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December 12, 2017

**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

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, Health Agency

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

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Director, Health Agency

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

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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*

"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."



(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.

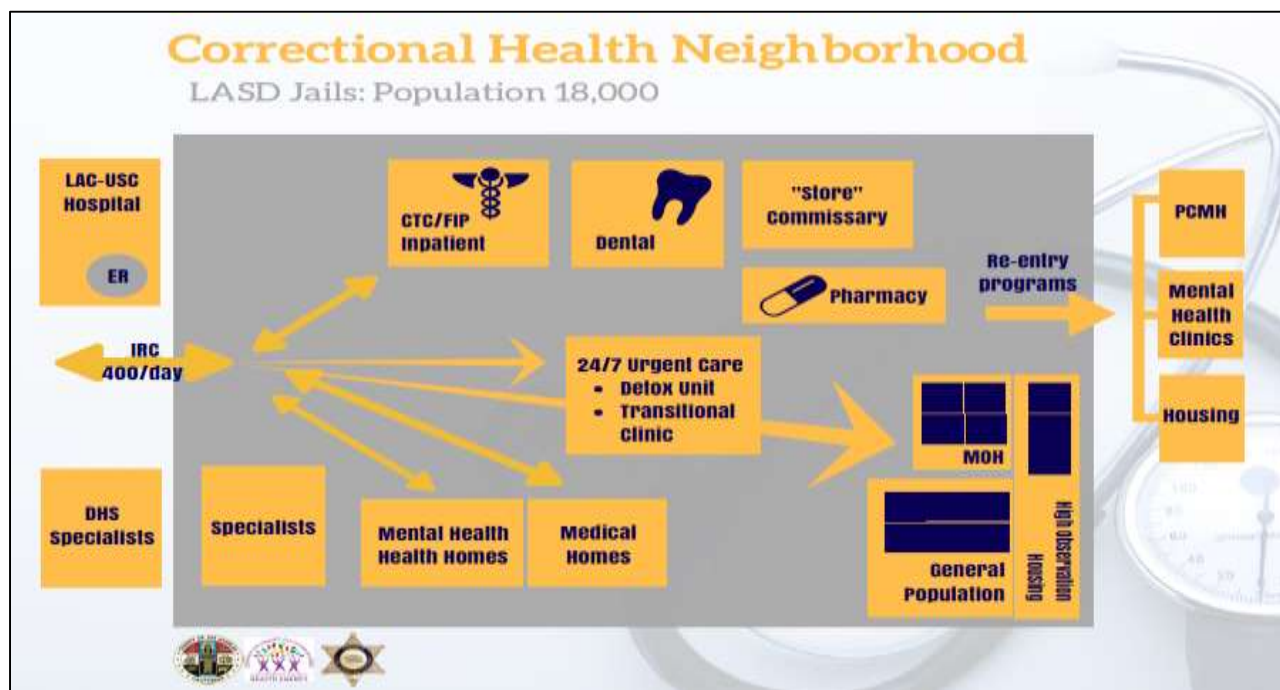
The Correctional Health Neighborhood, simply put, has five areas of care:

- (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

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.



Update on the Los Angeles County Health Agency

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

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

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

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

December 12, 2017

HEALTH AGENCY MISSION



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.

HEALTH AGENCY STRATEGIC PRIORITIES



1. Consumer Access and Experience
2. Housing and Supportive Services for Homeless Consumers
3. Overcrowding of Psychiatric Emergency Departments
4. Cultural Competency and Linguistic Access
5. Diversion of Corrections-Involved Individuals to Community-Based Programs and Services
6. Expanded Substance Use Disorder Benefit
7. Vulnerable Children and Transition Age Youth
8. Chronic Disease and Injury Prevention



CONSUMER ACCESS AND EXPERIENCE

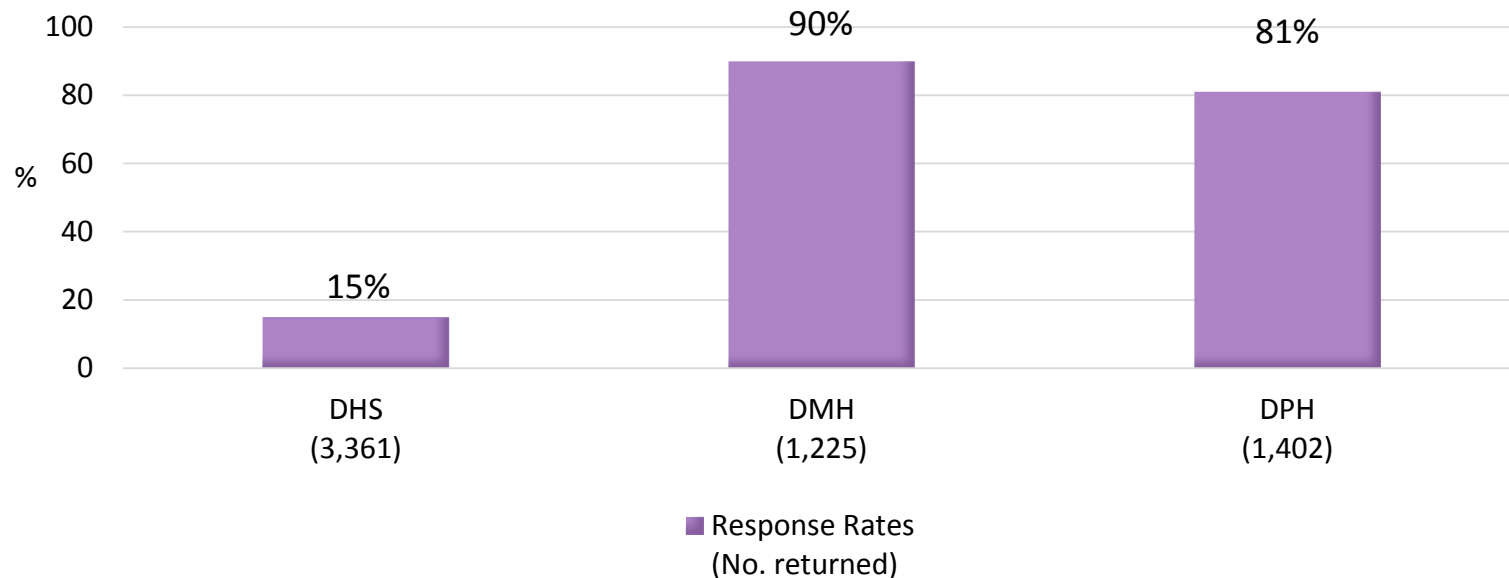
CONSUMER FEEDBACK SURVEY



- DMH's survey was administered at 22 DMH outpatient clinics in October 2016.
- DPH's survey was administered at 14 public health centers in November 2016.
 - 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
- DHS used the Press Ganey Survey and it was mailed to each adult who received outpatient services from November 2016 to March 2017.



SURVEY RESPONSE RATES



Surveys are available in:

DHS: English and Spanish, Chinese (Traditional)

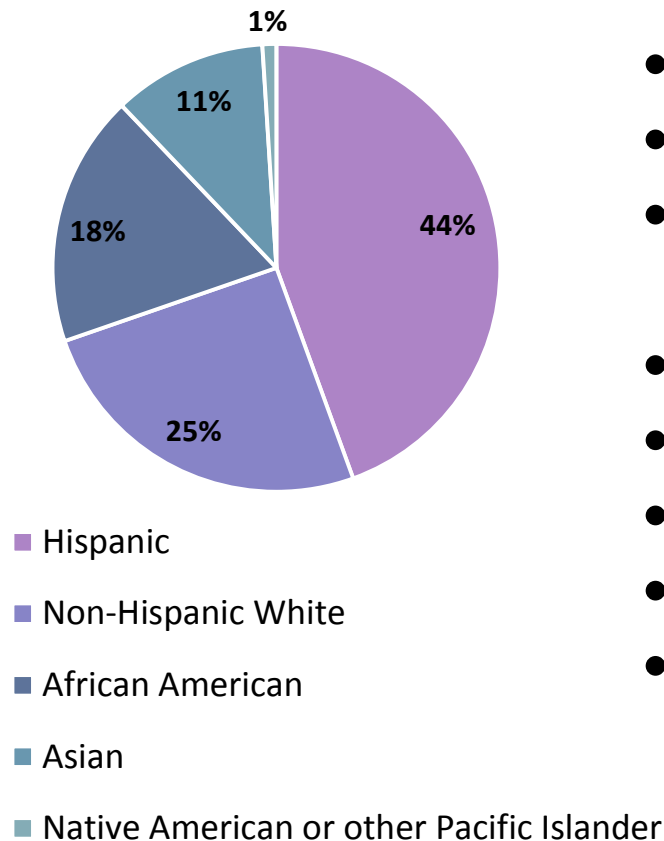
DMH: English and Spanish

DPH: English, Spanish, Chinese (Traditional), Farsi and Armenian

DEMOGRAPHICS



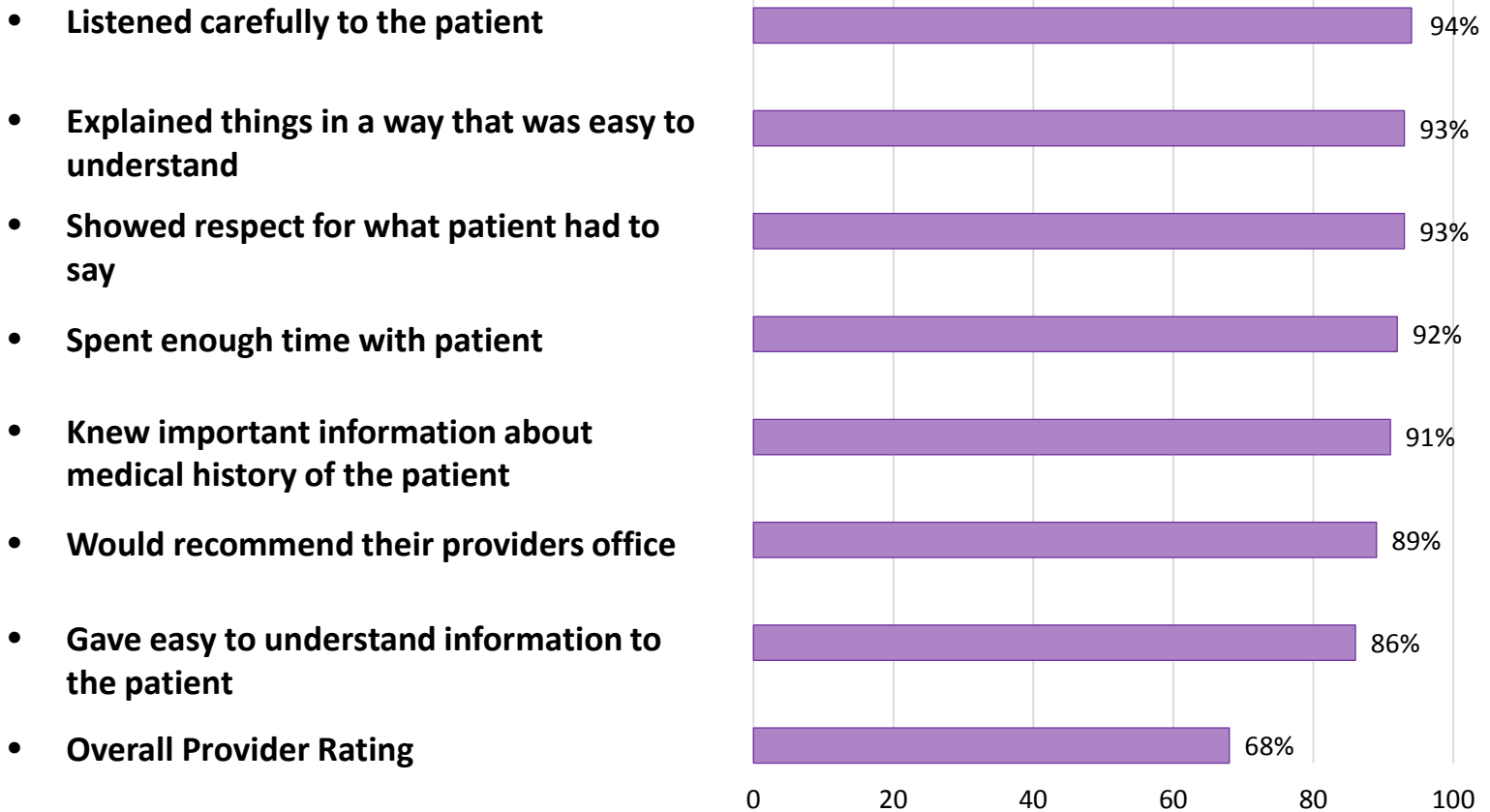
Race/Ethnicity



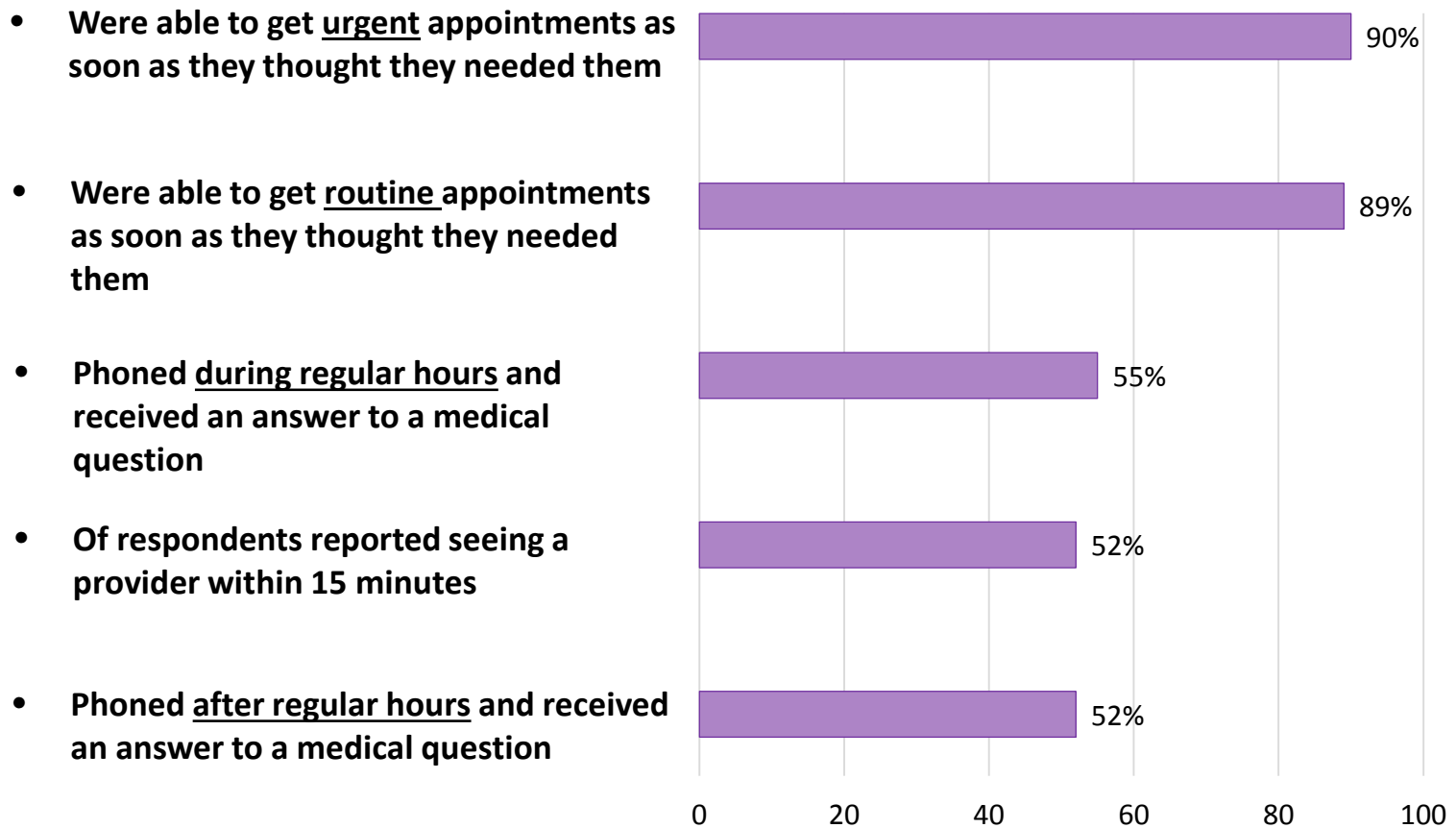
Of **5,988** total respondents:

- 52% female; 43% male
- 42% between 50-64 years of age
- 59% were high school graduates or higher
- 58% received Medi-Cal
- 13% received Medicare
- 11% had private insurance
- 13% were uninsured
- 12% were homeless at time of survey

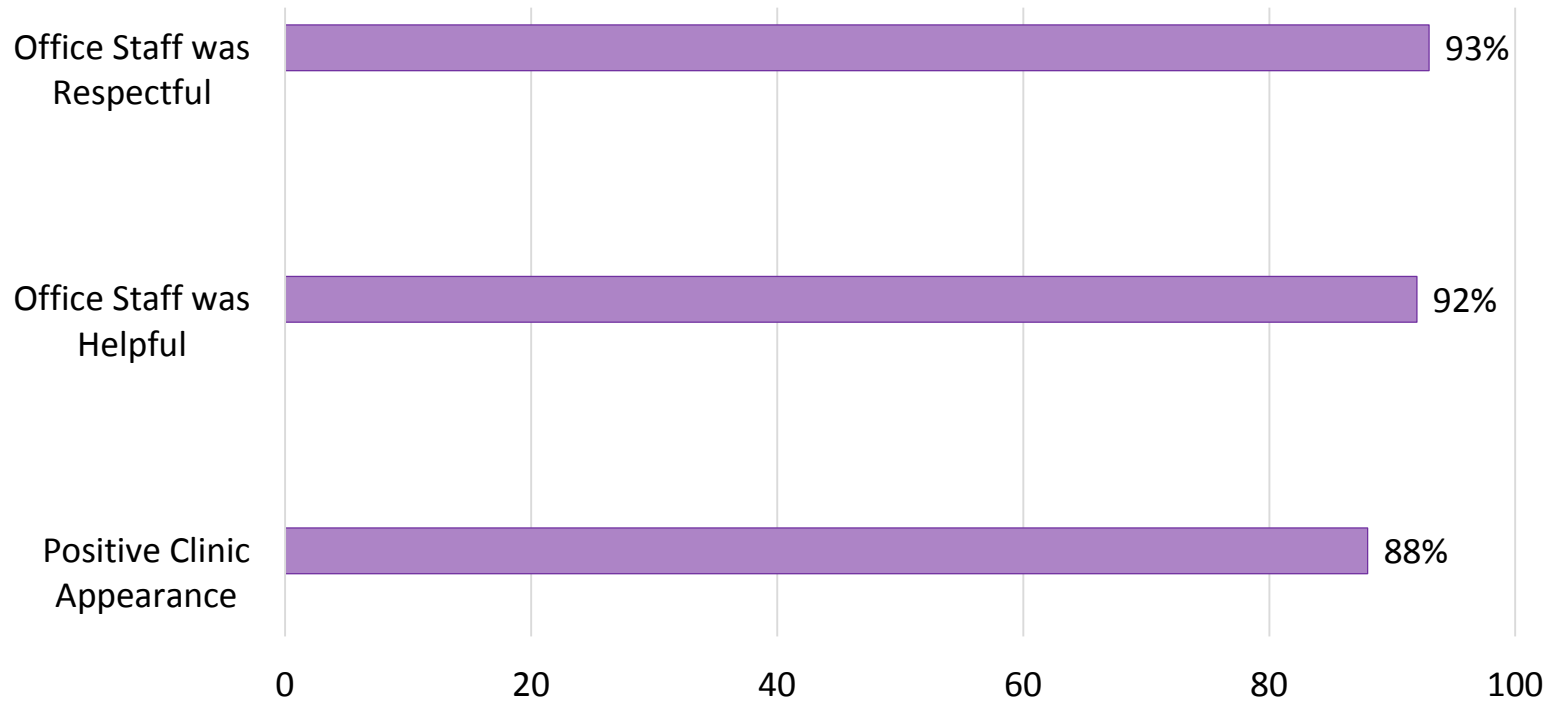
PROVIDER RATING AND PROVIDER COMMUNICATION



ACCESS TO HEALTH CARE



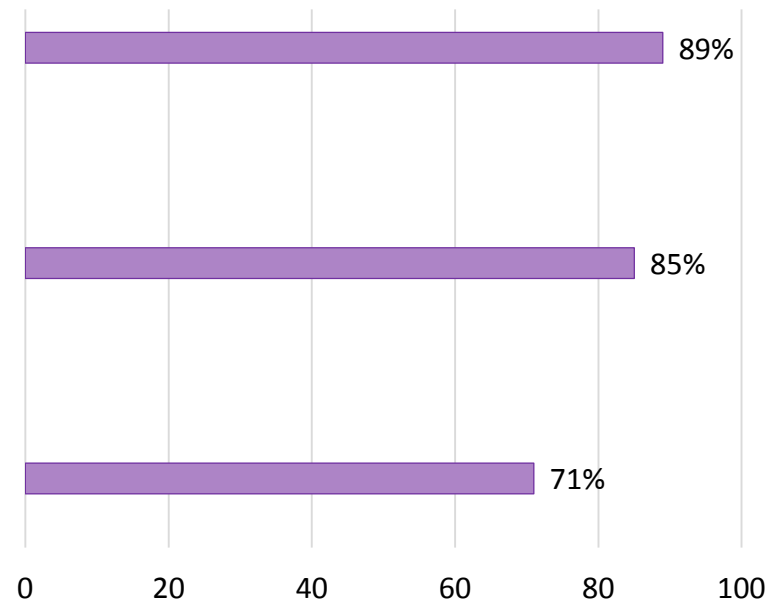
CLINIC APPEARANCE AND OFFICE STAFF QUALITY



CULTURAL AND LINGUISTIC COMPETENCY



- **Services were provided in their preferred language**
- **Written information was available in their preferred language**
- **Agreed that staff was sensitive to their cultural background**



CULTURAL COMPETENCY



1. Screening for REAL (Race, Ethnicity, and Language)-SOGI (sexual orientation/gender identity) built into EHR
 - Commenced training of staff on how to appropriately communicate with patients regarding these sensitive questions
2. EHR Patient Portal being modified to include materials in Spanish



DIVERSION OF CORRECTIONS-INVOLVED INDIVIDUALS TO COMMUNITY-BASED PROGRAMS

OVER 1,400 DIVERTED



- **Misdemeanor Incompetent to Stand Trial-Community Based Restoration (MIST-CBR):** Since October 2015, 590 clients have been removed from jail and connected to community based treatment including community outpatient, inpatient, and supportive housing programs.
- **Office of Diversion and Reentry (ODR) Housing:** Since August of 2016, 866 homeless clients with serious mental or substance use disorders have been released to housing from LA County jail. Program provides intensive case management services, linkage to mental health and substance use treatment, interim housing, and permanent supportive housing.

