

Health Agency



June 8, 2016

Los Angeles County
Board of Supervisors

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Second District

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"The mission of the Los Angeles County Health Agency is to improve health and wellness across Los Angeles County through effective, integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy people living in healthy communities."

TO: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **SUPPLEMENTAL LOS ANGELES COUNTY HEALTH AGENCY REPORT (ITEM #S-1, AGENDA OF AUGUST 11, 2015)**

On August 11, 2015, your Board approved the establishment of the Los Angeles County Health Agency (Health Agency) to integrate services and activities related to the eight strategic priorities across the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH). Your Board also established a quarterly set item on the Board Agenda to report back on the progress made by the Health Agency.

The Health Agency memo and attachments dated May 3, 2016 addressed questions raised during the February 16, 2016 Board meeting and contained updates on the Health Agency priority areas. This supplemental report addresses questions raised by your offices, the Integration Advisory Board (IAB), and others on how we intend to track the progress made by the Health Agency over time.

Background

Although inter-departmental collaborations occurred prior to the establishment of the Health Agency, the three Departments had different missions and sets of priorities. The overarching Health Agency mission, strategic priorities and operational framework approved by your Board on September 29, 2015 (Attachment I) provides a foundation to integrate and optimize resources in order to better address complex and multifaceted problems.

In order to track the performance and outcomes of the Health Agency in the strategic priority areas over time, we undertook an iterative effort to develop a set of proposed Health Agency metrics that incorporated joint planning from the three Departments' staff, input from your offices and external stakeholders such as the IAB, various commissions, and labor unions. Through this process, we discussed the intended goals of the Health Agency.



The proposed metrics afforded an opportunity to discuss the intended goals of the Health Agency and provided a forum for different stakeholders to engage in the process. Given the short window of time that we have had to share the proposed metrics, we recognize the importance to continue our engagement efforts with stakeholders.

Health Agency Performance and Outcome Metrics

Attachment II contains the set of proposed metrics listed under the corresponding eight strategic priorities. Once your Board has the opportunity to review these proposed metrics, we will begin the process of pulling and developing the dashboard from the different data sources. Attachment III highlights three of the eight priorities. We will update the remaining five priority areas and present them in future updates. We expect that it will take time to “move the needle” on these important initiatives. By having these metrics, this will further galvanize us to work together toward improved health outcomes.

Joint Activities

In addition to the collaborative work on the eight strategic priority areas, the responses to the Exide and Porter Ranch public health crises demonstrate that services delivered together can be more comprehensive and effective. We are also exploring joint staff education and training opportunities and collaborative partnerships with labor to promote dialogue and relationship building between staff that will ultimately improve the delivery of our services, as well as identifying opportunities to leverage common needs in areas like information technology, space planning and management.

Next Steps

As the Health Agency evolves, we will continue to work with your offices and stakeholders to further develop our metrics. Finally, to facilitate a greater sense of transparency, we also plan to develop a Health Agency website, which will allow the public to follow our progress and evolution.

The Health Agency continues to make progress in meeting the complex health needs of our County residents. In addition to the strategic priority areas, we are also collectively placing a greater emphasis on joint planning on improving customer service and staff experience. By working together, we believe that we can more effectively promote the health and well-being for Los Angeles County residents.

If you have any questions or need additional information, please let me know.

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Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

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 relative 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.

Health Agency Strategic Priorities Proposed Metrics

Strategic Priority 1: Consumer Access and Experience

Goal(s)*	Metric	Milestones or Quantitative	Process or Outcome
All	Improve consumer experience by X% improvement per year in standard survey tools.	Quantitative	Outcome
1, 2, 3, 5 and 6	Track number of unique individuals who receive care and services from multiple Health Agency departments.	Quantitative	Process
1, 2, 3, 5 and 6	Increase # of clinical sites with co-located services or designated regional health neighborhood partnerships.	Milestones	Process
3	Increase # of Health Agency directly operated providers on eConsult platform.	Quantitative	Process
3	Track number of eConsults submitted across Departments.	Quantitative	Outcome
3	Track number/percentage of eConsults completed with face to face and no visits needed.	Quantitative	Outcome
1	Revise the clinical workflow and policies necessary to utilize patient/client demographics for those using more than one Health Agency Department.	Milestone	Process
6	Implement the information technology solution that allow Health Agency Departments on EHRs to share demographic and clinical information for shared clients.	Quantitative	Process
6	Track the number of health information exchanges between DHS/DPH and DMH.	Quantitative	Process

Strategic Priority 2: Housing and Supportive Services for Homeless Consumers

Goal(s)	Metric	Milestones or Quantitative	Process or Outcome
1, 2, 3, 5 and 7	Reduce ED and inpatient use by 50% for homeless individuals 12 months post being permanently housed compared to before being housed.	Quantitative	Outcome
All	Maintain 90% housing retention rate for formerly homeless individuals who retain housing for 12 months.	Quantitative	Outcome
1, 2, 3 and 8	Add 2,500 community-based residential slots administered by the Health Agency in 2016.	Quantitative	Process
1, 2, 7 and 8	Connect 90% of housed individuals to appropriate health, mental health, substance use, and other supportive services.	Quantitative	Process

