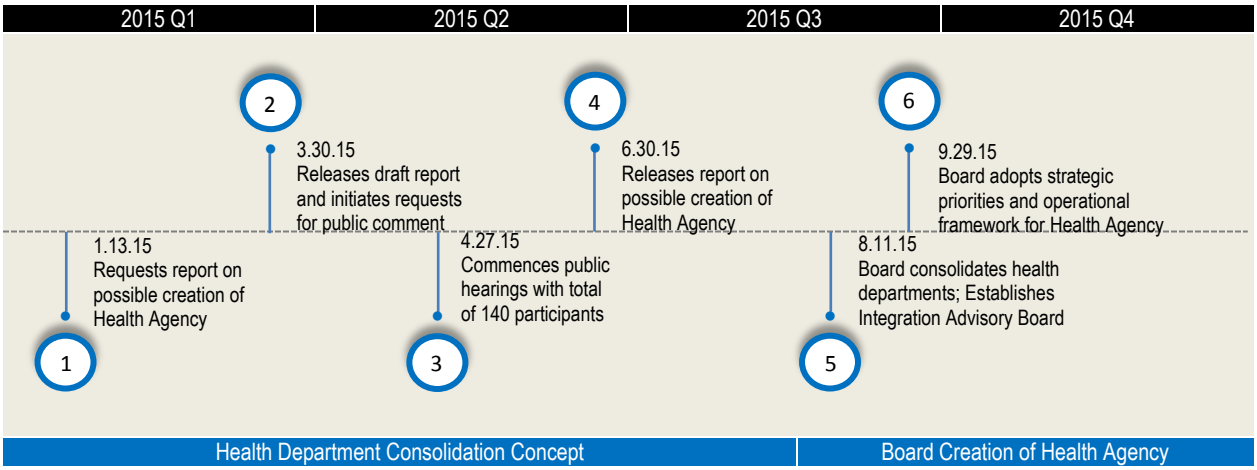
HEALTH INTEGRATION

Topic	Document	Date
Consolidation Concept	**1. Board Motion** - Consolidation of the Departments of Health Services, Public Health, and Mental Health	1/13/15
	2. Board Motion - Ensuring Quality Health and Mental Health Care Services in LA County Custody Facilities	3/3/15
	3. Board Correspondence - Final Report on Possible Creation of a Health Agency	6/30/15
Creation of Health Agency	**4. Board Motion** - Health Agency	8/11/15
	5. Board Letter - Approve the Strategic Priorities and Operational Framework for the Los Angeles County Health Agency – Approved	9/29/15

- Information Available on County Health Initiative Website at: http://priorities.lacounty.gov/health/
- Board Correspondence may be searched by title and date at: http://portal.lacounty.gov/wps/portal/bc

HEALTH INTEGRATION TIMELINE



AGN. NO.____

MOTION BY SUPERVISORS MARK RIDLEY-THOMAS AND MICHAEL D. ANTONOVICH

MARCH 3, 2015

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

On January 13, 2015, the Board of Supervisors (Board) passed a motion approving in concept the creation of a health agency and directed the Interim Chief Executive Officer (CEO), in collaboration with County Counsel, the directors of the Department of Human Resources, Department of Health Services (DHS), Department of Mental Health (DMH), Department of Public Health (DPH), and the Agricultural Commission, to report back in 60 days on the benefits, drawbacks, proposed structure, and implementation steps and timeframe. The motion directed the CEO to establish a stakeholder process to solicit input on the issues to be addressed in the report. To provide external stakeholders with sufficient time to review and provide input on a draft version of the report, it is prudent to extend the deadline for submitting a final version of the report to the Board.

The motion was also amended to consider including the Los Angeles County Sheriff's Department's (LASD) Medical Services Bureau in the health agency.

- MORE -

	MOTION
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RIDLEY-THOMAS	_____
KUEHL	_____
KNABE	_____
ANTONOVICH	_____

Currently, health care services for County inmates are provided by four separate County departments: DHS, DMH, DPH, and LASD. Due to concerns surrounding the quality of health care provided within the jails, the motion asked for consideration of including jail health services in the health agency and how such a move might be structured and accomplished in light of the federal consent decree negotiations and the County Commission on Jail Violence's recommendations. It is critical that the extended timeline for gathering stakeholder input on the draft health agency report not hold up progress on taking immediate action to improve the quality of health care provided to inmates in the County jails.

WE THEREFORE MOVE THAT THE BOARD OF SUPERVISORS:

Direct the Interim Chief Executive Officer, in conjunction with County Counsel and the Directors of the Department of Human Resources, Health Services, Mental Health, Public Health, and the Sheriff's Department, to:

1. 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. 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; and

2. Report back to the Board in writing in 30 days summarizing the status of jail health services in Los Angeles County, including issues pertaining to physical health, mental health, and public health. The report should also outline a set of the proposed approaches and strategies to address these issues and improve the overall quality and delivery of the care provided.

# # # #

(YV)

AGN. NO. 2

AMENDING MOTION BY SUPERVISOR MARK RIDLEY-THOMAS JANUARY 13, 2015

Consolidation of Sheriff Medical Services Bureau

I THEREFORE MOVE THAT THE BOARD OF SUPERVISORS include the Sheriff's Department in the working group discussions on health department consolidation and instruct the departments to include in the 60 day report back a recommendation on whether the Sheriff's Department Medical Services Bureau should be included in the consolidation, and if so, how it should be structured and accomplished.

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YV

	MOTION
SOLIS	_____
RIDLEY-THOMAS	_____
KUEHL	_____
KNABE	_____
ANTONOVICH	_____

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	_____
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KNABE	_____
ANTONOVICH	_____

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 Department**s** 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.**

# # #

MDA:flh
s:\motions\DHS DPH DMH Consolidation - Amendment

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First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

June 30, 2015

To: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
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.