LEVERAGING NON COUNTY DOLLARS



- Launched LA County's first **Law Enforcement Assisted Diversion (LEAD)** program to divert individuals with substance use disorders at the point of arrest for drug or prostitute charges. Awarded \$5.9M from the Board of State and Community Corrections. 48 individuals have been diverted since November 2017.
- Awarded \$20M in **Proposition 47** funding from Board of State and Community Corrections to provide supportive services, linkage to mental health and substance use treatment services, and recovery bridge housing to over 1200 individuals.
- Launched LA County's first **Pay For Success** project to scale ODR work to provide permanent supportive housing to homeless inmates with mental health and substance use disorders. Awarded \$2M from the Board of State and Community Corrections and raised \$10M from private investors.

CRISIS INTERVENTION TRAINING (CIT)



- Over 2,000 first responders from 48 jurisdictions have received Crisis Intervention Training (CIT) in the last 18 months.
- The total number trained to date as of October 19 is 606.
- The CY17 anticipated total trained patrol personnel is 702.

JAIL REENTRY SERVICES



- The Whole Person Care (WPC) Reentry program aims to enroll 1,000 LA County jail inmates per month who are eligible for Medi-Cal, are high utilizers of health or behavioral health services, and are at high risk due to chronic medical conditions, mental illness, substance use disorders, homelessness, or pregnancy.
- WPC staff conducts a comprehensive assessment covering areas including health, mental health and substance use history, homelessness, education/employment, family and social support.
- Clients are also assigned a WPC Community Health Worker (CHW) in the community, who has a shared lived experience of incarceration.
- Since the program began ramp up in May 2017, 1,461 WPC Reentry clients have been served.



IMPLEMENTATION OF EXPANDED SUBSTANCE USE DISORDER (SUD) BENEFITS



DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

- Launched on July 1, 2017
- 70 providers are under contract with 210 overall sites
- Methods to facilitate and promote access to SUD services have been developed and implemented:
 - Substance Abuse Service Helpline
 - Service and Bed Availability Tool (SBAT)

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT) TRAINING



- DHS has incorporated SBIRT into its ORCHID workflow and is now focused on training staff on SBIRT to operationalize this new functionality.
- DMH has incorporated SBIRT into its IBHIS workflow and has also trained staff on SBIRT.
- SBIRT services will be tracked beginning January 2018.

MEDICATION ASSISTED TREATMENT (MAT)



- SAPC, DHS, and Safe Med LA have worked together to launch two learning collaboratives focused on Medication-Assisted Treatment (MAT):
 - One for primary care providers; the second for specialty SUD providers.
 - They are focused on expanding the number of MAT programs across the County by building the operational and clinical expertise needed for the programs.
- SAPC is working with the Opioid Treatment Programs that are leading the California Hub and Spoke grant implementation in the 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 the County.



HEALTH AGENCY COLLABORATION

CENTER FOR HEALTH EQUITY



Center for Health Equity Initial Launch Event 10/10/17

- First public event introducing the Center to leaders from other County Departments and community organizations

Resident & Community Engagement

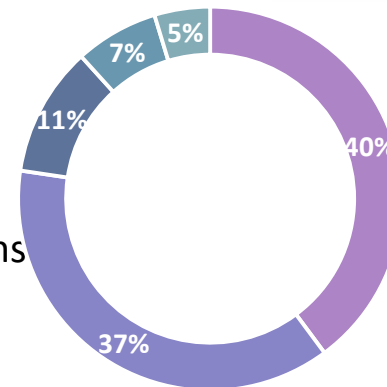
- One listening session in each Supervisorial District being scheduled

Workforce Engagement

- Interactive webinar for each Health Agency department

Summary Report

- All information collected during listening sessions will be used to finalize the Center's work plan



**Attendees
by Org Type
N=128**

- Government
- Community Orgs
- Healthcare
- Non Profits
- Academia

THE CENTER'S KEY FOCUS AREAS



Infant Mortality



Sexually Transmitted
Infections (STIs)



Environmental Justice



Health Neighborhoods



Cultural & Linguistic
Competency

JUST CULTURE



- One policy across the Health Agency
- In-person training for all Health Agency staff
- Town Hall Meeting
 - Support from Labor Partners
 - Audio/visual-related technical assistance for satellite sites

A JUST CULTURE FOR ALL

LEARN MORE ABOUT OUR LABOR MANAGEMENT
TRANSFORMATION COUNCIL'S NEW JUST CULTURE POLICY
KEEP UP TO DATE ON OUR NEW APPROACH TO SAFETY
SHAPE THE FUTURE OF OUR HEALTH AGENCY'S
PARTNERSHIP & INTEGRATION EFFORTS

**LOS ANGELES COUNTY
HEALTH AGENCY TOWN HALL**
WEDNESDAY, AUGUST 30 • 11:30 AM - 1 PM

WATCH IT ONLINE:
[HTTPS://TINYURL.COM/JUSTCULTURETOWNHALL](https://tinyurl.com/justculturetownhall)

LOS ANGELES COUNTY HEALTH AGENCY
DEPARTMENT OF PUBLIC HEALTH
DEPARTMENT OF MENTAL HEALTH
DEPARTMENT OF HEALTH SERVICES

LOCAL 721 SEIU

CIR

AFSCME

UAPD
Union of American
Physicians and Dentists

We are a Provider of Choice & Employer of Choice staffed by Employees of Choice!

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.

Continuous improvement is central to our mission. Whether predictable or unforeseen, just culture establishes an environment where learning and improvement are possible when safety concerns arise!

313 N Figueroa St, Los Angeles, CA 90012



CORRECTIONAL HEALTH SERVICES (CHS)

CORRECTIONAL HEALTH – SYSTEM ACHIEVEMENTS



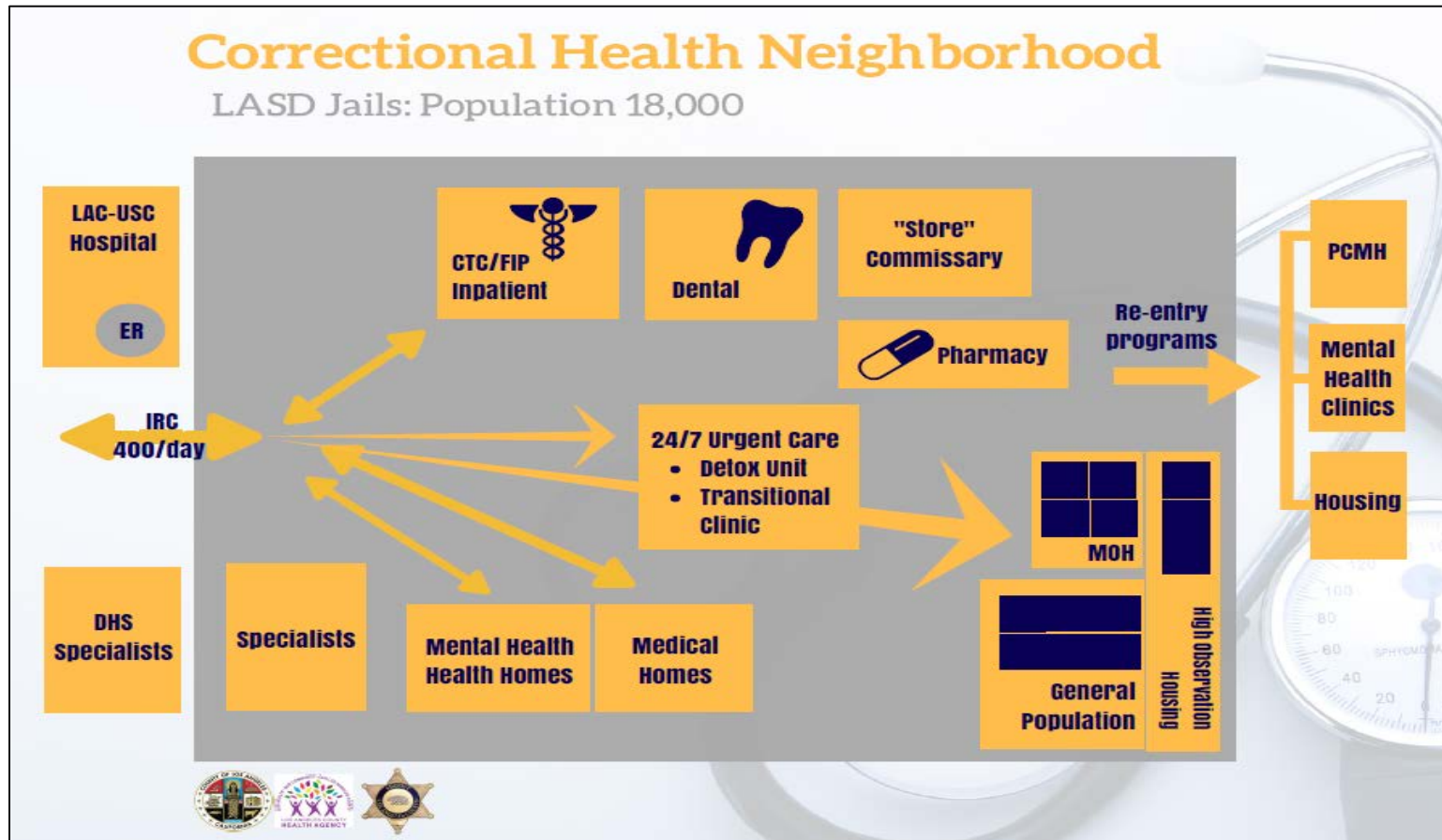
- Completed transition from LASD and DMH to DHS in May 2017
- 107 staff hired in past 4 months; 36 new hires pending
- Physicians hired: 4 full time; 4 part-time; 13 relief physicians (in process)
- Nearly 400 hrs./wk. of physician & NP coverage secured in last 3 months
- Expanded 24/7 Urgent Care to open in March 2018
- 47 acute psychiatric beds added – *near doubling of available acute beds*
- Detox Units opened at men’s Inmate Reception Center (IRC) and Century Regional Detention Facility (CRDF)
- Olive View & Harbor-UCLA supporting Pitchess & CRDF, respectively
- Continuous Quality Improvement (CQI) unit created
- Cerner jail electronic health record contract transferred to DHS

CORRECTIONAL HEALTH – PATIENT CARE IMPROVEMENTS



- Mental Health Unit wait time significantly reduced
- 1,300 patients admitted to the new Detox Unit(s) in past 6 months
- 40% fewer incidents of hyper or hypoglycemia among diabetics
- Reduced “Sick Call” wait time from 5 days to less than 2 days
- Many patients receive essential medications in IRC
- Over 300 individuals enrolled in jail Substance Treatment programs
- Over 1,400 patients enrolled into reentry services program (i.e. WPC)

NEW CARE MODEL – CORRECTIONAL HEALTH NEIGHBORHOOD



MISSION POSSIBLE – REBRANDING CHS TO RECRUIT TALENT FOR OUR FUTURE



- CEO Communications team filmed “A day in the life of a jail doctor.”
- To create mini-clips and a documentary about correctional health
- Used for recruitment visits and CHS website/social media postings
- Coupled with attractive salary and incentives – loan repayment, relocation support, signing bonuses – we hope to show that CHS is a wonderful place for doctors to make a difference and serve
- Goal is to hire new primary care physicians for the Correctional Health Neighborhood implementation to start over the next 10 months

DRAFT

**Health Agency Consumer Surveys
Department of Mental Health (DMH)
Department of Public Health (DPH)
Department of Health Services (DHS)
2016 Preliminary Findings**



November 2017

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Assessment of Consumer Access to and Experience with Clinical Services in the Los Angeles County Departments of Mental Health, Public Health, and Health Services: Results from the 2016 Consumer Feedback, 2016 Patient Experience, and 2016-17 Press Ganey Surveys

Executive Summary

In 2016, the Los Angeles County Health Agency launched its first coordinated assessment of consumer access to and experience with outpatient clinic services in the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH). With the assistance of two Health Agency workgroups - Consumer Access to and Experience with Clinical Services (CAECS) and Access to Culturally and Linguistically Competent Programs and Services (ACLPCS) - 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 three 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, Chinese, Armenian, and Farsi.

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. Over a period of approximately 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 a sample of adults 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% of respondents agreed with the following statements: they would recommend their provider office (89%), were able to receive 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%), and written information was available in their spoken language (85%).

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%).

Lastly, only a little over a third of respondents strongly agreed that the staff were sensitive to patient's cultural background (39%).

Table 1. Sociodemographic characteristics of Respondents seeking services provided by the Department of Mental Health (DMH; n=1,225- October 24 -November 10, 2016), Public Health (DPH; n=1,402- November 7- December 6, 2016), and Health Services (DHS; n=3,361- November 1, 2016-March 31, 2017), Health Agency Consumer Survey 2016-2017.

Demographics	Total		DMH		DPH		DHS		P value (DMH vs. DPH vs. DHS)
	n	(%) [^]	n	% [^]	n	% [^]	n	% [^]	
Total	5,988	(100)	1,225	100	1,402	100	3,361	100	
Gender (q3 ^{1,2,3})									
Male	2,579	(43)	530	43	735	52	1,314	39	< 0.01 ^{^^&}
Female	3,099	(52)	675	55	648	46	1,776	53	
Transgender woman	18	(<1)	11	1	7	<1	---	---	
Transgender man	6	(<1)	1	<1	5	<1	---	---	
Other	1	(<1)	1	<1	---	---	1	<1	
Age (q1 ^{1,2,3})									
18-34 Years	1,129	(19)	316	26	617	44	196	6	< 0.01 ^{&}
35-49 Years	1,282	(21)	400	33	402	29	480	14	
50-64 Years	2,490	(42)	438	36	267	19	1,785	53	
65-79 Years	722	(12)	63	5	90	6	569	17	
80 Years and older	95	(2)	8	1	26	2	61	2	
Race (q6 ^{1,2} , q32 ^{3,4})									
White (non-Hispanic)	1,522	(25)	281	23	243	17	998	30	< 0.01 ^{&}
African American/Black	1,079	(18)	340	28	284	20	455	14	< 0.01 ^{&}
Asian	673	(11)	68	6	291	21	314	9	< 0.01 ^{&}
Native Hawaiian or other Pacific Islander	47	(1)	17	1	15	1	15	<1	0.01
American Indian or Alaskan Native	110	(2)	39	3	27	2	44	1	< 0.01 ^{&}
Other	525	(9)	67	5	82	6	376	11	< 0.01 ^{&}
Ethnicity (q5 ^{1,2} , q31 ³)									
Hispanic, Latino or Spanish	2,650	(44)	513	42	567	40	1,570	47	< 0.01 ^{&}
Non-Hispanic, Latino or Spanish	2,603	(43)	673	55	807	58	1,123	33	
Educational Attainment (q4 ^{1,2} , q30 ³)									
8th grade or less	839	(14)	124	10	127	9	588	17	< 0.01 ^{&}
Some high school, but did not graduate	877	(15)	250	20	178	13	449	13	
High school graduate or GED	1,390	(23)	344	28	401	29	645	19	
Some college or 2-year degree	1,334	(22)	371	30	352	25	611	18	
4-year college graduate	532	(9)	82	7	215	15	235	7	
More than 4-year college degree	294	(5)	50	4	94	7	150	4	
Insurance status (q7 ^{1,2,3,4})									
None	781	(13)	60	5	579	41	142	4	< 0.01 ^{&}
Private	631	(11)	45	4	194	14	392	12	< 0.01 ^{&}
Medi-Cal/Medicaid	3,464	(58)	1,012	83	428	31	2,024	60	< 0.01 ^{&}
Medicare	757	(13)	159	13	71	5	527	16	< 0.01 ^{&}
Does not know	118	(2)	27	2	91	6	---	---	< 0.01 ^{&}
Other	106	(2)	33	3	73	5	---	---	< 0.01 ^{&}
Homeless (q2 ^{1,2})	322	(12)	238	19	84	6	---	---	< 0.01 ^{&}

[^] Excludes missing values, totals may not sum to 100% due to rounding and/or multiple entries.

^{^^} Due to sparse data in some cells, Monte Carlo estimate for Fisher's exact test was used to obtain this p-value.

[&] Chi Square is statistically significant at 0.05 level.

¹ DMH survey questions (Overall Response Rate: 90%).

² DPH survey questions (Overall Response Rate: 81%).

³ DHS Press Ganey question, or field in dataset. (Overall Response Rate: 15%)

⁴ Totals and percentages may exceed 100% due to multiple responses (i.e., respondent could have marked more than one race and insurance type).

Note: One individual from DPH and five individuals from DMH did not provide their age and were marked as "Over 18" on the survey,

Note: Overall Response Rate of DHS Press Ganey mail-in survey was 15%.

Table 2a. Responses to common questions* on the Health Agency Consumer Surveys Respondents seeking services provided by the Department of Mental Health (DMH; n=1,225- October 24 -November 10, 2016), Public Health (DPH; n=1,402- November 7-December 6, 2016), and Health Services (DHS; n=3,361- November 1, 2016-March 31, 2017), Health Agency Consumer Survey 2016-2017.

Domains and Questions	Total		DMH		DPH		DHS		P value (DMH vs. DPH vs. DHS)
	n	(%) [^]	n	% [^]	n	% [^]	n	% [^]	
Total	5,988	(100)	1,225	100	1,402	100	3,361	100	
Provider Ratings									
Overall Provider Rating** (% rated provider 9 and 10, q18 ¹ , q19 ² , q22 ³)	4,045	(68)	763	62	998	71	2,284	68	< 0.01 ^{&}
Recommend this provider office (q19 ¹ , q20 ² , q23 ³)									
Yes, definitely**	4,550	(76)	973	79	1,218	87	2,359	70	< 0.01 ^{&}
Yes, somewhat	752	(13)	179	15	141	10	432	13	
No	310	(5)	69	6	26	2	215	6	
Provider had patient's medical records (q17e ¹ , q18e ² , q19 ³)									
Yes, definitely**	4,840	(81)	964	79	993	71	2,883	86	< 0.01 ^{&}
Yes, somewhat	251	(10)	125	10	126	9	---	---	
No	536	(9)	125	10	248	18	163	5	
Access To care									
Patients got <u>urgent</u> appointments as soon as they thought they needed them (q9 ¹ , q10 ² , q4 ³) [#]									
Yes	2,409	(90)	664	92	380	95	1,365	87	< 0.01 ^{&}
No	283	(10)	62	8	18	5	203	13	
Patients got <u>routine</u> appointments as soon as they thought they needed them (q11 ¹ , q12 ² , q6 ³) [~]									
Yes	3,740	(89)	821	93	571	95	2,348	87	< 0.01 ^{&}
No	447	(11)	66	7	31	5	350	13	
Had an appointment for check-up or routine care (q10 ¹ , q11 ² , q5 ³) ⁴	4,407	(74)	928	76	693	49	2,786	83	< 0.01 ^{&}
Had an appointment for care needed right away (q8 ¹ , q9 ² , q3 ³) ⁴	2,796	(47)	766	63	442	32	1,588	47	< 0.01 ^{&}
Patient saw provider within 15 minutes (q16 ¹ , q17 ² , q13 ³) ⁵	2,774	(52)	507	47	379	31	1,888	62	< 0.01 ^{&}
For those with a routine appointment (q10 ¹ , q11 ²) ⁶	657	(41)	424	46	233	34	N/A	N/A	< 0.01 ^{&}
For those with an urgent appointment (q8 ¹ , q9 ²) ⁷	491	(41)	347	45	144	33	N/A	N/A	< 0.01 ^{&}

* Source of questions from DHS Press Ganey CG CAPHPS 2016.

** Top Box Scores are indicated. For DHS the answer choices for this question were "yes" and "no" only; therefore, the "totals" for "yes definitely" answer choice only includes DMH and DPH, and the p value comparison does not include DHS numbers.

& Chi Square is statistically significant at 0.05 level.

[^] Excludes missing values, totals may not sum to 100% due to rounding and/or multiple entries.

[#] 664 of 724 (92%) DMH patients, 380 of 398 (95%) DPH patients, and 1,365 of 1,568 (87%) DHS patients got an urgent appointment as soon as they thought they needed it.

[~] 821 of 887 (93%) DMH patients, 571 of 602 (95%) DPH patients, and 2,348 of 2,698 (87%) of DHS patients got a routine appointment as soon as they thought they needed it.

¹ DMH survey questions (Overall Response Rate: 90%).

² DPH survey questions (Overall Response Rate: 81%).

³ DHS Press Ganey questions (Overall Response Rate: 15%).

⁴ Some respondents checked "Yes" for both questions.

⁵ 507 of 1,084 DMH patients, 379 of 1,232 DPH patients, and 1,888 of 3,062 DHS patients waited 15 minutes or less before seeing their provider.

⁶ 928 DMH patients and 693 DPH patients visited the clinic for a routine appointment.

⁷ 766 DMH patients and 442 DPH patients visited the clinic for an urgent care appointment.

