was fully taken into account. Detail on Department input that was not incorporated in the initial draft is included in the "Process" appendix to draft report.

Following submission of the draft report, the CEO held a 60-day public comment period which closed May 29, 2015. Public input during this public comment period was accepted in several ways. First written comments were accepted if submitted through the Health Integration website or if sent (or copied) directly to its staff. Written comments received by May 29th are included in full as Appendix VII, with identifying information redacted when requested by the submitting individual/entity. Verbal comment/input was obtained at a variety of stakeholder meetings (over 40 meetings took place during the open comment period), per the request of the stakeholder group, and at five public convenings, each facilitated by Community Partners, held throughout the County. Details related to public convenings were agreed to with Community Partners staff, a represented from each Department as appointed by the Department head, and staff from the CEO's Office of Health Integration. Individuals attending public convenings had access to translation services if requested in advance. A video of the presentation at one of the convenings was posted on the health integration website. Community Partners' summary of the public convenings is available in Appendix VIII.

The totality of input from stakeholder meetings, written comments, public convenings, and input from County staff was taken into account in revising the draft document to generate this final report. A vast majority (>95%) of the direct edits received from DHS, DMH, and DPH were accepted and incorporated into the report. Edits were not accepted if they were factually incorrect or if they altered a view expressed by stakeholders. Additional edits that were not accommodated include requests by DPH to remove text related to the following:

- The agency or Departments' ability to address health disparities.

- How an agency could help promote unified leadership, priority-setting, vision of broad health system issues, etc.
- How DPH could use EHRs within DHS and DMH to monitor, study, and learn about diseases in vulnerable populations.
- Opportunity to integrate and coordinate services for those using community-based needle exchange sites.
- That some believed that efforts to streamline access to care and create a unique identifier wouldn't be realistically possible without an agency.
- Examples of potential joint policy/legislative activities that pertain to public health.

Quotations included in this report are actual statements made during the stakeholder process; in certain cases, they were edited for the sake of brevity. Quotes are included from both internal County staff and external stakeholders and are only included if they represented the general perspective raised by more than one individual. Identifying information is intentionally withheld, even in those cases where the speaker may have been willing to be identified since not all individuals were willing to be quoted and since such information would not add to the quality of the narrative.

Appendix III: Overview of Department Responsibilities

Los Angeles County Department of Health Services

The Los Angeles County Department of Health Services (DHS) is the second largest municipal health system in the nation. The DHS mission is 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. The Department employs nearly 19,000 full-time staff, and has an annual operating budget of $4 billion. DHS serves approximately 600,000 unique patients and provides over 2.9 million outpatient visits annually. During the 2013-14 fiscal year, DHS provided approximately 265,000 Emergency Department (ED) visits, 23,000 Psychiatric ED visits, 192,000 urgent care visits, and 443,000 inpatient patient days of care, including inpatient medical, psychiatric, and rehabilitation services.

DHS more broadly serves all ten million residents of the County through two 'Level 1' trauma centers, a burn center, and the 911 emergency response system run by its Emergency Medical Services (EMS) Agency – the largest multi-jurisdictional EMS system in the country.

For primary care services, DHS has empaneled over 450,000 patients into patient-centered medical homes in which each patient is assigned to a provider team at a "home" clinic. Empaneled patients at DHS include Medi-Cal managed care members, Medi-Cal and Medicare fee-for-service continuity patients, and low-income residually uninsured patients. DHS medical homes are located at 19 free-standing health centers and at the hospital-based outpatient clinics. DHS also provides the entire spectrum of specialty care services and has implemented specialty care improvement initiatives including eConsult, which has provided over 120,000 electronic consultations in 33 specialties to over 2000 primary care providers located within DHS, other County departments, and in community-based primary care sites.

DHS also contracts with private nonprofit clinics and federally qualified health centers, called Community Partners, to expand access to primary care services for low-income, uninsured, and uninsurable residents. In 2014, DHS established My Health LA, a no-cost program for eligible children and adults that covers primary, specialty, emergency, and prescription medications at Community Partner clinics for up to 150,000 individuals who do not qualify for public insurance.

DHS hospitals and clinics have also played a pivotal role in training new generations of doctors for 150 years. Through academic affiliations with the University of Southern California (USC) and the University of California, Los Angeles (UCLA), LAC+USC Medical Center, Olive View-UCLA Medical Center, and Harbor-UCLA Medical Center provide unparalleled training settings for physicians completing their graduate medical education ("residencies") in nearly every specialty and subspecialty. DHS also oversees the LA County College of Nursing and Allied Health, a public community college that supports the educational needs of DHS and the LA County healthcare community by providing nursing and allied health curricular programs and career development opportunities.

DHS' specialized rehabilitation hospital, Rancho Los Amigos National Rehabilitation Center, first gained international attention treating patients with polio. Over the decades, Rancho has brought research to practice and helped thousands of patients who have suffered stroke and spinal injuries regain independence. In recent years, Rancho has showcased the exciting area of assistive robotics, allowing paralyzed patients to walk and gain new functionalities.

Extending beyond the walls of the clinics and hospitals, DHS also works to create long-term solutions to societal issues that impact the health of vulnerable populations and contribute to rising system costs. The Housing for Health division collaborates with private foundations, developers, and homeless service providers to develop supportive housing for chronically homeless patients and probationers. DHS provides health services to youth in the juvenile justice system and

specialized medical services to children in foster care. Through new linkages with law enforcement and other county agencies, DHS is building a new correctional health care model to integrate mental and physical services, reduce recidivism, and improve outcomes.

Through these and other innovative programs and services, DHS continues to meet the evolving needs of all County residents in a new era of health care.

Los Angeles County Department of Mental Health

The mission of the Los Angeles County Department of Mental Health (DMH) is "Enriching lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency." DMH has three fundamental areas of responsibility: 1) DMH provides, through its staff and partners, emergency, crisis, and disaster mental health and community outreach services for the entire population of Los Angeles County. 2) DMH is the Local Medicaid Managed Care plan responsible for ensuring that all Medi-Cal beneficiaries in Los Angeles County specialty mental health services. 3) It is the safety net provider, through its direct clinics and contracted providers, for all of the mental health needs of indigent individuals in the County. To fulfill these responsibilities, DMH works with its stakeholders and community partners to provide clinically competent, culturally sensitive and linguistically appropriate mental health services to our consumers in the least restrictive manner possible. As the largest mental health system in the United States with an annual operating budget of $2 billion, DMH serves over 260,000 individuals each year.

A significant portion of DMH's services are delivered in collaboration with other County departments including the Department of Health Services (through co-located programs), the LA Sheriff's Department, Probation Department, Department of Public Social Services and the Department of Children and Family Services. DMH also partners with the County Libraries, Parks and Recreation and the faith community to extend outreach for early intervention services into local communities.

DMH offers a broad range of comprehensive clinic and field-based services at or from numerous locations throughout the County. DMH's provider network includes multi-disciplinary teams consisting of licensed and unlicensed personnel working in directly operated or contracted agencies. Services are designed to help individuals of all ages attain and maintain their highest possible level of recovery from mental illness. DMH is the State's Local Mental Health Plan (LMHP) for the County of Los Angeles and is responsible for administering all Medicaid and State grant funds for mental health services. These services are designed to ensure accessible, quality mental health care for Medi-Cal beneficiaries.

DMH also serves as the County's Public Guardian, acting as conservator for persons gravely disabled by mental illness and the frail elderly. Services are targeted at those who are functionally disabled by severe and persistent mental illness and those who are low-income, uninsured and temporarily impaired.

DMH's major initiatives are listed below:

- Jail Diversion: A Pre-booking Diversion Program to re-route individuals whose low level offenses appear to be the result of or associated with their mental illness to mental health services from the justice system is under development. Additional DMH Urgent Care Centers and Crisis Residential Treatment Programs are being made available to Pre-booking Diversion Program clients as well as other individuals in crisis. Laura's Law Assisted Outpatient Treatment will also serve this purpose.
- Law Enforcement: Each Law Enforcement Team (LET) pairs a DMH clinician with a law enforcement officer to respond to 911 or patrol officer requests involving persons of all ages with mental health issues. LET provides crisis intervention, de-escalates potentially violent interactions, makes service referrals, and/or arranges psychiatric

hospitalization. DMH has 57 clinicians assigned to law enforcement agencies throughout the County and plans to expand to other agencies next fiscal year.

- Specialized Foster Care ("Katie A" Settlement): As a result of a class action lawsuit against the State and County alleging that children in contact with Counties' foster care systems were not receiving all of the mental health services to which they were entitled, DCFS and DMH must ensure prompt identification of children in the child welfare system who are in need of mental health services and provide intensive mental health services as required. This system is in place and its outcomes being measured.
- Health Care Reform (HCR): The ACA requires greater clinical, programmatic and fiscal integration among Mental Health, Substance Abuse, and primary health care services. The HCR programs that directly impact DMH are the Medi-Cal Coverage Expansion (MCE) and the Coordinated Care Initiative (CCI) to integrate Medicare and Medi-Cal services for "dual eligibles," known as Cal MediConnect (CMC). DMH, DHS and DPH are working with LA Care, HealthNet, and associated sub-plans like Kaiser and Anthem Blue Cross to ensure smooth integration of specialty mental health care for these individuals. Health Neighborhood collaborative efforts have been put in place in seven communities and expansion is on-going.
- Cal MediConnect (CMC): Los Angeles County was selected by Centers for Medicare and Medicaid Services and State Department of Health Care Services to participate in a three-year demonstration project, aimed at improving quality of life and health of high utilizers of health care. Under this initiative, selected Health Plans have been given a capitated rate for managing the Medicare benefit, including mental health and substance abuse services funded by Medicare. Specialty Mental Health Services funded by Medi-Cal are carved out of the initiative and remain the responsibility of the DMH.
- AB109: In April 2011, the Governor signed into law Assembly Bill (AB) 109, which realigns certain public safety functions from the State to the counties. The supervision of parolees including identification of the level of acuity and treatment options available as well as immediate access to services is critical to assisting PSPs' and N3s' successful re-integration into the community and has reduced the risk of recidivism significantly for those engaged in mental health treatment.
- Integrated Behavioral Health Information System (IBHIS): This is the Department's electronic health record and claiming system. It provides integrated clinical, financial, and administrative functionality, including referral management, appointment scheduling, clinical documentation and authorization, and claims management. The implementation of this system enables the Department to meet the Federal and State mandates associated with the ACA. IBHIS began a phased implementation in December 2013, and in January 2014 began rolling out incrementally across directly operated programs and contract providers.
- The Investment in Mental Health Wellness Act of 2013 (SB 82): Is administered by the California Health Facilities Financing Authority and makes $39.1 million in one-time capital development funds available to increase capacity for client assistance and services and limited start-up costs for crisis stabilization and crisis residential beds as well as on-going MHSA funding for mobile crisis support teams.

