Subject: Alternative for California Health & Human Services: Rebuttal to "An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California"

Dear Governor Newsom, Secretary Ghaly, and California County Health Departments

1. The complexity since the pandemic and the economic lockdown seem so overwhelming that the California State Health and Human Services Agency has decided that talking about universal health and social services would be a distraction. I wish to make the case that <u>focusing on immediate implementation of universal health and human services information and data is the ONLY productive thing the State of California can do to manage the social and economic chaos the coronavirus is causing</u>.

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2. While you have endorsed the idea of universal health care, the legislation establishing the Healthy California for All Commission gives it last priority:

"The Commission is charged with developing a plan that includes options for advancing progress toward a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians."

The first half of the Commission's expected output, An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California focuses entirely on the

continuing problems created by sickness insurance, while ignoring any consideration of how the system looks like from the stand point of moving to universal care.

3. Choices facing California Policymakers as of October 30, 2020

- Trump is re-elected: Obamacare is made optional, MediCare and MediCaid are reduced, private sickness insurance inconsistent, health care out-of-pocket costs increase;

- Biden is elected, year 1: Obamacare is expanded at great additional expense, premiums go up, current confusion and inefficiencies become worse;

- Biden is elected, year 2: with great fanfare, Public Option is introduced, but it is just another version of something not that different from Covered California: too expensive, and not comprehensive; again, additional expenses, premiums go up, current confusion and inefficiencies become worse; US health costs approach 25% GDP.

- California implements centralized state-wide health care, SB 562, maintaining large complex hospital based systems with profit incentives for unnecessary surgeries and hospital stays, heavy dependence on pharmaceuticals, little financial control or quality control.

- California can implement a community clinic focused health care system that meets health problems where they are. Hospitals require too large a population catchment area to be able to be responsive to health promotion and disease prevention challenges. Clinics with Community Health Teams of primary care physicians, nurses and community health agents serve a population of up to 10,000 people. Each community has an elected 7-member Community Health Council, and a federal annual allocation. Unlike in a sickness insurance system, the data needs are coordinated, so that they can be updated daily: clinical, pharmaceutical, financial, management, and needs assessment are all monitored to make sure every clinic is in compliance with all federal and state regulations. Health outcomes improve; cost controls are maintained.

4. The sickness insurance information system is so complicated that it cannot be made manageable; it is only going to get more out of control, and more expensive. Expanding MediCal and Covered California insurance coverage does little to improve access, availability or quality.

- the only way to get a statewide handle on the coronavirus,
- the only way to have daily testing at every school, church, and major community meeting areas,
- the only way to have a registry of everyone's testing and contact history,
- the only way to monitor the state's health care system information on a daily real time basis, and assure availability and access,
- the only way to get health personnel to where they are needed in a timely way,
- the only way to keep track of the expenses,
- the only way to plan a budget,
- the only way to actually manage the statewide health resources,
- the best way to improve health outcomes,
- the only way to safely reopen the schools,
- the only way to get the state economy back up and running,

is to implement single payer health care.

5. A Paradigm Shift in Your Thinking, Governor Newsom

Whenever I think about the information in the health care delivery system, I am reminded of this quote about Einstein from Thomas Kuhn's The Structure of Scientific Revolutions:

Science in Crisis
        The established paradigm's "complexity was increasing far more rapidly than its accuracy and a discrepancy corrected in one place was likely to show up in another."
        "Paradigms provide scientists not only with a map but also with some of the directions essential for map-making. In learning a paradigm the scientist acquires theory, methods, and standards together, usually in an inextricable mixture. Therefore, when paradigms change, there are usually significant shifts in the criteria determining the legitimacy both of problems and of proposed solutions."
        "Copernicus complained that in his day astronomers were 'so inconsistent in these [astronomical] investigations' he concluded, 'it is as though an artist were to gather the hands, feet, head and other members for his images from diverse models, each part excellently drawn, but not related to a single body, and since they in no way match each other, the result would be monster rather than man.'
        "Einstein, restricted by current usage to less florid language, wrote only, 'it was as if the ground had been pulled out from under one, with no firm foundation to be seen anywhere, upon which one could have built.'"