Table 2a (continued). Responses to common questions* on the Health Agency Consumer Surveys of Respondents seeking services provided by the Department of Mental Health (DMH; n=1,225- October 24 -November 10, 2016), Public Health (DPH; n=1,402- November 7-December 6, 2016), and Health Services (DHS; n=3,361- November 1, 2016-March 31, 2017), Health Agency Consumer Survey 2016-2017.

Domains and Questions	Total		DMH		DPH		DHS		P value (DMH vs. DPH vs.)
	n	(%) [^]	n	% [^]	n	% [^]	n	% [^]	
Provider's Communication Quality									
Explained things in a way that was easy to understand (q17b ¹ , q18b ² , q14 ³)									
Yes, definitely**	4,888	(82)	1,030	84	1,279	91	2,579	77	< 0.01 ^{&}
Yes, somewhat	688	(11)	162	13	96	7	430	13	
No	133	(2)	30	2	17	1	86	3	
Listened carefully to the patient (q17a ¹ , q18a ² , q15 ³)									
Yes, definitely**	5,002	(84)	1,037	85	1,293	92	2,672	80	< 0.01 ^{&}
Yes, somewhat	587	(10)	152	12	90	6	345	10	
No	135	(2)	35	3	16	1	84	2	
Gave easy to understand information to the patient (q17c ¹ , q18c ² , q17 ³)									
Yes, definitely**	4,580	(76)	1,012	83	1,285	92	2,283	68	< 0.01 ^{&}
Yes, somewhat	581	(10)	173	14	95	7	313	9	
No	152	(3)	39	3	16	1	97	3	
Knew important information about medical history of the patient (q17d ¹ , q18d ² , q18 ³)									
Yes, definitely**	4,663	(78)	967	79	1,144	82	2,552	76	< 0.01 ^{&}
Yes, somewhat	763	(13)	193	16	159	11	411	12	
No	263	(4)	63	5	75	5	125	4	
Showed respect for what patient had to say (q17f ¹ , q18f ² , q20 ³)									
Yes, definitely**	5,108	(85)	1,049	86	1,292	92	2,767	82	< 0.01 ^{&}
Yes, somewhat	475	(8)	133	11	86	6	256	8	
No	106	(2)	35	3	13	1	58	2	
Spent enough time with patient (q17g ¹ , q18g ² , q21 ³)									
Yes, definitely**	4,704	(79)	1,010	82	1,243	89	2,451	73	< 0.01 ^{&}
Yes, somewhat	782	(13)	168	14	127	9	487	14	
No	206	(3)	46	4	20	1	140	4	
Office Staff Quality									
Office staff were helpful (q20 ¹ , q21 ² , q24 ³)									
Yes, definitely**	4,692	(78)	981	80	1,245	89	2,466	73	< 0.01 ^{&}
Yes, somewhat	847	(14)	195	16	119	8	533	16	
No	148	(2)	47	4	22	2	79	2	
Office staff treated patients with courtesy and respect (q21 ¹ , q22 ² , q25 ³)									
Yes, definitely**	4,977	(83)	1,049	86	1,286	92	2,642	79	< 0.01 ^{&}
Yes, somewhat	616	(10)	140	11	85	6	391	12	
No	87	(1)	32	3	11	1	44	1	

* Source of questions from DHS Press Ganey CG CAPHS 2016.

** Top Box Scores are indicated.

[^] Excludes missing values, totals may not sum to 100% due to rounding and/or multiple entries.

[&] Chi Square is statistically significant at 0.05 level.

¹ DMH survey questions (Overall Response Rate: 90%).

² DPH survey questions (Overall Response Rate: 81%).

³ DHS Press Ganey questions (Overall Response Rate: 15%).

Table 2a (continued). Responses to common questions* on the Health Agency Consumer Surveys of Respondents seeking services provided by the Department of Mental Health (DMH; n=1,225- October 24 -November 10, 2016), Public Health (DPH; n=1,402- November 7-December 6, 2016), and Health Services (DHS; n=3,361- November 1, 2016-March 31, 2017), Health Agency Consumer Survey 2016-2017.

Domains and Questions	Total		DMH		DPH		DHS		P value (DMH vs. DPH vs. DHS)
	n	(%) [^]	n	% [^]	n	% [^]	n	% [^]	
Access to care in the past 3 months									
Phoned <u>during regular hours</u> and got an answer to a medical question that same day (q13 ¹ , q14 ² , q7 ³ , q8 ³) [#]									
Always	1,202	(55)	396	52	301	67	505	53	< 0.01 ^{&}
Usually	457	(21)	186	24	80	18	191	20	
Sometimes	339	(16)	150	20	49	11	140	15	
Never	170	(8)	30	4	20	4	120	13	
Phoned <u>after regular hours</u> and got an answer to a medical question that same day (q15 ¹ , q16 ² , q9 ³ , q10 ³) [~]									
Always	560	(52)	225	50	141	53	194	55	< 0.01 ^{&}
Usually	229	(21)	100	22	65	24	64	18	
Sometimes	192	(18)	102	22	44	16	46	13	
Never	91	(8)	27	6	18	7	46	13	
Clinic Appearance									
Cleanliness of the mental health or medical clinic (q24 ¹ , q25 ² , q2-2 ³)									
Very good [*]	3,522	(59)	631	52	907	65	1,984	59	< 0.01 ^{^^&}
Good	1,711	(29)	458	37	424	30	829	25	
Fair	328	(5)	111	9	52	4	165	5	
Poor	31	(1)	9	1	3	<1	19	1	
Very poor	39	(1)	13	1	11	1	15	<1	
Cultural and linguistic competency									
Staff were sensitive to patient's cultural background (q25 ¹ , q26 ² , q35 ³)									
Strongly agree	2,307	(39)	463	38	605	43	1,239	37	0.01 ^{&}
Agree	1,919	(32)	458	37	444	32	1,017	30	
Neutral	794	(13)	201	16	200	14	393	12	
Disagree	173	(3)	39	3	42	3	92	3	
Strongly disagree	210	(4)	56	5	77	5	77	2	
Services were provided in patient's preferred language (q26 ¹ , q27 ² , q36 ³)									
Yes	5,339	(89)	1,185	97	1,332	95	2,822	84	< 0.01 ^{&}
No	193	(3)	37	3	55	4	101	3	
Written information was available in spoken language (q27 ¹ , q28 ² , q37 ³)									
Yes	5,117	(85)	1,118	91	1,251	89	2,748	82	< 0.01 ^{&}
No	367	(6)	102	8	113	8	152	5	

* Source of questions from DHS Press Ganey CG CAPHPS 2016.

[^] Excludes missing values, totals may not sum to 100% due to rounding and/or multiple entries.

[&] Chi Square is statistically significant at 0.05 level.

[#] 762 (62%) of DMH, 450 (32%) of DPH, and 956 (28%) of DHS patients called during the regular hours.

[~] 454 (37%) of DMH, 268 (19%) of DPH, and 350 (10%) of DHS patients called after the regular hours.

¹ DMH survey questions (Overall Response Rate: 90%).

² DPH survey questions (Overall Response Rate: 81%).

³ DHS Press Ganey questions (Overall Response Rate: 15%).

^{^^} Due to sparse data in some cells, Monte Carlo estimate for Fisher's exact test was used to obtain this p-value.

Table 2b. Additional Non-Press Ganey Questions asked from the Respondents to the Health Agency Consumer Surveys by the Department of Mental Health (DMH; n=1,225- October 24 -November 10, 2016), and Public Health (DPH; n=1,402- November 7-December 6, 2016).

Domains and Questions	Total		DMH		DPH		P value (DMH vs. DPH)
	n	(%) [^]	n	% [^]	n	% [^]	
Total	2,627	(100)	1,225	100	1,402	100	
Additional Non-Press Ganey Questions							
Providers were courteous and respectful of patient's privacy (q17h ¹ , q18h ²)							
Yes, definitely *	2,388	(91)	1,080	88	1,308	93	< 0.01 ^{&}
Yes, somewhat	195	(7)	120	10	75	5	
No	35	(1)	25	2	10	1	
During this visit the overall wait time was acceptable (q22 ¹ , q23 ²)							
Yes, definitely *	1,969	(75)	897	73	1,072	76	0.07
Yes, somewhat	490	(19)	251	20	239	17	
No	136	(5)	66	5	70	5	
Patient was satisfied with the mental health care or medical care received from provider (q23 ¹ , q24 ²)							
Yes, definitely *	2,219	(84)	986	80	1,233	88	< 0.01 ^{&}
Yes, somewhat	305	(12)	179	15	126	9	
No	55	(2)	42	3	13	1	
Appointment/Walk-in (q8b ²)							
Walked in and received a same-day appointment	303	(22)	---	---	303	22	---
Walk-in with no appointment	437	(31)	---	---	437	31	
Pre-scheduled appointment	636	(45)	---	---	636	45	
Services Received (q8a ²)							
Nurse Clinic Walk-in (Immunization, TB testing)	419	(30)	---	---	419	30	---
Tuberculosis (TB-MD/X-ray)	374	(27)	---	---	374	27	
STD (Sexually Transmitted Diseases)	524	(37)	---	---	524	37	
Refugee Clinic	72	(5)	---	---	72	5	

* Top Box Scores are indicated.

& Chi Square is statistically significant at 0.05 level.

[^] Excludes missing values, totals may not sum to 100% due to rounding and/or multiple entries.

¹ DMH survey questions (Overall Response Rate: 90%).

² DPH survey questions (Overall Response Rate: 81%).



11/07/2017





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Fifth District

October 18, 2017

TO: Each Supervisor

FROM: Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director *Barbara Ferrer*

SUBJECT: **UPDATE ON PROGRESS TO ABATE ELEVATED HEXAVALENT CHROMIUM LEVELS IN THE CITY OF PARAMOUNT**

On December 20, 2016, your Board instructed the Department of Public Health (DPH) to report back monthly on the progress to abate the endangerment posed by elevated hexavalent chromium ("Chromium-6") emissions in the City of Paramount. This tenth monthly progress report provides information on five key elements of the interagency response: air quality monitoring, soil assessment, enforcement, occupational health, and public communication. DPH is a part of the interagency team consisting of the South Coast Air Quality Management District (SCAQMD), Los Angeles County Fire Department, California Department of Toxic Substances Control (DTSC), California Environmental Protection Agency (CalEPA), California Air Resources Board (CARB), and the Long Beach Department of Health and Human Services.

Air Quality Monitoring

SCAQMD continues air quality monitoring across the City of Paramount in order to identify and address sources of Chromium-6. Monitoring is focused on several geographic areas: compliance monitoring points previously established outside of Anaplex Corporation (Anaplex) and Aerocraft Heat Treating Company, Inc. (Aerocraft), the southern investigation area approximately a half-mile south of these facilities, and three area schools.

Anaplex and Aerocraft Facility Monitoring: When Chromium-6 emissions (measured over a 24-hour period) at the compliance monitoring points outside of Anaplex and Aerocraft exceed 1 nanogram per meter cubed (ng/m³), the SCAQMD requires shut-down of all operations that contribute to Chromium-6 emissions. In the month of September, no shut-downs have been triggered. As shown in the table below, average Chromium-6 emissions in the original investigation area have remained below 1 ng/m³ since April 2017, with the exception of average emissions near Anaplex in July 2017.

Hexavalent Chromium Monitoring Results (ng/m³) – Aircraft, Anaplex and Nearby Residential Areas

Month	Industrial		Residential
	Aircraft	Anaplex	300 ft downwind
October 2016	26		4.7
November 2016	12	11	2.0
December 2016	3.0	2.5	0.7
January 2017	1.0	2.1	0.5
February 2017	1.1	0.5	0.6
March 2017	1.1	0.8	0.7
April 2017	0.6	0.4	0.3
May 2017	0.7	0.6	0.4
June 2017	0.5	0.5	0.8
July 2017	0.3	1.9	1.6
August 2017	0.4	0.2	0.3
September 2017	0.6	0.2	0.5

Note: Grey shading indicates air monitoring was not conducted for this location during month listed.

Southern Investigation Area: Emissions in the southern investigation area (in and around Jackson Street, between Minnesota Avenue and Illinois Avenue) were similar to the previous month. In September, Chromium-6 concentrations in air ranged from 0.1 to 2.6 ng/m³, with 14% of the samples in exceedance of 1 ng/m³. SCAQMD’s investigation into the source of Chromium-6 in the southern area continues, including facilities located in the City of Long Beach.

Area Schools: Monitoring by SCAQMD and CARB continues at three schools: Lincoln Elementary, Lynn Mokler Elementary, and Wesley Gaines Elementary. In September 2017, Chromium-6 levels at these schools ranged from 0.04 to 0.35 ng/m³, which are lower than levels reported for previous months. The average Chromium-6 concentration at Lincoln Elementary School was 0.19 ng/m³ during the month of September.

The Paramount Unified School District released its report of indoor air sampling that was conducted at five schools between August 4 and 9, 2017. DPH is reviewing the indoor sampling protocol and results, and will recommend next steps to the District.

Soil Assessment

DPH attended the Paramount City Council meeting on September 19, 2017, when the City Council received into the record DPH’s final soil assessment report, *Soil Sampling Results – Residential Areas Near Anaplex and Aircraft Heat Treating. 2*

Enforcement

As follow-up to the health directives issued in July 2017, DPH continues to track compliance with SCAQMD rules and permit applications to implement more effective pollution control measures. SCAQMD reported that it is currently reviewing permit applications for new pollution control equipment for Weber Metals, Press Forge and Mattco Manufacturing.

Each Supervisor
October 18, 2017
Page 3

Additionally, Carlton Forge Works has been curtailing grinding operations during the hours of 3:00pm and 5:00pm, as required by the SCAQMD Stipulated Order for Abatement. SCAQMD continues to monitor odors through two mechanisms: 1) daily odor surveillance, and 2) odor complaint tracking. SCAQMD reports that it receives odor complaints outside of the curtailment hours, suggesting that grinding operations at Carlton Forge Works are contributing to these odors. As a result, Carlton Forge Works will be implementing additional mitigation measures in its grinding room to control odors.

Occupational Health

DPH is continuing to track previous referrals made to the California Occupational Safety and Health Administration (Cal/OSHA) regarding Anaplex and Aerocraft. The Cal/OSHA reports have been completed and DPH has requested copies for review.

Communication

DPH continues to distribute health education material to Paramount residents. In the past month, this has included staffing a table at the weekly farmers' market.

DPH will continue to work closely with SCAQMD, the Fire Department, and County Counsel to report monthly on progress to protect the public's health in the City of Paramount. If you have questions or need additional information, please let me know.

BF:ab

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors
Fire Department



MAX HUNTSMAN
INSPECTOR GENERAL

COUNTY OF LOS ANGELES
OFFICE OF INSPECTOR GENERAL

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February 2, 2018

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

FROM: Max Huntsman
Inspector General

SUBJECT: Services and Programs Offered to Pregnant Prisoners and Mothers

At the November 14, 2017 Board meeting, Supervisor Hilda Solis instructed the Inspector General to report back to the Board with information on the services provided to pregnant prisoners at Century Regional Detention Facility (CRDF). The Office of Inspector General monitors gender responsive programming and reproductive justice issues as part of its ongoing site visits and attendance at the Los Angeles County Sheriff's Department's (Department) monthly Gender Responsive Advisory Committee meetings. In December 2017 and January 2018, the Office of Inspector General conducted multiple site visits and met with personnel and prisoners specifically regarding the Department's provision of services to pregnant prisoners at CRDF.

Programs

As of January 2018, there were thirty-five pregnant prisoners at CRDF. The Department currently operates six programs for pregnant prisoners and mothers, and a seventh program is in the planning phase. For each program listed, the OIG has spoken with providers and participants and has reviewed curricula where available. Programs include:

Lactation Program

The Department implemented its lactation program in January 2016. This program is offered to pregnant prisoners during their initial prenatal appointments or their post-delivery assessments, and to prisoners who report that they were breastfeeding prior to incarceration. To be eligible for the program, the prisoner must pass a medical clearance, the child must be under six months old, and a designated person must commit to retrieve frozen milk weekly. Currently, there are six participants in the program and the Department makes accommodations for participants whose families can only pick up milk every two weeks.

Correctional Health Services (CHS) and the Department are doing effective outreach to pregnant and postpartum prisoners and current participants expressed to the Office of Inspector General gratitude toward the Department for its existence. The Department does not have historical data regarding the number of participants since the program's inception. However, the Department reports that no one who meets the eligibility criteria has been refused. The Office of Inspector General has commended the Department's lactation program efforts and has recommended that it begin to track participation data to highlight those efforts and prisoner participation rates.

Adults Bonding with Children (ABC) Program

The ABC Program allows for contact visits between prisoners and their children under the age of twelve. The visits occur weekly in a room that offers games, movies, activities, books and toys. Prisoners qualify for participation if they are currently enrolled in Education Based Incarceration (EBI) and meet other criteria based upon prisoners' bail amounts, current charges and criminal histories. The Department reports that in the last six months, 36 prisoners were approved for participation in ABC and 120 were rejected. The program currently has seven prisoner participants and ten children.

The ABC program and the custody assistant who runs ABC are highly regarded by the prisoners and their families, and the Office of Inspector General has recommended that the Department evaluate all options for increased participation, including expanding participation criteria.

Families & Criminal Justice Miracle Project (Miracle Project)

The Miracle Project is provided through EBI and is available to parents and pregnant prisoners. It offers support groups, child custody advocacy and

offers programming in child development, pregnancy and prenatal development, human reproduction, childbirth, and the postpartum experience. The Department reports that there are currently eleven participants and two civilian instructors for the program. The Miracle Project may be beneficial to more pregnant prisoners at CRDF, however, the Office of Inspector General has not determined how many of CRDF's pregnant prisoners would participate in the program if given the opportunity.

Harriet Buhai Center for Family Law

The Harriet Buhai Program is a three-day legal clinic that educates and engages prisoners in, among other areas, dependency law, domestic violence, paternity, child support and life skills. The program is offered on a rotating schedule throughout CRDF general population housing areas.

Gender Responsive Rehabilitation (GRR) Program

The GRR Program is offered in one EBI housing module which houses pregnant and general population prisoners. It has a dedicated GRR Family Services Coordinator who maintains a caseload of pregnant and postpartum prisoners, specifically. The Family Services Coordinator works with Department of Child and Family Services (DCFS) social workers and attorneys to assist pregnant and postpartum prisoners with custody issues and provide group and individual counseling based on a therapeutic community model.

As of January 2018, the Family Services Coordinator had a caseload of eight prisoners. The program and access to the Family Services Coordinator would surely be beneficial to more of CRDF's pregnant and post partum prisoners, however, the Office of Inspector General has not determined how many additional prisoners would participate if given the opportunity. For example, some pregnant prisoners suffer from severe mental illness and program participation eligibility is dependent upon the acuity of their symptoms at the time one of the 124 spaces becomes available.

Mama's Neighborhood

Mama's Neighborhood is a Department of Health Services (DHS) program that is currently offered in the community only, but the Department has partnered with Mama's Neighborhood to expand to CRDF by the end of February 2018.

Mama's Neighborhood provides health services and referrals, assistance with depression, postpartum depression, behavioral changes, and parenting, as

well as assistance with negotiating the DCFS process to reunite with children upon release. When participants are released, their cases will be transferred to community care coordinators who will follow participants for up to 18 months. In addition to case management, Mama's Neighborhood is exploring the possibility of utilizing a registered nurse or volunteer to provide support services during labor and delivery. The Office of Inspector General will continue to monitor and report on the development and implementation of this program.

Women's Integrated Services Program (WISP Pilot)

The Department reports that the WISP pilot is a collaboration between the Department, DHS and the Los Angeles County Probation Department, and provides services to CRDF general population prisoners with non-violent offenses. WISP Pilot probation personnel work with prisoners to determine their post release probation plans where necessary. Two WISP Pilot social workers and two deputy probation officers conduct a comprehensive assessment and work with prisoners on re-entry planning as well as access to services while in custody and in the community upon release. The Department reports that, as of January 2018, there were nine participants in the program.

Drinking Water

Over the last three years, the Office of Inspector General has received complaints regarding the taste, quality and sanitation of the water at CRDF. On multiple occasions, Office of Inspector General personnel have observed drain fly and larvae infestations¹ in sink holes and drains throughout the facility. The Department has stated that the infestations are caused by the prisoners putting food down the drain and are exacerbated by the prisoners clogging sink holes and drains with tissue paper (in efforts to control infestations).

Water conditions were also identified in a March 2016 letter to the Department from the Sybil Brand Commission which reported "brown" water quality and "gnats" in sink holes. In April 2016, the Department issued a Corrective Action Plan (CAP) that promised the installation of a facility-wide filtration system as well as weekly pest control and thorough facility cleanings.

¹ These flies live and breed in the organic matter present inside moist drains.

Facilities Services Bureau (FSB) personnel confirmed that the filtration system was installed in July 2016, and that the Department tests the chlorine levels twice monthly to ensure compliance with the California Environmental Protection Agency's standard for the allowable chlorine levels in drinking water.² Office of Inspector General personnel confirmed weekly visits from a pest control agency. However, pest control efforts are not facility-wide each week and do not address drain fly and larvae infestations.

The facility reports that it allows for weekly "double scrubs" of each module, but drain solvent is not regularly provided, and the infestations are not specifically addressed. In its April 2016 CAP, the Department indicated that its long-term plan is the replacement of all CRDF underground pipes. Department personnel indicate that new pipes are still necessary to improve the water quality generally, and that frequent and thorough drain cleaning with the correct solvents is necessary to eliminate the infestations specifically.

Facility leadership expresses concern about the infestations and professes a genuine desire to remedy them, but have indicated that underground pipe replacement is cost prohibitive and would require additional budget allocations to implement. The Office of Inspector General has recommended that the Department make available to prisoners, trustees and anyone responsible for housing-unit sanitation, sufficient cleaning supplies to address *all* module sanitation needs. The Department has committed to the purchase of sufficient drain solvent for the regular treatment of every affected housing area until a permanent solution can be identified and implemented.