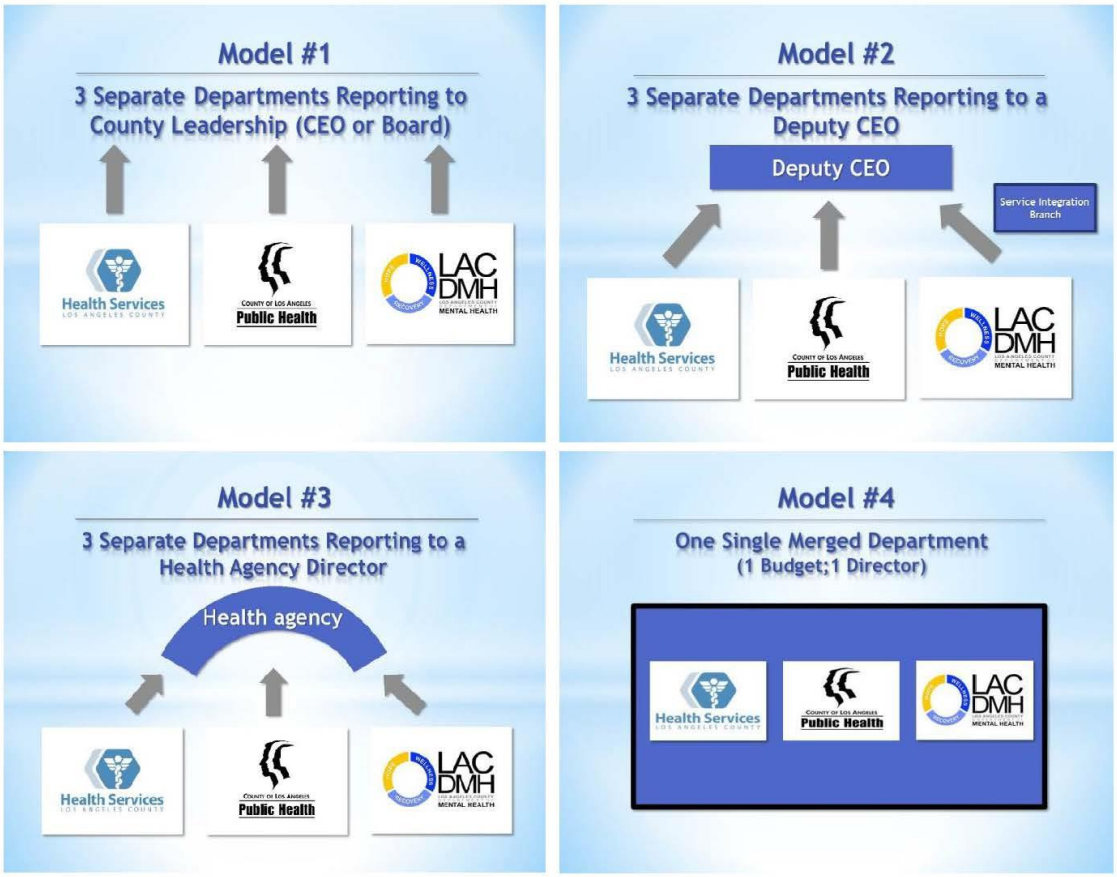
As noted in the introduction, virtually all stakeholders agree with the need to integrate activities (direct clinical services and programs extending beyond care delivery) across the three Departments. While many initially questioned the need for change, highlighting areas of success particularly within 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.

Ensure accountability and oversight of the agency

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.

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SACHI A. HAMAI
Interim Chief Executive Officer

"To Enrich Lives Through Effective And Caring Service"

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

September 29, 2015

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

Dear Supervisors:

APPROVE THE STRATEGIC PRIORITIES AND OPERATIONAL FRAMEWORK FOR THE LOS ANGELES COUNTY HEALTH AGENCY

(ALL DISTRICTS)

(3 VOTES)

SUBJECT

Approval of the Strategic Priorities and Operational Framework for the Los Angeles County Health Agency (Health Agency).

IT IS RECOMMENDED THAT THE BOARD:

Approve the Strategic Priorities and Operational Framework for the Health Agency as developed by the temporary Health Agency Steering Committee.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

On August 11, 2015, the Board directed the Interim Chief Executive Officer to create a temporary steering committee ("Steering Committee"), comprised of the Directors of Health Services (DHS), Mental Health (DMH), Public Health (DPH) and the Public Health Officer, to develop within 45 days, taking into account input from community stakeholders, a strategic plan and operational framework for integrating the three Departments with priorities, specific outcome measures and a preliminary associated workplan.

The Strategic Priorities and Operational Framework as developed by the Steering Committee are attached. Five public convenings were held to obtain input from community stakeholders on the draft version of these documents. Formal written comments were also accepted and were taken into account in this final report to the Board.

During the August 11, 2015 Board meeting, the Steering Committee was also asked to consider creation of a Community Prevention and Population Health Task Force (Task Force). DPH is taking the lead role in developing and supporting the Task Force. This Task Force will play a key role in promoting healthy, equitable communities by making recommendations to the Board of Supervisors, the Health Agency, and DPH on improving health equity and population health in Los Angeles County. The Task Force will oversee DPHs ongoing County-wide community health planning efforts to improve the population health for all Los Angeles County community members, with a particular focus on guiding the development and implementation of the Community Health Improvement Plan (CHIP). The CHIP is a 5-year strategic plan for DPH and community stakeholders to collectively improve the health of all residents. In addition, the Task Force will create connections between the CHIP and other key plans and initiatives in Los Angeles County with similar goals, such as the DMH's "Health Neighborhoods" initiative which aims to improve coordination of services for behavioral and personal health and address social determinants of health, such as poor housing and poverty.

A draft proposal for the Task Force was developed and shared with community stakeholders at a September 23, 2015 public meeting. The draft proposal will be revised to incorporate feedback from stakeholders and submitted to the Board of Supervisors under separate cover. The draft proposal contains recommendations for the Task Force's mission, responsibilities, size, member terms, selection process, as well as the desired qualifications of Task Force members.

Implementation of Strategic Plan Goals

The recommended action supports Goal 1 - Operational Effectiveness and Goal 3 - Integrated Services Delivery.

FISCAL IMPACT/FINANCING

None.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

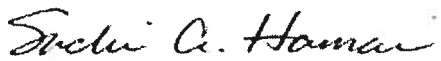
The recommended Strategic Priorities and Operational Framework take into consideration the input received from community stakeholders at the public convenings and throughout the public comment period, and reflect the Steering Committee's efforts to develop and fulfill the Health Agency's mission to improve the health and wellness of Los Angeles County residents through the provision of coordinated care and services.

The Steering Committee considers the strategic priorities to be three-year goals. Progress in each of the priorities over the next three years would yield substantial benefits to the residents of Los Angeles County and will require significant collaboration across each of the three Departments. Specific action steps and metrics, including indicators by sub-population and region/SPA where relevant, will be developed and modified over time. Overall progress in achieving these priorities will be shared in the quarterly updates to the Board on the Health Agency. Stakeholder input for specific priorities/goals will continue to be obtained over time in a manner and from groups/individuals relevant for each priority.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Your approval of this recommendation will improve access, health outcomes, and system efficiency.