6. Old Paradigm: Monetization of Sickness Care

The Republicans spent the 20th century putting a price tag on as many public services as they could imagine, as though that would best reflect reality. Now costs define things to a fault. That is especially the case with health and human services. Rich people don't care, but it hurts everyone else. Every time a health professional asks a patient if their insurance covers a cost, it lowers the health interaction. Sickness insurance is only designed to obstruct the potential for treatment.

The consequences for a sickness insurance dominated information system is that the management of patient care, the management of health resources, and the management of future time are all seen through the lens of financial concerns, rather than on their own merits.

 "Administration is not a numbers game" from Judgment In Administration by Ray E. Brown: "The deification of numbers can cause the administrator to favor those facts that can be measured and to push aside intangibles that may greatly exceed them in importance. She may forget that facts that cannot be quantified are still facts and must be dealt with. Dealing with unquantifiable intangibles is a particular responsibility of the administrator. The concrete and definable tangibles should be acted upon at the organizational level where they first appear if the organization is functioning properly and if the administrator is spending her time appropriately. Numbers are not magic. They only represent a narrow, specialized language that permits the administrator to deal concisely with things where 'number' can be used to denote a common property. This conciseness can be purchased only at the cost of ignoring the identity of other properties."

7. New Paradigm: <u>Warm Data</u> about People

　　　Gregory Bateson saw the universe as patterns that connect.　"We do not live in the sort of universe in which simple lineal control is possible. Life is not like that."

　　　Gregory's daughter, Nora Bateson has established the International Bateson Institute in Stockholm, Sweden to study the interactions of complex living systems, at the intersection of ecology, social change, health, economic issues, art and education, what Nora calls "transcontextual."　The key is to look in other ways so that we might find other species of information and new patterns of connection not visible through current methodologies, what Nora calls "Warm Data."

"Warm Data" is information about the interrelationships that integrate elements of a complex system. It is found in qualitative dynamics and offers another dimension of understanding to what is learned through quantitative data, (cold data). Warm Data will provide leverage in our analysis of other streams of information. The implications for the uses of Warm Data are staggering, and may offer a whole new dimension to the tools of information science we have to work with at present.

In order to interface with any complex system without disrupting the circuitry of the interdependencies that give it its integrity we must look at the spread of relationships that make the system robust. Using only analysis of statistical data will offer conclusions that can point to actions that are out of sync with the complexity of the situation. Information without interrelationality is likely to lead us toward actions that are misinformed, thereby creating further destructive patterns.

"The more I was thinking about big data the more suspicious I became of having information derived by taking things out of context, and not putting them back into context.　So to begin to understand especially living systems and complexity, there is a need for a kind of information that holds the interrelationships and the inter-dependency of all the different aspects that are in process in that complexity or in that system."

"We don't have a word or even a way of being comfortable in deriving information that has to do with that very important relationality.　So 'Warm Data' became a kind of term to hold space for that idea, that there could be another kind of information that would augment and work with the existing notions of data that are taken by taking things out of context.　So we could have decontextualized specific detailed data information, and have another thing, warm data that would give us the information that was about how the system was working, why is it being the way it is being, how it is functioning in its larger set of relationships.　These two types of information could be friends; they could be in tandem to each other: we could get all of the statistics on something, and then we could say to someone, and what is the warm data on this?　How is it working in its interdependency of other things?"

8. Stafford Beer's <u>Viable System Model (VSM)</u>, "Disseminated Regulation in Real Time, or How to Run a Country", and <u>Quantified Flow Charts</u> to monitor sectors of an economy.

The information template we are using is called "The Viable System Model."　The VSM model is a structure for the parts of a multi-layered organization operating in a changing environment.　It is useful to identify areas of confusion and conflict, and ways to improve

organizational communication. The VSM models organizational dynamics in terms of several layers of hierarchy, and how they tend to confuse and miscommunicate with each other. Please google "Jon Walker" + "VSM" for an introduction.