Although the water is tested regularly and is deemed safe to drink, the presence of flies and larvae in the drains from which the drinking water is dispensed is concerning. The Office of Inspector General and Department personnel have received confirmation that some prisoners, including pregnant prisoners, are disinclined to drink the water because of its perceived danger and/or poor taste.

Until recently, all CRDF prisoners were limited to the purchase of five bottles of water per week from commissary. Additional bottles could be purchased through vending machines if prisoners had sufficient funds. In response to

² The California Environmental Protection Agency's allowable chlorine in tap water is no more than 4.0 parts per million and the Department documents indicate that on December 28, 2017, the chlorine levels were within compliance. The Department also notes that the tap water inside the facility is from the same civic water supply that is available in the surrounding community.

Office of Inspector General concerns, the Department now allows pregnant prisoners to purchase as much water as they need from commissary. Indigent pregnant prisoners who cannot afford to purchase water are still limited to tap water from the sink.

Because pregnant prisoners are advised to drink two liters of water per day, the Office of Inspector General has recommended that the Department pursue all available solutions to all water-related issues and implement identified solutions as soon as possible. The Department reports that it is in the process of exploring the feasibility of the installation of additional water filtration systems to the communal sinks in all housing areas at CRDF. The Office of Inspector General will continue to monitor the Department's progress in this area.

Prenatal Diets

In monitoring dietary accommodations for pregnant prisoners, the Office of Inspector General spoke with five Los Angeles County Medical Center (LCMC) obstetricians as well as prisoners and Department and CHS personnel. The CRDF Director of Women's Health Services stated that pregnant prisoners are advised not to consume cold-cut meats for various health reasons, some potentially serious. The Office of Inspector General has received complaints from pregnant prisoners that they have been given cold-cut meats in their custody diets. LCMC medical personnel reported to the Office of Inspector General that they, too, have received similar complaints from CRDF prisoners.

CRDF personnel explained that, at times, pregnant prisoners do not receive their prenatal diets if they change housing locations, and if staff on the floor are not immediately notified of special diet accommodations. The Department has committed to brief all custody personnel on the handling of prenatal diets to ensure that no breaks occur as prisoners change housing locations, and to ensure that prenatal diets are accurately labeled.

Recreation Time

Department personnel have reported, and eUDAL documentation confirms, that CRDF housing locations are generally limiting unstructured recreation time to an average of two hours per day. The Department correctly notes that this exceeds the minimum three hours weekly identified in California Code of Regulations Title 15 Minimum Standards for Local Detention Facilities. For the remaining twenty-two hours, unless otherwise engaged in structured programs or treatment, prisoners may be confined to their cells

or bunks. This includes pregnant prisoners and those who are assigned to sleep in triple bunks in module dayrooms. The current housing and out-of-cell schedules are insufficient for pregnant prisoners and are inconsistent with a direct-supervision model which is widely regarded as more suitable for women's facilities.

The Department reports that it cannot offer additional out-of-cell time for 120-prisoner housing modules without additional assigned personnel. If so, the Department must re-evaluate and adjust existing resources to increase out-of-cell time for all prisoners, and particularly for those who are pregnant. In the interim, the Office of Inspector General has recommended that the Department permit prisoners to eat meals in housing unit dayrooms. This will increase out-of-cell direct supervision time, and may decrease fly infestation issues if prisoners and personnel can ensure that food is disposed of in dayroom trash bins rather than toilets inside prisoners' cells. The Department has agreed to permit prisoners to eat two meals in module common areas, and the Office of Inspector General will continue to monitor the Department's progress in increasing unstructured recreation time.

Restraint of Pregnant Prisoners

The Office of Inspector General received several complaints from pregnant prisoners that they have been "dragged around" while restrained to non-pregnant prisoners during transport to and from court. Department personnel confirmed that general population prisoners, including pregnant prisoners, were being transported in fours, and handcuffed together by one hand each. The four single cuffs were connected to chain tethers that intersect at a locking mechanism centered between them. This form of restraint subjects each prisoner to the movements of others and may not be safe for physically vulnerable or pregnant prisoners.

The Department was responsive to these complaints and reports that it has now discontinued the practice of tethering pregnant prisoners to other prisoners. The Office of Inspector General will continue to monitor the Department's use of restraints on pregnant prisoners.

The Custody Division Manual states that a prisoner "in labor, during delivery, or in recovery after delivery, shall not be restrained by the waist, wrists, or ankles." The Office of Inspector General conducted an unannounced visit with a pregnant prisoner in active labor at LCMC and verified that she was not restrained. Prisoners are left unrestrained for two to three hours post-delivery and interviews with postpartum prisoners revealed that the

Department complies with this requirement and has made efforts to extend the amount of time prisoners are unrestrained post-delivery.

Support Services During Labor

In December 2016, the Office of Inspector General reported that the Department had partnered with the American Civil Liberties Union to coordinate doula services to assist prisoners during child birth. Doula services would be especially valuable because family is not permitted to be present during labor and delivery. In December 2017, the Department reported that the doula program was never implemented due to liability and security concerns. For example, the Department is concerned that volunteers may violate security policies, such as notifying family members who have been barred from notification when a prisoner is going into labor.

The Department recognizes that pregnant prisoners should not be without emotional support during labor and delivery, and that these services are more appropriately planned and implemented by medical personnel and CHS. The Department has expressed a commitment to increasing support services during labor and delivery through the Mama's Neighborhood program.

The Office of Inspector General has recommended that:

- CHS, DHS and the Department collaborate in the development of a policy that allows for the provision of sufficient support services during labor and delivery.
- the policy include the presence of family during delivery, where possible, and that the specific support provided be communicated to prisoners and everyone involved in their care and security, prior to delivery, and as part of a comprehensive birth plan.

LCMC Unit Order 8-22-010 states that prisoners in the open ward,³ which is where prisoners deliver, are not permitted to make phone calls.

The Office of Inspector General has recommended that:

- the Department, CHS, and DHS develop policy and procedure that allow for advance communication between facility medical personnel, custody leadership, prisoners, and prisoners' loved ones.

³ The unsecure area of the Los Angeles County Medical Center.

- phone calls be arranged in advance with additional discretion for deputies to increase phone access if time and operations permit.
- that calls be permitted when prisoners arrive at the hospital, as well as pre and post delivery.

Visits with Newborn

Prisoners who deliver at LCMC are permitted to have varied contact with their newborns for the duration of their hospital stays. According to LCMC custody personnel, deputies take into account prisoner behavior, attitude, and criminal history when making these determinations.

The Office of Inspector General has recommended, and the Department agrees, that if and how these factors impact the time prisoners may spend with their newborns should not be determined solely by custody personnel. As with emotional support services during labor and delivery, the Office of Inspector General has recommended that determinations about the amount of time prisoners spend with their newborns be a collaborative effort between medical, mental health, and custody personnel.

The Office of Inspector General has recommended that prisoners' preferences receive strong consideration, that determinations be part of comprehensive birth plans, that they be communicated to prisoners and their loved ones in advance, and that any deviation from a plan that limits visits be clearly articulated in writing and communicated at the earliest available opportunity. The Department has committed to ensuring that prisoners who are determined not to pose a threat, are permitted the maximum amount of time with their newborns, including rooming in where possible. The Office of Inspector General will continue to monitor the amount of time prisoners are permitted to spend with their newborns.

Conclusion

The Department has expressed a commitment to providing pregnant prisoners with the necessary tools, resources, and accommodations to assist them while in custody and during their transition back to the community.

The Department has dedicated a full time, unfunded custody assistant to tracking and facilitating services for pregnant prisoners. The Office of Inspector General receives positive remarks from prisoners about the nurse

practitioner and custody assistant assigned to their care. Prisoners describe them as kind and attentive to their questions and concerns, which are essential to limiting stress and supporting safety during childbirth. These personnel may be excellent candidates to plan and implement the above recommendations should the Department dedicate appropriate resources to the effort.

The Office of Inspector General commends the Department for its commitment to reproductive justice for Los Angeles County prisoners and will continue to monitor the Department's progress at CRDF.

If you have any questions please contact me at (213) 974-6100.

MH:vb:nz

c: Jim McDonnell, Sheriff
Sachi A. Hamai, Chief Executive Officer
Lori Glasgow, Executive Officer
Mary C. Wickham, County Counsel
Mark Ghaly, Deputy Director, Community Health



COUNTY OF LOS ANGELES PROBATION DEPARTMENT

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TERRI L. McDONALD
Chief Probation Officer

February 14, 2018

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

FROM: Terri L. McDonald
Chief Probation Officer

SUBJECT: **90-DAY REPORT BACK – PROBATION DEPARTMENT’S PRISON RAPE
ELIMINATION ACT (PREA) IMPLEMENTATION PLAN**

On November 14, 2017, on motion of Supervisors Hahn and Kuehl, your Board instructed the Chief Probation Officer to report back to the Board within 90 days on progress made in developing a plan for PREA compliance within its juvenile detention facilities, including a grievance/complaint procedure that effectively and safely allows for reporting of incidents, and will be PREA compliant. The following provides a response to this motion.

I. PROPOSED PREA COMPLIANCE UNIT STAFFING MODEL

The Probation Department has identified a staffing model for a PREA Compliance Unit based on PREA (2003) §115.311 that will align with current Departmental classifications. The Department has also been working with the Chief Executive Office (CEO) on a staffing analysis that will comply with PREA mandates in our halls and camps. Only three additional budgeted positions will be needed as the Department will absorb the PREA compliance on-site duties by utilizing existing managerial positions. The proposed PREA Compliance Unit will consist of the following items:

- **One (1) PREA Coordinator** (Director level management position reporting directly to the Chief Probation Officer, or her designee). This item has been requested in the Department’s FY 2018-19 Recommended Budget to comply with the following Department of Justice (DOJ) Code of Federal Regulation requirement:

PREA (2003) §115.311 (b) An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

- **Two (2) PREA Unit Compliance Managers (PUCM)** (Assistant Director level management positions, one each to oversee halls compliance and one to oversee camps compliance, both reporting directly to the PREA Coordinator). These items have been requested in the Department's FY 2018-19 Recommended Budget to support the PREA Coordinator.

As the largest Probation Department in the nation, with three Juvenile Halls and eleven Camps spanning the entire County of Los Angeles, two PUCMs are necessary to ensure proper coverage and compliance monitoring. Each PUCM will report directly to the PREA Coordinator, and will assist each PREA Facility Compliance Manager in gaining and maintaining PREA compliance by reviewing and ensuring compliance with:

1. The 1:8 PREA mandated staffing ratio;
 2. The appropriate deployment of video monitoring systems and other monitoring technologies to supplement supervision; and
 3. Policies or practices and that they are appropriate and adequate to prevent, detect, or respond to sexual abuse.
- **Fourteen (14) PREA Facility Compliance Managers (PFCM)** (Existing managerial positions will report PREA matters directly to the PUCMs)

Based on standard, the Department has identified existing funded and filled items at each juvenile facility. All PREA duties at the Juvenile Halls will be overseen by each facility's Superintendent. Similarly, all PREA duties at the Camps will be overseen by each facility's Director.

The implementation of the proposed unit will assist in developing a path towards compliance with PREA (2003), and the development of relationships between internal and external staff responsible for the maintenance of compliance and reporting. This unit's functions will be essential to not only achieve compliance with PREA (2003), but help to ensure sustained compliance.

II. PHYSICAL PLANT / TECHNOLOGY IMPROVEMENTS

The Department is making physical plant improvements that align with PREA (2003). At some of the juvenile facilities, we have initiated the installation of items, such as, privacy/modesty screens/panels in all restrooms, for both toilets and shower areas to meet PREA (2003) standards. The initial pilot placement of the panels was at Los Padrinos

Juvenile Hall and Camp Glenn Rockey. Based on the initial pilot placement of these items, we determined that a full departmental implementation would be appropriate. The Department anticipates that the ordering and installation for all juvenile facilities should be completed by June 2018. Additional one-time funds will be needed for other physical plant improvements on a phased-in basis, that are contingent on facility assessments and cost estimates. We will work with the CEO's office and will address this under separate cover to your Board.

The Department has also completed a comprehensive review of its CCTV network at all juvenile facilities. Taking into account PREA (2003) standards, an estimated 2,207 cameras would be required to ensure optimal video coverage. The Department has proposed a phased-in three-year plan, beginning in 2018 and concluding in 2020, to incorporate these additional cameras. The plan prioritizes camera installation by the number of incidents reported at each location, based on the Department's proposed and current plans to consolidate and close several of these facilities in the near future. We have requested an estimated \$39.5 million to complete the project.

III. TRAINING AND EDUCATION

In 2014, the Department was awarded a PREA grant through the DOJ's Bureau of Justice Assistance (DOJ-BJA). This grant was utilized by the Department to initiate a consulting contract with Just Detention International, Inc. (JDI), a nationally renowned organization in the areas of addressing prison rape and sexual abuse within institutions.

In collaboration with JDI, preliminary training on PREA (2003) for the Department's institutional staff and partner agency staff began in 2015. The content of this training was based on a draft PREA (2003) Compliance Directive, which was drafted in a collaborated effort between the Department and JDI. The Probation Department has already convened several focus groups comprised of potential trainers to help in the development of additional training material and to identify and address any possible barriers.

In April 2015, JDI PREA consultants began providing an 8-hour training-for-trainer's class that was attended by teams of the Department's institutional staff and leaders. The course focused on creating familiarity with the material and giving the participants tools to eventually facilitate the development of a curriculum that is customized and specific to the needs of the Department. Over 1,700 line staff, over 200 Supervisors and Managers, and a multitude of representatives from partner agencies, such as the Department of Mental Health, Juvenile Court Health Services, and Los Angeles County Office of Education have attended the training.

Additionally, all newly-hired Officers being trained in the Juvenile Corrections Officers Core Academy are now required to complete the initial 8-hour course regarding PREA and Sexual Violence. In accordance with PREA (2003), the Department will conduct its first series of refresher trainings for institutional staff beginning this year. Our Staff Training Office (STO) is in the process of identifying staff who are required to receive this training,

and will then proceed to schedule the trainings. We estimate a completion date by the end of December 2018, for all staff identified to be trained.

The Department will continue its partnership with JDI to develop a training curriculum, tailored to the Department's specifications for working with youth, for PREA investigative staff and PREA Compliance Managers (PCM). This training will be provided to the Department's Internal Affairs Unit, PREA Unit personnel, facility supervisors and managers as required by PREA (2003). The projected completion of this curriculum is June 2018. Full completion training of all identified investigative staff and PCMs is projected by the end of December 2018.

The Department is also working with its Contracts and Community & Intergovernmental Relations sections to ensure that pursuant to PREA (2003), vendors and volunteers who may come in contact with youth are also trained on their responsibilities under the Department's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The Department projects that this training will be completed, with all appropriate documentation accounted for, also by the end of December 2018.

The Department has collaborated with outside Probation agencies such as San Diego and Riverside Counties to obtain videos, poster designs and other educational materials to assist in addressing the mandates expressed in PREA (2003). A video has been procured which will discuss the subject matter tailored to the specific needs of the youth served by the Department. Several newly designed PREA posters will be distributed to all of the institutions.

Youth Orientation Handbooks and the facility orientation processes have also been updated to include the language of the Department's Zero Tolerance Policy on Sexual Abuse or Harassment and information on how to report incidents of or suspicions of sexual abuse or harassment. The Department is also collaborating with JDI to explore additional options such as educational software and/or systems designed to ensure the proper delivery of continued PREA educational sessions to our youth. We anticipate completing and implementing these plans by the end of December 2018.

IV. REPORTING AND GRIEVANCE PROCESS

The Department is currently reviewing its grievance procedures and processes. As part of this review, the Department is exploring the concept of incorporating a form of electronic hardware to be utilized in the reporting complaints or grievances to mitigate risks of a youth's anonymity being compromised. This process will also include the incorporation of PREA (2003). The grievance process continues to evolve to reflect legislative and organizational changes. The most significant update occurred in 2015, which was successfully reviewed during the completion of a biennial Board of State and Community Corrections audit of 2016.

As part of the Department's continuous quality improvement efforts to ensure that the process continues to work efficiently and most importantly effectively, the following measures have been taken:

- As recommended by the Probation Commission, the Department is in the process of ordering large signs that will clearly advise the youth that they can file a grievance and that anything filed will remain confidential.
- Exploration of the feasibility of incorporating an iPad or Kiosk reporting system for its facilities.
- Managerial Weekend Visits were implemented by the Department to assist in identifying areas of concern, including monitoring to ensure that a grievance process is readily available for youth.
- Working with The Center for Juvenile Justice Reform at Georgetown University in implementing the Youth in Custody Practice Model and thoroughly reviewing the grievance system to see what additional short-term enhancements can be implemented while continuing to explore best practices across the nation.
- Conducting assessments of the three Juvenile Halls and examining how to facilitate the implementation of the LA Model similar to that at Campus Kilpatrick.

The Department is continuing its research in expanding the utilization of the already established Ombudsman office as a means in fulfilling PREA (2003), and the identification of a rape crisis or national victim advocacy organization to provide an established hotline for both youth and staff to utilize.

V. PREA ASSESSMENT AND PRE-AUDITS

The Department is working with both JDI and the National PREA Resource Center (NPRC) to conduct assessments of our facilities and our Departmental processes and policies. This tutorial experience and training will seek to create identified PREA Subject Matter Experts within the Department who will have the ability to conduct an independent analysis of and self-assessment of our operations to identify and correct gaps or deficiencies prior to an official PREA audit.

It is imperative to have a PREA Coordinator, PREA Compliance Managers, and PREA trained investigators identified, trained and in place prior to the coordination of a pre-audit/assessment. These positions are critical to successfully maintain compliance with the most basic standards of PREA and are vital to assist the Department as it attempts to establish its PREA program.



COUNTY OF LOS ANGELES SHERIFF CIVILIAN OVERSIGHT COMMISSION

World Trade Center
350 South Figueroa Street, Suite 288, Los Angeles California 90071
(213) 253-5678

February 28, 2018

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

From: Brian K. Williams 
Executive Director

Brian K. Williams
Executive Director

MEMBERS

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Vice-Chair

Hernán Vera
Commissioner

UPDATE REGARDING THE LOS ANGELES COUNTY SHERIFF'S DEPARTMENT (LASD) ON PROGRESS MADE IN DEVELOPING A PLAN FOR PRISON RAPE ELIMINATION ACT (PREA) COMPLIANCE

On November 14, 2017, the Board of Supervisors (Board) directed the Sheriff Civilian Oversight Commission (COC), Office of Inspector General (OIG) and LASD to report back to the Board within 90 days relating to progress made in developing a plan for PREA compliance, including a grievance complaint procedure that effectively and safely allows for reporting of incidents.

Pursuant to this Board directive, the COC, OIG and the LASD met on December 6, 2017, to initiate dialogue on the status of LASD's development of a strategy plan for PREA compliance. Key personnel from COC, OIG and LASD attended the meeting and engaged in discussions on LASD challenges. On January 16, 2018 a meeting was organized with Karen Dalton, Assistant Division Director, Custody Services—Specialized Programs with the Sheriff's Department to discuss PREA which was to be followed by a tour of the Century Regional Detention Facility (CDRF); however, due to a scheduling conflict, the meeting was canceled and rescheduled for February 13, 2018. The subsequently scheduled meeting was held and a tour conducted. During the meeting the Sheriff's Department shared the steps it has initiated to move forward to achieve PREA compliance. Staffing and funding the PREA Compliance Unit continue to be an issue for the Sheriff's Department. The COC supports the Sheriff's Department's objective to have PREA compliance managers at all facilities to oversee compliance monitoring and to have funding allocated to support the PREA compliance unit.

The COC remains committed to working closely with the OIG and LASD to monitor and assist in the development of a PREA compliance plan. To that end, the COC has received some preliminary information from LASD, including several approved PREA policies, a number of unit orders, staffing model for a PREA Compliance Unit and budget proposal on staffing the PREA program. The COC has not yet received all of the policies from LASD because they are in the revision process and pending approval. It is clear the LASD takes this issue very seriously. However, because the COC has not been able to review all of the proposed policies of the LASD, the COC is unable to provide a comprehensive assessment regarding the status of the LASD's PREA implementation plans.

This memorandum is being submitted after consultation with the OIG and the LASD.

If you have any questions, please contact Brian K. Williams, Executive Director at (213) 253-5678, or via e-mail at BWilliams@coc.lacounty.gov or Daniel Delgadillo at (213) 253-5675, or via e-mail at ddelgadillo@coc.lacounty.gov.

BKW:dd

c: Executive Office, Board of Supervisors
County Counsel
Los Angeles County Office of Inspector General
Los Angeles County Sheriff's Department
Justice Deputies

In collaboration with NPRC and JDI, the following four-phase implementation plan has been established by the Department:

- Phase 1 -** A complete facility assessment and tutorial walkthrough of a Juvenile Hall and Camp facilities by NPRC or JDI with Department identified staff;
- Phase 2 -** A complete policies, procedures, and processes evaluation by NPRC or JDI;
- Phase 3 -** A Department wide self-assessment of remaining facilities; and
- Phase 4 -** Address any identified facility and/or departmental deficiencies prior to official audits. These assessments and evaluations would begin in August 2018 after the identification and training of departmental PREA staff.

With the completion of the assessments and evaluations, the Probation Department will be better prepared to take the final steps towards compliance of PREA (2003). A completed gap analysis will assist the Department in determining where it can enhance current policies and procedures and assist with establishing a foundation to developing processes and systems to address standards yet to be addressed, such as the proper collection, review, and storage of PREA-specific data.

VI. CONCLUSION

The Probation Department has initiated steps to move forward to achieve PREA compliance and will continue to work on a plan to allocate the remaining DOJ-BJA funding during FY 2018-19. Proposed items under consideration are:

1. Development of Departmental PREA training curriculums;
2. Continued physical plant improvements; and
3. Identification and implementation of youth PREA educational programs.

