LOS ANGELES COUNTY HEALTH AGENCY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Mitchell H. Katz, M.D.
Director, Health Agency

Christina R. Ghaly, M.D.
Acting Director, Department of Health Services

Jonathan E. Sherin, M.D, Ph.D.
Director, Department of Mental Health

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director, Department of Public Health

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

"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."

December 12, 2017

TO: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

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

SUBJECT: **HEALTH AGENCY UPDATE (ITEM #S-1, AGENDA OF AUGUST 11, 2015)**

On August 11, 2015, the Board approved the establishment of the Los Angeles County Health Agency (Health Agency) to integrate services and activities related to the eight strategic areas across the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH). Attachment I contains the list of approved metrics for all eight Health Agency Strategic Priorities. The Board established a quarterly item on the Board Agenda to report on progress made by the Health Agency. This report will focus on updates for three strategic priorities: *Consumer Access and Experience, Diversion of Corrections-Involved Individuals to Community-Based Programs and Services and Expanded Substance Use Disorder Benefits* (see Attachment II), as well as progress made in achieving Health Agency goals.

On August 1, 2017, the Board instructed the Health Agency Director to include the following in this report: (a) appropriate infrastructure for the Health Agency and (b) a plan to increase the number of Department of Children and Family Services (DCFS) involved children that receive a comprehensive screening within 30 days, along with industry standard data to show progress. Also included, is the most recent update on the levels of hexavalent chromium in the City of Paramount (see Attachment IV).

Consumer Access and Experience

In 2016, the Health Agency launched its first coordinated assessment of consumer access to and experience with outpatient clinic services in DHS, DMH, and DPH. With the assistance of two Health Agency work groups - *Consumer Access to and Experience with Clinical Services*

Health Agency Strategic Priorities
Approved Metrics

Strategic Priority 1: Consumer Access and Experience
(Approved by the Board on January 10, 2017)

	Metric
1	Consumer experience will improve across the Health Agency* by 10 % over the next two years as measured with standard survey tools.
2	Enhance four clinical sites with co-located services or designated regional health neighborhood partnerships by end of CY 2017.
3	Operationalize a Health Agency-wide referral system and necessary infrastructure to track and refer patients from one Health Agency department to another.
4	Implement the recommended information technology solution that allow Health Agency Departments of EHRs to share demographic and clinical information for shared clients by FY 2018.

*Health Agency directly operated clinics.

Strategic Priority 2: Housing and Supportive Services for Homeless Consumers
(Approved by the Board on June 8, 2016)

	Metric
1	Add 2,500 community-based residential housing slots* administered by the Health Agency in Calendar Year 2016.
2	Engage 90% of housed individuals to appropriate health, mental health, substance use, and other supportive services.
3	Reduce Emergency Department and inpatient use by 50% for homeless individuals 12 months post being permanently housed compared to before being housed.
4	Maintain 90% housing retention rate for formerly homeless individuals 12 months post placement in permanent housing.

*Includes emergency, interim, and permanent housing

Strategic Priority 3: Overcrowding of Emergency Department by Individuals in Psychiatric Crisis
(Approved by the Board on June 8, 2016)

	Metric
1	Decrease the number of days that County PES is above capacity by 5%, as compared to the prior year.
2	Decrease total administrative days in county inpatient psychiatric units by 15%, as compared to the prior year.
3	Increase the ratio of psych urgent care visits to PES visits by 10%.

Strategic Priority 4: Access to Culturally and Linguistically Competent Programs and Services
(Approved by the Board on September 20, 2016)

	Metric
1	Assess consumer experience with cultural and linguistic services delivered at the Health Agency clinics by end of CY 2017.
2	Implement a common set of basic demographic information (i.e. race, ethnicity, language, sexual orientation and homeless definition) by end of CY 2017.
3	Implement five or more new community based programs (i.e. promotoras, community health workers, health promoters, navigators) and cross-train existing staff by end of CY 2017.