Los Angeles County Department of Public Health

The Los Angeles County Department of Public Health's (DPH) mission is to protect health, prevent disease and injury, and promote health and well-being for everyone in Los Angeles County. DPH strives to achieve the vision of "Healthy People in Healthy Communities."

A primary departmental function is the continual improvement of the availability, use, and integration of prevention-focused, evidence-based health care services critical to protecting the public's health. The department administers vaccinations to thousands of children and adults to protect against vaccine-preventable diseases. Through its clinics, DPH

also provides screening and treatment services for tuberculosis and sexually transmitted diseases. DPH supports the delivery of lifesaving medical care and support services to over 10,000 low-income residents living with HIV/AIDS each year; and in 2014, DPH supported the delivery of more than 150,000 HIV tests. DPH helps young, low-income, first-time mothers by offering free home visitation services to improve pregnancy outcomes and promote positive parental behaviors. The Department also works with community partners to reduce infant mortality rates in specific areas. Special tailored programs have resulted in fewer infant deaths within the most vulnerable groups.

Another longstanding core function of the Department is to protect residents from health threats. DPH develops collaborative relationships with community organizations to engage in emergency preparedness planning, and maintains a comprehensive plan that allows rapid deployment of staff to provide medication, vaccines and other resources to reduce disease and death caused by public health-related emergencies. DPH is the only public health department in the nation with an established, daily partnership with the FBI, which supports assessment of potential health-related terrorist or criminal acts. DPH also detects and responds to emergent health threats via an early warning system that includes disease tracking and monitoring and a 24/7 state-of-the art laboratory. The Department's Environmental Health division ensures that food and water supplies are safe for the public, and sends inspectors out to address complaints and violations related to food items, housing conditions, noise pollution, and animal infestations. Recent health protection activities have included leadership of a County-wide interdepartmental taskforce focused on Ebola preparedness, and response to outbreaks of diseases such as measles, pertussis and meningococcal meningitis, and collaborating with the Board regarding the closure of the Exide facility.

DPH also plays an essential role in supporting and developing neighborhoods and communities to create environments to aid healthy lifestyles. The Department informs local leaders, decision makers and community advocates of data findings with recommended actions for health improvement on a number of issues. DPH works closely with partners to inform policies designed to protect residents from the effects of tobacco use, improve access to spaces for physical activity, and increase access to affordable and healthy foods in order to address the obesity epidemic. DPH's restaurant grading system has been adopted in cities across the U.S., and its charge to mandate calorie labels on menus led to state laws. In addition, DPH conducts health facility licensing and inspection activities on behalf of the State.

DPH works to support each person in Los Angeles County in attaining his or her full health potential regardless of socially determined circumstances. The Department serves as a technical resource for decision makers outside the traditional health sector, in order to ensure that policies incorporate efforts to achieve health equity. Recent activities include Health Impact Assessments (HIA) addressing transportation and joint use policy decisions.

Finally, DPH serves as a support system for individuals as they make informed decisions about their health. Activities center around improving internal and external capacity to help consumers understand basic health information and make appropriate health decisions. To that end, DPH provides user-friendly information about a wide range of health topics in several languages by way of press conferences, telephone hotlines, social media and a robust website. The Department also works to identify and counter misleading promotion of health-related products and services.

This diverse body of work is conducted by a highly skilled and specialized workforce of professionals across 39 programs and services, 14 public health centers, and four Area Health Offices. The Department employs nearly 4,600 full-time staff, and has an annual operating budget of $946 million. Major responsibilities are grouped into four bureaus that share common clients, missions, and outcomes.

- Health Promotion Bureau**:** Improves community health outcomes by influencing the physical environment, preventing injuries, maximizing early childhood health programs, delivering services to children and youth with special needs, preventing and treating substance abuse, and promoting healthy living across the lifespan.

- Health Protection Bureau**:** Ensures public safety, freedom from environmental hazards, and safe living conditions. It oversees emergency preparedness and response planning and community resilience initiatives.
- Medical Director and Disease Control Bureau**:** Includes two branches. The Disease Control branch tracks health and disease, minimizes disease burden, and advocates for health-promoting policies. The Chief Science Officer branch addresses the broad data and science needs of DPH and oversees Departmental planning and evaluation. The bureau also includes Medical Affairs, Nursing Administration, Oral Health and Public Health Investigation.
- Operations Support Bureau**:** Manages and streamlines administration, information systems, training, and compliance activities Department-wide.

Three units function outside of the bureau structure: Communications and Public Affairs, which includes health education and policy and legislative affairs; the Chief of Staff; and the Board Liaison.

DPH is recognized as a national leader in local public health improvement. Through a variety of innovative programs and services, DPH protects and improves the health of the ten million LA County residents across every stage of life.

Appendix IV: History of DHS, DMH, and DPH Organizational Structure

The Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) were initially created as separate entities. In 1972, DMH and DPH were merged with hospitals (and veterinary services) to create a single Department of Health Services in response to the findings of the Board-established Health Services Planning Committee that found having multiple departments resulted in service fragmentation, duplication of effort, and difficulties in coordinating health programs. Many stakeholders have also pointed out that the move to combine mental and physical health also stemmed from the availability of new funding in the mental health arena and the desire from some to use that funding more flexibly to address gaps in hospital budgets.

The next six tumultuous years were characterized by unstable leadership in mental health, competing geographic program structures, de-prioritization of mental health services that were overshadowed by hospital issues, inadequate attention to the ongoing de-institutionalization of mental health care that was a major theme at the time, and diversion of mental health funding to address physical health service needs. In response, the Board adopted an ordinance in 1978 establishing an independent DMH which held responsibility for all mental health services functions except for inpatient and emergency psychiatric treatment which continued to be provided at DHS facilities with DMH responsible for the cost of this DHS-provided care. In addition to hospitals, DHS retained duties associated with public health and the County Health Officer; alcohol and drug programs; and the County veterinarian services. At that time, all physical health clinics were a function of the DHS division of public health. In the early 1990s ambulatory clinics, except twelve public health clinics, were aligned with the hospital facilities and became today's Comprehensive Health Centers and Health Centers.

That structure remained until 2006 when the Board created a separate Department of Public Health. While a variety of factors influenced the Board's decision, five primary stated concerns supported the need for separate a Department:[65] 1) Anticipated budget reductions for public health activities as a result of projected deficits in DHS hospitals and clinics, a tension amplified by public health being a general fund unit whereas health services operates as an independent enterprise fund.[66] 2) Different missions – DHS being that of care to 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 its interests before the Board and greater ability for DHS' director to focus attention on "critical indigent health issues and long-term funding problems." 4) Anticipated growth in size and scope of public health activities and roles. 5) The need for an experienced public health physician leader to act as the County's Public Health Officer. At that time, the possibility of DHS hospitals shifting to an alternative governance structure under a Health Authority model also appears to be a factor in the decision. While recommending the split, Mr. David Janssen, the County CAO at the time, wrote of the need to "continue to integrate prevention activities into the personal health care system" a fact which would require a "strong agreement" between the two departments to guide such activities. In expressing concern with the split, DHS Director Dr. Thomas Garthwaite, expressed concern that continued collaboration would suffer, depending entirely on the "will of leadership" and "not assured or promoted by the structure."

This separation resulted in hospitals, ambulatory clinics (except those specific to public health services only), and other services (e.g., managed care, juvenile court health, and emergency medical services) making up DHS. By ordinance, DPH included public health services, AIDS programs, alcohol and drugs programs (SAPC) and children's services. Over the subsequent three years, the County briefly considered moving select functions, such as Alcohol and Drug Program Administration, Children's Medical Services, the Office of Women's Health, and Emergency Medical Services but opted to retain the existing reporting relationships. This general division of departmental responsibilities remains in place today.

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[65] Based on a memo from David Janssen, Chief Administrative Officer, to the Board on June 9, 2005.

[66] A government's general fund is a pool of cash raised from taxes and can be spent wherever the government needs it. In contrast, an enterprise fund can only be spent on a specific purpose with most of the funding coming from revenue related to the fund's mission.

Appendix V: Structure of Health-Related Services in other Counties

LA County is the largest county in the United States with a population of nearly ten million residents. It is also one of the nation's most ethnically and socio-economically diverse counties. While no county can be put forward as a perfect comparison to LA County, it is still helpful to understand how other large counties structure their health departments, particularly those within California given the different ways that other states structure state vs. local roles and responsibilities, and also among very large counties outside of California, which are helpful comparisons due to their size and diversity.

For this report, we reviewed the structure of county health-related services in the largest California counties and also the ten largest counties outside of California. A brief summary of the structure of these comparison counties is provided below.

Fifteen largest Counties in California:

County	Population[67]	Sq. Miles[68]	Organizational model[69]			Brief description
			Fully integrated	Partially integrated	Separate	
Los Angeles	9,818,605	4,058			✓	Separate departments of Health Services, Mental Health and Public Health
San Diego	3,095,313	4,207	✓ [limited scope]			Mental health, public health and substance abuse, along with social services, report to the County's Health and Human Services Agency. There are no public hospitals or clinics in San Diego County.
Orange	3,010,232	791	✓ [limited scope]			Mental health, public health, and substance abuse report to the County's Health Care Agency. There are no public hospitals or clinics in Orange County.
Riverside	2,189,641	7,206	✓			The Riverside Board of Supervisors voted to merge the previously separate Departments overseeing hospitals/clinics, mental health (including substance abuse), and public health in March 2015.
San Bernardino	2,035,210	20,057			✓	Separate mental health, public health and physical health departments.