Updated information on the implementation status of these and other plans will be provided in the next follow-up report to your Board.

Please contact me if you have any questions or require additional information, or your staff may also contact Acting Deputy Director, Luis Dominguez, at (562) 940-2746.

TLM:SEM:LD:mr

c: Sachi A. Hamai, Chief Executive Officer
Lori Glasgow, Executive Officer, Board of Supervisors
Mary C. Wickham, County Counsel
Sheila Williams, Senior Manager, CEO
Justice Deputies



County of Los Angeles CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
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SACHI A. HAMAI
Chief Executive Officer

March 21, 2018

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

From: Sachi A. Hamai 
Chief Executive Officer

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

FUNDING AND STAFFING RECOMMENDATIONS FOR SHERIFF AND PROBATION PRISON RAPE ELIMINATION ACT COMPLIANCE UNIT (ITEM NO. 48B, AGENDA OF NOVEMBER 14, 2017)

On November 1, 2017, the Board of Supervisors directed the Chief Executive Officer (CEO), in collaboration with the Sheriff Department (Sheriff) and Probation Department (Probation), to develop funding recommendations and a staffing model for two Prison Rape Elimination Act (PREA) Compliance Units, one in each respective department. The motion also directs the CEO to include in the staffing model, attorneys, paralegals, and non-sworn employees who would report directly to the Sheriff and Chief Probation Officer.

PREA

The federal PREA of 2003 was created to prevent, detect and respond to incidences of sexual abuse and sexual misconduct within our institutions nationwide. Correctional agencies are required to implement national PREA standards with the goal of creating “zero tolerance” cultures for sexual abuse and misconduct. Federal regulations for PREA and the Department of Justice’s 2012 final rule and national standards require the following:

- Training and Education – Staff should be trained and educated on ten (10) specific topics as detailed in the standards to prevent, detect and respond to sexual abuse and sexual harassment and to create a culture of sexual safety in the facility. In addition, inmates must receive information at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or harassment;

- Screening and Assessment of those at Risk of Sexual Victimization and Abusiveness – Inmates shall be screened and assessed to identify those at heightened risk of being sexually victimized and those at heightened risk of being sexually abusive so that staff can make housing and programming decisions with the goal of being able to use this information to prevent sexual abuse;
- Reporting – Inmates and staff shall be able to report (verbally or in writing) sexual abuse and be afforded multiple internal and external avenues (including third parties) for them to privately report sexual abuse, harassment, and/or retaliation by other inmates or staff, as well as staff neglect or violation of responsibilities that may have contributed to such incidents;
- Investigations – All allegations of sexual abuse and harassment are to be investigated thoroughly and properly so that incidences are substantiated when they should be, both to deter these incidents and increase reporting. Investigations should be documented and evidence be preserved; be completed regardless of the status of the victim or perpetrator; and all substantiated allegations that arise to the level of a criminal offense be referred for prosecution; and
- Data Collection – Facility staff shall collect accurate and uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The PREA standards also require a comparison of the current year's data and corrective actions with those from prior years, and mandates that an assessment of the agency's progress in addressing sexual abuse be completed.

CEO's Recommendation

The CEO met with each department to discuss and review its staffing proposal for the PREA Compliance Units. Based upon our review, the CEO recommends 19 positions at an estimated annual cost of \$3.2 million for the Sheriff's Department and three (3) positions at an estimated annual cost of \$0.5 million for the Probation Department. In addition, we determined that \$0.4 million in funding is needed to continue the Just Detention International (JDI) PREA consulting services contract for a total estimated cost of \$4.1 million. Lastly, after consultation with the Office of Inspector General (OIG), we do not recommend the allocation of attorneys or paralegals at this time. Adjustments to the above staffing recommendations will be considered once the units are established and workload data is available. The \$4.1 million in additional funding will allow the departments to begin monitoring its facilities to ensure compliance with the above PREA standards.

Sheriff's PREA Compliance Unit

The Sheriff requested \$3.9 million for 23 positions to create a PREA Bureau to be housed in the Custody Services Division. The Operations Assistant III positions would function as the PREA compliance manager at each jail facility with an Operations Assistant II position providing administrative support. The Operations Assistant IIIs and IIs would report to an Administrative Services Manager III. The Department requested two Sergeants - one would be responsible for operations while the other would oversee training and investigations. The Civilian Investigator positions would investigate PREA cases and submitting them to a Sergeant for final review. The Bureau would be overseen by a Director position who would function as the PREA coordinator. Twenty-one of the 23 requested positions are non-sworn.

CEO's Analysis

POSITIONS	SHERIFF'S REQUEST	CEO'S RECOMMENDATION
Administrative Services Manager III	1	1
Assistant Dir, Bureau Operations	1	1
Civilian Investigator, Sheriff	5	5
Director, Bureau Operations	1	0
Law Enforcement Technician	1	1
Operations Assistant II	5	5
Operations Assistant III	6	4
Secretary V	1	0
Sergeant	2	2
Total Positions	23	19
Estimated Annual Cost:	\$3,868,000	\$3,146,000

CEO reviewed the Sheriff's proposal including the organizational structure and duties and responsibilities of the requested positions. Our office recommends 19 out of the 23 positions requested of which 17 are civilians. The estimated annual cost is \$3.2 million.

Probation's PREA Compliance Unit

Probation requested \$0.5 million for a Probation Director and 2 Assistant Probation Directors for a total of 3 positions to create a PREA Compliance Unit. The Probation Director would function as the PREA coordinator and the 2 Assistant Probation Directors would function as the compliance managers.

CEO's Analysis

POSITIONS	PROBATION'S REQUEST	CEO'S RECOMMENDATION
Probation Director	1	1
Assistant Probation Director	2	2
Total Positions	3	3
Estimated Annual Cost:	\$530,000	\$530,000

CEO reviewed Probation's request and is recommending all three positions at an estimated annual cost of \$0.5 million. The current juvenile population in Probation's juvenile halls and camps is approximately 1,000. The CEO believes the positions requested are adequate based on the juvenile population, Probation's organizational structure and duties and responsibilities of the requested positions.

Staffing Levels and Video Monitoring

PREA also requires that "detention facilities develop, document and make its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring to protect individuals against abuse. "

To comply with the above PREA standards, Probation plans to implement a staffing ratio of 1:8 during resident waking hours and 1:16 during sleeping hours. According to Probation, the above staffing ratios will be achieved, utilizing existing personnel, via the camp consolidation plan. However, full implementation of the camp consolidation plan is not expected until July of 2019 and thus it is unknown if existing personnel, as contemplated in the plan, will be available to redeploy toward this effort.

In addition, Probation has completed a comprehensive review of its Closed-Circuit Television (CCTV) network at all juvenile facilities and estimated 2,207 additional cameras would be required to ensure optimal video coverage. The review also took into consideration future camp consolidation efforts. The department has proposed a three-year phased in plan. The total estimated cost for all three phases is \$41.7 million of which \$38.9 million is one-time and \$2.8 million is ongoing. The plan is considered a critical unmet need and the CEO will continue to work with Probation to address this priority.

According to the Sheriff, existing staffing levels in the jails mandated under Title 15 and to ensure compliance with the Citizens Commission on Jail Violence recommendations and other settlement agreements are sufficient to meet the staffing levels required under PREA. In addition, in Fiscal Year 2012-13, the Sheriff was allocated 5 additional positions and \$26.4 million in one-time funding to expand CCTV throughout the jails. Cameras existed at Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF) and the Inmate Reception Center (IRC). The \$26.4 million in additional funding allowed the Department to enhance the fixed camera system at MCJ, TTCF and IRC as well as expand the system to Century Regional Detention Facility, Los Angeles County Medical Center Jail Ward and Pitchess Detention Center.

Attorneys and Paralegals

The CEO met with the OIG to discuss the inclusion of attorneys and paralegals in each department's PREA Compliance Unit. It is the OIG's opinion that attorneys and paralegals are not critical items at this time. The priority and focus should be for each department to establish a compliance unit so that they can begin PREA monitoring immediately. The OIG indicates that if legal staff are needed, County Counsel could temporarily reassign staff to assist.

JDI

Sheriff and Probation currently utilize JDI as an expert consultant on PREA compliance in detention facilities. The OIG recommends that the both departments continue to retain JDI throughout implementation of the PREA Compliance Units and until the departments' first successful PREA audit. The grant which offsets the costs of this service is set to expire in 2018. The departments are requesting \$0.4 million in ongoing net County cost to continue the contract for an additional year and until they are fully compliant with PREA.

Funding for the PREA Compliance Units

The Sheriff has been proactively applying for grants and was successfully awarded a grant from the Bureau of Justice Assistance for PREA implementation. The CEO also inquired as to the feasibility of utilizing Inmate Welfare Fund (IWF) for this purpose, but County Counsel has opined that any costs associated with providing services that are mandated under PREA cannot be paid for with IWF. It was also determined that the IWF could not sustain the ongoing costs associated with the PREA Compliance Unit.

Each Supervisor
March 21, 2018
Page 6

PREA is a federal mandate, however, no ongoing federal funding has been allocated for implementation nor to sustain these efforts. The CEO will continue to work with Sheriff and Probation to identify an ongoing funding source for the PREA Compliance Units.

Conclusion

A total of \$4.1 million is needed to establish the PREA Compliance Units: 19 positions and \$3.2 million for the Sheriff Department; 3 positions and \$0.5 million for the Probation Department; and \$0.4 million for JDI's PREA consulting services. As always, our office recommends that the allocation of any additional general fund monies be considered during the budget process. This will allow recommendations to be made within the context of the overall budget and numerous competing funding priorities and requests.

Should you have any questions, please do not hesitate to contact me or Rene Phillips, at (213) 974-1478.

SAH:JJ:MM:SW
RP:DC:cc

c: Executive Office, Board of Supervisors
County Counsel
Sheriff
Office of Inspector General
Probation



OFFICE OF THE SHERIFF

COUNTY OF LOS ANGELES

HALL OF JUSTICE

JIM McDONNELL, SHERIFF



April 4, 2018

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

Dear Supervisors:

THE LOS ANGELES COUNTY SHERIFF'S DEPARTMENT REPORT BACK REGARDING THE PRISON RAPE ELIMINATION ACT COMPLIANCE

On November 14, 2017, the Board requested the Los Angeles County (County) Sheriff's Department (Department) report back on the Prison Rape Elimination Act (PREA) compliance within the County jail system. The Board requested the report back include funding possibilities for a PREA Compliance Unit with a staffing model to consider lawyers, paralegals, and non-sworn employees who would report directly to Sheriff Jim McDonnell. The Board requested information on progress made in developing a plan for PREA compliance including a grievance/complaint procedure that effectively and safely allows for reporting of incidents and is PREA compliant.

PREA COMPLIANCE UNIT STAFFING MODEL

The Department and the Chief Executive Office (CEO) created a staffing model for the department-wide implementation of PREA. The staffing model was reviewed by the Office of the Inspector General (OIG) and the Sheriff Civilian Oversight Commission's (COC) PREA Ad Hoc Committee. The Department initially requested 23 positions including an executive level PREA Coordinator, operations staff, and five PREA compliance teams to ensure proper implementation. The CEO recommended 19 of the 23 positions with consideration for future growth. Refer to the CEO recommendation letter titled "Staffing Recommendations for Sheriff and Probation Prison Rape Elimination Act Compliance" (Item No. 48B, Agenda of November 14, 2017). Based on the current cost calculations, the 19 positions being recommended by the CEO would equate to an approximate \$2.7 million funding need/request (related to staffing alone)

211 WEST TEMPLE STREET, LOS ANGELES, CALIFORNIA 90012

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and an overall funding request of approximately \$3.6 million related to the establishment of the Sheriff's PREA Compliance Unit, which includes staffing and operational costs. These operational costs are in the form of services, supplies, and capital assets. The operational costs do not include costs associated with structural modifications and/or technology systems.

The Department considered the need for attorneys and paralegals, along with the CEO and OIG, and concurs with the County Counsel's Office that only one full-time funded attorney position may be necessary. However, an attorney position is not included in the present funding request. Additionally, the Department is exploring a contract renewal with Just Detention International (JDI) at \$400,000 per year. JDI is a health and human rights organization exclusively dedicated to ending sexual abuse in detention facilities. JDI's work is informed by the wisdom and experiences of prisoner rape survivors. This group has a proven track record of working with policymakers, advocates, and corrections officials to ensure the basic human rights of all incarcerated inmates by assisting correctional facilities to become PREA compliant. JDI has been providing consulting services to the Department under an existing contract set to expire in May 2018. A new contract is essential as the Department prepares for PREA audits for each of its custody facilities.

PROGRESS MADE IN PREA COMPLIANCE

The United States Congress passed PREA in 2003 with unanimous support from both parties. Its purpose was to "provide for the analysis of the incidence and effects of prison rape in federal, state and local institutions to provide information, resources, recommendations, and funding to protect individuals from prison rape." PREA required developing national standards to prevent incidents of sexual abuse and harassment in prison. Shortly after those national standards became effective in August 2012, the Department received a technical assistance grant from the Bureau of Justice Assistance and the PREA Resource Center. After the solicitation process, the Department also entered into its current contract with JDI to receive assistance with policy creation and revision, as well as staff and inmate training based on nationwide best practices. Consistent with PREA standards, the Department appointed Assistant Division Director, Karen Dalton, as the PREA Coordinator, and assigned a PREA Compliance Manager at each facility to begin the complicated process of implementing the 43 PREA standards and 300 PREA provisions.

The PREA standards recognize the vulnerability of incarcerated inmates who are lesbian, gay, bisexual, transgender, or intersex. To ensure the proper and safe housing and care for transgender and intersex inmates, the Department created the Gender Identity Review Board (GIRB). The Department also operates the K6G Unit, a

nationally recognized housing unit at the Department's Men's Central Jail, where the Department houses gay and transgender inmates apart from other inmates for their protection.

REPORTING SEXUAL ABUSE AND SEXUAL HARASSMENT AND THE GRIEVANCE PROCESS

The PREA standards require multiple methods for inmates to report sexual abuse and harassment by staff members and other inmates. To educate the inmate population on how to report an incident, the Department created both PREA pamphlets and posters which are presently distributed and posted at the Department's Century Regional Detention Facility (CRDF). These documents describe the current internal grievance process and also describe other options, including verbally reporting an incident to a staff member or volunteer, telling a loved one, or reporting the incident to an independent organization outside of the facility.

The Department is finalizing agreements with local rape crisis centers and the Los Angeles Regional Crimestoppers. It has also provided training to staff, volunteers, and contractors on how to report sexual abuse or sexual harassment, and also access free, confidential, support services as needed. Inmates now have the ability to enter an override code into the inmate telephone system to confidentially contact a rape crisis center toll-free. The Department has trained the inmates at CRDF on how to use this override code and will begin educating inmates at all custody facilities at Town Hall meetings beginning in May 2018.

The Department is currently reviewing the inmate grievance process to ensure that inmates know how to report sexual abuse or sexual harassment and to improve the ability to track PREA-related complaints. The Department is also exploring the possibility of allowing inmates access to electronic tablets to submit grievances.

PREA IMPLEMENTATION PLAN

During the Cluster Agenda Review meeting on March 7, 2018, the Justice Deputies requested a PREA implementation plan in this report back. Though the Department is committed to full PREA compliance, it currently lacks the necessary resources to fully implement the PREA standards in all custody detention facilities.

Should the Board approve the 19 positions recommended by the CEO, the Department will immediately recruit staff for the Department's PREA Compliance Unit and begin a nationwide search for a PREA Coordinator with extensive experience in bringing local jurisdictions into PREA compliance. Should the Board approve the new contract with JDI, the Department will also continue to consult with JDI as it finalizes PREA compliant policies and continues the process of institutionalizing PREA compliant practices.

The Department has identified three priorities as it moves towards full PREA implementation:

1. Facility Analysis

The PREA Compliance Unit will complete a detailed analysis of each custody facility, including the Department's Inmate Reception Center and court lockups, to identify blind spots with the intent to improve visibility by, upgrading the lighting and/or installing cameras where necessary. The PREA Compliance Unit will also determine whether structural modifications are needed to the shower and toilet areas throughout the custody facilities to ensure privacy. The PREA Compliance Unit will identify secure areas where transgender and intersex inmates may shower privately.

2. Data Collection

PREA Standards require the collection of a significant amount of statistical data about the occurrence and prevalence of both sexual abuse and sexual harassment. The PREA Compliance Unit will create forms and work with other Department units to implement tracking systems designed to collect all of the required data.

3. Training

PREA Standards require all staff, volunteers, and contractors who have contact with inmates to be fully trained every two years and to receive a refresher course during gap years. The PREA Compliance Unit will develop the training curriculum and implement and manage these courses with the assistance of the Department's Custody Training and Standards Bureau and the Department's Inmate Services Bureau.

Should you have any questions, please contact Chief Christy Guyovich, Custody Services Division, Specialized Programs, at (213) 893-5888.

Sincerely,

JIM McDONNELL, SHERIFF



KELLY L. HARRINGTON
ASSISTANT SHERIFF



County of Los Angeles CHIEF EXECUTIVE OFFICE

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SACHI A. HAMAI
Chief Executive Officer

December 6, 2018

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

From: Sachi A. Hamai
Chief Executive Officer

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

**REPORT BY THE DIRECTOR OF COMMUNITY HEALTH AND INTEGRATED PROGRAMS,
DEPARTMENT OF HEALTH SERVICES, ON THE ISSUES RELATED TO RECRUITMENT,
HEALTH OF THE POPULATION BEING SERVICED, AND WHETHER THERE IS A NEED FOR
ADDITIONAL OUTREACH (ITEM NO. 37 AGENDA OF NOVEMBER 14, 2017 AND
DECEMBER 12, 2017)**

On November 14, 2017, the Board directed the Director of Community Health and Integrated Programs, Department of Health Services, in his role overseeing Correctional Health Services (CHS), to report back on a quarterly basis on issues related to recruitment, health of the population being serviced, and whether there is a need for additional outreach in the jails. Attached is a full report with an initial Executive Summary that explains the progress of CHS in its efforts to transform the health care services provided to patients in Los Angeles County jails.

Beginning January 1, 2019, oversight of CHS will return fully to the Department of Health Services. Thank you for your ongoing support of our work and efforts to make CHS the highest quality, patient-focused health system it can be.

If you have any questions, please contact Dr. Mark Ghaly at (213) 974-1276 or mghaly@ceo.lacounty.gov or Jackie Clark-Weissman, Director, Correctional Health Services at (213) 893-5450 or JClarkwe@lasd.org.

SAH:MG:JL:JC:dh

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Health Agency
Health Services
Sheriff

Correctional Health Services Update

November 29, 2018

Executive Summary

Under the direction of the Los Angeles County Board of Supervisors (Board), the provision of health care for incarcerated individuals in county jails transferred from the jurisdiction of the Los Angeles County Sheriff's Department (LASD) and the Department of Mental Health (DMH) to the Department of Health Services (DHS), through the creation of Correctional Health Services (CHS). The final phase of this transition was completed in May 2017.

Now, a year and a half since the transition, we reflect on the progress we have made and the work that lies ahead. In this report, we present a brief snapshot of updates and improvements across the major service lines as well as new innovations that strengthen patient care. We also list challenges that must be addressed to continue improving.

We call particular attention to the major strides we are making in accelerating access to care through the IRC Redesign project, Urgent Care expansion, psychiatric medication access improvement in the IRC, Health Services Request Form revamp, new emergency response processes, and improvements in provider scheduling which dramatically decrease wait times. Other notable accomplishments include:

- We have increased the number of patients seen in the Twin Towers Correctional Facility Tower II clinic by over twofold due to novel scheduling protocols and workflows, which are now expanding to other facilities.
- By creating an innovative diabetes care team including physicians and a clinical pharmacist, we have improved diabetes control among our most severe diabetic patients by 30%.
- CHS administered over 10,000 doses of Hepatitis A vaccine during the outbreak, more than any other single County entity, supporting the Department of Public Health on its way to earning an LA County Productivity and Quality Award.
- We established a new Orthopedic Care Clinic in collaboration with LAC+USC that now provides care for over four times as many patients each month than previously, when patients were required to go to the hospital to receive services.
- Through an innovative partnership created through a Board Motion, which includes California State University, Los Angeles, 23 registered nurses are over halfway through their training program to become Family Nurse Practitioners, after which they will join the CHS provider workforce and apply their education and experience to serve our in-custody patients.
- We decreased the wait time for psychiatrist evaluation among moderately acute mentally ill men from four to six weeks down to less than two weeks upon entry into the system.
- Through a one-time \$5 million AB 109 funding allocation from DPH Substance Abuse Prevention and Control, we established the Substance Treatment and Re-entry Transition (START) program, providing in-custody substance use disorder services and treatment. Over the past six months, approximately 1,200 patients were referred to START.

As a maturing health care organization in the nation's largest jail, we face the challenging mission of developing a system that provides high quality care to some of the most vulnerable people in our county. Three out of ten of our patients have mental illness, over two-thirds have a substance use disorder, and

many more suffer from poorly managed chronic illnesses and diseases that have not been sufficiently cared for in the community. Socially, over half are uninsured, at least 12% are homeless, and many more are living in poverty, under the yoke of a cycle of recidivism that all too often leads back to jail or to the emergency room.

As a 2,000-member strong workforce team, CHS faces this mission with humility and with a deep sense of purpose. We believe that human dignity, empathy, and compassion don't end when one is placed in handcuffs. We believe that delivering world-class care is not only possible, but inevitable in our jails. And we believe that as we continue to empower our staff to create and accelerate improvement, anything becomes possible.

We are Correctional Health Services – *Mission Possible*.