Strategic Priority 5: Diversion of Corrections-Involved Individuals to Community-Based Programs and Services **(Approved by the Board on January 10, 2017)**

	Metric
1	Provide and coordinate mental health and substance use services for at least 5,000 persons with justice involvement, either pre- or post-booking, over a 3-year period.
2	Integrate health and justice data to identify persons with the greatest need for intervention and use integrated data to make informed, person-level treatment decisions.
3	The number of first responders trained in Crisis Intervention Training will increase to over 4,000 total first responders trained by the end of 2017.

Strategic Priority 6: Implementation of Expanded Substance Use Disorder Benefits
(Approved by the Board on January 10, 2017)

	Metric
1	By 2020, increase percent of Medi-Cal or uninsured people* who receive SUD treatment from 18% to 23%.
2	Between 2017 to 2020, reduce SUD-related* DHS ED visits and hospitalizations by 2% per year.
3	By end of 2018, train at least 80% of designated Health Agency clinical staff on Screening, Brief Intervention, and Referral to Treatment (SBIRT) for SUDs.
4	Increase qualified Health Agency patients receiving medication-assisted treatment from <1% to 3% by 2020.

Strategic Priority 7: Vulnerable Children and Transitional Age Youth
(Approved by the Board on September 20, 2016)

	Metric
1	Each DCFS involved child/youth receives comprehensive health screening and referrals to specialties* within 30 days by CY 2017.
2	>95% of children/youth identified by DCFS as commercially sexually exploited children (CSEC) will receive a comprehensive health screening and referrals to specialties* within 14 days by CY 2017.
3	>90% of youth released from probation camp who report not having a primary care provider are linked to a clinic.

*Specialty referrals if needed include mental, physical and substance use services.

Strategic Priority 8: Chronic Disease and Injury Prevention
(Approved by the Board on June 8, 2016)

	Metric
1	Decrease the prevalence of tobacco use from 13% to 10% in L.A. County by 2020.
2	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.
3	Reduce by 10% from 2015 to 2018 the number of violence-related trauma center ED visits and hospitalizations among residents of Park After Dark (PAD) communities in L.A. County using Emergency Medical Services data.
4	75% or more of the Health Agency directly-operated clinics will have a smoking cessation protocol implemented by the end of 2018.

(CAECS) and *Access to Culturally and Linguistically Competent Programs and Services* (ACLCPS) - the three departments collaborated to generate a common set of questions derived from the monthly DHS Consumer Assessment of Healthcare Providers and System Clinician & Group Survey (CG-CAHPS; CL#17234-CV0101-01-04/16), administered by Press Ganey® (http://www.pressganey.com), a nationally recognized health care survey vendor. The common set of survey questions consisted of several domains: 1) demographics, 2) provider results, 3) access to care, 4) provider's communication quality, 5) office staff performance, 6) access to care in the past 3 months, 7) clinic appearance, and 8) cultural and linguistic competency. The DMH and DHS surveys were available in English and Spanish; and the DPH surveys were available in English, Spanish, Armenian, and Farsi. DHS has also recently launched survey availability in Chinese.

The Surveys in All Three Departments

The *Consumer Feedback Survey* (DMH's survey) was administered at 22 DMH outpatient clinics in October 2016, and the *Patient Experience Survey* (DPH's survey) was administered at 14 public health centers in November 2016 (see Attachment III). Over a period of 30 days, the self-administered surveys were sequentially and systematically offered in a similar manner to both DMH and DPH adult patients. The only exception was that DMH patients were offered non-monetary incentives to complete the survey. By contrast, the Press Ganey® Survey (DHS's survey) was mailed to each adult who received outpatient services from November 2016 to March 2017.

Survey Response Rates

Overall, a total of 1,225 and 1,402 surveys were returned to DMH and DPH sites, with response rates of 90% and 81%, respectively. In comparison, a total of 3,361 mail-in surveys from DHS were returned, with a response rate of 15%.

