PLEASE CLICK ON THE COUNTY OF LOS ANGELES SEAL
TO RETURN TO THIS PAGE

CLICK HERE FOR THE DIRECTORS OF HEALTH SERVICES, MENTAL HEALTH AND PUBLIC HEALTH'S REPORT DATED MARCH 9, 2021

CLICK HERE FOR THE DIRECTORS OF HEALTH SERVICES, MENTAL HEALTH, PUBLIC HEALTH AND THE CHIEF OPERATING OFFICER OF THE ALLIANCE FOR HEALTH INTEGRATION'S REPORT DATED MARCH 21, 2022

CLICK HERE FOR THE DIRECTORS OF HEALTH SERVICES, MENTAL HEALTH, PUBLIC HEALTH AND THE CHIEF OPERATING OFFICER OF THE ALLIANCE FOR HEALTH INTEGRATION'S REPORT DATED MARCH 23, 2023

ALLIANCE FOR HEALTH INTEGRATION

Los Angeles County Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Jaclyn Baucum
Chief Operation Officer
Alliance for Health Integration

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

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

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

313 N. Figueroa Street, Suite 1014
Los Angeles, CA 90012

"The mission of the Alliance for Health Integration is to improve the health and well-being of Los Angeles County residents by aligning and efficiently implementing Board-approved prevention, treatment and healing initiatives that require the collaborative contributions of the three health departments."

March 9, 2021

TO: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Christina R. Ghaly, M.D.
Director of Health Services

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

Barbara Ferrer, PhD., M.P.H., M.Ed.
Director of Public Health

SUBJECT: **IMPLEMENTING THE LOS ANGELES COUNTY ALLIANCE FOR HEALTH INTEGRATION (ITEM 13, BOARD AGENDA OF FEBRUARY 18, 2020)**

This is in response to the February 18, 2020 motion by the Board of Supervisors (Board) directing the Department of Mental Health (DMH), Department of Health Services (DHS), and the Department of Public Health (Public Health), collectively "Departments", to adopt the proposed structure, priorities, and accountability framework for the Los Angeles County (LA County) Alliance for Health Integration (Alliance), as recommended in the Department's November 12, 2019 report (Directive 1). The motion further instructs the three Department Directors (Directors) to hire a Chief Operating Officer, as well as six staff (Directive 2), to support the Alliance in achieving the proposed priorities and metrics and to report back within 180 days and annually thereafter on progress of the Alliance, including updated priorities, objectives, and metrics (Directive 3).

Immediately following the adoption of this motion, the Directors formed the Alliance to strengthen innovation and collaboration and make significant improvements in health outcomes for LA County residents. Currently chaired by Dr. Christina Ghaly, Director of Health Services, the Departments held regular meetings to ensure consensus decision

making and shared governance and engaged with the Board, department leadership teams, labor partners, all health-affiliated County Commissioners, and community stakeholders to establish agreed-upon priorities. The following three priorities of the Alliance are able to achieve measurably improved health outcomes for vulnerable populations across LA County:

- Priority 1: *Integration and Development of Prevention, Treatment, and Healing Services*
- Priority 2: *Reduction of Health Inequities*
- Priority 3: *Improvement of Organizational Effectiveness*

As the Directors began to assign teams to support the execution of strategies and activities to address the Alliance priorities, LA County became impacted by the novel coronavirus disease (COVID-19). On March 4, 2020, the LA County Board and Public Health declared a local and public health emergency in response to the spread of the novel coronavirus across the country and in LA County. As of February 23, there have been 1,183,378 confirmed positive cases of COVID-19 across all areas of LA County and a total of 20,057 deaths. The pandemic has required a massive mobilization and response by the Departments and across all LA County departments. The response necessitated redirection of substantial resources and focus to prioritize, manage, and support activities that protect, treat, and support all LA County residents from the pandemic.

Despite the redeployment of many of the Department staff, the Directors worked to fulfill Directive 2, by launching a recruitment effort in early March to hire a senior level Chief Operating Officer for the Alliance. After extensive review of applicants, the Directors conducted interviews in September. In early October, the position was offered to and accepted by Jaclyn Baucum. She began on December 1, 2020. Recruitment is underway for the remaining 6 positions (1 administrative support position and 5 project managers).