Respectfully submitted,



SACHI A. HAMAI
Interim Chief Executive Officer

SAH:CRG:jp

Enclosures

c: Executive Office, Board of Supervisors
County Counsel
Auditor-Controller
Health Services
Mental Health
Public Health

Los Angeles County Health Agency Strategic Priorities
September 29, 2015

Consumer Access to and Experience with Clinical Services

Strategic Priority: Streamline access and enhance customer experience for those who need services from more than one Department, including by promoting information-sharing, registration, care management, and referral processes, training staff on cross-discipline practice, and increasing co-location of services.

Goal 1: Implement staff workflow processes and technical infrastructure necessary to ensure clients can access services in another Department without having to duplicate registration, financial screening, and eligibility/determination processes; where prudent, align Departments' financial policies governing eligibility and payment for services from self-pay individuals.

Goal 2: Develop joint care management plans for individuals served by more than one Department.

Goal 3: Implement Agency-wide referral processes and technical infrastructure and train staff on protocols through which clients can be identified and referred directly to services in or funded by another Department.

Goal 4: Expand number of directly-operated and contracted clinical sites at which individuals can receive co-located physical, mental, substance use, and public health services; train staff to effectively work within co-located sites.

Goal 5: Successfully implement DHS' Electronic Health Record (EHR) "ORCHID" at all DPH sites that deliver health care services suitable for ORCHID implementation.

Goal 6: Determine best short- and long-term course of action with respect to the secure sharing of personal health information, in a manner consistent with all applicable state/federal privacy and security regulations, on clients shared between DMH and DHS/DPH, including consideration of a Cerner Hub approach vs. potential shift to a single EHR with appropriate interfaces to contracted partners as needed to ensure efficient billing mechanisms.

Proposed outcome metrics:

- Number of DPH sites that have completed ORCHID implementation
- Board-approval of short- and long-term method for sharing clinical information between DMH and DHS/DPH
- Adoption of common registration, financial screening, and eligibility processes
- Increased number of staff cross-trained to properly identify and manage and/or refer individuals needing care within another domain
- Increased number of referrals between Departments that are appropriately dispositioned using a streamlined referral process; wait time to access services/programs post-referral
- Increased number of individuals with care plans incorporating more than one system
- Increased number of staff trained on effective care management practices within co-located clinical sites
- Increased number of individuals provided with multi-departmental services (directly operated and as contracted via the County) within co-located sites
- Enhanced customer experience as measured by surveys or other standard tools

Major organizational next steps:

- Map scheduling, registration, financial clearance/screening, and referral processes in each Department; convene a work group from the three Departments to determine how best to harmonize differences.
- Convene Health Agency IT Leadership Council comprised of technical and business leadership from each Department to ensure IT-related strategy and decisions made within each Department balance Agency-wide and Department-specific interests.
- Hire external consultant to perform a detailed, objective assessment of the best way to share information across the three Departments, understanding the needs of community partners and the complexity of financial/billing functions and responsibilities, including consideration of a health information exchange, interfacing existing applications, and implementation of an enterprise, single EHR for clinical functions.
- Convene a Health IT Task Force, including representation from DHS, DMH, DPH, Probation, Sheriff, CIO, and CEO, to assist consultants in the above evaluation, providing open access to their specific Department's resources and IT infrastructure, to ensure the outcome of the consultant's report outlines clear recommendations, to be delivered to the Board of Supervisors (BOS), regarding best short-and long-term strategy with respect to sharing/accessing clinical information; other County Departments (e.g., DCFS) should be consulted and involved as needed.
- Assess availability of space at all directly-operated clinical sites, including potential for space swaps.
- Evaluate and, where appropriate, develop mechanisms to align existing processes for obtaining input from clients/consumers/patients on service/program quality and customer experience, (e.g., surveys, complaints and grievances).

Housing and Supportive Services for Homeless Consumers

Strategic Priority: Develop a consistent method for identifying and engaging homeless clients, and those at risk for homelessness, across the three Departments, linking them with integrated health services, housing them, and providing ongoing community and other supports required for recovery.

Goal 1: Evaluate and reconfigure, as needed, housing and homeless services within the Agency and Departments to facilitate improved outcomes for homeless clients, including but not limited to the reduction/elimination of eligibility barriers and greater sharing of Departmental resources, to ensure that resources are available to homeless clients regardless of where they present.

Goal 2: Develop an accurate way to identify homeless clients, and those at risk of homelessness, currently served across the three Departments (e.g., development of a real-time unduplicated database, flag within shared client record) for the purpose of identifying priority clients who are determined to be likely to benefit from services from multiple Departments to regain health and residential stability.

Goal 3: Develop and implement shared standards and practices for ensuring a full range of housing, health, and prevention services are able to be delivered to clients based on client-specific needs.

Goal 4: Improve and expand upon multidisciplinary street engagement teams capable of effectively engaging homeless people living outdoors throughout the County with the express goal of securing interim and permanent housing.

Goal 5: Develop and open a range of "bridge" residential services that provide low-barrier, welcoming programs (e.g., sobering centers; day centers with showers, meals, and health services; recuperative care; detox centers; stabilization housing; congregate supervised living; and other effective bridges to permanent housing) for homeless individuals with complex health conditions in high density neighborhoods (e.g., Skid Row, Hollywood, Venice) and in unincorporated areas of LA County.

Goal 6: Maintain a real-time inventory of available residential slots, funded and usable by all three Departments, that facilitate immediate placement of homeless clients into available interim and permanent residential options appropriately matched to various need indicators (e.g., accessibility, level of on-site services, neighborhood, age).

Goal 7: Obtain Medi-Cal coverage, when possible, and successfully link individuals, where clinically appropriate, to comprehensive, integrated health services that are delivered in a way that is tailored for the unique needs of homeless individuals.

Goal 8: Develop screening questions for those conditions that lead to homelessness that could be incorporated into the practices of all three Departments along with methods and plans to link individuals to needed supports and services as part of the delivery of health care, mental health and public health services.

Goal 9: Engage in policy development and technical assistance activities to enhance the availability of high-quality, affordable, stable housing stock within LA County.