Highlights of Results

Of the total 5,988 respondents, 52% were women, 42% were between 50-64 years old, 44% were Hispanic, 25% were non-Hispanic White, 18% were African American, 11% were Asian, 2% were American Indian or Alaskan native, and 1% were Native Hawaiian or other Pacific Islander. Fifty-nine percent of respondents were a high school graduate or higher. With respect to insurance status, 58% had Medi-Cal/Medicaid, 13% Medicare, 11% private, and 13% were uninsured. Twelve percent indicated that they were homeless at the time of the survey.

For the most part, the consumer experience scores were high. Overall, 68% of respondents rated their provider a 9 or 10 on a 10-point scale. Approximately 90% percent of respondents agreed with the following statements: they would recommend their provider office (89%), received urgent and routine appointments as soon as they thought they needed them (90% and 89%, respectively), thought providers explained things in a

way that was easy to understand (93%), indicated that providers listened carefully to them (94%), rated the office staff as helpful (92%) and respectful (93%), felt that services were provided in their preferred language (89%), felt that written information was available in their spoken language (85%), and agreed that staff were sensitive to their cultural background 71%.

Areas for Improvement

Despite the high satisfaction with clinical services, there were some areas that needed improvement. For example, only about half of the respondents reported seeing a provider within 15 minutes (52%); only half of respondents who phoned during regular or after hours had always obtained an answer to a medical question that same day (55% and 52%, respectively); and approximately half rated the cleanliness of the clinics as "very good" (59%). Departments have a variety of initiatives underway to enhance customer service in each of these areas as well as across all of the domains captured in the survey and are confident that we will see continued improvement in the scores over time. The full data is included in Attachment III.

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

Improving Referrals

The Office of Diversion and Re-Entry (ODR) has been working in collaboration with Courts 95 and 123, as well as with other courts throughout the County. Since the ODR Housing program launched in August 2016, 795 individuals have been referred to ODR. Since the Misdemeanor Incompetent to Stand Trial-Community Base Restoration program launched in October 2015, 545 individuals have been released to the program. ODR also works in collaboration with DMH and Substance Abuse Prevention and Control (SAPC) to connect clients to appropriate mental health and substance use disorder treatment.

Crisis Intervention Training (CIT)

Over 2,000 first responders from 48 jurisdictions have received Crisis Intervention Training (CIT) in the last 18 months. As of October 19, 2017, the total number trained to date is 606. The Calendar Year (CY) 2017 anticipates 702 total trained patrol personnel.

Whole Person Care (WPC) Linkage

The WPC staff conducts a comprehensive assessment covering areas including health, mental health and substance use history, homelessness, education/employment, family and social support. Inside the jail, this is generally done by a bachelor's level case manager (Medical Case Worker (MCW)). This staff person works with the client to develop a care plan/reentry plan, addressing the issues the client feels are most important, and works with the client on those parts of the plan that can be accomplished during their incarceration - e.g., referring a client to internal programs such as START

(substance use treatment) or arranging for admission and transportation to a shelter upon release.

Clients are also assigned a WPC Community Health Worker (CHW) in the community, who has a shared lived experience of incarceration. The CHW conducts either a videoconference visit or attorney room visit with the client prior to release. The CHW tries to meet with the client soon after release, reviews and updates the reentry plan, and links clients to appropriate services. For example, the CHW may accompany the client to Department of Public Social Services to activate General Relief (GR) and CalFresh, assist in making an appointment and accompany a client to a medical or mental health visit, work with the client to ensure the client checks in as required with Probation, etc. The CHWs and MCWs use a variety of tools to find resources, including One Degree, websites, resource lists, and others.