"Disseminated Regulation in Real Time, or How to Run a Country" explains how to model a sector of an economy or a large organization, how to graph Quantified Flow Charts of the important interactions, what variables to monitor to measure performance against federal and state standards, and what to identify as incipient instability that is usually an indicator of potential trouble.

9. Beer-Li Model for organizing Community Economies: How to Make the Welfare System Work

We are applying this "community" biased model: this model couches community as a niche within its environment:

Individual/Family/Neighborhood/Village//

//Community//

//District/Region/State

The idea is to shift the information focus in a decentralized way that gives greater meaning and power to each individual. The "system-in-focus" becomes the Community instead of the Society.

Introducing a new app "mycommunityeconomy": a computer information structure for creating a global grassroots economy. Basically it is a dynamic information catalogue for all the parts of a woman's life: income, food, housing, health care, transportation, clothing, education, media, entertainment, taxes, managing the economy, public services, infrastructure, utilities. That information matrix has components that scale up physically/geographically: family, 10; neighborhood, 100; village, 1,000; community, 10,000; district, 100,000; and region, 1,000,000.

In each element, say "transportation, 10,000", you identify the Quantified Flow Charts for the service providers, then you map where there are unmet resource needs.

What becomes apparent is that each of the categories affects your health. This is an information template for an individual, a family, or a community to organize the resources of their lives. It becomes an information grid for a 7-member elected Community Health Council to organize a viable health system that meets their community's current and future needs.

10. Federally Qualified Health Center: Universal Comprehensive Medical, Behavioral and Social Services

Each community of up to 10,000 people has responsibility to provide a full range of services for its population. In return for the per capita equivalent of $25 million per year for a population of 10,000, a community elects a 7-member Community Health Council. The council has responsibility to identify the needs for health and social services, provide for those needs, and evaluate how to improve services and outcomes.

Most primary care services in the community will be provided by clinic staff Community Health Teams which include a primary care physician, a nurse, community health agents, and other health professionals. All secondary medical services, hospital care, surgery and long term services and support is coordinated through the clinic staff Community Health Teams.

11. Optimal 21st Century Science: The Brazilian Design-Dutch Implementation Model: Clinic, Community, City, County, Region, Area, State, National

Brazilian Health VSM Eleven Layer Analysis 1.0
VSM1 of conception/consciousness of Brazil's health (including voodoo, African, primitive, native, evangelical Christian, Roman Catholic)
VSM2 of Brazil's government's health: Organized Happy Society
VSM3 of Brazil's health care system resources: Organizing the system
VSM4A of Brazil's unified health system (Sistema Unico de Saude): healthy populations and individuals
VSM4B Brazilian Private Health System: Healthy Individuals and Profit
VSM5 State Level Health Care is in a particular State of Brazil: Sao Paulo: Guarantee Specialists Consultations and complex levels of care
VSM6 is the municipality's total health resources: Guarantee Primary Care Full Coverage
VSM7 is the health service delivery area of the particular program: AIDS
VSM8 is the particular program: AIDS: Universal Access and Empowerment
VSM9 is the clinic: Healthy and happy population: VSM Basic Care Clinic (Basic Health Unit): Promote physical, mental and social well-being
VSM10 is the Health Family Team: population full coverage: physical, mental, social
VSM11 is the interaction with a particular patient.

12. US Federal Community Focused Information System Structural Units: Community, City, County, Region, Area, State, National

This is a proposal to establish 75 community clinics in each US Congressional District in the US, so that rural Mississippi and war torn Minneapolis both have adequate health care at the community level.
Federal standards monitored daily. 133 VSM statistics determined in each clinic: 1 global number, 12 categories, 10 statistics in each category: required complete federal compliance.
This also becomes the ONLY FEDERAL AND STATE GOVERNMENT.
All bureaucrats work in a specific community, for that community.
At the city, county, area, state and national level, you only need seven people at each level: 2 for health, 2 for behavioral health, 2 for social services, 1 servant leader who can fill in in all areas - at each level, their job is surveillance and compliance with all issues in their jurisdiction. The city's job is to ensure coordination between the clinics, the specialty medical professionals, the hospitals for the 15% of the care that is necessary and appropriate based on science rather than what the health insurance rewards, and the medical schools producing new generations of health professionals.