Proposed outcome metrics:

- Increased number of families at risk for homelessness that are provided support services to prevent homelessness

- Decreased number of emergency department visits and ambulance transports of homeless individuals for non-emergency services
- Decreased rate of incarceration for non-violent offenses related to being homeless
- Increased number of homeless individuals newly placed in Permanent Supportive Housing (PSH), including breakdown by geography (e.g., Skid Row, unincorporated areas)
- Increased percent of individuals housed by the Departments who remain housed two years after initial placement
- Increased number of individuals incarcerated in LA County jails who are housed upon community re-entry (among those who otherwise would have been homeless upon release)
- Increased number of homeless clients able to be placed in interim or permanent housing on the same day they have been identified as willing to move into housing and/or receive services
- Among homeless individuals assigned to a DHS or community partner medical home, increased number with at least one primary care visit in the past 12 months
- Increased number of homeless individuals who are linked to physical, mental, and/or substance use services
- Increased number of homeless individuals assisted via street outreach efforts in areas of the County experiencing high concentrations of people living outdoors

Major organizational next steps:

- Analyze housing/homeless-specific services and current program eligibility criteria in each Department to determine what level of further integration/consolidation would be useful toward achieving improved outcomes for homeless people, how these efforts interact with non-health related efforts, how eligibility criteria can be aligned Agency-wide, and any areas of additional funding needed to expand services.
- Explore with IT and other appropriate parties the most effective way to develop and maintain a real-time database/log of shared clients who are homeless.
- In partnership with other County Departments and non-County community partners, develop a priority list of types of residential programs that are most in need and develop a specific timeline for bringing them online.
- Work closely with CEO Homeless initiative coordinator to ensure other County departments (e.g., Sheriff, Probation, CDC, Fire, DPSS, DCFS) are working together to build a County-wide service system for homeless individuals.
- Work with DPSS and Community and Senior Services to create necessary program linkages and supports.

Overcrowding of Emergency Departments by Individuals in Psychiatric Crisis

Strategic Priority: Reduce overcrowding of County Psychiatric Emergency Services (PES) and private hospital Emergency Departments (EDs) by children and adults in psychiatric crisis.

Goal 1: Increase alternatives to PESs and private EDs across all regions of LA County by establishing additional psychiatric urgent care centers and crisis residential services, augmenting the spectrum of lower levels of care to include psychiatric recuperative care and additional crisis stabilization capacity, expanding access to structured outpatient services accessible to those at/before a time of crisis, and fully implementing the Alcohol and Drug Medicaid benefit.

Goal 2: Improve the utilization of inpatient services by ensuring that individuals who can be managed in a less restrictive setting are dispositioned appropriately and that those who are admitted to inpatient units are discharged as soon as clinically appropriate.

Goal 3: Maximize federal funds available for the purchase of services or placements to support care to individuals in or recently in crisis.

Goal 4: Assess and redesign existing processes to improve audits of IMD utilization in order to reduce length of stay and thus reduce wait times for those in public and private inpatient psychiatric units.

Goal 5: Ensure law enforcement and community-based mental health assessment teams are adequately trained on the wide array of outpatient service, programmatic (e.g., case management) and placement options available to individuals in psychiatric crisis.

Goal 6: Evaluate options to increase the stock of private psychiatric inpatient beds (e.g., increasing rates, developing mechanisms to take advantage of changes in the IMD exclusion).

Proposed outcome metrics:

- Decreased average morning census of children and adults on involuntary holds in County PESs and private EDs
- Decreased administrative days as a percent of inpatient psychiatric days in public and private hospitals
- Increased number of visits to urgent care centers by individuals on involuntary holds and ultimate disposition type (e.g., home, PES/ED, inpatient admission, community-based placement)
- Decreased average length of stay in public and private EDs by those on involuntary psychiatric holds
- Increased number of new urgent care centers opened
- Increased number of individuals in psychiatric crisis in public and private EDs who are discharged to non-locked settings with medication and outpatient follow-up plans
- Increased number of alcohol and drug residential and detox service placements/slots available
- Increased number of crisis residential beds available
- Recidivism rate among those visiting County PESs (and private EDs to the extent data is available)

Major organizational next steps:

- Assess current and anticipated future financial allocations from each Department toward individuals in psychiatric crisis, especially those on involuntary holds, so that resources can be maximally aligned toward services and placements most capable of responding to the needs of the target population.
- Assess and align, where indicated, DHS, DMH, and DPH clinical, programmatic, and housing services to create novel placements for individuals who could be diverted from EDs or inpatient units.

- Open additional 24/7 LPS-designated psychiatric urgent care centers, including at sites near Olive View-UCLA Medical Center, in the Antelope Valley, in the Long Beach area, in the East San Gabriel Valley, and in association with Harbor-UCLA Medical Center.
- Assess utilization of inpatient psychiatric units and IMDs to identify opportunities to improve flow.

Access to Culturally and Linguistically Competent Programs and Services

Strategic Priority: Ensure access to culturally competent and linguistically appropriate services and programs as a means of improving service quality, enhancing customer experience, and helping to reduce health disparities.

Goal 1: Implement mechanism to systematically collect and analyze Race, Ethnicity and Language (REAL) data and data for other culturally relevant factors (e.g., LGBTQ, physical disability) among consumers; use data to identify and report relevant health-related disparities and inform ongoing program design.

Goal 2: Systematically survey and publicly report client satisfaction with Department activities and services from a cultural perspective.

Goal 3: Design, establish, and implement core competencies for new employees and regularly train existing County workforce on providing culturally relevant care and customer service, including attention to the needs of specific race/ethnic groups, the disabled, veterans, LGBTQ, immigrant/refugees, the elderly, and other vulnerable groups within local communities.

Goal 4: Ensure clinical sites are able to provide real-time professional interpreter/translation services when required or requested by the client through building both in-person and technology-based (e.g., telephone, video-conferencing) resources; ensure clients are proactively made aware of their right to receive and the availability of such services.

Goal 5: Ensure clinical sites have signage and written client materials available in the preferred primary languages of their local communities.

Goal 6: Share and coordinate existing culturally appropriate efforts and staffing models across Departments that have been proven effective in reducing disparities, enhancing care coordination, and increasing community awareness of health issues and that have demonstrated positive health outcomes.

Proposed outcome metrics:

- Disparities according to REAL and other relevant cohorts
- Results from clients/consumers/patients surveys
- Evaluation of impact and effectiveness of training programs related to cultural competency; number of individuals who have completed training
- Percent of total clinical sites that can provide real-time access to translation/interpreter services
- Percent of sites that have completed self-assessments and enhancements of signage and written materials that met the cultural and linguistic needs of communities served

Major organizational next steps:

- Convene and/or evaluate existing Department-, program-, and/or facility-level cultural competency committees, comprised of consumers, their families, and front-line staff, to provide input on how to continually enhance cultural competency of existing programs.
- Perform cultural competency assessment of directly-operated and contracted sites using an externally validated tool appropriate to the size and diversity of the County.
- Create mechanism to formally survey clients/consumers/patients on cultural competency of services and programmatic offerings.
- Engage organized labor on ways to formally enhance delivery of culturally competent care/services.