[67] U.S. Census Bureau, Census 2010
[68] U.S. Census Bureau, Census 2010
[69] Refers to the reporting relationship for hospitals, physical health clinics, public health, mental health, and alcohol and drug programs to County governance when such functions exist at the County level. Not all counties in California operate public hospitals or clinics; these are noted as "limited scope". For the counties outside of California, some states delegate responsibilities for public and mental health to the state or city, rather than the county. Those geographies where the full set of responsibilities does not reside at the county level are indicated as "limited scope." "Fully integrated" refers to a structure in which the health-related functions (those that exist in the county) report to a single individual who is responsible for health. This may indicate either an agency structure or a merged department structure. "Partially integrated" refers to a structure in which some, but not all, of the available health-related functions report to a single individual responsible for health. "Separated" means that each health-related function reports separately to County leadership.

County	Population[67]	Sq. Miles[68]	Organizational model[69]			Brief description
Santa Clara	1,781,642	1,290	✓			All components (hospitals, clinics, public health, mental health, substance abuse) report to Santa Clara County Health and Hospitals System.
Alameda	1,510,271	739		✓		Mental health, public health, and substance abuse, among other functions, report to the County's Health Care Services Agency. Public hospitals and clinics report to the Alameda Health System, a health authority.
Sacramento	1,418,788	965	✓ [limited scope]			Mental health, public health, substance abuse, and clinics, along with social services, report to the County's Health and Human Services Agency. There are no public hospitals in Sacramento County.
Contra Costa	1,049,025	716	✓			Mental health, alcohol and drugs, public health, hospitals, and clinics, as well as other functions, report to Contra Costa Health Services.
Fresno	930,450	5,958			✓ [limited scope]	Separate mental health and public health departments. Substance abuse is contracted out by both public health and mental health. There are no public hospitals or clinics in Fresno County.
Kern	839,631	8,132			✓	Separate mental health, public health and physical health departments. Kern County is in the process of creating a health authority for hospitals and clinics.
Ventura	823,318	1,843	✓			Mental health, alcohol and drugs, public health, hospitals, and clinics, as well as other functions, report to Ventura County Health Care Agency.
San Francisco	805,235	47	✓			Mental health, alcohol and drugs, public health, hospitals, and clinics, as well as other functions, report to San Francisco Department of Public Health.
San Mateo	718,451	448	✓			Mental health, alcohol and drugs, public health, hospitals, and clinics, as well as other functions, report to the County of San Mateo Health System.
San Joaquin	685,306	1,391		✓		Public health, mental health, and substance abuse report to San Joaquin Health Care Services Agency. The public hospital and clinics report separately to the County Board of Supervisors.

Ten largest US Counties outside of California

County	Population[70]	Square Miles[71]	Organizational model[72]			Brief description
			Fully integrated	Partially integrated	Separate	
Cook County, IL	5,194,675	945	✓ [limited scope]			Hospitals, clinics, jail services and suburban public health are integrated under the Cook County Health and Hospitals System. Chicago has a separate public health department. Mental health is a state / city function in IL.
Harris County, TX	4,092,459	1,703			✓ [limited scope]	County public hospitals and clinics (Harris County Health System) report separately than public health. Mental health is a state function in TX.
Maricopa County, AZ	3,817,117	9,200			✓ [limited scope]	Maricopa Integrated Health System is a health authority with hospitals & clinics. The county runs a separate Department of Public Health. Mental health is a state function in AZ.
Miami-Dade County, FL	2,496,435	1,898		✓ [limited scope]		Hospitals, clinics, mental health, and substance abuse are integrated under the Jackson Health System. Public health is a state function in FL.
Kings County, NY	2,504,700	71		✓		Health-related services in the counties that comprise New York City are managed by the City. Mental health, public health, and substance abuse are merged within the NY City Department of Health and Mental Hygiene. NY Health and Hospital's Corporation operates NYC's public hospitals and public health clinics separately under an authority model.
Dallas County, TX	2,368,139	871			✓ [limited scope]	County public hospitals and clinics report separately (to Parkland Health System) than public health. Mental health is a state function in TX.
Queens County, NY	2,230,722	109		✓		Same as Kings County, NY, above.
Clark County, NV	1,951,269	7,891			✓ [limited scope]	County public hospitals and clinics report separately than public health. Mental health is a state function in NV.
King County, WA	1,931,262	2,116			✓	County public hospitals and clinics, mental health, and public health report separately.
Tarrant County, TX	1,809,034	864			✓ [limited scope]	County public hospitals and clinics report separately than public health. Mental health is a state function in TX.

[70] U.S. Census Bureau, Census 2010
[71] U.S. Census Bureau, Census 2010
[72] See explanations of organizational model in footnotes to California table above.

In compiling this report, a number of leaders in California county health departments/agencies were interviewed about their county's structure for health functions and the impact of this structure on the ability to integrate care and maximize benefits to county residents. Numerous stakeholders inquired about the availability of objective data from counties with an agency department model as to the impact of the organizational structure on integration activities. Inquiries were made to agency counties in response to this request; however, data was not available for several reasons. First, in many cases, the agency (or in some cases merged) model in "fully integrated" counties, has been in place for decades and thus it is not possible to compare pre- vs. post- agency implementation. Second, while counties could site successes related to integration, it is not possible to definitively state that these successes are as a result of the organizational structure without an objective assessment aimed at making this determination, a study that has not been performed. Finally, even in counties that may be perceived as having achieved more success in integration, numerous arguments could be made as to why LA County is different, due to its size (population and land mass), cultural diversity, social challenges, etc. While anecdotal perspectives are not meant to be a substitute for an objective, third party assessment, they are still helpful in understanding the breadth of perspective by those in positions of leadership within county health departments/agencies. Themes raised in these conversations, and representative quotations, are included below.

A change to organizational structure, including development of an agency, is helpful but not sufficient for achieving integration goals: Those within an agency structure were almost unanimously supportive of it, even when speaking with those in charge of specific areas, such as mental health, public health, and clinics. In some cases, individuals in counties that separated their health-related departments had an interest in the agency model. Several people commented on how separating health functions into different departments reflected outdated practices. At the same time, those interviewed offered words of caution as to how completely or quickly benefits could be achieved.

- "If you were to design a new health system from scratch in 2015, there's no chance anyone would design it as three separate departments. That may have been necessary in the past when people didn't recognize mental illness or appreciate the value of population health activities. But doing it today is a recipe for non-action."
- "People are not their diagnoses. [LA County] has institutionalized its fragmentation."
- "Technically, you could integrate without an agency. But in practice, it will never happen. All of the forces, including financing very slowly, are moving toward integration. If you aren't organizationally structured to do it, you won't make progress at the rate you should."
- "It's insane that we have allowed ourselves to create a system where these services are separated. People are whole people, not separate body parts and organ systems."
- "Of course they should be together. But hopefully no one is fooling themselves that it will be a panacea. No real progress of any size and scope will be made without it, but it won't solve everything either. Organizational structure is a prerequisite; it's necessary but not sufficient."
- "The structure can help the County make progress on priorities. That said, everything can't be a priority all at the same time. You have to make tough choices about what to push forward."
- "Our system is unfortunately very fragmented and does not serve the population well. If an agency could help with that, I'd be interested."
- "In light of the ACA, the whole country is looking at how to better integrate health delivery systems."

Considerations of how LA County's size should impact decisions on agency structure: Many people commented on LA County's size and its uniqueness and complexity as a result. Despite these comments, people did not have firm opinions as to what this size should mean with respect to organizational structure.

- "I'm not sure if it's the biggest reason to do the agency or it's the biggest reason not to. LA County is huge: the size of the agency would be immense, with all of the problems that can bring. But at the same time, LA County is huge: there's no way progress can be made at scale without hardwiring it into the structure of the organization."

- "We [small county] can integrate care without reorganizing ourselves because we all know everyone in the county by name. LA can't do that. Maybe that's a reason why the agency is needed there."

Importance of maintaining vigilance regarding budgets, spectrum of services, and service levels: Several county leaders agreed with the Board's proposal of an agency rather than a merged structure, because of the impact on maintaining separate budget appropriations and the greater confidence that separate departments would be able to maintain existing services. Two individuals, however, felt the budget separation, while necessary, would detract from the benefit of the agency.

- "Given LA's sordid history, there's no way this should be pursued unless there are firm safeguards around separate department budgets. It would be a shame to see happen again what happened to public health in the 2000s."
- "The advantages of an agency are obvious but the difficulties are practical; can you ensure clients who the system works for now can still get the care they need."
- "I imagine you have to make sure there's a steel firewall between the budgets, but really it is very limiting. You can't maximize available federal and state reimbursement unless you allow yourself the ability to move funds around between units."
- "The challenge will be making sure public health concerns don't get crushed under the weight of clinical delivery system crises. It can be done, but you have to be intentional."
- "It works for us because we have an agency director who cares deeply and is knowledgeable about all of the areas."
- "It's a missed opportunity to pass up the merger. All of the money to support population health and social determinants is in the delivery system. Public health should be clambering for a chance to merge funding with the clinical delivery system."

Appendix VI: Principles as Approved by External Stakeholder Groups

COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY

Member Driven. Patient Focused.

Principles for the Integration of LA County Mental Health, Health Services and Public Health

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. LA's Community Clinics and Health Centers support integration of services and improved coordination of care for our County's most vulnerable patients. While the motion to consolidate the departments aims to improve integration, it does not guarantee it. Each department plays critical functions that impact the health and safety of the communities we serve, such as direct patient care or the timely inspection and licensing of community clinic facilities. Any consolidation must do no harm to the vulnerable communities that rely on Public Health, Mental Health and Health Services.

LA's Community Clinics and Health Centers have adopted the following principles for the planning and implementation of any proposed consolidation/integration.

- **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.
  - ***Administrative Integration:*** Any action to consolidate or integrate planning, business, and administrative functions must also demonstrate that it adds clear value (meaningful savings, administrative simplification and improvement in services) to each of the departments and their partner agencies.
- **Thoughtful and Measured Approach:** Integration holds great promise, but it isn't easy. 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.
  - ***Implementation:*** Implementation of any changes as well should not be rushed. 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.
  - ***Ongoing Monitoring:*** Any plan to consolidate should have clearly defined objectives, along with a plan to evaluate and monitor progress toward those objectives.
- ***Transparency & Stakeholder Engagement:*** Each of the three Departments plays a critical role in the lives of countless LA residents and the many types of agencies that serve them. Stakeholders can provide vital input to ensure that integration is effective for all. Therefore, 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.