13. COMPUTA: Daily Health Management Information at the Community Level: Universal Health and Human Services Software Package 1.0

The purpose of the information software package is to support the Office of Epidemiological Accountability. Its functions include: personal growth for the patient, the clinicians and the support staff; effective communication; social support; financial and other data about management information; resource optimization; and, program evaluation.

It replaces insurance with a clinic focused computer program that will manage the information for the data, the health resources, the personnel, the equipment, the pharmacy, the money, the testing, the data collection, the scientific inquiry, the training and personal development, and the response to new health problems.

Information System Primary Units: The Community, the Community Member, the Clinic, the Patient, the Family, the primary care Health Professional.

Information System Secondary Units: multiple community Memorandums of Understanding, coordinated at the city level: secondary/support medical specialties, hospitals, surgery, pharmacy, long term service and support, ambulance and other health related businesses.

This starts as a 1) a flow chart 2) for a computer program, 3) that becomes the new information structure, 4) for a community clinic's needs internally, 5) with 133 daily Viable System Model internally defined criteria for monitoring incipient instability, in compliance with city, state and federal limits on community options. ALL government becomes focused on making sure you can go anywhere in the country, and have excellent care.

Health Funding Information Management Structure: based on H&HS 7 member Office of Epidemiological Accountability "Health Information Systems Operations Team":
December: Parameters Design Committee: Announce RFP criteria for US Universal Health Care guidance and control at each station level: community/clinic, city, HSA, state and national
January: Select 3 possible software package options; Choose 1
End of January: 1st prototype
February: Statewide skeleton
March: Full implementation
May: smoothly running operations whole month statewide
June 1: error free in all 50 states: operational in every clinic, provider and hospital nationally
July 1: daily reporting, evaluation and reassessments – managing in the real time present future.
Ongoing operations: The master information system allows complete access for the patient up to the communitywide level. However, city, HSA, State and National can only access aggregate community data. Daily reports of patient activity, levels of care, money, problems and challenges.

Flaws in computer program resolved before June 1.

14. Create an Office of Epidemiological Accountability at Your Level Using the Viable System Model

How can we monitor everything we need to know to get back on top of our day to day social existence? The Office of Epidemiological Accountability is designed to find new answers to those questions. It is laid out in different parts of this report.

15 U.S. Universal Care: Health and Social Services Budget 2021-2 through 2024-5 (in billions, 2019 US $)

Revenue
2021-22: for the 3/4ths of the adult population who file income tax, 10% income tax should cover health care. (It is 17.8% now.) For the lower 90% of the taxpaying public, compared to Obamacare, there will be a significant reduction in annual total cost for much more accessible and available services, and better health outcomes. That is what happened in Europe, Canada and Taiwan when they converted from insurance to universal care.

Expenditure (in billions, 2019 US $)

	Health Care & Behavioral Health Social Services	Long Term Support	Total for Taxpayers	Net Savings
Current System 2020-21	$4,000	$500	$4,500	$0
Universal Care 2021-22	$2,500	$1,500	$4,000	$500
2022-23	$2,000	$1,700	$3,700	$800
2023-24	$1,800*	$1,800	$3,600	$900
2024-25	$1,800	$1,800	$3,600	$0

Beginning in 2021-22, of the funds for Health Care & Social Services, 50% goes to Clinics, and 50% goes to Hospitals and Medical Schools; 5% of the total budget (10% of the hospital budget) is for the 5% of the population who live in rural/low density areas where the expense of care minimizes economies of scale.
*2023-24: Medical School funding stays the same; Hospitals take $200 billion in cuts

2021-22 U.S. H&HS Community Clinic Budget
$1,250 billion
40,000 Community Clinics at $25 million@ =$1,000 billion for annual operating costs.
$150 billion innovative community program