The Alliance's response to Directive 3 is ongoing with the recent hiring of Ms. Baucum. Currently, a full review of the objectives/metrics is being conducted to update them in light of the pandemic response and in order to adjust the anticipated timelines. A revised priority document, including progress updates, will be shared with the Board in the next scheduled report back. Ms. Baucum has already engaged and met with the Labor Management Transformation Council (LMTC) and relevant County departments and stakeholders to begin work on Priority 3: *Improvement of Organizational Effectiveness*.

For the first report back to your Board, the Alliance would like to present a review of the coordinated pandemic work between the Departments. The attached report, "LA County's Alliance for Health Integration: Coordinated COVID-19 Response" summarizes the Departments efforts to rapidly respond to the pandemic and work on critically important activities related to the Alliance's priorities.

If you have any questions, please contact Jaclyn Baucum, Chief Operating Officer of the Alliance via email at JBaucum@ahi.lacounty.gov.

CG:JS:BF:jb

Attachment

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

LA County's Alliance for Health Integration: Coordinated COVID-19 Response

Christina R. Ghaly, M.D.
Director, Los Angeles County Department of Health Services

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

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

Jaclyn Baucum
Chief Operating Officer, Los Angeles County Alliance for Health Integration

Introduction

On February 18, 2020, the Los Angeles County Board of Supervisors (Board) unanimously approved a motion directing the Directors of Mental Health (DMH), Health Services (DHS), and Public Health, collectively "Departments", to report back to the Board within 180 days and annually thereafter on progress of the Alliance of Health Integration (Alliance), including updated priorities, objectives, and metrics.

Immediately following the adoption of this motion, the three Department Directors (Directors) formed the Alliance to strengthen innovation and collaboration and make significant improvements in health outcomes for Los Angeles County residents. Currently chaired by Dr. Barbara Ferrer, Director of Public Health, the Alliance has held regular meetings to ensure consensus decision making and shared governance and engaged with the Board, department leadership teams, labor partners, all health-affiliated County Commissioners, and community stakeholders to establish agreed-upon priorities. The following three priorities of the Alliance are able to achieve measurably improved health outcomes for vulnerable populations across the County:

- Priority 1: *Integration and Development of Prevention, Treatment, and Healing Services*
- Priority 2: *Reduction of Health Inequities*
- Priority 3: *Improvement of Organizational Effectiveness*

As the Directors began to assign teams to support the execution of strategies and metrics to address the Alliance priorities, Los Angeles County became impacted by the novel coronavirus disease (COVID-19). On March 4, 2020, the Los Angeles County Board of Supervisors and Public Health declared a local and public health emergency in response to community spread of the novel coronavirus across the country and in LA County. With little preexisting immunity to COVID-19, the global pandemic continues to pose a grave threat to virtually everyone's social, emotional, and physical health in the County. As of February 23, there have been 1,183,378 confirmed positive cases of COVID-19 across all areas of L.A. County and a total of 20,057 deaths. The pandemic has required a massive mobilization and response, which necessitated redirection of substantial resources and focus to prioritize, manage, and support activities that protect, treat, and support all County residents from the pandemic. This report summarizes the Departments efforts to rapidly respond to the pandemic and highlights the critical importance of the Alliance's mission to improve health and well-being of County residents.

Coordinated COVID-19 Response

When COVID-19 began to sweep through Los Angeles County, the Departments, under Public Health's leadership, worked diligently to identify the vulnerable populations that would need extra resources and support, such as under-resourced communities and communities of color, our homeless population, the incarcerated, residents of Skilled Nursing Facilities (SNF) and other non-SNF congregate settings. Each Department mobilized its own response to the pandemic, but there are some areas of integration that align with the Alliance. Most notably, the Departments collaborated to expand testing access to all County residents, manage outbreaks, decompress inpatient psychiatric beds, provide medical sheltering and a coordinated response for persons experiencing homelessness, optimize prevention through coordinated communication and outreach efforts, and coordinate with the Unions on reopening plans.

COVID-19 Testing

On April 20th, DHS was asked to assume responsibility for the County-wide community-based testing strategy, and support access to testing for entities implementing testing in vulnerable settings. DHS' overarching goal is to provide communities with widespread access to high-quality testing in a way that supports public health, protects vulnerable populations, and allows the County to safely re-open. As a part of this, DHS placed a high priority on rapidly expanding testing in the most impacted communities.