- Conduct inventory of currently available translation/interpreter resources/infrastructure, signage, and written client materials within clinical sites.
- Assess the ability of specific programs/facilities to care for special populations (e.g., use of peers/those with lived experience, family involvement) and take advantage of the strengths of each Department.

Diversion of Corrections-Involved Individuals to Community-Based Programs and Services

Strategic Priority: Successfully divert corrections-involved persons with mental illness and addiction who may otherwise have spent time in County jail or State prison by placing them into structured, comprehensive, health programming and permanent housing, as tailored to the individual's unique situation and needs.

Goal 1: Establish the Office of Diversion and Re-entry with the capability to coordinate diversion efforts across Departments, create placements appropriate for the wide array of individuals who might be diverted and develop programs that support the recovery and improved health of these diverted individuals. The Office will provide contracting, technical and evaluation support, and expansion of current evidence-based diversion programs run by DHS, DMH, and DPH necessary for a successful County-wide intervention.

Goal 2: Establish placement opportunities and comprehensive health programs (i.e., physical health, mental health, public health, and substance use case management and clinical services) to address the needs of individuals deemed eligible for diversion.

Goal 3: Work with Court 95 and the LA County District Attorney's Office to establish sufficient community placements to meet the relevant demand among Misdemeanants Incompetent to Stand Trial (MIST) deemed eligible by law enforcement for diversion.

Goal 4: Build the necessary administrative infrastructure necessary to rapidly place potential diversion candidates into housing (e.g., possible creation of a Diversion Connection Access line with extended hour capabilities).

Goal 5: Develop diversion education and awareness campaign to heighten awareness of diversion opportunities and programs among County courts, prosecuting and defense attorneys, law enforcement and custody staff as well as mental health, substance use, and other relevant clinical staff.

Proposed outcome metrics:

- Increased number of individuals diverted from jail, by intercept and offender category (e.g., MIST)
- Percent of diverted individuals who successfully complete diversion plan
- Percent of diverted individuals who have not re-offended within one year following completion of their diversion plan
- Average time spent in custody after diversion plan is approved
- Increased number of diversion programs and housing units available to diversion clients
- Increased number of cases where diversion programs are the recommendation of the Courts

Major organizational next steps:

- Establish the organizational structure and key leadership positions within the Office of Diversion and Re-entry.
- Hire an Office Director and team with a sufficient leadership structure to interface with the courts and custody as well as develop and identify providers for required housing, placements, and programming.
- Build multi-department diversion stakeholder group to guide Office priorities.
- Continue to build relationship with District Attorney's ongoing diversion effort.
- Determine how DMH and Substance Abuse Prevention and Control (SAPC) programs and resources interact with and support a broad County diversion program.
- Align program metrics across each Department's current diversion programs.

Implementation of the Expanded Substance Use Disorder Benefit

Strategic priority: Maximize opportunities available under the recently approved Drug Medi-Cal waiver to integrate Substance Use Disorder (SUD) treatment services for both adults and youth into LA County's mental and physical health care delivery system.

Goal 1: Transition homeless and criminal justice-involved individuals receiving SUD residential treatment into appropriate Department housing programs as part of the SUD continuum of care.

Goal 2: Develop knowledge and skills of clinical staff in Departments' directly-operated and contracted primary and specialty care facilities on the American Society of Addiction Medicine's (ASAM) levels of care based on medical necessity, including the interaction of SUDs with physical health and mental health conditions, and how to appropriately screen and link individuals with SUDs into appropriate levels of care.

Goal 3: Advocate with the State Legislature and the Department of Health Care Services (DHCS) to place all drug treatment medications approved by the federal Food and Drug Administration (FDA) on the Drug Medi-Cal (DMC) formulary; expand the use of these medications by both mental and physical health practitioners within LA County's health care delivery system.

Goal 4: Increase the number of Departments' directly-operated and contracted providers that are DMC-certified.

Goal 5: Implement SUD Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol in Departments' directly-operated and contracted clinics and programs.

Proposed outcome metrics:

- Increased number of eligible homeless and criminal justice-involved individuals referred to DHS and DMH housing programs upon completion of their SUD treatment
- Increased number of SUD homeless and criminal justice-involved patients with co-occurring SUD mental health and/or physical health conditions housed in DHS and DMH programs
- Increased number of clinical personnel in directly-operated and contracted County clinics trained to accurately identify SUDs, provide Medical Assisted Therapy (MAT), and make referrals for SUD treatment based on medical necessity as determined by ASAM criteria
- Addition, by California DHCS, of all FDA-approved addiction treatment medications to the DMC formulary without a TAR requirement
- Increased number of Departments' directly-operated and contracted facilities that are DMC certified
- Increased number of Departments' directly-operated and contracted clinical personnel trained in SBIRT
- Increased percentage of Departments' clients in directly-operated and contracted clinics receiving an annual screening for substance use in the past year

Major organizational next steps:

- Prepare and submit the DMC Organized Delivery System (ODS) implementation plan required under the 1115 Waiver's DMC ODS Special Terms and Conditions to obtain BOS approval to opt into the Waiver.
- Upon BOS approval, submit the DMC ODS implementation plan to DHCS and Centers Medicaid and Medicare (CMS) for approval as required under the STCs.
- Establish workgroups comprised of DHS, DMH, DPH, other County departments, and key external stakeholders to execute the DMC ODS Waiver implementation plan once approved by DHCS and CMS.

- Provide technical assistance, training and infrastructure investments for the three Departments and their provider networks to build administrative, clinical, and workforce capabilities and capacity to meet the increased demand for SUD services under the DMC ODS Waiver.

Vulnerable Children and Transitional Age Youth

Strategic Priority: Improve the County's ability to link vulnerable children, including those currently in foster care, and Transitional Age Youth (TAY) to comprehensive health services (i.e., physical health, mental health, public health, and SUD services).

Goal 1: Develop comprehensive individualized treatment plans, including temporary and permanent placements able to provide integrated mental health, substance use, and physical health services, for children in foster care that are "difficult-to-place" due to health-related issues.

Goal 2: Develop and implement new approaches to community outreach and engagement to high-risk children/youth and TAY (e.g., those with HIV/STDs, homeless youth, LGBTQ, unaccompanied minors).

Goal 3: Continue to develop and evolve a comprehensive health services package (i.e., physical health, mental health, substance use, public health) available to Commercially Sexually Exploited Children (CSEC) in LA County.

Goal 4: Develop a package of comprehensive aftercare services, including mechanisms for appropriate referral and linkage available immediately upon release, for youth in Probation Camps and Juvenile Halls and TAYs in the adult corrections system.