Expanded Substance Use Disorder (SUD) Benefits

Drug Medi-Cal Organized Delivery System

The Drug Medi-Cal Organized Delivery System (DMC-ODS) launched on July 1, 2017. Seventy providers are now under contract with 210 overall sites. Methods to facilitate and promote access to SUD services have been developed and implemented. They include:

- The Substance Abuse Service Helpline, which is available 24/7/365 and screens and refers the client to an appropriate level of care based on American Society for Addiction Medicine (ASAM) standards for specialty SUD services.
- The Service and Bed Availability Tool (SBAT), which is a web-based service locator that is available to the general public and contains all publicly-funded SUD providers in the County. It allows end users to filter providers based on level of care, language spoken, special population (e.g., justice involved, perinatal, LGBTQ) and service type.
- The Client Engagement and Navigation System (CENS) to serve as liaisons with community partners such as the courts and probation who refer clients into the specialty SUD system.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

DHS has incorporated SBIRT into its ORCHID workflow and is now focused on training staff on SBIRT to operationalize this new functionality. DMH has also incorporated SBIRT into its Integrated Behavioral Health Information Management System (IBHIS) workflow and has also trained staff on SBIRT. SBIRT services will be tracked beginning January 2018.

Medication Assisted Treatment (MAT)

Substance Abuse Prevention and Control (SAPC), DHS, and Safe Med LA have worked together to launch two learning collaboratives focused on Medication-Assisted Treatment; one for primary care providers and another for specialty SUD providers. These learning

collaboratives are focused on expanding the number of MAT programs across the County by building the operational and clinical expertise necessary to start MAT programs.

SAPC is working with the Opioid Treatment Programs that are leading the California Hub and Spoke grant implementation in LA County to ensure that these efforts are aligned with the broader MAT expansion efforts across the County.

The Safe Med LA MAT Action Team has trained over 150 new buprenorphine prescribers in LA County.

Response to Questions from the August 1, 2017 Board Meeting

Plan to Increase Number of DCFS Involved Children Who Receive a Medical Screening within 30 days

Ensuring health screenings to DCFS involved children within 30 days of detainment is a joint responsibility between the child social worker (CSW) and public health nurse (PHN). However, CSWs are the primary case managers, with PHNs providing consultation and support as consultants.

Currently, to ensure that the caregiver is aware of the appointment, the Hub staff contacts the parent/caregiver to remind them of the appointment. Changes in the child's placement status (i.e., investigation to detained) and placement location (i.e., home to foster parent's residence) are factors that often require appointment rescheduling and consequently can delay screenings.

The Hub team in the Health Agency are examining internal processes and the specific duties of the Hub and Regional PHNs to identify opportunities to increase timely referral and follow-up. In addition, as part of the Hub expansion across the County, the team is also evaluating physical space and staffing plans that will ensure timely appointments in an environment that is conducive to providing the same level of quality care across all Hubs. The team is also working closely with DCFS to develop and implement procedures to ensure communication between CSWs and PHNs when follow-up is needed.

Response to Questions from the November 14, 2017 Board Meeting

Correctional Health Services (CHS)

Two years ago, the Los Angeles County (LAC) Board of Supervisors (BOS) unanimously voted to unify jail medical and mental health services under the Department of Health Services (DHS) to improve the efficiency and quality of healthcare provided to the nearly 17,500 inmates in LAC's jails. The unification under DHS established the simple premise that individuals incarcerated in the County jails can and should receive the same high quality, patient-centered care that individuals, already in the DHS and larger Health Agency system, receive. Phase I of the transition occurred in September 2016, and the

final phase, Phase II, was completed in May 2017. The transition involved moving over 2,200 staff and positions, mostly providers and nurses, many contracts for ancillary and other support services, and a budget totaling approximately $300m.