There are currently over 170 community testing sites across the County that are operated by the City of Los Angeles (10), LA County (27), State (10) and additional partner sites (127). DHS performed analyses to identify testing gap areas, and focused new testing sites in the most impacted areas. DHS worked closely with the Community Clinic Association of Los Angeles County (CCALAC) to increase access to community testing in federally qualified health centers (FQHCs) and partnered with 26 FQHC organizations to provide testing for all community members, including nonmembers. The partnerships between the clinics and the testing sites are going well and are reaching many individuals who may need regular health care and medical homes. These efforts have reduced the disparity in testing access in impacted communities. The gap in percent positivity (a marker of testing access) between the wealthiest and poorest communities has narrowed with percent positivity decreasing in the poorest communities.

Congregate Facilities

DHS and DMH worked closely with Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs), in consultation with Public Health, to ensure readiness to respond to potential COVID-19 cases in congregate facilities. This included developing and distributing various guidance documents, creating a weekly COVID-19 related webinar for facility administrators and developing weekly surveys to monitor for newly identified cases within facilities. When positive cases were identified, assigned facility leads would follow up by phone to triage the outbreak and provide Technical Assistance (TA) and guidance on next steps. This included information on how to contact Public Health to report the outbreak, how to access Personal Protective Equipment (PPE), assistance with quarantine and isolation protocols, and assistance with linking to facility-wide testing. Prior to testing resources being widely available in the community, DMH and DHS assisted facilities in identifying labs who could serve as testing partners and provide onsite testing to residents at no cost to the facility regardless of insurance. DMH and DHS leveraged relationships built through the Enriched Residential Care (ERC) Programs to encourage facilities to address barriers to following CDC guidance and to engage in continued surveillance testing facilitated through lab partners to monitor for COVID-19 within the facilities. This COVID-19 response has continued to grow and evolve as resources for these facilities have become more readily available and as Public Health has expanded their role in these facilities. One example of this growth in COVID-19 response has been the development of DHS COVID Response Teams, which feature capacity to provide onsite testing and infection control guidance to ERC facilities deemed to be especially high risk.

Additionally, as a part of the testing efforts, the Departments jointly worked on a plan to expand testing in congregate living settings. Through this partnership, a lab resource guide and other training materials were developed to assist and train congregate operators. Public Health also made mobile testing strike teams available, in the event testing was urgent and difficult for the facility to arrange. In addition to community-based testing, DHS took lead on operationalizing testing within correctional health settings (jail and juvenile halls/camps) and in testing for persons experiencing homelessness (PEH). Moreover, DHS provided TA and support, including assisting with access to testing supplies needed to implement the plan in these other congregate settings as well. DHS also developed the above referenced laboratory reference guide to provide these entities access to labs, developed contracts with laboratories and other service providers, and resolved supply shortages (e.g., swabs) that might otherwise hamper a facility's ability to use its own directly contracted commercial laboratory. The coordinated testing response for vulnerable populations is in line with Priority 1: *Integration and Development of Prevention, Treatment and Healing Services*.