The Correctional Health Workforce

Recruitment and Hiring

In an effort to dramatically expand the health care provider workforce amidst a tight labor market, a recruitment campaign known as “Mission Possible” was launched earlier this year. Through collaboration with CEO Countywide Communications and County Counsel, this culminated in a 13-minute documentary showing prospective applicants what it's like to serve incarcerated patients, a new website with profiles of featured health care providers, a streamlined application portal, and more. This successful initiative recently earned a 2018 Health and Human Services Merit Award from the California State Association of Counties and it continues to serve as a foundation for further recruitment and outreach campaigns. Due to the Board's enactment of a new County ordinance, we were also able to offer a recruitment bonus and a loan repayment program as incentives to assist in physician recruitment.

This year, CHS participated in provider recruitment events in seven hospitals in LA County and was present at the Pri-Med Conference in Anaheim, which attracted over 6,000 attendees. We obtained contact information for over 500 providers. CHS has also been reaching out to potential candidates through online mechanisms such as *PracticeLink*, a physician job portal, and *LinkedIn*. We are currently developing a calendar of potential conferences and career events. In addition to our national residency recruitment outreach, we are exploring additional avenues to target mid-career physicians and those re-entering the workforce. CHS has conducted a total of 67 provider interviews and a total of 21 providers have been hired.

Furthermore, as described later in this report, 23 registered nurses are currently undergoing training to become Family Nurse Practitioners through an innovative educational partnership. They will serve our patient population as providers upon graduation.

Over the last six months, nursing leadership has taken an active role in recruiting new nursing staff for CHS, including holding weekly HR meetings to set priorities and resolve issues with the onboarding process. The Nursing Directors and Chief Nursing Officers worked with the DHS Exam Unit to review, update, and open four nursing exams specifically for Correctional Health. We are in the process of opening four additional exams within the next month. Nursing leadership has scheduled multiple interview and hiring sessions to accommodate applicants since the exams were posted. Over the last six months, we conducted 163 interviews. Fifty-one candidates were selected for promotion (of which 18 were hired and 23 remain in the hiring process) and 112 candidates were selected for employment (of which 29 were hired and 53 remain in the hiring process). Additionally, we continue to utilize

approximately 40 DHS contract and registry nursing personnel across various facilities to ensure full coverage of nursing assignments.

In 2017, we hired one licensed vocational nurse (LVN), 27 registered nurses (RNs), one Nursing Instructor, and one Nurse Manager. Thus far in 2018, we have hired 10 LVNs, 69 RNs, and one Nursing Director. Pending hires that are currently in process include: 36 LVNs, 72 RNs, and one Public Health Nurse. The speed at which new hires are processed is dependent on dual department requirements, including DHS and LASD background checks, DHS health clearance, LASD IT account set up, among many others. Timeliness of onboarding is something that CHS has been monitoring and seeking to continuously improve.

These new hire numbers are far greater than any previous year prior to the transition, signifying our success in accelerating nursing recruitment. This success in nursing hiring has allowed us to begin having nurses work more to the top of their licenses and allows us to have the right level nurse doing the right type of nursing work within the jail. Thus, we assure better quality and efficiency.

Under the current staffing model, CHS has a total of 553 FTE vacancies, of which there are plans to fill up to 400 vacancies by the end of FY 2018-19. The breakdown of these vacancies includes: 79 FTE Administrative and Clinical Support; 58 FTE Mental Health; 293 FTE Nursing; 47 FTE Providers; and 76 FTE Ancillary staff. Positions which are not needed to fulfill the new care model CHS is implementing will be deleted.

The following chart depicts new employees and employees pending start between April 1, 2018 and September 30, 2018:

MENTAL HEALTH ITEMS

Classification Name	# of Employees Started	# of Employees Pending to Start
PSYCHIATRIC SOCIAL WORKER I/II	15	14
MEDICAL CASE WORKER I/II	3	4
PSYCHIATRIC TECHNICIAN	1	
RECREATIONAL THERAPIST		1
MENTAL HEALTH CLINICAL SUPERVISOR	1	
CLINICAL PSYCHOLOGIST I/II	3	4
MENTAL HEALTH PSYCHIATRIST		3
COMMUNITY WORKER		
SUBSTANCE ABUSE COUNSELOR		
	23	26

PROVIDERS

Classification Name	# of Employees Started	# of Employees Pending to Start
CHIEF PHYSICIAN I	1	
CHIEF PHYSICIAN II		
NURSE PRACTITIONER	5	3
PHYSICIAN SPECIALIST	2	4
RELIEF PHYSICIAN	11	8
SENIOR PHYSICIAN	1	
PHYSICIAN, POST GRADUATE		
DENTIST		
PUBLIC HEALTH NURSE		1
	20	16

ANCILLARY ITEMS

Classification Name	# of Employees Started	# of Employees Pending to Start
PROCUREMENT ASSISTANT I		1
PROCUREMENT ASSISTANT II	1	
RADIOLOGIC TECHNOLOGIST	4	
WAREHOUSE WORKER I		1
WAREHOUSE WORKER III		1
HEALTH INFORMATION ASSOCIATE		
PHARMACIST		
PHARMACY TECHNICIAN		
	5	3

CLERICAL/ADMIN ITEMS

Classification Name	# of Employees Started	# of Employees Pending to Start
ASSISTANT STAFF ANALYST	1	3
STAFF ANALYST	1	
INTERMEDIATE CLERK		
INTERMEDIATE TYPIST CLERK	5	3
SENIOR CLERK	1	
SENIOR TYPIST CLERK		1
SENIOR SECRETARY III	3	
	11	7

NURSING ITEMS

Classification Name	# of Employees Started	# of Employees Pending to Start
LICENSED VOCATIONAL NURSE I	4	18
NURSING ASSISTANT, SHERIFF		16
NURSING INSTRUCTOR		
NURSE MANAGER		
REGISTERED NURSE I	11	53
REGISTERED NURSE II		14
REGISTERED NURSE III		1
SUPERVISING STAFF NURSE I		2
CLINICAL NURSING DIRECTOR II	1	
CERTIFIED MEDICAL ASSISTANT	4	4
	20	108

Correctional Health Overall Totals	Total # of Employees Started	Total # of Employees Pending to Start
	79	160

Labor Relations

Over the past 12 months, CHS management and its labor partners have conducted town halls and established a monthly meeting in an effort to both improve working conditions for staff and improve patient care. Agendas for these meetings are jointly approved and previous topics have included staff safety, staffing levels, and policy and procedures that impact staff. From these meetings, committees have been formed to address issues that arise. For example, the Safety Committee, which includes all three labor groups, LASD, DHS, and staff from CHS, has been successful in addressing safety concerns that were brought up via a staff survey and our joint partnership meetings. After identifying joint training as an opportunity for improvement, we worked with stakeholders to conduct trainings that enhance our staff's knowledge while meeting professional continuing medical education (CME) requirements for licensure. We will continue to work with our labor partners and LASD in advancing our improvement efforts for both patients and staff.

Physical Health Updates and Improvements

Patient Centered Medical Home

CHS has been working to improve our health care quality and efficiency by developing a new medical care delivery model within all LA County jail facilities. The principles of this model include continuity of care, patient empanelment, and interdisciplinary collaboration involving medical and mental health staff. The model is based on the patient centered medical home concept which is widely used across Los Angeles and in all DHS Ambulatory Care Network clinics. Though popular in the community, models such as this have only been implemented in a handful of prisons and no jails in the United States due to a belief that patient turnover is too rapid.

Twin Towers Correctional Facility (TTCF), specifically Tower II (T2), began early implementation of a medical care team delivery model in January. Prior to November 2017, clinical coverage in the T2 clinic was split among multiple providers. Since then, the clinic care team has been restructured to include five permanent members: the lead physician who serves as the clinic director, two nurse practitioners, an advanced practice pharmacist, and a medical assistant. This model has already enhanced continuity of care for patients and improved collaboration among different disciplines and between care encounters.

The T2 team has piloted several new initiatives, including a novel scheduling priorities protocol in collaboration with the Centralized Scheduling Unit (responsible for appointment scheduling). This protocol ensures that patients are appropriately scheduled based on clinical need and that patients have appropriate follow-up care based on medical complexity. This is discussed in further detail later in this report. The T2 nursing team has also been working to more efficiently manage "walk-in" appointments through improved triaging procedures and appropriate use of the jail's urgent care.

Because of these combined initiatives, the total and average number of patients seen in the T2 clinic has steadily risen, as seen below:

Total CSU Patients Seen Monthly in the T2 Clinic



In August, CHS began staffing a second care team in Tower I, which currently includes a lead physician, two nurse practitioners, and a medical assistant. This team will implement many of the best practices of the T2 clinic while adapting some aspects to meet the needs of their patients, who have higher levels of severe mental illness.

CHS leadership is actively working on staffing permanent care teams in Men’s Central Jail and Century Regional Detention Facility. In addition, executive and facility-based working groups are meeting to identify the full spectrum of provider, nursing, mental health, and custody practices and workflows that will be needed to create and sustain jail-based medical homes. This includes plans for staffing, roles and responsibilities, and how to “empanel” this transient population to more proactively manage not just their acute or episodic but also their chronic health care needs. Lastly, we are working on protocols to ensure our most complicated medical home patients in custody make smooth transitions into community care upon release.

Diabetes Care

The diabetes care management team consists of two physicians and an advanced practice pharmacist who oversee the care of approximately 900 inmates with diabetes housed across various facilities. In order to bridge knowledge gaps and promote consistency of practice among nursing and medical providers, the care management team has led training efforts system wide. This includes nine in-services on insulin management across the facilities. Similarly, the team has developed and disseminated an evidence-based diabetes management care guideline for medical providers. This guideline was influenced by the existing DHS diabetes care guideline and medication formulary, allowing CHS to leverage existing expertise and align with larger system efficiencies.

Patients requiring insulin are managed by an internal medicine physician with expertise in diabetes care. With this new program, patients on insulin had a 14.1% average reduction in HbA1c (1.39 unit reduction for an average baseline HbA1c of 9.8), representing better control of their diabetes. Among more severe diabetics with a baseline HbA1c ≥ 10 , patients had even stronger improvement with a 26.6% average HbA1c reduction (2.8 unit reduction).

Patients whose diabetes can be managed by oral medications are co-managed by our advanced practice pharmacist. Notable achievements include the following:

- Better diabetes control with a 30% average HbA1c reduction in patients with severe diabetes (baseline HbA1c \geq 10%; 3.1 unit reduction) and a 8.5% global average reduction of HbA1c (0.7 unit reduction)
- 72% increase in appropriate statin therapy initiation, as recommended by national society guidelines

In an effort to reduce gaps in care when patients transition back to the community, we have partnered with our pharmacists to provide glucometers for patients to take home as well as glucometer teaching prior to release. Going forward, we are planning on integrating a nurse care manager to further augment care management and care transitions in this important patient population so that we ensure gains earned while in custody can be maintained and improved upon when patients return to their communities.

Infection Control

A new Chief Physician from the Department of Public Health (DPH) joined CHS in June 2018. Among her many duties, she serves as the Chief of the Infection Control Unit and is the main liaison to DPH. Over the past year, CHS has partnered with DPH on several issues of public health importance, given the prevalence in our population of infectious diseases, such as tuberculosis, flea born typhus, sexually transmitted infections (STIs), and Hepatitis A.

In early 2018, CHS joined DPH's Congenital Syphilis Morbidity and Mortality Review Board, a workgroup involving representatives across the Health Agency focused on reviewing cases of congenital syphilis to identify opportunities for prevention. This analysis revealed that half of the mothers involved in congenital syphilis cases had a history of incarceration, suggesting the potential for expanded syphilis screening within the women's jail (CRDF) to avert potential cases of congenital syphilis. CHS has been aggressively screening and treating pregnant women for syphilis, so this initiative was focused on testing women of reproductive age in order to identify and treat syphilis prior to a woman becoming pregnant. The initial pilot in May-June was successfully implemented, demonstrating the acceptability and feasibility of offering rapid testing within the jail's dormitories. Over 250 women were tested and two new cases of syphilis were found and treated. The pilot will resume in early November after DPH obtains additional rapid syphilis test kits, and plans are being made to expand testing to additional dormitories within CRDF.

CHS administered over 10,000 doses of Hepatitis A vaccine during the peak of the Hepatitis A outbreak, more than any other single County entity. As a result, CHS was a key partner to DPH who recently received an LA County Productivity and Quality Award in recognition of our robust Hepatitis A outbreak response. CHS is building on this success by working with DPH's Vaccine Preventable Disease program to obtain state funded vaccines, which will be delivered to patients through primary care teams in conjunction with our annual dormitory-based influenza vaccine program.

Over the past 12 months, seven patients with active (infectious) tuberculosis have been incarcerated at the jail, which represents a significant increase over previous years, which yielded 0-2 cases per year. Despite the increased workload, the Infection Control Unit has responded to this emerging public health issue by continuing their close case management of active cases with the DPH Tuberculosis Control Program and taking the lead on the extensive contact investigations for inmates and staff who may have been exposed to the disease.

Positive Care Team

The CHS Positive Care team, which consists of three HIV-trained physician specialists, a public health nurse, and two medical assistants, provide primary medical care to over 400 patients with HIV across three facilities. DPH-funded transitional case managers (TCM) work to assist patients with pre-release planning to ensure patients are linked to care when they return to the community. Over the past year, the TCMs have become more integrated into the HIV clinic team and clinic workflow, allowing for better care coordination during and after incarceration.

CHS continues to support the LAC+USC HIV fellowship program by allowing physicians to train with the team; this partnership has been beneficial for both institutions. LAC+USC is able to provide fellows with a unique training opportunity working in a facility with the largest concentration of HIV positive clients in LA County and CHS has been able to recruit several of the fellows to moonlight, providing primary care or urgent care services in the jail. In addition, CHS has been working with the LAC+USC HIV fellowship program director on a new grant to pilot Hepatitis C screening within the Inmate Reception Center. This collaboration has resulted in enhanced clinical guidelines and formalized linkage to care in the community post-release for patients with Hepatitis C.

Lastly, the Positive Care team has continued to be the leaders in sexual and LGBT health within CHS, with one physician incorporating transgender care and pre-exposure prophylaxis (PrEP) for HIV prevention into her practice. Since starting to offer PrEP in May 2017, CHS was able to evaluate 85 patients, with the goals of offering testing for sexually transmitted infections (STIs), assessing HIV risk, and counseling on HIV prevention strategies, including offering PrEP when indicated. Of these, 65 were initiated, continued, or restarted on PrEP during their incarceration; the remainder were deemed to be lower risk at time of evaluation or declined to start PrEP in jail and were offered STI testing and referrals to clinics offering PrEP in the community.

In general, we found that our patient population requesting PrEP is at significant risk for HIV, with 96% identifying as gay, bisexual, or transgender, 27% reporting a history of sex work, 42% reporting or treated for recent bacterial STI, 73% reporting methamphetamine use, and 72% reporting having a current partner in jail with unknown HIV status or known to be HIV+. About half of our patients on PrEP are still incarcerated, while the other half have been released or extradited to state prison or another custody agency. Moving forward, we hope to partner with programs targeting incarcerated gay, bisexual, and transgender individuals to educate these populations about PrEP and with community clinics to improve our linkage rates and retention in care upon release.

Urgent Care and Specialty Care

Significant progress has been made in our plans to expand and enhance Urgent Care. Appropriate space has been secured and floor plans were designed for the Urgent Care expansion; however, issues with cost and payment have delayed the completion of the new space. A new workflow was also created to facilitate streamlined care delivery. In addition, we have on-boarded six new mid-level providers, three new medical assistants and two new intermediate typist clerks for the Urgent Care. As a result of this staffing increase and workflow enhancement, Urgent Care's capacity to care for patients has increased, as noted below:

Total Jail Urgent Care Patients

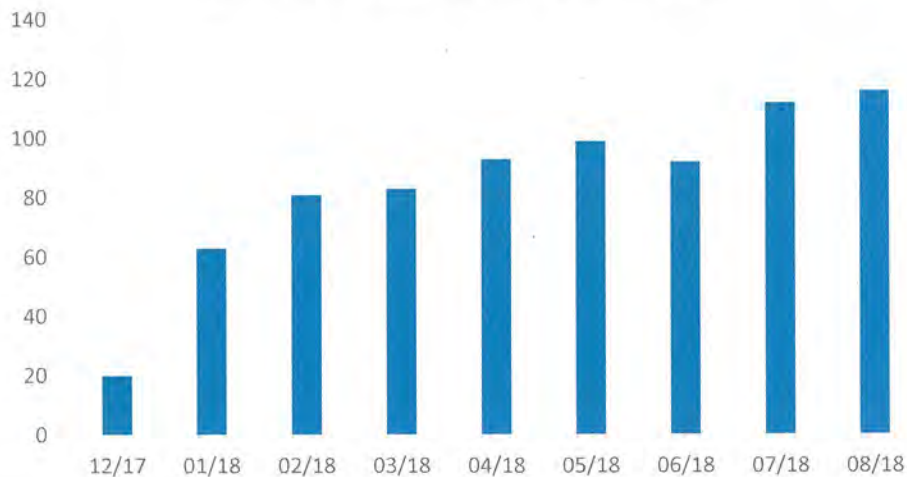


In addition to providing acute clinical care 16 hours per day, Urgent Care providers have begun serving in various other important roles in support of our patients, including working with Pharmacy and the Care Transitions team to ensure that high risk, clinically complex, patients leave jail with a 30 day supply of their home medications, performing medical clearance exams for those entering our highest acuity housing locations, and ensuring that patients returning from LAC+USC do not fall through the cracks by engaging them in proactive complex patient management to ensure that all medication and follow up orders are planned appropriately.

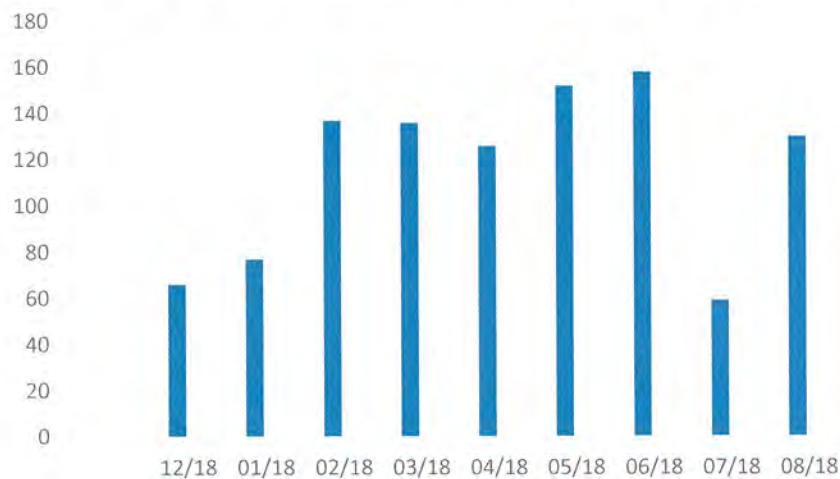
In terms of specialty care, the following specialty clinics were created:

- LAC+USC Orthopedic Clinic – A collaborative effort between LAC+USC and CHS, this on-site clinic allows us to provide orthopedic evaluations in jail without sending patients to LAC+USC unless hospital services are needed, improving patient care and resource utilization. It has decreased hospital-based clinic appointments by up to 50%. An average of 84 patients are seen each month.
- Podiatry Clinic
- Physical Therapy Clinic – We added a second Physical Therapist (PT) to meet the needs of our patients. Our focus is now on the acquisition of a PT Supervisor to spearhead the evolution of our nascent program into a mature cooperative venture with DHS rehabilitation services focused at Rancho Los Amigos.

Number of Orthopedic Patients Seen



Number of Physical Therapy Patients Seen



Women's Health

In November 2017, CHS recruited a Director of Women's Health at Century Regional Detention Facility (CRDF), the women's jail. This Director oversees prenatal care provided by a full-time nurse practitioner and a family medicine physician from Harbor-UCLA. A new Senior Physician was also recruited to oversee all health care in CRDF.

This year, CHS began a partnership with MAMA's Neighborhood, a DHS program that provides individualized care coordination, prenatal classes, breastfeeding consultations, and more. Since February 2018, a MAMA's care coordinator and social worker visit pregnant and postpartum women in the jail, with the goal of planning for and coordinating re-entry into the community by arranging resources for any needs patients might have.

CRDF has also developed a closer partnership with the Office of Diversion and Re-entry (ODR) to address the health and well-being of women, focusing on the unique needs of each patient's socio-economic

determinants of health. In collaboration with ODR, nearly all pregnant and postpartum women are evaluated for diversion. Since this initiative started in March, ODR has diverted 40 maternal health clients out of the jail with an additional six women currently pending a court outcome.

Through a grant funded opportunity, we have procured long-acting reversible contraception (LARC), such as intrauterine devices and implants, for our patients in CRDF. Previously, patients had to be referred to LAC+USC for these devices.

The census of pregnant women at CRDF has increased from 35 in late 2017 to a peak of 72 in August 2018, and currently consistently remains above 50. Despite this, thanks to close collaboration between our OB nurse coordinator and the physical health providers, our patients continue to receive timely and comprehensive prenatal care. Since November 2017, there have been no unplanned cesarean deliveries.

CHS has worked to increase the services available within CRDF for pregnant women, including mental health consultation, antepartum fetal monitoring, gestational diabetes management, and post-partum LARC provision. The leadership team has instituted bi-weekly OB collaborative care meetings that include representation from physical health, mental health, nursing, custody, ODR, and MAMA's Neighborhood. LASD has also approved a program to allow patient-identified support persons to be present during delivery. This program is still in its infancy but has had some successes and will continue to expand.

Other advancements at CRDF include the creation of a transitions of care team to ensure safe coordinated transfers between CRDF, high acuity housing units at other jail facilities, emergency rooms, Labor and Delivery, and re-entry into the community. We have also planned and scheduled tattoo removal training classes and ultrasound training classes to increase our providers' capacity to provide patient-centered services. We are also developing a yoga class to support the well-being of pregnant patients. CHS, along with a number of partners, authored a report to the Board on July 24, 2018, that outlines in greater detail services provided to pregnant women in custody.