Strategic Priority 3: Overcrowding of ED by Individuals in Psychiatric Crisis

Goal(s)	Metric	Milestones or Quantitative	Process or Outcome
2 and 4	Decrease the number of days that County PES is above capacity by 5%, as compared to the prior year.	Quantitative	Outcome
4	Decrease total administrative days in county inpatient psychiatric units by 15%, as compared to the prior year.	Quantitative	Outcome
1 and 2	Increase the ratio of urgent care visits to PES visits by 10%.	Quantitative	Outcome

Strategic Priority 4: Access to Culturally and Linguistically Competent Programs and Services

Goal(s)	Metric	Milestones or Quantitative	Process or Outcome
All	Improve consumer experience with Health Agency cultural and linguistic services with standard survey tools by X% per year.	Quantitative	Outcome
1,3 and 6	Implement a common set of basic registration demographic information (ie. REAL-Race, Ethnicity and Language and Language; SOGI- Sexual Orientation and Homeless Measures).	Milestone	Process
1	Percentage or number of staff trained on collection of REAL, SOGI and homeless measures.	Milestone	Process
4	Track use of interpretation services (phone).	Quantitative	Process
4	Track number of bi-lingual staff in each Departments.	Quantitative	Process
6	Expand peer support services in departmental programs.	Milestone	Process

Strategic Priority 5: Diversion of Corrections-Involved Individuals to Community-Based Programs and Services

Goal(s)	Metric	Milestones or Quantitative	Process or Outcome
1, 2 and 5	Increase number of individuals diverted from jail through programs like Misdemeanants Incompetent to Stand Trial (MIST) or sobering centers by X% per year.	Quantitative	Outcome
All	Track number individuals with no criminal justice system interaction one year after release from jail with no jail time.	Quantitative	Outcome
1 and 5	Number of first responders trained in diversion program.	Quantitative	Process

Strategic Priority 6: Implementation of Expanded Substance Use Disorder Benefits

Goal(s)	Metric	Milestones or Quantitative	Process or Outcome
All	Increase number of referred patients who successfully complete substance use treatment services.	Quantitative	Outcome
All	Number of people who were discharged from treatment centers with positive compliance.	Quantitative	Outcome
2 and 5	Number of individuals referred to substance use treatment centers that are from DHS, DMH and DPH directly operated clinics.	Quantitative	Outcome
2 and 5	Reduce use of ED and inpatient use by the same person for substance use reasons by X % per year.	Quantitative	Outcome
2 and 5	Percent of Health Agency directly operated clinic patient/clients who are screened for substance use.	Quantitative	Process
2 and 5	Percent or number of Health Agency staff trained on Screening and brief intervention and referral tool (SBIRT).	Quantitative	Process
2, 4 and 5	Number of clinics certified for medication assistance treatment (MAT) of individuals with substance use.	Quantitative	Process
4 and 5	Number of Health Agency patients/clients receiving MAT treatment.	Quantitative	Process
4	Number of total county clients who use substance uses treatment services.	Quantitative	Process

Strategic Priority 7: Vulnerable Children and Transitional Age Youth

Goal(s)	Metric	Milestones or Quantitative	Process or Outcome
All	Number of HUB patients with physical, mental and/or substance use challenges with no placement disruptions in 12 month period.	Quantitative	Outcome
3	Track the number of youths and specific high risk children and youths and number of LGBTQ or sexually exploited youths who use the Medical HUBS.	Quantitative	Process
3	Track the number of youths at the hubs using mental health and/or substance use services.	Quantitative	Process
4	Number of Juvenile Hall discharged youth that have been linked to a primary place for care.	Quantitative	Process
5	Identify and deploy a mobile tool that enables youth to gain access to educational and service information by X.	Milestone	Process

Strategic Priority 8: Chronic Disease and Injury Prevention

Goal(s)	Metric	Milestones or Quantitative	Process or Outcome
1	Decrease the prevalence of tobacco use from 13% to 10% in L.A. County by 2020.	Quantitative	Outcome
3	Decrease the prevalence of obesity for adults from 24 to 22% and children with obesity from 22% to 20% in L.A. County by 2020.	Quantitative	Outcome
1	Reduce by 10% from 2015 to 2018 the number of violence-related trauma center ED visits and hospitalizations among residents of Park After Dark communities in L.A. County using Emergency Medical Services data.	Quantitative	Outcome
3	75% or more of the Health Agency directly-operated clinics will have a smoking cessation protocol implemented by the end of 2018.	Quantitative	Process