Approved February 9, 2015

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Mental Health Commission
"Advocacy, Accountability and Oversight in Action"

PLANNING PRINCIPLES
DEPARTMENTS OF MENTAL HEALTH, HEALTH AND PUBLIC HEALTH

Department Mission Statement/Vision Statements

➢ **DEPARTMENT OF MENTAL HEALTH**
Enriching lives through partnerships designed to strengthen the community's capacity to support hope wellness, recovery and resiliency.

➢ **DEPARTMENT OF HEALTH SERVICES**
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.

➢ **DEPARTMENT OF PUBLIC HEALTH**
To protect health, prevent disease and injury, and promote health and well-being for everyone in Los Angeles County.

PLANNING PRINCIPLES
Overall planning efforts should ultimately result in 1) The best possible client care experience (including quality and satisfaction); and 2) The best possible culturally competent integrated care for clients and their families of all three systems.

- Transparency and Stakeholder Involvement: Discussions regarding consolidation or integration must be characterized by transparency and a meaningful process for stakeholder input into developing the recommendations to the Board of Supervisors.

- Equity and Parity: Public health, mental health and substance use systems must be equity partners with physical health care systems. Parity among these services must be considered at every level.

- Autonomy: Each Department must have an independent voice with direct access to the Board of Supervisors ensuring responsiveness to their unique constituency groups.

- Service Integration vs. Consolidation: Agreement regarding how best to integrate services should inform the design of any potential agency governance structure. Information technology must support integration efforts while retaining essential subject-matter expertise and required functions specific to each of the involved departments.

- Demonstrated Value Added: The transition to integrated services and consolidation (if necessary) must demonstrate enhanced service delivery, access, quality of care, and consumer satisfaction.

- Existing Partnerships: Impact on existing commitments to providers, other County Departments and other partners (including, but not limited to: law enforcement and other first responders, school districts, faith-based initiatives, etc.) must be analyzed and considered; proper balance in these commitments must be continually monitored. Population health initiatives must be maintained.

- Quality: Quality standards must continue to be the foundation of all clinical and recovery oriented services.

Amended and adopted by the Mental Health Commission, January 23, 2015
Adopted by Department of Mental Health System Leadership Team, January 21, 2015

Attachment

Principles to Guide Discussions around the Integration of DHS, DMH and DPH Services

The Los Angeles County Board of Supervisors approved in concept the integration of DHS, DMH, and DPH services under a single health agency. The planning and implementation of this action requires the use of core principles to guide a thoughtful discussion leading to decisions that will best serve the needs of the people of Los Angeles County.

DELIVERABLES TO THE BOARD OF SUPERVISORS:

1. A structure for the "approved in concept" health agency model, uniting the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) under a single combined LA County health agency,
2. Possible steps for implementing a health agency,
3. A timeframe for transition to the agency model,
4. The expected benefits and disadvantages of the agency model.

CORE PRINCIPLES

1. **Clarity of Purpose**. Clearly define objectives that will be achieved by changes in organizational structure or processes. Develop a plan and evaluate it to measure benefits and impacts to each department.
2. **Transparent Decision-Making**. Act with integrity and transparency in decision-making to build trust with employees and community stakeholders. Use a consensus-based approach whenever possible.
3. **Autonomy**. Each Department must be empowered to carry out its mission with appropriate authority to manage key matters, including priority setting, budget, operational planning, resource allocation, and equal access to the Board of Supervisors.
4. **Mutual Respect**. During the process of planning integrated services, act in ways that demonstrate respect for each Department's unique contributions to achieving shared goals.
5. **Synergistic Opportunities.** Identify synergistic opportunities for integration that will protect population, personal, and mental health, prevent disease and injury, and promote overall health and well-being for everyone in Los Angeles County.
6. **Safe and Open Communication**. Promote an environment to fully discuss the advantages and drawbacks to the proposed agency structure and commit to clearly articulating the process by which key decision are being made.
7. **Essential and Legally Mandated Services**. Preserve and expand the programs and services that have the greatest impact on population health and elimination of health disparities, and promote health care access. Ensure that levels of resources, including dedicated funding streams, which are providing essential and/or legally mandated public health services, are continued in at least current levels in order to maintain access and quality.
8. **Sustained Leadership**. Ensure each Department retains a strong leadership team and the ongoing ability to attract and retain high-quality leaders who are capable of leading challenging initiatives in personal, mental and public health. Preserve a broad set of classifications and positions designated to assess, plan, implement and evaluate essential public health functions at multiple levels throughout each Department.
9. **Partnership and Collaboration**. Maintain and nurture existing key partnerships, both with internal County partners and external stakeholders and service providers, to pursue shared goals and outcomes. Each department has carefully cultivated community relationships that are unique and integration should not interrupt those partnerships but seek to leverage them for improved service delivery for everyone in Los Angeles County.
10. **Commitment to Efficiency**. Consider consolidating key planning, business, and administrative services only when such consolidation adds clear value and leads to meaningful savings and improvement in services, while assuring that access to these services is guaranteed for each Department at a level that is at least equal to what was available before the integration.
11. **Empowered Workforce**. Empower staff through approaches that support learning and growth, encourage innovations that facilitate change, and reward success. Promote cross-Department team-building.

Amended and adopted by the Public Health Commission, January 27, 2015
Adopted by the Department of Public Health Executive Team, January 22, 2015

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.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

Planning Principles

DHS-DMH-DPH

Department Mission/Vision Statements

DHS: Our mission is 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.

DMH: Partnering with clients, families and communities to create hope, wellness and recovery.

DPH: To protect health, prevent disease and injury, and promote health and well-being for everyone in Los Angeles County.

Planning Principles: Overall planning efforts should ultimately result in 1) The best possible client care experience (including quality and satisfaction); and 2) The best possible culturally competent integrated care for clients and their families of all three systems.

- **Transparency and Stakeholder Involvement:** Discussions regarding consolidation or integration must be characterized by transparency and a meaningful process for stakeholder input into developing the recommendations to the Board of Supervisors.
- **Equity and Parity:** Public health, mental health and substance use systems must be equity partners with physical health care systems. Parity among these services must be considered at every level.
- **Autonomy:** Each Department must have an independent voice with the Board of Supervisors to ensure responsiveness to their unique constituency groups.
- **Service Integration vs. Consolidation:** Agreement regarding how best to integrate services should inform the design of any potential agency governance structure. Information technology must support integration efforts while retaining essential subject-matter expertise and required functions specific to each of the involved departments.
- **Demonstrated Value Added:** The transition to integrated services and consolidation (if necessary) must demonstrate enhanced service delivery, quality of care and consumer satisfaction.
- **Existing Partnerships:** Impact on existing commitments to providers, other County Departments and other partners (e.g., faith-based initiatives, school districts, LAHSA, etc.) must be analyzed and considered; proper balance in these commitments must be continually monitored. Population health initiatives must be maintained.
- **Quality:** Quality standards must continue to be the foundation of all clinical services.

Adopted by the DMH System Leadership Team
January 21, 2015 V7

Appendix VII: Public Comments

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. Letters/e-mails are ordered by date. Names have been redacted for those individuals who wish to remain anonymous. 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.

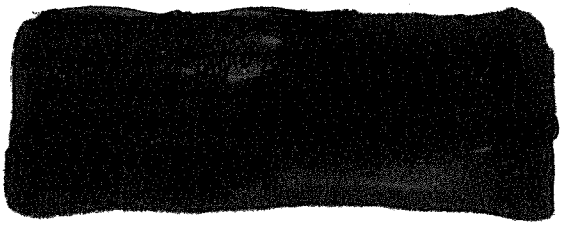
However, there are clearly advantages to ending the silo-ization of the different agencies. Health and Mental Health are an obviously-related pair of variables that are highly dependent upon each other. It would be beneficial to have a more smooth interplay between the two types of services, that sounds 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.

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

Communities taking action to improve depression care in Los Angeles

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New Vision Church of Jesus Christ

First African Presbyterian Church

Walls Counseling and Learning Center

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	Marvin Southard	Cynthia Harding
Los Angeles County	Los Angeles County	Los Angeles County
Department of Health Services	Department of Mental Health	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.

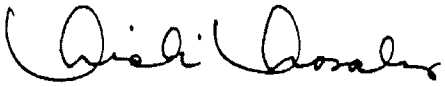
Post ACA, County has continued to enhance its role as a provider of specialty care, inherently reliant on the provision of primary care through FHQC partners. FQHCs are the entry point for many Los Angeles County residents seeking services within the contemplated fully integrated continuum of care. Efforts 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.

Honorable Board of Supervisors
May 19, 2015
Page 2

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

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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.]