$100 billion remodel existing or available or new facilities

2021-2022 U.S. H&HS Medical School and Hospital Budget
$1,250 billion
Half Medical School, Half Hospital
For the past century, these two institutions have been at the top, calling the shots, defining the tune everybody else must dance to. From now on, the med schools and the hospitals are totally dependent on the community clinics in their territory of responsibility. Not just accountable to the community clinics, controlled by the needs defined by the community clinics, and financed accordingly. Each med school and each hospital has an annual Memorandum of Understanding defining its relationship with the communities it is responsible to. Hospitals and Medical Schools are owned by the local community clinics, by new federal law. Many hospitals will be shut down, replaced with community clinic services with extensive outreach into the community's identified populations at risk, with improved health outcomes because hospitals generate illness.

Specialty medicine is paid for out of the Hospital global budget. Major reductions in surgeries that were previously motivated by the fee-for-service reward system, and the reduced attendant days recovering in the hospital. At least a $1trillion reduction in costs to the health system by preventing unnecessary surgeries. Total U.S. annual hospital expense reduced by 50%. Similar reduction in pharmaceutical usage and total cost. Shift from medicine to health care.

New U.S. Department of Health and Human Services Administrative Team Structure
County welfare and social services departments will be replaced by services provided as part of the clinic, for an administrative savings of 50%. Behavioral health services will be provided as part of the basic package for everyone.

The shift to universal care requires a complete dismantling of the federal micromanagement in the health care delivery system. All of the data in universal care will be generated at the clinic/community level. Therefore, the Administrative Team of "Reporters" at each of the stations for Health & Human Services at the clinic/community, city, Health Service Area, state, and federal station levels has seven, and only seven, positions: 2 Health, 2 Behavioral Health, 2 Social Services, 1 Team Leader-Servant.

Reporters' responsibilities include: on site witnessing, data collection, and theoretical analysis of what is really going on in the community, and how the clinic is not adequately responding to the changes happening in the community. The Viable System Model is useful for these particular tasks. Google Jon Walker + VSM Guide.

For the current federal and state Health & Human Services bureaucrats (Full Time Equivalent: 80,000 bureaucrats) have the choice to be retrained as "Reporters" in the Office of Epidemiological Accountability station in some clinic/community, city, HSA, or state seven member team, or they can be retrained to work in another field besides Health & Human Services, or if they are 60 or older, they can retire with a generous retirement package.

The current H&HS federal/state bureaucracy seems completely out of control; this eliminates the bureaucracy and its irresponsible behavior. All of the action is at the clinic/community/city levels:

Current Federal H&HS Full Time Equivalent: 80,000 people
2022-23 Federal H&HS Full Time Equivalent: less than 1,000 people

16. The Political Strategy
"Ultimately, organized health care will only happen in the U.S. when doctors are willing to help by working with consumer groups. The key is to network the families of the U.S. to demand restructuring of the entire health care non-system. 'Grassroots community organizing would be necessary to win any political campaign to establish such a system. The community organizing would develop a base for the community participation necessary to implement this system. While the medical and corporate establishment are split on their support of reform based on their own conflicting interests, to the users of the health care system it is a life or death issue.'" (Systemic Trauma: The Troubled Prospects for Managed Care in California and the United States, 1996)

17. What County Health Departments can do to give leadership

November
Create a new county map with population density
Respect City boundaries
Divide each city into natural geographic and transportation boundaries for "communities" of up to 10,000 people

December
Have a meeting of city representatives, and stake holders, and give up the maps to the people.
People in each city designate "contact people" for each Community
From this point on, the County Public Health Department's job is to monitor the efforts of each Community of up to 10,000 people within the county, and amplify any complaints that some Community group is being unresponsive.

January
In each city, and in unincorporated parts of the county, hold a weekly update meeting for all Community health coordinating groups.
Each Community group should be:
- Building a map of Community and city health resources for this unique Community
- Identifying all the populations of need within the Community
- Begin to build a picture of what health care should look like in this Community
- Each Community group schedules two meetings a week: one citywide meeting to get updated information, and a Community meeting to decide what to do next.