Mental Health Updates and Improvements

The Living Module

This year, CHS Mental Health and custody worked together to develop and implement the Living Module. This is a special housing area where patients in mental health programs receive a continuum of services and privileges based on the acuity of their symptoms.

When patients arrive on the unit, they are evaluated and, based on behavior, a determination is made regarding the amount of time they can tolerate outside of the cell and whether they can be un-cuffed while out of the cell. The purpose and goal of the Living Module is to allow patients the most freedom and privileges that can be tolerated by the patient given their mental health condition. Patients in several of the housing pods in this module spend most of their days outside of the cell and most are uncuffed while in the day room – this is compared to the recent past when these same individuals would spend most of the day in their cells or cuffed while outside of their cells. During that time in the day room, they receive group therapy, education, and are encouraged to interact socially with each other and staff.

Until recently, the Living Module was operated with patients either being cuffed or un-cuffed in large groups while out of their cell. A recent proposal has been approved in which patients can be identified to be uncuffed in smaller groups so that both health care and custody staff can monitor and assess the patient's ability to eventually remain uncuffed in larger groups. This new process recognizes that patients have individual needs and serves to provide a more therapeutic environment for those with mental illness

to receive treatment. It also assists with compliance with the Department of Justice Settlement Agreement by allowing patients as little restriction as is necessary for safety reasons while helping to prepare them for release into the community.

Timeliness of Psychiatric Medications

In 2018, a focus of CHS Mental Health has been to get newly arrived patients evaluated by psychiatry services as soon as possible. This facilitates the continuation of medications from the community as well as identification and treatment of those needing it as soon as possible. This initiative has been a high priority because clinical data show that those with serious mental illness do better if they are stabilized on appropriate medications in a timely way. Also, patients who take appropriate medications are more compliant with programming and therefore encounter fewer adverse outcomes while in custody.

This endeavor has required a redirection of some resources from other areas of the jail, but the outcome has been positive. For example, during the month of August 2018, for female patients needing psychiatric medication evaluation, the average wait time for the most acute patient was two days; for the moderately acute, four days; and for those who receive medication but reside in general population, three days. Given that the female population is smaller, and the largest portion of female psychiatric patients reside in moderately acute housing, they have been able to significantly reduce the wait time more easily than the Men's Program, which has a population four times the size of the females.

Despite its growing number, the Men's Program at Twin Towers has also been able to focus on reducing wait times for psychiatric evaluation. Data from the months of July through September 2018, reflect that 80% of males in mental health programs at the moderately acute level of care receive evaluation by a psychiatrist within 14 days of entry into the system. This number reflects over 1,100 individuals in this level of care receiving an evaluation in a timeframe that is likely timelier than in the community. This is a significant improvement from earlier times when many patients in this level of care waited four to six weeks before seeing a psychiatrist due to the prior focus being centered on those with higher levels of acuity. Within the higher levels of acuity, clinicians see patients in the IRC immediately and a psychiatrist evaluates the patient within one week of arrival with follow-ups being less frequent if patients remain stable on their medications.

Department of Justice Settlement Agreement

The Settlement Agreement between the Department of Justice and the County includes 34 provisions for which CHS Mental Health has primary oversight, involving suicide prevention, the provision of mental health treatment, and the establishment of a robust quality improvement program. There are currently 12 provisions (35%) which are in Substantial Compliance and 15 provisions (44%) which are in Partial Compliance. The provisions for which compliance has been achieved encompass the timeliness of assessments at intake, the elements of documentation and a review process for serious suicide attempts, therapeutic services for inmates in clinical restraints, the maintenance of a Bi-Annual Suicide Prevention Committee meeting, and the supervisory review and oversight of clinical staff.

Improvements to information technology (IT) and physical plant changes or construction would greatly assist the County in reaching substantial compliance. For example, there is currently no automated way to easily track individuals who consistently refuse their medications. We are exploring an IT solution within the medication administration record, which would be a significant step to bringing this provision into compliance. Physical plant issues continue to be an impediment to providing the required 10 hours of structured treatment for the over 900 individuals in higher levels of care. There are no group rooms or

adequate confidential treatment space. Therefore, all treatment currently occurs on the day room floor, in view of other inmates and staff.

Exploring Psych Techs

CHS and LASD have been discussing the idea of utilizing licensed psychiatric technicians (LPT) within areas of the jails currently staffed by LASD deputies. This pilot is scheduled to start in early November 2018 in Twin Towers High Observation Housing (HOH). The HOH population consists of severely mentally ill patients who cannot function safely in general population and require close monitoring and observation. The pilot will include four LPTs working in HOH conducting rounds, Title 15 safety checks, and clinical checks, duties currently being performed by LASD deputies.

Having LPTs perform these duties will benefit patient care as LPTs are clinical professionals trained in detecting early signs of suicidal behavior and decompensation. If the pilot is successful, the goal would be to replace approximately 125 deputies assigned to Twin Towers HOH and the Correctional Treatment Center (CTC) with LPTs. This would allow LASD to redirect those deputies to the Access to Care Bureau and support other clinical programs.

Nursing Updates and Improvements

The CHS Nursing department has been an integral leader and stakeholder in almost all system-wide initiatives mentioned in this report in part since the lion's share of CHS caregivers are nursing professionals, providing the bulk of front line care each day. These initiatives include the establishment and operation of the Withdrawal Management (Detox) unit, administering Hepatitis A vaccines during the outbreak, assisting with the Urgent Care expansion plans, and supporting the development of the Patient Centered Medical Homes, all discussed elsewhere in this report.

Since the transition to DHS, CHS Nursing has made several improvements which have enhanced our ability to provide high quality nursing care to our vulnerable patient population. Several of these discrete improvements are listed below:

Training

One of our first endeavors was coordinating and delivering numerous trainings that nursing staff were required to attend, while at the same time ensuring that patients received adequate nursing care. The trainings were quite an undertaking and included but were not limited to: DHS Policy and Procedures, Time-I / eHR, GHX Procurement, Performance Management, Return To Work, Employee Relations, Just Culture, Helping Healers Heal, and ORCHID training. Several of these trainings are described elsewhere in this report.

Food and Fluid Intake Program

Due to an adverse patient event over two years ago, CHS performed a root cause analysis which identified an opportunity to better find and monitor patients who are not consuming food or fluids due to clinical issues, such as decompensated mental illness. As a result, we developed a multidisciplinary Food and Fluid Intake program which has benefited numerous patients and assists all disciplines in monitoring patients and ensuring we provide appropriate care.

Standing Orders and Standardized Procedures

We developed and updated a new set of standing orders (SOs) and standardized procedures (SPs), giving nurses the authority to practice at the top of their clinical license and deliver care in a more autonomous and efficient manner. Over the past year, 15 SPs were developed and/or revised, and five SOs were

revised, for a total of 26 SPs and nine SOs for nurses. Utilization of the SOs and SPs has resulted in a decrease in the number of patients being referred to providers because nurses have the capability to deliver needed care immediately. The following are the Standardized Procedures and Standing Orders that were developed and/or revised and are all in-line with existing DHS-wide SOs and SPs.

Standardized Procedures

Developed – 10

1. Alcohol Withdrawal
2. Benzodiazepine Withdrawal
3. Bridge Medication
4. Cerumen Impaction
5. Chlamydia, Gonorrhea and Trichomonas
6. Hypoglycemia
7. Opioid Overdose
8. Pediculosis/Lice
9. Adult Tetanus and Diphtheria Toxoid (Td) and Acellular Pertussis (Tdap) Immunization
10. Influenza Vaccination

Revised – 5

1. Dental Problem
2. Common Colds
3. Chest Pain
4. Dermatitis
5. Urinary Tract Infection

Standing Orders

Revised – 5

1. Hypertension Screening in Reception Centers
2. Diabetes Mellitus Screening
3. Diagnostic Tests – Sexually Transmitted Infections
4. Blood Pressure and Blood Glucose Monitoring
5. Tuberculosis Screening Refusal in Reception Centers

Patient Care Huddles

Daily communication huddles were initiated at CRDF, CTC, and TTCF to facilitate the ability for any member of the interdisciplinary team to share information about patients and develop ways to meet patient needs. This has resulted in a more efficient way of sharing patient care information, alerting the team to those in need of additional attention, and coordinating complex care plans.

Improvements at Pitchess Detention Center

The Pitchess Detention Center (PDC) nursing management team was instrumental in meeting with the new DHS Olive View Medical Center (OVMC) providers who are caring for patients at PDC. In collaboration with nursing, OVMC providers have been able to significantly decrease the wait time for a patient to see a provider. This is evident by the following: On May 9, 2018, PDC had a provider line backlog total of 516 patients, with an average wait time of 20 days. As of October 2018, the total number of patients pending provider evaluation is 238, with a wait time to see a provider now at seven days or less. Patients with any urgent or emergent complaints, however, are seen the same day.

IRC Redesign

Efforts to further decongest the IRC are ongoing, as mentioned elsewhere in this report. As key stakeholders in this effort, we have initiated a new streamlined workflow which enables the immediate transfer of appropriate patients from the IRC to the Medical Outpatient Specialty Housing (MOSH) unit, both freeing up space in the IRC and enabling patients to be housed sooner.

Also, due to the large numbers of new bookings being processed through the IRC, typically in large groups as opposed to being spread evenly throughout the day, an effort to screen inmates for health concerns earlier in the intake process was initiated. A nurse has been assigned to work at the Criminal Courts Building completing medical and mental health screening on those inmates who are done with their court proceedings and are awaiting transport to IRC. This has resulted in the early identification of patients who are in need of health care, while at the same time making the process in IRC more efficient secondary to the screening having been completed prior to the inmate's arrival in IRC.

Critical to this project has been the development of a revised Medical and Mental Health screening tool and intake process, which was completed and implemented in the first week of June 2018. The new screening process and form have proven to be more efficient than the previous multi-step process. This project is described further in the IRC Redesign section of this report.

Health Services Request Enhancements

Patients who request health care services do so via a standardized health services request form. The form in its revised iteration allows nursing staff to more accurately triage and record these requests. In doing so, the elapsed time between the request receipt and nursing triage was reduced from at times multiple days and even weeks, down to a monthly average of 1.9 hours from December 2017 through August 2018. This dramatic improvement in triage time enables nursing staff to identify and treat any urgent or emergent issues. This has a profound impact on patients, allowing care to be delivered more expeditiously.

Narcan Deployment

With the proliferation of opioids and synthetic drugs, an increase in the number of emergency responses secondary to substance use has increased. To be better prepared to address this, all nursing staff were trained on the use of Narcan (an opioid reversal agent), resulting in many saved lives. Further, the Standardized Procedure for Opiate Withdrawal was revised to allow for the administration of Narcan in a more expedient manner.

One example of this was when five inmates lost consciousness in the IRC after using a recreational substance, requiring an emergency response from health care and custody staff. Narcan was administered to each of these inmates, resulting in lives saved. All five of them were taken to the acute care hospital for follow-up, wherein four of them were released within 12 hours after completely recovering. One inmate made a full recovery and was released from the hospital after another 24 hours of observation. Without early Narcan administration, the outcome would have likely been fatal.

Expansion of Mental Health Housing

With the growing number of mental health patients being cared for in the jail, there was a need to create more mental health housing space. Pitchess Detention Center, North Facility was identified as an ideal location given its wide outdoor areas, which provide mental health patients a calmer milieu in which to recover. Two hundred Moderate Observation Housing (MOH) patients are now cared for at the North

Facility and we have noted positive improvements in their wellbeing. We are seeking to move additional mental health patients to the North Facility soon and are working on this plan with LASD.

Also, we worked collaboratively to expand MOH housing into Men's Central Jail by helping develop the HOPE dorm. The HOPE dorm was created to assist those mentally ill patients who otherwise would take the route of self-harm as a solution. The dorm setting enables patients, custody, and health care staff to all be physically in the same area, also known as direct observation. The program has allowed staff to develop stronger rapport with patients and to pick up on signs of likely self-harm and address these signs quickly.

Town Hall Meetings

Each month, custody arranges and advertises town halls in the visitor area of TTCF. Six town halls have been conducted thus far. Nursing management participates in these meetings and answers questions and concerns from family members and friends of inmates alongside inmate services, the Community Transition Unit, Education Based Incarceration, and Food Services. These meetings help provide information to the public on services CHS offers and alleviate some of their concerns. We look forward to continuing public engagement in the future.

Emergency Response

This year, we launched several initiatives with the goal of improving the quality of our responses to emergencies. To begin with, CHS partnered with the LA County College of Nursing and Allied Health to provide enhanced emergency response training to nursing staff who respond to emergency calls. It helped to not only better prepare and educate the nursing staff, but also increased the number of positive patient outcomes resulting from emergency care. Furthermore, the initiation of skills validation testing throughout CHS has been developed and implemented.

To help facilitate teamwork and efficacy, joint emergency response drills with health care and custody staff occur on each shift at all facilities. Staff Development Unit Nursing Instructors have been present at these drills to evaluate nursing performance and provide feedback and coaching to the team. Positive results have been noted by the Instructors, as well as during the review of actual emergency responses.

Logistically, a new emergency response triage workflow and charting template were created to reduce delays when caring for unstable patients. To support the emergency response teams, the physical health and nursing departments have worked to modernize the equipment nurses bring when responding to emergencies. They have identified essential emergency medications (including Narcan) and supplies, and have started utilizing new emergency response bags.

Finally, Automated External Defibrillators (AEDs) are well validated as one of the most important lifesaving tools in medical emergencies. We have identified and ordered additional AEDs to be deployed in each housing unit system-wide since each minute an AED is delayed diminishes a patient's chance of survival.

Quality Improvement & Patient Safety

The department of Quality Improvement and Patient Safety continues to make major strides towards widespread system change and infrastructural improvement. Components of our multipronged plan to improve quality are developing in the following ways.

Quality Improvement (QI) Infrastructure

In August, we recruited a new Director of Quality and Patient Safety who previously served as a Quality Manager at LAC+USC. The department also recently held its first staff Summit in which all eight department members worked together to develop Iodestar vision, mission, and values statements to guide future work.

We are also planning a redesign of the CHS QI Committee effective January 2019 to better promote collaboration and shift from a focus on quality assurance to quality improvement. This was successfully piloted in the Mental Health service line in which weekly QI mentorship from this department and leadership from the Mental Health QI Chief and others have led to significant improvements in the Critical Incident Review Committee (CIRC), Joint Quality Improvement Committee (JQIC), and other mental health functions. These committees now focus more on root causes of issues, leading to collaborative change, and are actively working to expand data trending capabilities. This work is largely responsible for the Department of Justice lifting the QI provisions of the Settlement Agreement out from non-compliance, a waypoint marker of success.

In terms of staffing for QI and patient safety, we have hired three assistant staff analysts, and have pending hires for an additional two assistant staff analysts and one staff analyst. This team will serve as QI specialists, responsible for managing critical projects related to quality (e.g. patient flow, access to care and services). This team will also assist with collecting and analyzing data, researching best practices, and supporting quality improvement and patient safety projects throughout the system. They will continue to be deeply engaged and work with the larger QI infrastructure across DHS.

Quality Improvement Capacity

A total of 12 staff members from various facilities and departments have graduated from the Quality Academy Program, a rigorous six month didactic and mentored QI learning experience at LAC+USC. In October, an additional three new staff members have started in the new class. Graduates of this program serve as QI Leads at their home CHS facilities and service lines, helping to grow capacity and align strategic improvements. In addition to previously developed teaching modules on Quality Improvement Basics, Root Cause Analysis, and Morbidity and Mortality inquiry, we are building out new educational modules geared toward the unique correctional environment. These materials will be collected and available to staff on our QI intranet website which was created last year and continues to expand in capability.

Data as a Tool for Improvement

As previously discussed, robust population-level data analysis has been stymied by limitations in the electronic medical record software and siloed Sheriff's Department (LASD) computer systems. Nevertheless, because we believe that data drives improvement, we continue developing an evolving and expanding Quality Dashboard, pulling in often manually curated data. We have expanded the monthly Dashboard to cover 41 metrics. Future work includes collaborating with Cerner to automate reports where able and emphasizing data validation. Staff has attended technical training sessions to help bolster their ability to achieve this.

To support the next evolution of quality improvement projects, we are developing a new standardized scorecard for facilities and service lines to better ensure that projects created are aligned with CHS goals. The scorecard will also assist staff in defining and identifying their quality and safety initiatives, target goals, plans of action, and data measures.

In addition, the previously established Longitudinal Improvement Projects dashboard, which currently contains 14 improvement projects across CHS, continues to be updated monthly and serves to maintain momentum on key long-term initiatives.

Patient Safety

When opportunities for improvement are identified, we use best-practice approaches from health care and work in an interdisciplinary manner to explore root causes and develop testable solutions. For example, earlier this year we found that patients with end-stage renal disease who require hemodialysis sometimes felt they had to occasionally decide whether to go to their life-sustaining and regularly scheduled hemodialysis or go to court. CHS leaders found that they were able to use an agreement with the hemodialysis contractor to expand options for unscheduled hemodialysis. In doing so, we are now able to ensure optimal access to hemodialysis while reducing unintended constraints on patients' due process.

In addition to the robust incident investigation practices we have put in place over the past couple years (including death review, peer review, root cause analysis, and critical incident review), we are working to strengthen the IT mechanisms that facilitate this analysis. Much progress has been made in updating, customizing, and training staff in Safety Intelligence, our patient safety incident reporting system. Its use among staff continues to increase and we are exploring its utility for expanded deployment.

We believe that a cornerstone to our work is supporting the development of a culture that is modern, transparent, and follows Just Culture principles, which has been validated in health care settings nationally. Nearly all our available managers and supervisors have been Just Culture trained in an effort led by both labor and management leaders. Further, over 78% of our front-line staff has already received Just Culture education in just four months.

In addition to caring for our patients, we believe in taking good care of our staff. In health care, and especially in the correctional environment, there is a phenomenon known as the "second victim." This affirms that health care providers take the traumas and emotional effects of their job home with them, which often have detrimental effects on their mental wellbeing. Therefore, we are working hard to establish and expand the Helping Healers Heal (H3) program, which will provide a structured peer-support layer to help staff, in addition to other Employee Assistance Program resources. We have established a steering committee and 13 staff members have been trained as peer supporters to date.

Since 2013, the number of deaths occurring within LASD facilities has declined from 34 cases in 2013 to 23 cases in 2017. As of November 5, 2018, there have been 22 in-custody deaths this year. Compared to cases in 2017, fewer deaths this year were due to potentially reversible medical conditions, in other words, a larger proportion of deaths this year were due to causes that were likely neither predictable nor preventable. Two individuals who were in custody died prior to IRC arrival (court and station jail) after they were unable to be resuscitated upon transfer to the hospital, ten deaths occurred in jail, and the remaining ten occurred in local hospitals.

Innovations in Correctional Health Care

Addiction Medicine Services

CHS Addiction Medicine Services (AMS), created by the Board in 2016 as part of CHS, is responsible for the Substance Treatment and Re-entry Transition (START) program which provides substance use

disorders (SUD) services and medications to treat SUDs within the Los Angeles County Jail System. The following outlines key accomplishments achieved by AMS during this reporting period.

START Treatment Services

In collaboration with LASD, CHS START treatment housing and classroom space were identified at four county jails to treat 500 inmates daily. Treatment services include American Society of Addiction Medicine (ASAM) levels 1.0 outpatient (up to nine hours of treatment per week) and 2.1 intensive outpatient level of care (up to 19 hours of treatment per week). START treatment services were implemented with a one-time \$5 million AB 109 funding allocation to CHS from the Department of Public Health Substance Abuse Prevention and Control. LASD and CHS are currently in discussions to expand START to other jail locations to meet the SUD treatment needs of inmates' contingent on securing funds to sustain and enhance the program. During the last six months, approximately 1,200 patients were referred to START treatment services.

Grant Awards

CHS was awarded a technical assistance grant by the California Health Care Foundation (CHCF) to assist with establishing policies and procedures for Medications for Treatment (MAT) of addiction and developing a planning process to expand SUD treatment in the County jails. Included are site visits to peer institutions nation-wide, including Riker's Island in New York, San Mateo County Jail, Cook County Correctional Facility in Chicago, and the Rhode Island Department of Corrections. CHCF grant funds were also used to develop and implement a planning process to address community capacity to support ongoing SUD treatment/MAT and assisted in an evaluation of policies and procedures for prescribing and administering naltrexone and long acting Vivitrol. Through the support of this grant, CHS was able to phase in the use of MAT for addictions across all jail health operations. One immediate focus for the jails is to ensure that MAT can be continued when a patient who had been on MAT in the community is booked into custody. The need to continue this service will only ensure that the patient remains on MAT after release.

CHS was also awarded a MAT Learning Collaborative Grant to form a team of high level County criminal justice partners to prepare county teams to improve and expand access to MAT throughout the state in local jails, drug courts, and/or criminal justice diversion programs. The project will broaden county knowledge and understanding of MAT and its place in the criminal justice system. The learning collaborative includes leaders from the following county departments: CHS, Public Defender, Probation, LASD, DPH and the Countywide Criminal Justice Coordination Committee. CHS was also awarded a highly competitive grant through the USC Clinical Science Translational Institute (CSTI) to conduct a research study on the effectiveness of a new expedited triage to treatment pathway for patients in this population.

Withdrawal Management (Detox)

CHS implemented a 24-hour medically monitored withdrawal management (WM) housing unit for alcohol dependency, with a capacity of 28 beds, treating an average of 20 patients per day. The team of staff specially trained in addiction includes a supervising psychiatrist, clinical pharmacist, nursing, and a substance abuse counselor. At least 20% of all patients were determined to be at high risk of complicated withdrawal based on clinical features. These patients were evaluated by a clinical pharmacist and provided a tailored care plan that included MAT and/or referral for SUD assessment (80% were referred to a SUD counselor for ASAM screening and referral to jail-based START or community treatment upon release). Ongoing quality

improvement measures have been implemented including guidelines for nurse interventions, assessing potential utility of Prediction of Alcohol Withdrawal Severity Scale (PAWSS) for monitoring, and review of alcohol withdrawal related hospital transfers.