Since DHS' creation of Correctional Health Services (CHS), steady progress toward the transformation envisioned by the BOS has occurred. In the past four months alone, because of the tremendous support from the BOS, over 100 new staff have been hired and another 35 hires are in process. Recruitment continues. Also, a new organizational structure is being finalized which includes consolidating clinical services under a single Chief Medical Officer (CMO) and creating a robust Quality and Performance Improvement unit led by a new Chief Quality Officer. These organizational changes have led to the creation of many new programs and initiatives which build toward a truly innovative correctional health care model founded on the patient centered medical home concept (PCMH) used throughout DHS. Overall, the transition to DHS has already led to meaningful changes for the sickest and most vulnerable patients in LAC's jails. Examples of the impact of these changes include:

Today, when inebriated individuals are booked into jail, they are cared for and allowed to safely sober up in the newly created Detox Unit. In the past, these individuals were housed throughout the jail and monitored in a decentralized and hard to track way.

Today, when one of the nearly 4,700 inmates with a serious mental illness needs an acute hospital bed, the CHS mental health team has more options than ever to house and serve these individuals as the result of creating several dozen new forensic inpatient psychiatry step-down (FIP step-down) beds.

Today, many patients with a serious mental illness are housed in double-man cells not single-man cells. Similarly, they are allowed to participate in more groups outside their cells without being in handcuffs.

Today, more patients than before, especially those suffering a mental illness receive their medication orders while in the inmate reception center (IRC). This practice helps ensure individuals do not experience avoidable clinical destabilization and poor outcomes.

Today, because of improved identification and assessment of diabetic patients in jail, we experience approximately 40% fewer incidents of hyper- or hypo-glycemia among our approximately 900 diabetic patients.

Today, individuals in custody requesting medical care wait about one-third the time they use to wait to receive attention via the CHS Sick Call system.

Today, many more individuals with chronic health issues are leaving jail with the medications they need, follow up appointments and connections to more services. These reentry services are expanding by the month.

Although each of these programs or system enhancements is valuable on their own, together they begin to move from an episodic-care based system toward a more modern-day health system like what is found in the community. We call this new system the

Correctional Health Neighborhood (CHN). The CHN is premised on key guiding principles mirroring those used by Patient Centered Medical Home (PCMH) models in DHS and the broader community. These include:

- Integrated team-based care (whole person, coordinated care)
- Patient Centered Medical Homes (continuity in care, preventative, chronic, accessible)
- Data driven decisions (use of health information)
- Evidence-based medicine
- Continuous quality improvement

The CHN also addresses fundamental truths about jail health systems in general:

- Medical health needs are mostly ambulatory (outpatient) in nature
- Serious mental health illness is common yet un- or under-treated
- Substance use disorders are common yet untreated
- Chronic illnesses are common yet under-diagnosed and un- or under-treated

These characteristics coupled with the nature of incarceration (short lengths of stay and a general inability to move freely to receive care) requires that the CHS model of care meld the best of a community-based PCMH model with an emphasis on integrated behavioral health services and with urgent care services always available.