<u>February</u>
Survey every house in the Community, for their health and social services needs

<u>March</u>
1st draft: Community Health Plan

<u>April</u>

<u>May</u>
In every Community in the county, elections for 7-member Community Health Council
Community Health Council hires medical staff

<u>June</u>
Physical, administrative, computer set up to be fully operational before July 1.

July 1: Temporary clinic opens in every Community in the US

<u>18. Timeline January 21 – June 30:</u>
<u>National:</u>
<u>Administration:</u>
Executive Order establishes Office of Epidemiological Accountability, U.S. Department of Health and Human Services Deputy Secretary level, using the Viable System Model by Stafford Beer;
Each office in the entire H&HS designate a "Reporter" to be the seed for the new Office of Epidemiological Accountability; the boss in the budget shop is disqualified by definition.
Beginning January 21, weekly H&HS nationwide aggregate reports by the local Office of Epidemiological Accountability "Health Information Systems Operations Team", consolidating the work of each individual in the office
February: "**US Universal Health VSM Map Top Down**": VSM map of the policy areas of each individual's area of policy responsibility (80,000 H&HS FTE employees), and aggregate the information into one set of VSM maps – 25 to 40 maps
March: Design VSM consolidation of all of the policy maps in each Federal Region, and in each State: 25 to 40 maps, will become 10 and then maybe 6 or 7 maps that better represent the country and its social needs.
April: Create a new master VSM information structure: "National US H&HS VSM System 4": national-region-state-HSA-city-community/clinic: uniting all H&HS information and policy areas at the community clinic level, limiting bureaucracy at the national-region-state-HSA-city levels.
May: implement new structure, eliminating the need for 90% of the H&HS bureaucracy except at the community/clinic level. ALL of the complications are at the community clinic level: at the national-region-state-HSA-city-community levels, it is only the Office of Epidemiological Accountability. Everything is evaluated in terms of community clinic effectiveness in providing primary care and improving health outcomes.
June: Daily Program Evaluation and Improvement for Implementation July 1.

<u>Congress:</u> January: Khanna HR 5010: State-based Universal Health Care Act is re-introduced, approved in the House and the Senate, and signed by President Biden by the end of January, allows states to apply for a waiver to establish universal care, expected to go into effect July 1. HR 5010 includes provisions for states to re-establish Health System Area Agencies (HSAs) and establish state H&HS 7 member Office of Epidemiological Accountability "Health Information Systems Operations Team" management structure.

Jayapal in the House, and Sanders and Warren in the Senate: Universal Care:

Re-introduce this year's HR 1384 (Jayapal) and S 1129 (Sanders):

By the end of February, come out of House Education and Labor, Energy and Commerce Subcommittee on Health, Oversite and Reform, and Ways and Means.

May 1: President Biden signs the Jayapal-Sanders US Universal Health Care and Social Services Act of 2021.

May 10: Governors of each of 50 states sign legislation implementing their waiver plans in HR 5010; red states have well-organized campaigns in every congressional district

May 31: Each State H&HS submits a waiver plan to implement US Universal Health Care July 1

June 1: 50 State waivers approved by U.S. H&HS

<u>State:</u> February: each state H&HS Agency moves key personnel into new H&HS 7 member Office of Epidemiological Accountability "Health Information Systems Operations Team" management structure, to be functional July 1, with everyone else in the agency transitioning into community and clinic health administration.

<u>July 1: Begin Universal Coverage</u>

- Conversion at the Patient/Taxpayer level from insurance to new payment structure
- most health professionals hired by community clinics;
- Conversion for the hospitals: all hospitals come under the jurisdiction and control of the community clinics grouped with federal legal Memoranda of Understanding (MOU);
- Conversion for the Health Insurance industry: employees aged 60 and older receive a generous retirement package; retraining for all other insurance employees into epidemiological accountability, or transitioning into another line of work;
- Establish H&HS 7 member Office of Epidemiological Accountability "Health Information Systems Operations Team" with guidance and control at each station level: community/clinic, city, HSA, state and national;
- Daily accountability of the entire system.

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