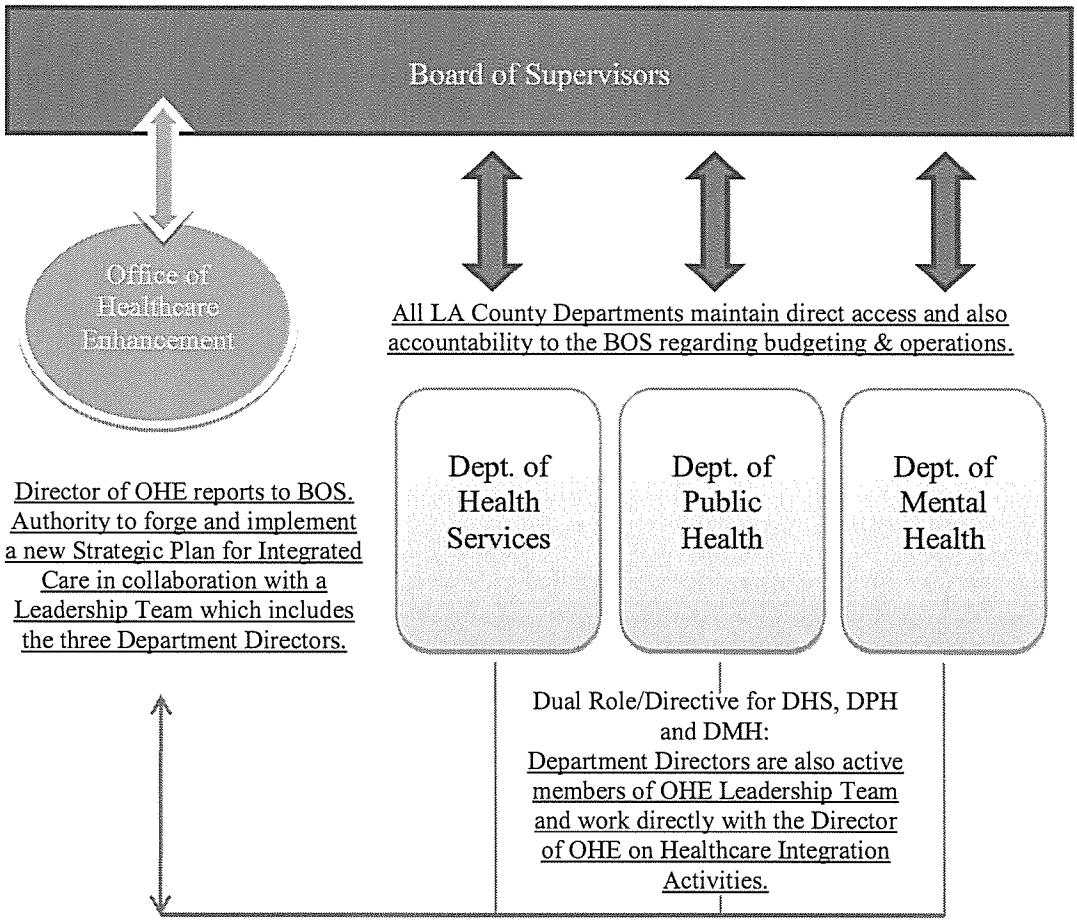
The Summary Description Position also makes the following important points pertinent to the Coalition's position: 1) the Director of the OCP, who would report directly to the Board of Supervisors, would be supported by a small but very talented staff; 2) the operating agencies working with the new Director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

[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.

[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

[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).

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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.

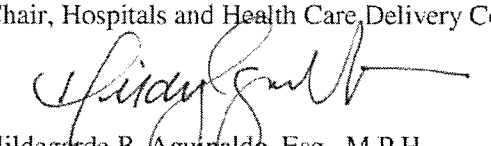
Will integration into a single health agency result in cost savings to the County of Los Angeles?

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

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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

ASIAN PACIFIC POLICY & PLANNING COUNCIL

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

phone: 213.239.0300 | 905 East 8th Street, Los Angeles, CA 90021 | www.a3pcon.org

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.

H • A • S • C
515 South Figueroa St., Suite 1300
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.

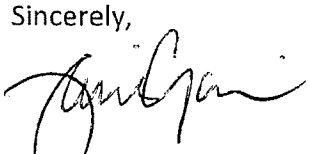
- **Nimble, Timely and Effective:** The plan does not offer metrics related to improving the County's response to public health threats; and does not address the role of private providers / county partners within the integrated model. Also, need to preserve the Hospital Outreach Unit which allows Public 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.

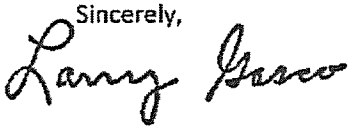
While focusing on what is required for effective service integration and improved healthcare, the strategic plan should plan for and ensure minimal transitional disruption to current services and programs and only that which is required to implement it. It should maintain, enhance, expand and replicate 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

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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

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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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

ECONOMIC ROUNDTABLE

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

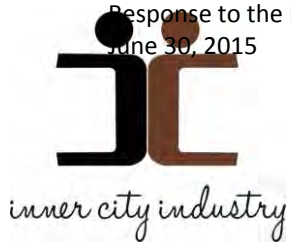
We appreciate the opportunity to comment and hope this information is useful to LA County in its efforts to adopt a promising model for care integration to address the comprehensive needs of the most vulnerable, costly and complex populations.

Sincerely,

Daniel Flaming, PhD
President

Deborah Maddis, MPH
Consultant

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



May 29, 2015

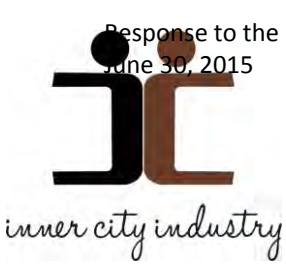
To: Los Angeles County Board of Supervisors
Re: Health Integration Draft Report

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 determinates 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 now stigmatized beyond repair. Since then, I have gained expertise in whole-system transformational change and currently represent both the 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 citizens 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 theories 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 suggests 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, key processes and a timeline to integrate multiple systems. In advance, please consider adhering to the summary points below to increase knowledge acquisition as a non-threatening approach to engaging all aforementioned stakeholders in further dialogue:



- As primary and essential to reducing racial/ethnic disparity, cultural competency must be embedded and considered in all aspects of decision making and delivery of services to strengthen the quality of care. As 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 an 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.

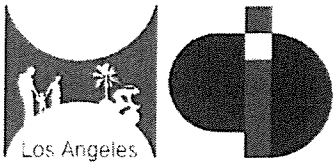
- Strategically increase opportunities for community input. Health integration of this magnitude at minimum is a five year process produced in multiple phases. Imperative to success is an effective social marketing strategy directed at community integration to gain legitimacy among county residents. Social marketing commences with mapping and analyzing resources, appointing transformational 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, or even 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



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

An Equal Opportunity / Affirmative Action Employer

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.

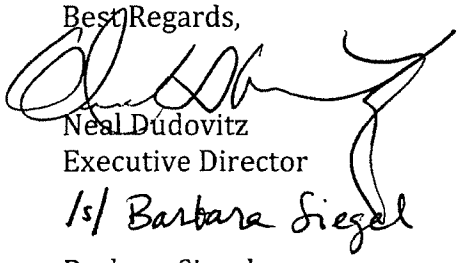
(5) **Regular evaluation and identification of unintended consequences.** The new health agency's successes and failures, based on a variety of metrics produced with stakeholder input, should be transparent. NLSLA endorses the view of the CEO that "Agency and Departmental leadership should ... be expected 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.

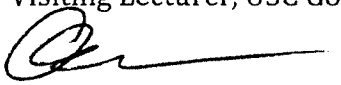
Best Regards,



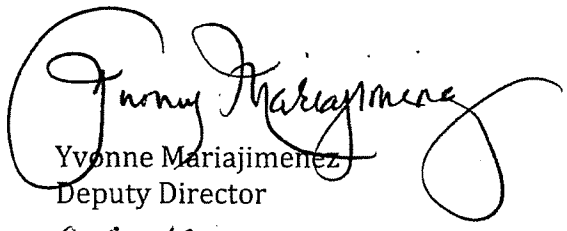
Neal Dudovitz
Executive Director

/s/ Barbara Siegel

Barbara Siegel
Visiting Lecturer, USC Gould School of Law

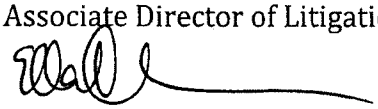


Gerson Sorto
Staff Attorney



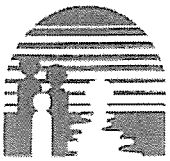
Yvonne Mariajimenez
Deputy Director

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,

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.

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]	MD/TAMARA ALOYAN	DMH

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:

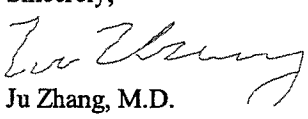
1. There are times when I see a patient who does not have a primary care doctor and there is no coordination to schedule them to see a County DHS provider. 2. When I see new clients who are part of the DHS system, I can't see their medical records electronically. 3. If I believe a patient needs to be 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]		
Signature	Printed Name	Department
	Shahin Khashayar	DMH
Signature	Printed Name	Department
	Aelred Boyle	DMH
Signature	Printed Name	Department
MD	Maria P. Aguilar, MD	DMH
Signature	Printed Name	Department

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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	Tyson Gevorkian	Jail MH service DMH
	Printed Name	Department
	Diana Mirzoyan	Jail MHS - TTCF
	Printed Name	Department
	AUSTIN J ANTHony	Jail MHS
	Printed Name	Department
	DIANA BOTEZAN MD	Jail MHS - TTCF
	Printed Name	Department
MD	Katherine Jutkowitz MD	Jail MHS-TTCF

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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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Signed,

Signature	Printed Name	Department
E. Gilmanes MD	Elena Gilmanes MD	DMH
C. Hitchcock MD	Conny Hitchcock MD	

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.

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Signed,

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

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Signed,

Signature	Printed Name	Department
[illegible]	FELIPE OBLIMA, 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, 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,