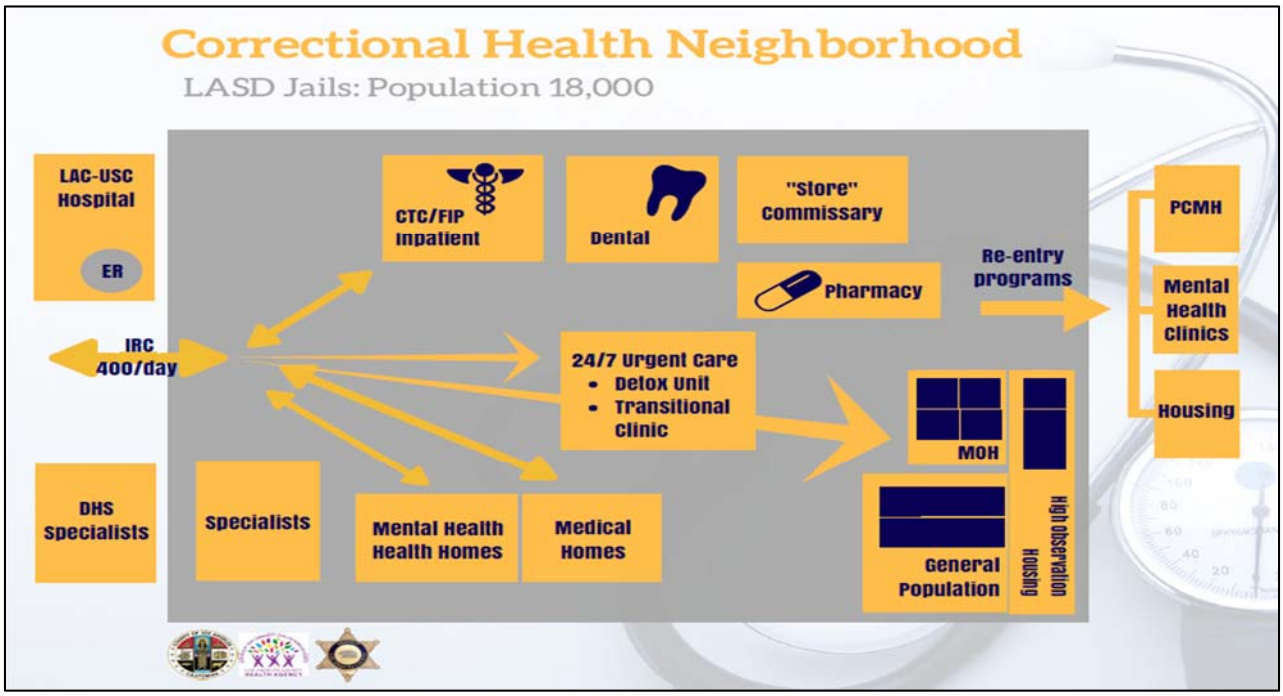
The Correctional Health Neighborhood, simply put, has five areas of care:

(a) Inmate Reception – where assessment, initial triage and movement to either enhanced treatment areas or housing units occurs.
(b) Primary Care Patient-Centered Medical Homes – attached to the housing units through the jail facilities where patients will be "assigned" a provider that provides basic and essential primary care. This will include specialized-PCMHs with some that focus on patients with HIV and others that focus on pregnant women.
(c) Urgent Care – a 24/7, robustly staffed unit where individuals with acute medical concerns (which do not require obvious or immediate hospital-based services) can come for care or further evaluation. This will also be the single point of entry of individuals returning from the emergency room or hospitalization into the jail. Creating a single point of entry increases the likelihood that sick individuals receive the follow up care and treatments they need after receiving care at the hospital.
(d) Specialized Care Units – Detox Unit for those sobering up from alcohol and some other drugs; the Correctional Treatment Center for the sickest individuals and those recently returning from hospitals; Mental Health Housing Areas where focused mental health services are provided based on acuity levels; SUD Housing where, when possible, clients work to manage their addictions receive services.
(e) Reentry and Transitions Services – provides support for the sickest patients at the point of release including accessing medications, navigating to services, arranging appointments, or obtaining housing.

The CHN aims to provide the same level of services individuals would have in their respective communities---over the counter medications without having to see a doctor, urgent care if you have an immediate need that cannot be addressed by your primary

doctor, mental health and/or addiction related clinical services, all supported by robust pharmacy, laboratory and other diagnostic services.

In the implementation of this model, when possible, CHS has leveraged existing DHS system-wide practices, policies and protocols so CHS meets community best practice standards. CHS has also leveraged existing DHS resources, especially as it comes to specialty care services, diagnostic and therapeutic services best provided in specialty centers and in information technology. For example, CHS uses DHS-wide eConsult, which allows doctors to consult with medical specialists electronically. CHS is also working to bolster existing services in the jails by leveraging core DHS expertise and services in the areas of women's health, ophthalmologic care, radiology and dental services.