The implementation of this WM housing unit in custody can greatly reduce the risks associated with alcohol withdrawal, including seizure, hallucinosis, delirium tremens, and in some severe cases, even death. This new service does not have an existing funding source and in order to sustain and expand WM to treat opioid dependence, we will need additional CHS staff resources. Successful expansion of WM services would require specialty care physicians, nurses, clinical pharmacists, and SUD counselors.

Staffing

CHS added SUD Counselor positions to the WM (Detox) housing unit as well as the mental health clinician teams to promote the integrated care approach for those inmates with co-occurring mental health and SUD. Additionally, CHS secured two positions in administration to assist with the proposed SUD treatment expansion efforts, data analysis, and development of process improvement plans. CHS also partnered with the University of California, Los Angeles to implement an addiction medicine services fellowship program which includes a rotation to provide direct clinical care, and assist with quality improvement projects, policy and procedure reviews.

Training and Technical Assistance

CHS conducted the following trainings and outreach sessions to educate criminal justice partners on the current efforts and future plans of addiction medicine services in the jails: an Addiction Summit for LASD and CHS leadership; a nationwide webinar on MAT and START implementation in the jail; a MAT presentation to the California Department of Public Health; addiction medicine overview trainings to Probation Officers and Public Defenders and Alternate Public Defenders; nurse in-services on WM protocols and Clinical Institute Withdrawal Assessment for Alcohol (CIWA) to manage complicated withdrawal seizures, hallucinosis, and/or delirium tremens; and quarterly buprenorphine X-waiver trainings for CHS Physicians and Nurse Practitioners. CHS currently has 30 X-waiver providers in-custody, which is higher than most community settings, due to the outreach efforts and trainings provided by the CHS AMS Medical Director.

Clinical Pharmacists

Five pharmacists were recruited from the main CHS pharmacy and were integrated into various healthcare teams to ensure effective and safe medication therapy via direct patient interaction. This team increased efficiency by augmenting the current providers, and provided educational services on new advances in medication treatment options and pharmacologic disease state management. Areas of clinical pharmacist implementation include diabetes, anticoagulation, clozapine laboratory monitoring, alcohol and opiate withdrawal management (detox), and the primary care clinic where the initial focus was on asthma and high blood pressure. During the first year of the program, one clinical pharmacist achieved Advanced Practice Pharmacist licensure.

The clinical pharmacist role in supporting the care of diabetic patients and withdrawal management is discussed elsewhere in this report. In terms of the anticoagulation clinic function, we found that this program improved the average percentage of therapeutic INR readings from 40% to 82%, achieving a 74.8% average individual percentage of time in therapeutic range, meeting the definition of "good control (>65%)." The clozapine laboratory monitoring function ensured 100% compliance with clozapine

prescribing requirements as set forth by the FDA. For clinical pharmacists supporting primary care, we found that the program helped 87% of patients with high blood pressure achieve their blood pressure goal and adjusted asthma medications in 67% of asthmatic patients.

Other value-added services provided by this team include nursing in-service education on blood thinning medications and lab monitoring, alcohol withdrawal management (CIWA protocol) and diabetes management. We also prepared and presented research posters at the 2018 California Society of Health-System Pharmacists seminar as well as presented at local hospital grand rounds. We created medication information handouts for various medications in high use to serve as a general reference for medical staff. An annual antibiogram was also created for CHS to promote antimicrobial stewardship.

Nurse Practitioner Program

The CHS Family Nurse Practitioner (FNP) program is an accelerated Master of Science in Nursing (MSN) academic partnership with DHS, the California State University, Los Angeles College of Professional and Global Education and the University's Patricia A. Chin School of Nursing. Its genesis can be traced back to a visionary motion by Supervisor Hilda L. Solis in September 2016 directing DHS to develop a program to train a group of CHS nurses to become credentialed FNPs and serve in the jail. Through an intense application review and interviewing process of over 80 applications received, 23 qualified nurses were selected.

This 18-month accelerated FNP program began in Spring 2018. The students began taking a wide range of courses covering health assessment, pharmacology, and the diagnosis and treatment of psychiatric health disorders. Students have now embarked on the second semester of the program which includes clinical rotation assignments in the areas of Women's Health, Pediatrics, Primary Care I & II, and Emergency Room preceptorships.

Partnering with medical providers, all students are gaining valuable clinical experience as frontline medical providers at various sites across DHS including Olive-View UCLA Medical Center, Mid-Valley Comprehensive Health Center, High Desert Regional Health Center, Edward R. Roybal Comprehensive Health Center, LAC+USC Medical Center, Hubert H. Humphrey Comprehensive Health Center, H. Claude Hudson Comprehensive Health Center, and Wilmington Health Center.

These students will graduate in December 2019 and at that time will apply their education, experience, and FNP license to serve as providers in CHS. This program represents an innovative approach to workforce development, growing a generation of clinical leaders in a unique practice environment. While it is mission critical to attract new workforce talent to the jails, we believe that investing in the wonderful staff who have already committed to serving incarcerated patients is equally if not even more important. Due to their previous experience serving our patients as CHS RNs, once they graduate and become FNPs, our provider team will be significantly enhanced and the need for outside recruitment will be nearly fulfilled.

Inmate Reception Center (IRC) Redesign Project

The ambitious project to redesign health services delivery in the Inmate Reception Center (IRC) is led by an inter-professional team that meets twice weekly to direct and oversee progress. We have made major strides including revamping the health screening interview to incorporate evidence-based clinical assessment tools, reducing redundancy of the interview to improve the patient experience, and revising and implementing a new integrated health screening policy guiding nursing staff on effective triage at intake.

This work has fundamentally transformed patient flow in the IRC through the following milestone achievements:

- We collaborated with LASD to identify individuals who will be immediately released from IRC, and when appropriate, divert them from inclusion in the standard medical processing queue, expediting their release as well as helping to prioritize care for individuals who will continue to be held in LASD custody.
- Piloted providing health screens to patients in the Criminal Courts Building (CCB) jail to ensure individuals have their health needs assessed as soon as possible, even before arriving at the IRC. This allows healthy individuals to be housed without waiting unnecessarily in the IRC health screening area, ensuring others with more pressing needs may be seen sooner by CHS clinical staff.
- We replaced LASD custody assistants (CAs) who have historically performed inmate triage in the IRC with CHS RN staff. This allowed LASD to redeploy the scarce CAs in a more appropriate way and has allowed the medical triage function to be conducted by a member of the clinical staff.
- Trained IRC nursing staff on effective triage and health screening methods to ensure patients without urgent medical or acute mental health needs are not held unnecessarily in a clinic environment and that clinical resources are used more effectively.
- Piloted a reengineered flow of patients to housing so that patients with routine medical care needs may be housed first and then seen by a provider, versus being forced to wait in the IRC, without visitation privileges, and with fewer resources to see a provider for a non-urgent need.
- We are expanding our urgent care facility to provide 24-hour care for patients from all facilities in 2019. Patients with urgent care needs that are found in health screening in the IRC will be immediately transported and cared for prior to being housed. This potentially cost-containing effort transforms the prior approach of sending these patients to LAC+USC for care which often requires two LASD deputies for guarding and expensive medical transportation, not to mention the frequently avoidable use of hospital resources. Additionally, it prevents the inappropriate use of Internal Medicine and Primary Care physicians for urgent care assessment and triage, as was previously the practice.
- We also built a Withdrawal Management (Detox) Unit for patients to ensure that those with life-threatening alcohol withdrawal are seen and treated immediately. This is discussed further elsewhere in this report.
- Developed and implemented a roadmap for improving the use of data to inform decision-making at the executive level in collaboration with DHS Performance Improvement.

Physical Health Appointment Timeliness

We have focused attention on improving the timeliness of primary care provider appointments in jail. Workflow changes, such as having urgent care providers perform certain clearance exams, free up the clinic providers to see patients scheduled by the Central Scheduling Unit (CSU). New care guidelines and emergency alert criteria have also assisted with clinical triage and patient flow. As a result of these and other improvements, we have noted the approximate average number of days from appointment creation to the primary care patient encounter to have decreased from a peak of 78 days in December 2017 down to 21 days in September 2018. This meets the community-based, managed care standard of up to 30 days for routine appointments.

Care Transitions

The CHS Care Transitions unit has been implementing and expanding programs to provide release planning, case management, and linkage to community services for inmates experiencing health or mental health issues, substance use disorders, homelessness, and other conditions.

Whole Person Care Re-entry Program

The Whole Person Care (WPC) Re-entry Program, funded through the State's 1115 Medicaid Waiver, provides both pre-release (in-jail) and post-release (in-community) services. It enrolled its first clients in the jails in June 2017. The pre-release program has focused efforts during this period on recruiting and hiring staff and has grown to 46 jail-based staff located at all jail facilities, including Medical Case Workers, Community Health Workers, and Social Work Supervisors. As of July 2018, the pre-release program is enrolling approximately 400 new participants each month, with a total caseload of over 1,600 in-custody participants at a time. Protocols have been refined with DPSS to allow for activation of Medi-Cal enrollment within one to five days of release, and the WPC Release Desk in the IRC has expanded hours to seven days a week coverage. In addition, two program drivers have been hired to transport participants to interim housing locations, treatment programs, DPSS offices, and other locations upon release.

Jail Linkage (Care Transitions Mental Health)

The Jail Linkage program, which provides release planning for inmates in the jail's mental health programs, has moved into the Care Transitions unit and is changing its name to Care Transitions Mental Health (CTMH). Efforts are underway to standardize procedures across the WPC and CTMH programs and expand staffing. During this period, elements of a new draft release planning policy for inmates with mental illness were rolled out, including the provision of a written Initial Release Plan form to all clients at the intake visit.

Mentally Ill Offender Crime Reduction (MIOCR) Grant

The MIOCR grant, funded by the Board of State and Community Corrections, ended in June 2018, with evaluation completed by the RAND Corporation in September 2018. This evaluation showed that while program retention rates were modest, on average, participants who completed the program had improved health insurance status, benefits establishment, housing stability, and had fewer convictions in the post-enrollment period compared to the pre-enrollment period.¹ Further, they maintained or improved their self-reported mental health and substance use status. A total of 98 "tri-morbid" individuals with co-occurring mental illness, chronic or complex medical conditions, and substance use disorders were enrolled, exceeding the program target of 90 participants.

Women's Integrated Services Program (WISP)

The Women's Integrated Services Program (WISP) at CRDF provides case management and re-entry services to female inmates in the jail's general population, with a staff of three social workers funded by the Office of Diversion and Reentry (ODR). Through September 26, 2018, a total of 610 female inmates have received services.

¹ Hunter, Sarah B., Maya Buenaventura, and Matthew Cefalu, Local Evaluation Report for Los Angeles County's Mentally Ill Offender Crime Reduction (MIOCR) Program. Santa Monica, CA: RAND Corporation, 2018. https://www.rand.org/pubs/research_reports/RR2411.html.

Homeless Initiative D2 – Expanding Jail In Reach

Homeless Initiative Strategy D2 - Expanding Jail In Reach provides re-entry services to inmates who self-identify as experiencing homelessness. Four community-based homeless services agencies are contracted to conduct in reach with participants and to continue providing case management in the community after release. The case managers work in teams with CHS lead social workers. The program is serving approximately 500 participants per quarter and is designated for ongoing funding through the County's Measure H funding plan.

Collaboration with the Office of Diversion and Re-Entry (ODR)

In addition to ODR's work with pregnant and post-partum females in CRDF mentioned elsewhere in this report, ODR launched a Pay For Success program in October 2017. This program identifies homeless individuals in the jails who have a mental health disorder and connects them to permanent supportive housing. ODR has already enrolled 156 people, over halfway to its goal of enrolling 300 people over two years. Pay For Success is an approach to contracting that ties payment for service delivery to the achievement of measurable outcomes. In Los Angeles, the \$10M investment for the program came from United Healthcare and the Conrad N. Hilton Foundation and success payments are tied to housing stability and reductions in recidivism.

Further, in collaboration with the Chief Executive Office, ODR has been utilizing the County's "5% List," containing information on the sickest homeless individuals who disproportionately utilize safety net services and matching it against the jail population. ODR prioritizes diversion, legal charges permitting, on inmates who are on the 5% list, and ensures the housing and treatment package is especially robust to meet their needs.

Operations Update and Improvements

Health Information Management

This year, Health Information Management worked to improve its workflow efficiency by centralizing staffing and Release of Information operations. Instead of exclusively printing medical records, we implemented a procedure for releasing records on CD-ROM where appropriate, a move which will reduce the number of printed pages by an estimated one million sheets a year. We also completed a full-scale inventory of on-site paper medical records and eliminated 95% of them by scanning and converting the paper records into electronic format. We relocated over 300,000 remaining paper documents to off-site storage, creating over 1,500 square feet of space which will be converted for much needed clinical use.

Laboratory

Laboratory operations were re-organized this year to consolidate operations under three main service areas: Point of Care Testing, Specimen Processing, and Phlebotomy.

- Point of Care Testing (POCT) – We updated the POCT interfaces to automatically upload results into the electronic medical record, significantly improving patient safety. Previously, results were manually entered into the system, which introduced the opportunity for transcription errors. In collaboration with MLK Outpatient Center, CHS Lab leadership created a training program for all CHS Clinical Laboratory Scientists including training on DHS laboratory standards, cross-training of POCT clinical operations, interfaces, and validation processes. In line with the DHS Lab redesign project, CHS is expanding its rapid testing to housing modules, including urine toxicology testing, which will also assist its clinicians in addressing the opioid epidemic facing our population.

- Specimen Processing – We decentralized lab processing to the local facilities, significantly improving specimen integrity, reducing incidents of being lost in transport, and reducing the need to re-draw labs from patients, all the while improving result turnaround time.
- Phlebotomy – In an effort to improve the quality of services provided to patients, we held our first standardized training course to help ensure that phlebotomists consistently meet skill competencies and deliver high quality service.

Pharmacy

The Pharmacy Department passed the Pharmacy State Board inspections in 2017 and 2018. Capital projects include investing in and implementing new systems to improve efficiency of medication delivery and regulatory compliance through the purchase and deployment of Pyxis, Rees, and Talyst machines. We have also assisted in the implementation of the advanced practice pharmacist program for anticoagulation management, diabetes management and detox management, which is described in further depth elsewhere in this report. Through collaboration with IT, we have developed several on-demand reports which give clinicians information about their patients' medication use, better equipping them to manage the treatment plan.

Finally, through collaboration with Care Transitions, custody and others, this year we opened a new discharge pharmacy focused on providing medications to certain high-risk patients to take home as they are released from jail, including the mentally ill, WPC clients, and those living with HIV. Providing discharge medications helps decrease a critical barrier that our patients face when they re-enter the community and helps to decrease illness decompensation, unnecessary emergency room visits, and other detrimental effects. We are currently exploring mechanisms to thoughtfully expand this important service.

Radiology

This year, the Radiology department added ultrasound as a new testing modality to augment the previously available x-ray and CT scan modalities. Ultrasounds provide diagnostic value when imaging internal organs and soft tissue, without the radiation exposure and expense of a CT scan. Prior to the purchase of the full-size unit, clinicians were either limited to the poor resolution of handheld pocket ultrasound scanners or patients were transferred to LAC+USC for more expensive CT scans. This new service improves diagnostic options and helps providers make timely clinical diagnoses while reducing costs associated with transfers out to hospitals to obtain this test.

We also created a plan to replace obsolete equipment to meet community standards and reduce the risk of unnecessary radiation exposure to patients and staff alike. We also installed a new x-ray unit at CRDF and improved staffing by hiring 4 previously vacant radiology technician positions, allowing us to provide even greater service coverage for our patients.

Administration

This year we streamlined and reorganized the CHS warehouse by implementing a standardized process for all purchases known as GHX and instituting a monthly training class for staff. We also created the CHS Administrative Support Division which includes contracts administration and provides central oversight for the departments of finance, human resources, facilities planning, and information technology.

IT Update and Improvements

ORCHID View-Only Access

This year, through collaboration with DHS IT, we developed and implemented an ORCHID view-only online training course and provided CHS clinicians access to DHS-wide electronic medical records. This allows providers to view records of treatment rendered at DHS primary care, specialty, and emergency room sites and facilitates continuity of care for our vulnerable population. This is particularly beneficial for patients returning to jail from LAC+USC hospitalizations. In the past, there have been challenges in obtaining timely access to care information from outside of the jails. Access to ORCHID changes this and allows us to provide better care sooner. To date, over 250 members of the clinical team have been trained and now have access to view ORCHID.

WiFi Connectivity Improvement Project

The WiFi Improvement Project to install 370 DHS-procured Wireless Access Points (WAP) began in mid-September and continues to make progress. CHS and LASD are collaboratively resolving some technical obstacles to optimize the effectiveness of these WAPs. This should result in stronger, faster, secure wireless connections for the staff of both departments. Access to WiFi is critical to the work of the correctional workforce, especially as we increase our discharge planning efforts, which require real-time access to online resources and online referral systems.

Information Technology Staff

The four IT analyst positions mentioned in the previous update have completed “on-boarding.” They provide technical insight and project management to the business units, ensuring the operational aspects of the Jail Health Information System (JHIS) and the assessment of clinical workflows going toward ORCHID implementation are in alignment. Development of the necessary governance structure has been designed to review and manage further JHIS modifications.

Equipment Update Project

DHS/CHS began a computer update project in September, replacing all old workstations in clinical areas of the jail. This is another collaborative effort between the DHS and LASD technology teams. Working together, more than 900 DHS-provided computers will be replaced and offer a faster and more reliable user experience for CHS caregivers.

DHS / LASD Network Collaboration

The departments’ teams are working through the technical aspects of maintaining their respective security posture and providing users with a “Single Logon” computing experience. This work is challenging and taking longer than anticipated, as alignment on network security approaches have not yet been reached between the departments. Extending ORCHID into the jails will depend on developing a trusted network security relationship between both department domains. Delay in this work results in continued workarounds to coordinate care. Nevertheless, both departments continue to work toward a collaborative network solution.

AMION Scheduling Software

We also implemented a new web-based provider scheduling and on-call system across all CHS facilities, improving provider scheduling. This allows providers to view their schedules both inside and outside of the jail facilities, and also makes it easier to plan and maintain staff coverage. In addition, all CHS staff can view which colleagues are at work in jail facilities across the system.

Telemedicine

CHS has made progress in creating a tele-psychiatry pilot program. A project leadership group was created, and all facilities were surveyed to identify the best locations for the pilot. The Inmate Visiting Video System (IVVS) and Skype for Business were chosen as the teleconferencing infrastructure and system tests have been performed. CHS, however, continues to face obstacles that hinder the pilot roll out. Namely, Virtual Private Network (VPN) connections are not yet available for off-site providers to access JHIS (our jail electronic medical record system). The joint IT teams are building procedures to obtain the background clearance required for clinicians to gain approval for VPN access.

Vendor Support

When JHIS system administration transitioned from LASD to CHS, support of JHIS became a CHS responsibility. As a division of DHS, we negotiated substantially lower rates with Cerner for JHIS licensing and support. This was achievable through DHS' broad and longstanding relationship with Cerner. Current work includes reestablishing offline EHR data availability, in the case of system downtime. Cerner has completed an update to the Automated Justice Information System (AJIS)–JHIS interface, improving the connection between the two systems.

Looking Ahead

In addition to continuing to improve upon and scale the work noted above, we look forward to developing the following initiatives which will further expand our capacity and capability to provide optimal care to our patients:

- Mira Loma Detention Center – DHS is working closely with Mira Loma project design partners, LASD and DPW, to ensure that the clinical facilities at Mira Loma will be state of the art and sufficiently sized to allow for great care to be provided to its residents. Similarly, our transitions of care team is working with LASD to ensure discharge planning services are maximized and in-reach opportunities continue to increase so that women leaving the new facility and returning to the community have more options to receive services when they are home.
- Extending ORCHID into the Jails – Doing so will unify all electronic medical documentation across DHS, streamlining transitions of care, greatly improving continuity of care, and the patient and clinician experience. To date, we have LASD and DHS executive leadership agreement to move forward with the ORCHID transition and we have retained Gartner Consulting services to assess our readiness for this transition.
- Developing the full CHS staffing reorganization – We have designed the new model of care, created the staffing matrix to support this model, and are now working with CEO Classification, CEO Budget, and other essential county partners to refine the plan for full Board approval.
- Implementing more nursing and provider protocols consistent with other DHS facilities.
- Deepening partnerships with other DHS facilities in the same manner as OVMC and PDC, such as further growth of our Physical Therapy program by collaborating with DHS rehabilitation services.
- Expanding Urgent Care to 24/7 coverage – A new, larger Urgent Care space was identified and remodeled over the past eight months with a projected opening in six to eight weeks. New exam tables and chairs have been installed and new imaging equipment and monitors are part of the Urgent Care facelift. Staffing has been increased with in-house hires and the census has increased from 20–30 patients per day to up to 50 patients per day. The immediate goal is to extend coverage overnight and increase capacity to at least 100 patients per day by the end of this fiscal year.

- Implement the Psych Tech opportunity – This is better for patients, supports the Settlement Agreement with the Department of Justice, and allows custody to have more CAs who can be redeployed in this time when Sheriff recruitment of custody staff is urgent.
- Continue to work with ODR, DMH, and other partners to expand existing efforts and to ensure patients are either diverted as early as possible into safe and appropriate clinical settings or are released to available and effective services that serve patients and reduce recidivism.

Thank you for the opportunity to update your Board on the interval progress and improvements we have made in Correctional Health Services. We hope this report demonstrates that thoughtful action is being taken across all disciplines and service lines to improve our system of care. The road we travel is challenging and long, but through continued hard work, open collaboration, and with the critical support of this Board, we will achieve your vision of providing world-class care to our patients.