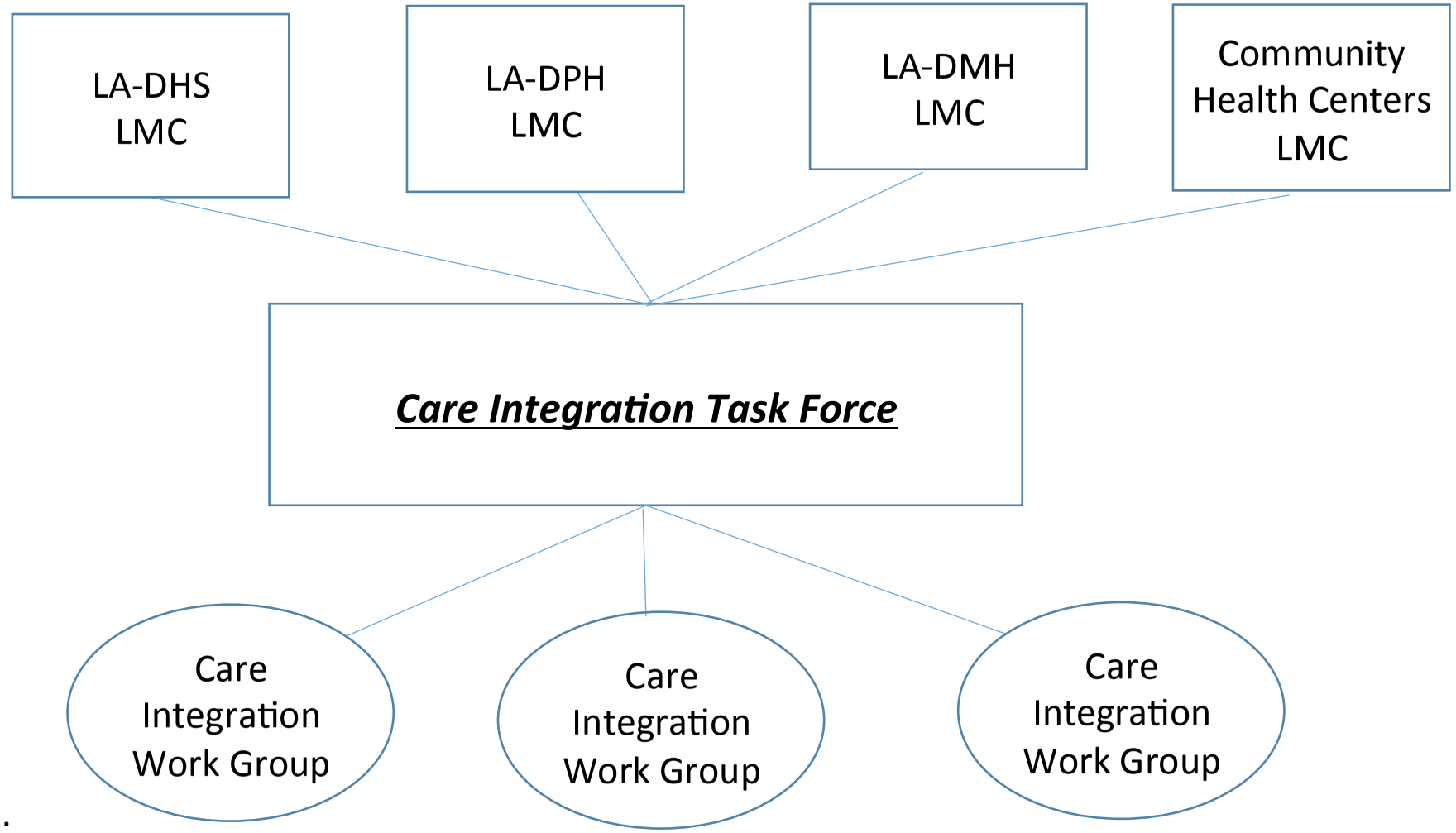
[1] Alegent Health and Fairview Health Services are just two examples of systems that have recently adopted this process.

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

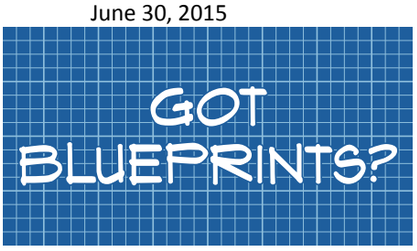
SEIU 721 Health Integration Planning Principles

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

Appendix VIII: Summary of Findings from Facilitated Public Convenings

Public Convenings on the Proposed Los Angeles County Health Agency:

Summary of Input and Feedback

Conducted by Community Partners®

Submitted to the Los Angeles County Office of Health Integration
June 18, 2015

1000 North Alameda Street, Suite 240, Los Angeles, CA 90012 *tel* **213.346.3200** *fax* **213.808.1009** *www.CommunityPartners.org*

A. BACKGROUND AND CONTEXT

On January 13, 2015, the Los Angeles County Board of Supervisors directed the Chief Executive Office (CEO), County Counsel, and the Department of Human Resources, in conjunction with the Departments of Health Services, Mental Health, and Public Health, to report back in sixty days on the benefits, drawbacks, proposed structure, implementation steps, and timeframe for the creation of a single integrated health agency. The temporary Office of Health Integration was formed by the CEO's office to lead the response to the Board's motion.

The Office of Health Integration released a draft report on March 30, 2015. This was followed by a 45-day (later extended to 60 days by the Board) public dialogue and comment period on the draft report. During this period, public convenings were conducted at different locations across the County. The Office of Health Integration contracted with Community Partners, a local nonprofit civic intermediary, to facilitate the public convenings and write a report summarizing the public input surfaced at the meetings.

March 30	Draft report from the Office of Health Integration released
March 27 – April 24	Planning period for the public convenings
April 27 – May 13	Public convenings

About the Public Convenings

Based on input from the Departments of Health Services, Public Health, and Mental Health along with requests from individual County Supervisors, we held five public convenings over a period of 17 days.

These public convenings are separate from the numerous stakeholder meetings that the Office of Health Integration has held with specific audiences, such as community councils, client coalitions, healthcare foundations, hospitals and clinics, advisory boards, Board-appointed Commissions, and more. These public convenings are also separate from the multiple labor-sponsored sessions held specifically for County employees and Department-sponsored sessions. Many of those other stakeholder meetings also resulted in formal written comments, submitted to the Board of Supervisors or the Office of Health Integration. The public was also invited to submit formal written comments. All formal written comments are available on the health integration website.

Recruitment and outreach for the convenings were handled by the three departments and the Office of Health Integration. They focused on notifying department employees and all stakeholder groups so they could share the convening notices with their members and members of the public. Please refer to the health integration website for the full list of stakeholders: *priorities.lacounty.gov/health-stakeholders/*.

Outreach efforts included:

- Announcements on the Office of Health Integration's website and the DHS homepage
- Multiple emails from each of the departments to their stakeholder groups with a request to further broadly disseminate the information to their colleagues and constituents
- Emails to groups and individuals who self-identified as having an interest in the agency proposal
- In-person announcements made by DMH and DPH at various commission meetings and constituent group meetings
- Regular email updates to employees, such as the DPH Director's weekly email to all DPH employees
- Emails sent by DHS to all of the ambulatory care clinics and hospital administrators with instructions that notices in English and Spanish were to be posted in patient areas

Convenings were held at:

April 27	Longo Toyota, El Monte
April 28	San Fernando Recreation Park, San Fernando
April 29	Martin Luther King, Jr. Outpatient Center, South Los Angeles
May 4	Exposition Park Administrative Offices for the Second District, Los Angeles
May 13	Antelope Valley Transit Authority, Lancaster

Total attendance at the public convenings was 140 people and a few participants attended more than once. We offered interpretation in multiple languages at every convening, but the service was requested only once. Some participants came as individuals representing personal views and others came on behalf of their organizations or constituents. Participants were encouraged to register in advance, but all walk-ins were accommodated. One of the convenings was video-taped and the video was posted on the health integration website for people who could not attend any of the sessions in person.

Convening Agenda

To design the convening agenda, we held multiple planning meetings with the Office of Health Integration and representatives from the Departments of Health Services, Public Health, and Mental Health selected by the department heads of their respective departments. All of the public convenings followed the same agenda. Each convening lasted two hours and staff also made themselves available to stay afterward for members of the public who wanted to share additional comments, which several did.

Agenda

I. Welcome and Introduction

II. Opportunities and Risks

a. Presentation summarizing these sections of the report
b. Table discussion to gather public input
    i. Is your perspective reflected in the benefits and opportunities listed in the report? Do you see additional ones that should be included?
    ii. Is your perspective reflected in the drawbacks and risks listed in the report? Do you see additional ones that should be included?
c. Question–and-answer period

III. Proposed Structure and Implementation

a. Presentation summarizing these sections of the report
b. Table discussion to gather public input
    i. If the agency model is implemented, what needs to be in place to make it most effective?
    ii. How would you like to see an ongoing stakeholder engagement process structured?
c. Question-and-answer period

IV. Closing Comments

The convenings were facilitated by staff members of Community Partners and the presentation was led by a staff member of the Office of Health Integration. Members of the public were seated at tables, where representatives of Community Partners facilitated and took notes on each discussion. We decided on the tabletop format to help ensure that every participant would have multiple opportunities to discuss the issues and so we could cover all of the sections of the report. Staff of the Office of Health Integration did not participate in these tabletop discussions in order to help encourage open and honest feedback from the public. Community Partners served as a neutral party to gather and reflect the public's feedback and did not advocate for any particular position or opinion regarding the health agency proposal.

Following the tabletop discussions was a question-and-answer period during which participants were invited to submit written questions for a staff member of the Office of Health Integration to respond to. All questions received were read aloud and addressed, with a range of 6-30 questions being received per convening.

We provided printed copies of the agenda and the presentation, as well as the executive summary of the report and comment forms in case people preferred to write their feedback rather than verbalize it in the discussion. Participants were also directed to the website to access additional materials, including the full draft report, public comment letters submitted to the Office, the Board meeting transcript and motion, notices of the public convenings, and a list of stakeholders.

About this Report

The purpose of this report is to summarize and reflect the input provided by attendees of the public convenings. All of the information in this report is drawn from the discussions that took place at the public convenings. Some participants provided comments in writing at the convenings and those are included as well. All participants were informed that their comments would be summarized and presented in this report in aggregate and without attribution. We did not attempt to assess the accuracy of the input provided, the efficacy of their suggestions, or the motivations of the people providing it.

The participants had varying levels of familiarity and experience with the County and spanned a variety of roles and relationships with the affected departments. This variety of perspectives sometimes affected the terminology used by the participants at the convenings, such as the use of the word “physician” to denote someone who is a health expert. This was most pronounced when referring to people who receive clinical, behavioral, or population health services from the County. While we mainly used the terms “clients” and “consumers” in the report and mean them to be inclusive of all those receiving services, there are times that we use the term “patient” to accurately reflect a participants’ comment.

Most input summarized here came from multiple individuals, although feedback provided by just one person was also included when relevant and is indicated as such. Please note that some participants came representing a larger organization or constituency, so even when a comment is noted as being stated by one person, it does not necessarily mean that others do not hold the same point of view. Some people stated that they were attending the convening in order to learn more about the agency proposal, as opposed to giving feedback, while others attended because they had particular perspectives they wished to share. Some comments contradict each other, as the participants often held varying opinions on certain issues, and there was not complete agreement on any one point.

B. OPPORTUNITIES

Overall, people were largely supportive of service integration. Of the minority who did not support service integration via any structure, their main concern was a disruption in services, programs, and provider continuity for consumers. It is important to note that most people had not fully read the draft report and were basing their information on the verbal presentation. Some people felt that the opportunities listed in the report were comprehensive, but discussion of the opportunities mostly centered on specific issues that individual participants wanted to prioritize, rather than the entirety of opportunities presented in the report. Some felt that the opportunities were overstated, oversimplified, and overly optimistic. Several people also want to use the restructuring as an opportunity to address long-standing issues with the County.