Goal 5: Create or adopt an externally available mobile tracking and communication tool usable by TAY to help them gain access to educational and service information.

Proposed outcome metrics:

- Increased percent of "difficult-to-place" youth in DCFS system that are successfully linked with comprehensive treatment services and receive timely, appropriate residential placement in a home-like setting where feasible
- Decreased number of children/youth with physical and/or mental health challenges who experience placement disruptions
- Increased number of high-risk TAY newly linked to and receiving mental health and/or SUD services
- Increased number of CSEC youth using services from an agency Department
- Increased number of youth and TAY leaving the correctional system with an aftercare plan addressing mental health, substance use, and/or physical health needs
- Increased number of youth/TAY with full implementation of their aftercare plan
- Increased number of TAY who use an electronic tool to "stay in touch" with service providers, DCFS social workers, Probation officers or other parts of their community

Major organizational next steps:

- Establish a working partnership between the Agency, the County's Office of Child Protection, relevant County Departments (e.g., DCFS, Probation), and community-based entities (e.g., school districts).
- Evaluate current models of integrated treatment teams (e.g., Child and Family Teams implemented by DCFS and DMH) and determine their applicability and potential scalability for improving management of target populations.
- In partnership with DCFS, clearly define "difficult to place" youth appropriate for Goal 1 interventions.
- Convene workgroup, involving entities outside the Agency as needed, to develop a mechanism (e.g., utilize a common data collection system) to ensure that all Department programs that may interact with CSEC have a way to identify individuals and employ consistent methods to capture relevant information.

- Convene an agency-level CSEC workgroup to enhance Department collaboration on health-related issues; participate in County-wide CSEC workgroups as appropriate.
- Identify funding to create and/or implement the mobile tracking and communication tool.

Chronic Disease and Injury Prevention

Strategic Priority: Align and integrate population health with personal health strategies by creating healthy community environments and strengthening linkages between community resources and clinical services.

Goal 1: Expand access to chronic disease prevention programs (e.g., National Diabetes Prevention Program (NDPP)) for priority populations.

Goal 2: Scale and spread the use of team-based care approaches in Los Angeles (e.g., Community Health Worker (CHW), pharmacist-led Medication Therapy Management (MTM) programs) for persons with chronic health conditions.

Goal 3: Expand access to evidence-based tobacco cessation treatment for priority populations.

Goal 4: Reduce youth violence through strategies targeted at the community-level and broader social determinants of health. Example tactics to be pursued include building on the Parks After Dark (PAD) model to expand gang intervention and safe passage programs, integrating DHS, DMH and DPH services and outreach into community-based youth violence efforts, and promoting a school climate that ensures adequate access to high-quality and coordinated social, medical, and behavioral health services for students and families (e.g., a coordinated school health model).

Goal 5: Encourage and assist high-risk populations (e.g., those prescribed atypical anti-psychotics) to engage in exercise and movement and to access healthy food/nutrition options.

Proposed outcome metrics:

- Increased number of at-risk persons enrolled in chronic disease prevention programs (e.g., NDPP)
- Increased number of at-risk persons with well-controlled chronic conditions (e.g., heart failure, diabetes, hypertension)
- Increased number and level of satisfaction of clients reached with CHW and MTM programs
- Increased number of healthcare providers trained in the provision of evidence-based tobacco treatment interventions
- Decreased prevalence of tobacco use among adult LA County residents
- Increased number of schools with wellness policies that adopt and integrate elements of a coordinated school health model
- Increased number of PAD parks in communities with high rates of violence that include co-located social, physical, behavioral, and public health services
- Decreased number of serious and violent crimes and gang-related crimes in PAD park communities relatives to comparison sites
- Decreased number of trauma-related ED visits and hospitalizations

Major organizational next steps:

- Develop assessment tools/methods for collecting needed baseline and ongoing performance/progress data for above initiatives.
- Perform baseline inventory and assessment of existing CDC-recognized NDPP providers in Los Angeles; develop and implement outreach and provider engagement strategy to promote and support broader provider participation.

- Perform baseline inventory and assessment of select existing team-based care models (e.g., community pharmacies screening programs, MTM programs); develop and provide technical assistance to agencies and providers interested in expanding participation.
- Establish standards of care for the delivery of evidence-based tobacco interventions; revise or update standards to address the assessment and treatment of tobacco dependence.
- Develop necessary education objectives, curricula, evaluation tools, and training schedules to enhance tobacco cessation efforts; train providers to deliver evidence-based tobacco cessation treatment.
- Analyze trauma-related data to better tailor and target prevention interventions.
- Conduct baseline inventory and assessment of existing violence prevention, social service, health and behavioral health resources in PAD park communities with a goal to develop a cross-referral system; convene key partners to develop and implement targeted strategies to facilitate referrals and coordination between organizations, provide technical assistance, and evaluate impact of initiatives.
- Analyze available data and assess impact of current programs targeted at social determinants of youth violence (e.g., diversion programs, Teen Court programs) to understand gaps and priority opportunities for future intervention.

Los Angeles County Health Agency Operational Framework

September 29, 2015

The mission of the Los Angeles (LA) County Health Agency ("Agency") is to improve the health and wellness of LA County residents through provision of integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy people living in healthy communities. This will be achieved through the aligned efforts of the Departments of Health Services, Mental Health, and Public Health ("Departments") and in partnership with our clients and their families and communities, LA County residents, organized labor, faith-based organizations, community providers and agencies, health plans, academia, and other stakeholders.

In pursuing their missions, the Agency and Departments shall adhere to the following operational framework, abiding by key values of clarity of purpose, transparent decision-making, mutual respect, and open communication with those inside and outside the County.