Although work toward implementing the CHN model is underway, an essential step is recruiting sufficient high quality primary care physicians. CHS has a goal of hiring approximately 30 new physicians. The ideal CHS physician should have strong primary care skills, whole-person orientation, the ability to work in interdisciplinary teams and the ability to use data and health information systems while adhering to evidence-based medicine. The new model requires the integration of mental health and addiction medicine specialists to support the primary care team, as well. To find these providers, over the past several months, with the help of many County partners such as CEO, Department of Human Resources (DHR) and County Counsel, DHS has prioritized and focused our recruitment efforts.

We have embarked on a targeted physician recruitment campaign that includes developing a new set of recruitment and retention benefits and re-branding of the CHS

work environment that focuses on the social justice and community health aspects of correctional health. The recruitment efforts are being rolled out now with events and efforts planned across Southern and Northern California through the end of February 2018. The new CHS tagline has been launched: "Mission Possible." CEO's Office of Communication with the great support of County Counsel has built approximately 5 short videos and a short documentary about working and serving at CHS. These will be invaluable tools in our hiring effort.

These new recruitment efforts will augment recent successes CHS has experienced since the BOS provided CHS/DHS delegated authority to enter into temporary new contracts and temporarily amend existing contracts to meet CHS needs. Specifically, pursuant to the motion providing this delegation, CHS has:

1) Reached close to 600 hours per week of additional provider time outside of the County workforce via contract or registry providers to serve jail patients.
2) Begun a new family practice rotation as part of the Harbor-UCLA Medical Center family practice residency training program. The rotation brings Harbor faculty and trainees to the women's jail facility at Century Regional Detention Facility (CRDF) on a weekly basis to provide direct patient care services.
3) Collaborated with registry companies to hire physicians in a "temporary-to-permanent" manner, which allows a clinician to gain experience at CHS on a temporary basis before pursuing County employment. We have on-boarded two physicians and are in-processing another two, using this approach.
4) Used the newly created Correctional Health Relief Physician item to engage DHS facilities to help staff core CHS CHN functions. In January, 2018 approximately 12-15 Olive View-UCLA Medical Center physicians will come together to "adopt" the North County jail facilities for primary care.

Before the recent delegated authority provided to CHS by the BOS, CHS was working to launch a Register Nurse to Nurse Practitioner (NP) training program. In January 2018, twenty-two existing DHS and CHS nurses will begin this program in partnership with California State University, Los Angeles, wherein our nurses, who all have jail experience, will be trained to become NPs. Their tuition will be provided in exchange for years of service. These providers will function well in the new model of care. This is a first in the nation program to retain staff already committed to the jails by offering a career ladder and training.

Although this update highlights many efforts already underway within CHS, there is much more to do. We look forward to providing ongoing briefings to the Board.

Before closing, CHS leadership wants to acknowledge the incredible partners who have helped make the progress noted here, and future progress, possible. The newly formed Los Angeles Sheriff Department Access to Care team has been a partner in both the planning and implementation of many CHS initiatives. County Counsel has provided tremendous support on both legal concerns but also project management support. The CEO has lent its expertise regarding finance, classification and compensation, as well as producing incredible branding materials that should improve CHS' ability to recruit the

talent we need to transform. The DHR has worked expeditiously to create new exams for the positions most critical to CHS, allowing CHS to quickly identify those candidates with experiences most needed to improve jail health. Overall, CHS has been a true County collaboration.

Health Agency Infrastructure
The Health Agency Director, the Department Heads, and the CEO are working together to determine the needed infrastructure for the Health Agency, and will report back to the Board as soon as possible.

Next Steps

The Health Agency is proud of the many accomplishments that have been made over the past year. As the Health Agency evolves, we will continue to work with our staff, union partners, consumers, community stakeholders and your offices to improve our services for County residents.

Please contact us if you have any questions or need additional information.

MHK:jyp

Attachments

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