Theme #1: A number of integration opportunities were desired and supported.

People were most interested in improving care for vulnerable populations and integrating departments to increase effectiveness.

Streamlining and integrating services for vulnerable populations
People were most excited about the opportunity to better serve consumers who need to access services across the three departments. Service integration is seen as a way to treat consumers as whole individuals, to offer a single point of entry, to be able to offer services under one trusted roof, to reduce time navigating separate structures, and to have more streamlined processes. Some commented that greater integration would be particularly beneficial for the homeless, those who are incarcerated, and those recently released, as they often cross all three departments.

Making departments more integrated and effective
Multiple providers and County employees looked forward to sharing information among departments and integrating health records, having an easier time identifying gaps in services, sharing innovations among departments, and having joint workforce development to broaden career opportunities. People were excited by the idea that shared data could result in better care and quicker access to services by presenting a more comprehensive picture of each client's needs and condition, by not putting the burden of reporting medical history on the client, and by eliminating duplicative paperwork.

Additional opportunities
Additional opportunities and desires mentioned include:

- Creation of shared standards and practices for procedures and training across the departments, resulting in more consistency in services offered and standards of care
- Cross-departmental training and education of employees to facilitate integration

> *"We talk in our separate silos but those conversations don't go anywhere. This is an opportunity to really talk about what we need."*
> -- Participant

- Integrated requirements across licensing boards to make it easier for graduates in the health field to work in different departments
- A research department that would be responsible for researching client needs, sharing data across departments, and creating a single data set for all three departments
- Inclusion of consumer and client feedback on performance evaluations for department employees and more effective ways to handle those who are under-performing
- Greater transparency in how contracted providers are chosen
- Re-thinking the billable hours threshold for County mental health employees and contract providers as well as inclusion of important tasks that are not currently billable
- Creation of an integrated, user-friendly referral list of agencies, services, and outside organizations
- Increasing the level of stakeholder participation in departments on an ongoing basis
- Making all of the affected departments more culturally competent and sensitive
- Better services for families and inter-generational integration
- More integration between mental health and substance abuse and their different cultures, as some feel that substance abuse doesn't get sufficient funding and attention
- Having a unified voice across the departments in the case of a disaster or emergency

C. RISKS

Even though people were largely supportive of service integration and some people noted that the departments and County already face many of the risks listed in the report (regardless of whether or not the agency is created), participants raised multiple risks they felt were inadequately addressed. As with the discussion on opportunities, most people based their information on the verbal presentation and not on the written draft report. A few people agreed with the risks as presented in the report; however, participants focused on particular issues of concern to them rather than the complete list of risks. There were also several concerns about whether the proposed health agency would be the appropriate structure to realize the opportunities listed and mitigate the risks.

Theme #2: Integration of data and technology generated multiple concerns.

While some see the integration of Information technology (IT) and electronic health records (EHR) as a positive, many others see it as a risk. Even though the report does not recommend making IT a shared function and instead recommends appointing an individual to oversee IT strategy and creating a data/planning unit, there are still concerns that integration of IT and EHR will be considered. One concern is privacy issues, with some consumers not wanting their records shared between departments. For example, multiple people expressed concern that if health services is informed about a client's mental illness, the level of care may be compromised due to stigma. Another stated concern is that each department has already spent millions of dollars on IT and EHR, that it would be a waste of funds to spend more to integrate them given the complexities, and that no estimate of costs is included in the report. A third concern is about data being lost in integration if departments don't track the same information. For example, if one department tracks sexual orientation and another doesn't, there are fears that the lowest common denominator would be used and that useful data would be lost.

Theme #3: Several additional risks to consumers and departments were cited.

Participants offered several additional risks they felt were either not included or inadequately addressed in the draft report. The risks mainly focused on impacts on consumers, department staff, department coordination, and providers.

Impacts on consumers

- Consumers may experience a disruption in services, programs, and provider continuity.
- Consumers of mental health services may face stigma from other departments once it becomes known that they are receiving mental health treatment.
- Services may actually be worse after this integration attempt, such as longer delays, increased paperwork, less staff capacity, and less flexibility.
- Any integrated service model needs to take into account that not all consumers can or want to receive services at the same place.

- Department decisions that may have been aired at public meetings might now be made internally within the agency, which may result in less transparency for the public and fewer opportunities for public discussion.

Impacts on department staff

- Staff morale may suffer, especially if they are asked to increase their workload, if their existing successes at integration are not acknowledged, or if progress moves too slowly.
- Employees, particularly ground level staff, may be required to meet expectations around integration without being provided with the appropriate tools to do so.
- Employees may not have sufficient time or willingness to add extra agency tasks to their existing work, particularly given a culture in which people are already overworked and reluctant to perform tasks outside of their job descriptions.

Impacts on department coordination

- Departments may micro-manage each other if their work more closely affects each other.
- Because departments access different funding streams with different requirements and limitations around usage, funding for additional integration expenses could prove challenging.
- If only one department can apply for a reimbursement for a particular consumer or service, but the services are provided across departments via integration, there may be some funding competition among departments.
- Innovations and partnerships that are currently being explored might be curtailed or lost as people shift focus to integration under the agency.
- Substance abuse may become further subsumed and invisible under an agency since some people feel that substance abuse is always marginalized in larger systems.

Impacts on providers

- Providers may need to take on extra work in order to provide services in an integrated environment and may need training in processes for all three departments, not just the one that they are contracted by.

Theme #4: Many people were skeptical that the health agency is the right structure to achieve service integration.

Some people were supportive of the health agency, many felt they did not have enough information to judge whether it was the right structure to realize the opportunities, and others were skeptical. Those expressing skepticism about a health agency as the most effective structure for integration generally fell into two camps. One group believed successful examples and models of integration are already happening within the existing structure, and that they could continue to grow and spread without additional structural changes or increased bureaucracy. Comments included: “fix what is broken instead of creating something new” and “integration is already happening.”

The other group sees integration as very complex and doubts that a health agency model is adequate to spearhead the overhaul that is needed. There was some feeling that the agency won't end up making a difference and that it won't make the departments collaborate if they aren't already. People felt that department employees will maintain the status quo, regardless of changes at the top, and that more attention would be paid to policy and structure than changing systems and behavior. Some felt that the County has not been successful at leading integration in other areas related to health, and the leadership from the three departments currently do not effectively collaborate with each other; consequently, evidence of collaboration would be needed to instill confidence in the agency.

> "*The medical model versus recovery model. Patients versus consumers. If we can't agree on the approach, then how can you integrate the departments?*"
> --Participant

Some felt that the main impact of the health agency will be increased bureaucracy and decreased power of departments. Assurances to the contrary during the Office of Health Integration's presentation were met with skepticism. People were also wary of the many assurances that several aspects of the departments will go unchanged while also being told of the multiple opportunities that can be achieved. As one person expressed, "how can it be transformative but not result in major changes?"

There was no consensus on what people preferred as an alternative to the proposed health agency model.

D. STRUCTURE & IMPLEMENTATION

Overall, people were concerned about the details of implementation and felt they lacked sufficient information to understand how the agency would actually work. There is a strong desire to have public involvement, transparency, and reporting in all areas if the proposal moves forward.

Theme #5: A well-designed stakeholder engagement process was raised as a top priority.

If the agency is created, there was general consensus that the stakeholder engagement process needs to be a major priority. People want a process that is designed from the bottom up, meaning that it starts with the needs and capacities of those who are most marginalized. They want a process that is ongoing throughout implementation, targets consumers and clients as the primary audience, and gears materials toward them. In the same vein, it was also requested that the public hearings be ongoing (not just for 18 months, as recommended in the report) and more frequently than quarterly. Participants also specifically mentioned indigenous populations, the homeless, children and families, those who are incarcerated, and those recently released as needing to be intentionally engaged. Residents of Antelope Valley in particular mentioned feeling generally isolated and ignored by the County and wanted to be included from the beginning.

Specific suggestions and requests included:

- Have whoever is responsible for designing and facilitating an ongoing stakeholder engagement process be neutral and open, not someone who is championing the agency.
- Include ground level staff and those who have expertise in the mental health community in any planning team.
- Provide transparency around measures and tracking, along with evidence of what is and isn't working.
- Provide clients and consumers with opportunities to share their experiences.
- Solicit public input before decisions are made about how the agency would function and allow the public input to have an impact on the decision.
- Provide a clear articulation for how employee, consumer, and public comment and feedback would be translated into action or change.

> *"Don't expect community members to come to you. You have to go to them."*
> --Participant

Suggestions for stakeholder engagement included: using existing meetings and structures to share and receive information; sending surveys; holding focus groups; and hosting all-day forums split into different sections or topics. Meetings or focus groups should be held in more intimate and familiar settings where consumers already receive services, such as senior centers and clinics, as well as churches, libraries, food banks, and schools. One person cautioned against relying on meetings, saying that patients and clients don't come to meetings and that alternative

processes need to be included. Some suggested establishing a community board or advisory committee; one person recommended that each service planning area should have a minimum of ten representatives, while another suggested that members include a mix of providers, consumers, clients, frontline staff, and union members. Another suggestion was to have the existing commissions be the forum to engage stakeholders.

Outreach suggestions included: a regular newsletter or bulletin to all employees; mailers to all consumers; and an appointed consumer leader from each department to focus on outreach and engagement. One person suggested that DHS and DPH create consumer engagement processes similar to DMH. Another also advocated for a social marketing campaign to help promote a shift to a culture of care and integration. Some people also requested that stakeholder meeting minutes be shared and made public.

Theme #6: People were especially concerned about workload, funding and costs, and the agency director position.

These aspects of structure and implementation generated the most discussion and input.

Workload for implementation
As noted in the risks section, both County employees and those representing external parties were concerned about the workload impacts on employees, particularly around staff morale, a potential lack of adequate tools, and having extra responsibilities added to their plates. Planning and processes for implementation should take these concerns into account and mitigate the negative impacts that ground level employees would need to shoulder.