1. **The Agency shall address Board-supported priorities relevant to health and well-being.** The Agency shall work to implement Board-supported priorities related to the health and well-being of LA County residents. The Agency shall guide the strategic, operational, and administrative alignment of activities, decisions, and external advocacy agendas within and among the three Departments in support of these aims and will include an explicit focus on change management practices that may support and reinforce necessary modifications of County practices/structures. The Agency shall publicly report on progress made toward achievement of specific goals related to these priorities.
2. **Departments shall maintain the full breadth of their mission and scope of activities.** Each Department has a critical mission in supporting the health and well-being of LA County residents; such missions should be maintained and supported in a way that respects each Department as equal partners in achieving the County's health-related goals. Departments shall continue to establish Department-specific priorities distinct from Agency-level priorities and initiatives and shall lead and participate in a full spectrum and scope of activities consistent with these priorities. Departments shall continue to enter into external contracts, grant agreements, and operational agreements with external entities (e.g., community-based organizations, private providers, health plans) in a manner consistent with Agency priorities.
3. **Departments shall be supported in fulfilling all legal responsibilities and mandates.** Departments shall be empowered and supported in delivering essential and legally-mandated services and in fulfilling their mandate to administer cross-departmental oversight and auditing processes. The Agency and Departments shall develop protocols to eliminate any conflict of interest that may arise during the course of a Department carrying out its regulatory and auditing responsibilities.
4. **Departments shall maintain independent and direct relationships with the Board of Supervisors.** Each Department should be expected to directly and regularly communicate with Board members in private and in public regarding Department-specific issues and concerns related to the Agency.
5. **Department budgets shall remain separate.** The budgets of the three Departments shall remain as separate appropriations within the County and shall not be merged within a single Agency budget. Services, budgets, and staffing for Department activities shall not be cut and financing streams shall not be redirected because of a transition to the Agency model. Over time, Department activities, services, and programs may be altered, integrated, and/or realigned between or among the Departments if such moves would demonstrably benefit the populations served by the County, with internal and external stakeholder input, and with approval of the Board. Current grant-funded activities shall not be redirected. Departments' risk management responsibilities shall be maintained separately; incidents of potential liability, claims, and lawsuits shall continue to be financially addressed by the relevant

Department. The Agency shall conduct strategic review of Department budgets to facilitate appropriate alignment with both Agency and Department-specific Board-supported priorities. Only the Board of Supervisors, pursuant to applicable laws and regulations, and not the Agency Director, has authority to change and/or reallocate Departments' appropriations and expenditures.

6. **The Agency shall support Departments in creating effective organizational structures.** The Agency Director shall interact with the Department Heads with the goal of creating organizational structures that meet the needs of Departmental and Agency mission, vision, and scope of work.
7. **The Agency shall avoid unnecessary bureaucratic processes.** The Agency shall operate in such a way as to ensure strategic alignment of operational and administrative activities within and between Departments in pursuit of Board-supported priorities. Bureaucratic processes that may unnecessarily extend Departmental tasks and operations (e.g., Agency-level signatures required for routine operations such as grant applications, supply chain purchases, and personnel action requests) shall not be implemented.
8. **Functions shall shift to being conducted and/or coordinated Agency-wide to the extent this enhances integration and/or when doing so is of strategic value to the County.** Agency-wide functions shall be implemented when doing so would produce a clear added value to clients, the Departments, and the County, taking into consideration the operational requirements of achieving specific priorities and administrative inefficiencies and/or redundancies. Regardless of placement, core administrative functions (e.g., information technology, service and managed care contracting, purchasing, finance, human resources) shall be planned, led, and executed in a manner that supports both Agency and Department priorities.
9. **The Agency shall lead labor-management partnership activities to reduce duplication and enhance the level of County partnership with organized labor.** Department leadership, or specific subject-matter experts, should be active participants in all relevant labor/management meetings and initiatives.
10. **The Agency shall respect current Department relationships and commitments.** Existing relationships and contracts with external entities shall be respected and maintained. Departments shall continue to maintain and nurture current internal and external partnerships in pursuit of Department-specific and shared Agency goals and efforts.
11. **Both the Agency and Departments shall maintain mechanisms to engage a broad set of internal and external stakeholders.** Department-specific mechanisms and forums for engaging County-employed workforce and external stakeholders shall be maintained and supported. The Agency shall establish complementary mechanisms to build transparent and meaningful partnerships with relevant stakeholders. The Agency shall proactively invite input from individuals and organizations with a variety of different perspectives and areas of expertise, including staff, clients/consumers/patients, and community-based organizations, in the design, implementation, and evaluation of programmatic and policy initiatives. The Agency shall transparently and clearly communicate with and report to the public on Agency activities and plans.
12. **The Agency shall embrace a full spectrum of services and programs aligned with the health and wellness needs of individuals across the life course and reflecting different social, cultural, and demographic groups.** Services and programs shall reflect an appropriate balance of clinical, recovery, community-based, and policy-related preventive and population health initiatives able to optimize health outcomes. Services and programs should be designed and implemented within the context of local communities, in a culturally competent manner, and utilizing evidence-based practices where feasible.
13. **The roles and responsibilities of Board-appointed Commissions shall remain unchanged.** The creation of the Agency does not alter the roles and responsibilities of existing County Commissions. Each

Commission should continue to advise Departments and the Board on issues related to their areas of interest and expertise. As is the current practice within Departments, Commission input shall be given significant weight and consideration in Agency decision-making.

14. **The Agency shall not alter or interfere with the duties and responsibilities of the County Health Officer.** Should a Health Officer Order impact any operations within the Agency, the Agency Director shall assure compliance to protect the health and safety of all residents.
15. **The Agency shall support public health emergency response activities and other time-limited, high-priority County preparedness initiatives.** The Agency shall respond to emergencies or crisis-level activities through development and implementation of effective plans, trainings and exercises to assure integrated service delivery and unified communication. Departments shall retain their respective roles, responsibilities, and legal authorities during emergencies.
16. **The Agency Director shall administer Department Head performance evaluations.** Department Head performance evaluations shall be drafted by the Agency Director for review and input by the County Chief Executive Officer. The Board of Supervisors shall maintain the ultimate authority over any individual Department Head's final performance evaluation and associated merit pay.

AGN. NO._____

MOTION BY MAYOR MICHAEL D. ANTONOVICH AUGUST 11, 2015

HEALTH AGENCY

On January 13, 2015, the Board of Supervisors unanimously approved in concept the integration of Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH), to create a single unified health agency (Health Agency). Furthermore, the Board directed staff to report back with a proposed structure of such an Agency and a timeline of how it would be implemented.

As part of the evaluation of this proposal, the Interim Chief Executive Officer (CEO) was directed to establish a stakeholder/public participation process to ensure that their input was considered in the staff report. This process resulted in extensive forums being held throughout the County to receive recommendations from both internal and external stakeholders. The resulting staff report validates the need to move forward.

While all parties agree that greater integration of these services is critical to the County's ability to address the needs of its patients, some critics of the Health Agency have argued that these three departments were linked in the past, but failed to provide integrated care delivery. This statement may be true, but it ignores how significantly the national thinking on health care has changed in the past 43 years.

This motion does not seek to eliminate or diminish the work done by DHS, DMH, or DPH. Nor does it subsume these departments into a "medical" model that ignores the recovery-based models and social determinants of health. The opposite is true.

National changes in the delivery of health care have created both significant opportunities and challenges for the County. New legislative mandates, service provisions and financing have caused a tremendous shift toward integrated delivery of care that better aligns physical, behavioral, community, and population health.