Funding and costs
People were very skeptical that the creation of the health agency would not result in some new costs and some cuts, despite what is reflected in the report and communicated by Office of Health Integration staff. Some felt that the term "lean," used in reference to costs and budgets in the report, was too vague and that they were looking for more specific ranges or estimates. Some advocated that separate funding be allocated to the agency to help assure the public that the departments wouldn't have to absorb those anticipated additional costs. Some also stated that, in addition to the costs of the agency itself, implementation of service integration would undoubtedly require some additional funding to realize the opportunities.

> *"If you're going to invest in it, then actually invest in it."*
> -- Participant

Agency director position
There was general agreement that the new director should be neutral, have experience in all three departments, be well versed in the recovery model, and not be someone with a dual role – meaning not concurrently employed in one of the departments. The ideal director was also described as someone who believes in cooperation, is inspiring, can serve as an ambassador, and understands the complexities

of LA County. There were fears that the director will either have so much influence as to take over the departments or too little influence with no authority to make changes. One person suggested that an effective manager is preferable to a celebrated physician, as long as the position is balanced with a strong team of people with medical backgrounds. Another said that a leadership steering committee may be more effective than a director. One person suggested that a possible makeup of a leadership team could be comprised of one physician, one therapist, one substance abuse specialist, and one client advocate.

There were several requests for public input on the qualifications needed, criteria, and the selection process for the agency director position. People did not want the Board of Supervisors to make the decision without public input. One person suggested that the Board could hire an interim director and then hire a permanent director after the public input process. They also wanted to see more transparency around the director's salary, the funding source, and the level of influence to be afforded the position.

Theme #7: People raised additional structure and implementation issues they want to see addressed in the report.

As indicated above, people largely felt that details around the structure and implementation were lacking, making it difficult for them to assess whether the proposed agency is the right structure. One commented, "the devil is in the details." People shared areas that they felt were either inadequately addressed in the report or not clearly stated, or additional suggestions they want included.

- Recommend the inclusion of consumer advocates, ombudspersons, and navigators to play crucial roles to support consumers who are having trouble accessing services, to help monitor the process, and to provide a place to take grievances if consumers are not getting the services they need.
- Address the need for and importance of cultural competency and sensitivity.
- Emphasize the importance of making the integrated system accessible and user-friendly.
- Provide space for department heads to delineate their own goals and priorities for the agency, what they don't want to be lost with integration, and their own measures of success.
- Recommend neutral evaluators, offer transparent benchmarks or metrics, and perhaps communicate results via a public report card.
- Specify whether the agency has its own human resources department.
- Emphasize the need for a public-friendly budget including costs that have already been incurred for this process.
- Include a timeline or deadlines for when integration service changes can be expected to occur.
- Describe the need for joint planning processes between departments.
- Clarify how employees will be held accountable to the integration goals and opportunities, who will have authority in this structure, who will choose what gets presented before the Board, and how decisions will be made about the agency structure.

- Provide clearly stated guarantees for the kinds of improvements that will actually be realized and assurances that certain risks will not come to pass.
- Include more about the stakeholder engagement process (see #5 of this report, above).
- Clarify how departments will be able to continue accessing the Board.
- Hire change experts and change facilitators to help minimize the chance that those who have fears and concerns will not derail the integration process.
- Specify processes for communication and reporting between departments.

E. OTHER COMMENTS

In addition to the opportunities, risks, structure and implementation, people shared feedback about the report overall, the overall process, and other models they want the Board to consider. While many of these items are outside the scope of what the Office of Health Integration was asked to address, they nonetheless generated significant discussion.

Theme #8: People raised additional issues they want to see addressed in the report overall.

People shared additional areas that they felt were inadequately addressed in the framing of the report and key constituencies they felt were not sufficiently included.

About the report overall

- Clarify what is meant by "community" and "stakeholders" and "behavioral health."
- Outline potential unintended consequences, recognizing that every opportunity has a cost, and be transparent about the pros and cons.
- Include more about the opposition to the proposed health agency, including the strength of the opposition and their main concerns.
- Clarify the role of the Affordable Care Act as an impetus to creating the agency and the impact of the agency on managed care and the medical home model.
- Provide evidence that the agency model has worked elsewhere, including case studies and a well-researched rationale for why this model is preferred over others.

Addressing key constituencies and partners

- Consider the perspectives of clients and consumers. Address the potential impacts the creation of the health agency may have on them and answer such key questions as whether clients can stay with their current providers at existing locations or whether My Health LA patients will be deprioritized.
- Address services for deaf and hard of hearing clients, including creating an intentional dialogue with providers, addressing challenges around requesting interpreters, and increasing outreach and accessibility.
- Document the impact on, and needs of, indigenous populations.
- Include more on the role of outside agencies and providers, both public and private.

Theme #9: There was criticism and distrust of the overall process.

The criticism and distrust expressed by participants centered around three areas:

- The process used by the Board of Supervisors to approve and review the motion to create the health agency
- The purpose, design, and outreach of the public convenings
- The accessibility of the information provided and level of detail available about the proposed health agency

Some people expressed that the process thus far has been discouraging to consumers and clients, and has contributed to a greater disconnect between consumers and clients and public entities. Given their high level of distrust, some participants expressed that the County's credibility is on the line and that they need to invest resources in helping rebuild that trust.

Approval and review of motion

Participants strongly felt that rather than starting with a motion to create a health agency, adequate time should have been taken to first research the integration opportunities and service gaps and then determine the appropriate structure to best meet these needs. Information and data on the efficacy of similar models and the impact on consumers was also desired. Comments included "why can't the agency be an experiment rather than permanent?" and "give the community more time to work with the County to develop this."

Several people stated that regardless of what was being said by official representatives, it felt like the decision to create a health agency was "a done deal" and that efforts at public comment were nothing more than "going through the motions." There was a lot of feedback that being invited to comment on a proposal is not the same as public engagement; the general consensus was that there should have been a public process prior to Board approval as well as a longer public process period afterward. One person shared that, while the Office of Health Integration has been responsive and accessible, direct access to decision-makers, such as the Board and department leadership, would have been preferable.

Public convenings

While most people appreciated having public convenings, there was criticism that the public convenings were not sufficiently accessible. Consequently, a few people said they did not believe that that the County was making a real effort to engage the public. People called for more meetings throughout the County and in trusted community settings (such as churches and schools). They were critical that not all the locations were easily accessible via public transit and that sessions were not offered during evenings or weekends.

> *"People shouldn't be fooled into thinking they have a voice. It's disingenuous to waste people's time."*
>
> -- Participant

Many people liked the format of facilitated table discussions with a question and answer period, but some wanted a 'town hall' type of approach or other opportunities to directly and publicly address the leadership of the departments.

Despite the outreach efforts described in the beginning of this report, efforts to publicize the meetings were also criticized. Some felt that attendance was not representative of the County and that more effort should have been made to encourage underrepresented constituencies to attend. Participants felt they weren't given sufficient notice, that meetings should have been advertised in local newspapers and on television, that meetings should have been shared on social media, and that more consumers, nonprofit groups, and advocates should have been directly contacted. It is possible that leaders of organizations received notices of the meetings but that the information was not shared with other staff, members, clients, and consumers.

Stakeholder meetings

Similarly, a few people also expressed that the stakeholder meetings aimed at specific audiences were not inclusive. They feel that County employees were hand-picked by department managers and that there was underrepresentation of ground level employees. They communicated concern about a lack of transparency around who from each stakeholder group actually attended. One person was concerned that consumers invited to stakeholder meetings had also been hand-picked.

Materials and information

There was a strong feeling that the materials provided – namely the draft report, the executive summary of the report, and the PowerPoint presentation used in the public convenings – were not sufficiently accessible to the public. Consequently, many people attending the convenings had not fully read the report. People requested that the report be written with the public, clients, and consumers as the key audiences. People requested that the materials be available in all of the LA County threshold languages and written at a fifth-grade reading level to increase comprehension by a greater number of people. One person requested that the video of the presentation at the public convenings include someone signing or closed captions to increase accessibility to those who are deaf. One person requested that feedback from consumers or clients be differentiated in the report so that their interests and needs would be clear.

Research on gaps in services and needs assessments, and deeper research on this model and other models were repeatedly requested. One person asked for an inventory map of all the County providers, contracts, and scopes of work to get a better sense of services being provided and identify the gaps.

Theme #10: Other models were offered for consideration.

Several participants suggested specific models to be considered in designing the health agency, as alternatives to an agency model, or as possible components of the agency:

- The Office of Child Protection's structure, its model for strategic planning, implementation of its new mission for child safety, the creation of the office of healthcare enhancement that involves representatives from all departments, and communication with other departments
- The appointment of 'czars' to oversee particular areas and policies, including health integration
- Learning from the way the three departments work together to coordinate services in the County jails
- Denver Health and Hospital Authority, Denver's hospital-based public healthcare safety net system
- MEND, a nonprofit agency in the San Fernando Valley, that integrates services successfully
- The National Alliance on Mental Illness' model of leadership

F. CONCLUSION

Community Partners is pleased to have had a role in providing the public with an opportunity to learn more, discuss, and be heard. The people who attended the public convenings hold a variety of roles and a range of relationships with the County Departments of Health Services, Mental Health and Public Health. As summarized in this report, they presented a broad range of perspectives and offered a variety of suggestions; there was no consensus on any one point. Our goal is for this public feedback to be considered and used by the Board of Supervisors as they continue to make decisions on how to provide the highest quality health-related programs and services for all Los Angeles County residents.

About Community Partners®

With more than 20 years' as a civic intermediary, capacity-builder, and fiscal sponsor, Community Partners has worked with hundreds of individuals, groups, foundations and other institutions to create new nonprofit projects, establish coalitions, and manage major philanthropic and civic initiatives to benefit the region.

We are experienced in designing a wide array of workshops, trainings, conferences, and other types of convenings. Our expertise lends itself well to serving as a neutral, third-party facilitator and to coordinating large-scale initiatives, including public stakeholder convenings.

Community Partners currently works with upwards of 150 projects and initiatives and manages $26 million in revenues. Our work spans the fields of civic engagement, arts and culture, education, social justice, health, public policy, social services and youth. To learn more, please visit us at ***www.CommunityPartners.org****.*