	MOTION
SOLIS	_____
RIDLEY-THOMAS	_____
KUEHL	_____
KNABE	_____
ANTONOVICH	_____

Further, we know that managing the care of our patients requires that we look closely at the social determinants of health, such as access to housing, food, and other necessities of life, as well as socio-economic factors that may affect how care is sought. By bringing together these three departments under a single Health Agency, we can bring to bear the available resources to meet our patients' needs.

Each day, the lives of the 10 million Los Angeles County residents are affected by the services provided by County Departments. Each program may have a different purpose, but all are unified in sharing one vision to "improve the quality of life in the County of Los Angeles by providing responsive, efficient, and high quality public services that promote the self-sufficiency, well-being, and prosperity of individuals, families, businesses, and communities."

Creating a single Health Agency is now a business imperative for the County to improve access, health outcomes, and system efficiency. In the present and expected future health care environment, and to best meet the needs of our constituents, the County must move from fragmentation to integration of its health care delivery system.

Creating a unified Health Agency also makes fiscal sense. Bringing these departments together can serve to increase the County's total delivery capacity by eliminating duplication among departments and allowing for creative multi-disciplinary collaboration to address such intractable problems as homelessness and diversion of criminal offenders.

Critics of a single Health Agency have also expressed concern that the voice of the individual departments, as well as the associated stakeholder groups, would be muted by the Agency model. This is not the intent. The department heads will still have direct access and regular interaction with the Board about their respective programs. Additionally, all three departments are supported by Board-appointed commissions with direct reporting to the Board and whose members have individual relationships with the Board members and their staff. This would continue to be the case under the Agency model.

Finally, those who oppose the Agency model argue that the larger entity could ignore long-standing community priorities by reallocating funding to other areas not supported by stakeholder groups. This Board recognizes the importance of maintaining separate departmental budgets to protect the unique funding streams and responsibilities of each department. Any changes or reallocations from one budget to another would require Board approval, just as such changes require now.

As the health care industry continues to experience dramatic shifts in how care is funded, a single Health Agency will also ensure the efficiency of administrative functions and potential cost savings. The County must embrace a cohesive delivery system in order to fully leverage and maximize all resources. This means moving from a "Department-centered" framework to a "client/patient/community-centered" model of care where there is no wrong door for those seeking care, especially the vulnerable, at-risk and socio-economically disadvantaged populations such as the homeless, infirmed and transitional age youth. Fully leveraging and coordinating each Department's expertise and resources will result in continuous quality improvement and innovation, bringing about higher accountability, effectiveness, efficiency and advocacy.

This Board demonstrates sustained leadership and fiscal stewardship in preserving and strengthening the County safety net. The time is now to position the County for continuing success by establishing a single unified Health Agency to break down the bureaucratic barriers faced by the County's patients and clients, identify and maximize synergies among DHS, DMH, and DPH programs, streamline operations, optimize finances, and align incentives so that all County staff can continue moving toward the goal of providing high quality and person-centered services across the full continuum of health services.

In its motion, the Board requested and received input from stakeholder groups. One of the ideas that came out of this discussion was the notion of an Office of Health Care Enhancement to facilitate the coordination and integration of services among the multiple County agencies. While this is a valid suggestion, such an office would have no accountability to the Board for implementing a coordinated system and would be advisory in nature. The Agency model holds not only the agency head, but the individual department heads accountable to implement initiatives to integrate service delivery.

The Board has, over the past several years, overseen an unprecedented expansion in the delivery of personal, public, and mental health services. This growth is based upon the notion of continuity and integration in the delivery all of these services. We are at a critical juncture in the evolution of the delivery of health care and it is crucial that we take action to facilitate the integration of services provided by our $7 billion health care delivery system.

I, THEREFORE, MOVE that the Board of Supervisors:

1. Approve the establishment of a Health Agency to integrate the operations of the Departments of Health Services, Mental Health, and Public Health and direct the Interim Chief Executive Officer (CEO) to ensure that separate budgets are maintained for each Department;

2. Direct County Counsel to draft a County ordinance within 30 days to create a Health Agency and work with the Chief Executive Office and Department of Human Resources to establish an ordinance position of Health Agency Director;

3. Direct the Director of Human Resources and CEO Classification-Compensation to develop and submit to the Board a job description and associated position for the Health Agency Director within 30 days; and initiate recruitment for the Agency Director;

4. Instruct the Interim CEO to create a temporary steering committee, made up of the Directors of Health Services, Mental Health, Public Health, and the Public Health Officer to develop within 45 days, taking into account input from community stakeholders, a strategic plan and operational framework for integrating the three departments with priorities, specific outcome measures, and a preliminary associated workplan to include, but not be limited to, the following:

    a. Streamlining access for those who need services from more than one Department and its community partners, including by promoting information-sharing, registration, and referral processes, training staff cross-discipline, and increasing co-location of services;
    b. Reducing homelessness among individuals with health-related needs; and
    c. Reducing overcrowding of public Psychiatric Emergency Services (PES) and private Emergency Departments (EDs) by individuals on involuntary psychiatric holds.

5. Direct the Interim CEO to convene a temporary Integration Advisory Board (IAB) made up of two representatives from each of the following Commissions: the Mental Health Commission, the Public Health Commission, Hospital and Health Care Delivery Commission, Commission on Alcohol and Other Drugs, and the Commission on HIV; one or two consumers from each Commissions' discipline; and one or two representatives from each Department's organized labor unions. The Commission and consumer representatives should be selected by public vote of each Commission. Labor representation will be determined by labor leadership. Two co-chairs of the IAB shall be selected by vote at the first public

meeting of the Advisory Board. The IAB will serve as an advisory body to the Board of Supervisors reporting in writing to the Board on at least a semi-annual basis for two years, on the impact (positive or negative) of the Health Agency on ongoing Departmental activities and operations and on achieving the County's health-related priorities. Commission and consumer representatives from each discipline should include comments as it relates to their particular area of focus; and

6. Establish a quarterly set item on the Board agenda in which the Agency Director and Department heads publicly report to the Board on the following topics:

    a. Progress in achieving agency goals and specific indicators and outcome measures;
    b. Financial status of each Department, including any notable changes in funding streams, sources and uses of funds by program and provider type, and number of individuals served; and
    c. Stakeholder engagement process.

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AGN. NO. S-1

AMENDMENT BY SUPERVISOR HILDA L. SOLIS

August 11, 2015

4.

d. Ensuring culturally competent and linguistic appropriate care in the health agency and across all three agencies.

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HLS:jyp

MOTION

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RIDLEY-THOMAS _____

KUEHL _____

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ANTONOVICH _____