COVID-19 Outbreak Management

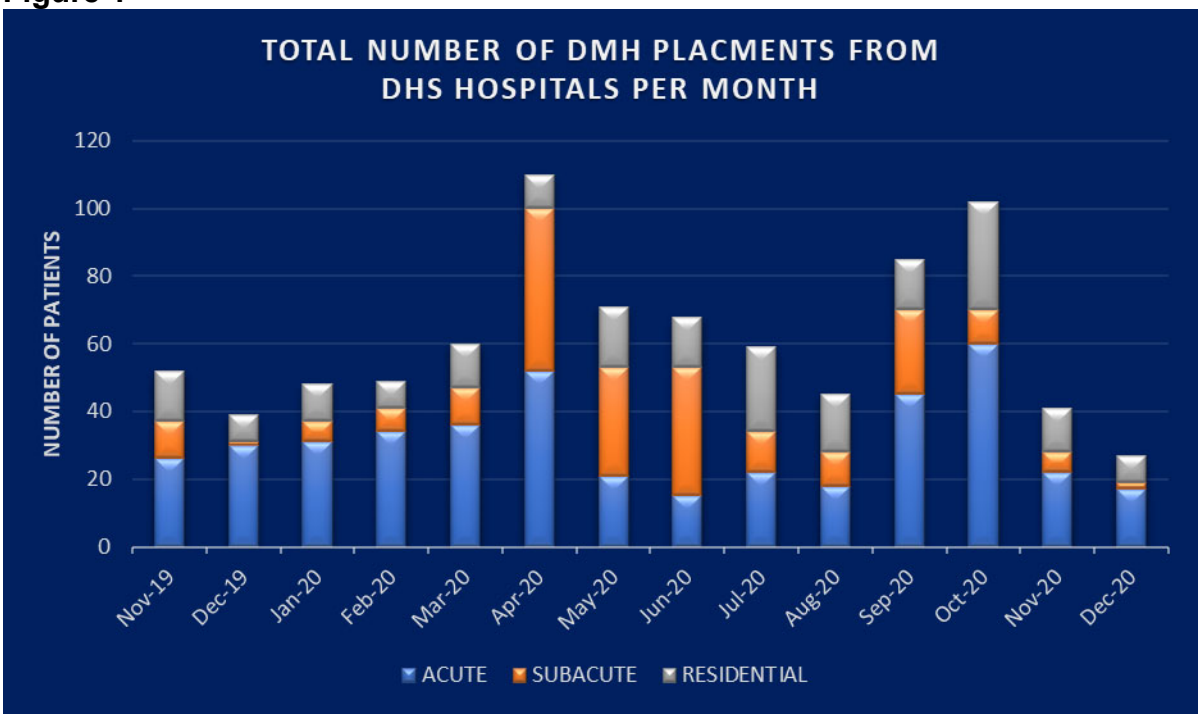
In collaboration with DHS and DMH, Public Health spearheaded the effort to address COVID-19 outbreaks throughout the County. Public Health's outbreak management entailed verifying the outbreak, interviewing those affected, (including staff and management), a site visit to ensure fidelity to directives, isolation of cases, testing, and quarantining of close contacts. Public Health increased the workforce responsible for responding to the growing number of COVID-19 outbreaks, reassigning staff and hiring staff at various levels. Also, Public Health developed an extensive training program to assure all outbreak investigation staff are well prepared. As of February 23, 2021, Public Health has investigated a total of 4,874 residential congregate settings and non-residential settings with at least 1 confirmed case of COVID-19. Of these, 930 are being currently investigated, and 3,944 are closed investigations.

COVID-19 Surge Planning, Decompressing DHS Inpatient Psychiatric Hospitals

In line with DMH's Oct 2019 report to Board and subsequently passed Board motion, DMH began a pilot program in early 2020 to increase mental health treatment bed capacity in our network by up to 500 beds (including acute, subacute, residential, and urgent care beds). In response to COVID-19 and the anticipated surge of COVID-19 patients to DHS hospitals, DMH worked closely with DHS to pivot the DMH bed pilot to focus especially on offloading clients from the DHS inpatient psychiatric hospitals, with the aim of freeing up these beds to treat COVID-19 patients. This surge planning resulted in a temporary increase in patient transfers out of the DHS inpatient psychiatric hospitals and into subsequent inpatient/residential care, from 248 total transfers between November 2019 and March 2020 to 353 total transfers between April and August 2020, a 42% increase (Figure 1). This trend was continued briefly in September, but due bed constraints, the subsequent two-month period from November 2020 to December 2020 did not continue. The most significant movement of patients was seen in April, September, and October 2020. DMH's bed expansions over the past year have prioritized surge and decompression in DHS facilities. These robust efforts prove that, with new, dedicated resources and support, transfer of patients from DHS to lower

levels of care in the community can be achieved. These results are key not only to our County's management of bed capacity during COVID-19, but also represent significant opportunities for improved patient experience (lowest level of care) as well as draw down of Federal match. In order to capitalize on this strategy, additional resources from the Federal, State and County, as well as focused advocacy (including IMD Exclusion waiver/repeal), are necessary.

Figure 1



Medical Sheltering

Hotel Accommodations for Frontline Staff Engaged in COVID-19 Response

DHS has facilitated hotel accommodations for its essential healthcare workers and developed a comprehensive plan outlining an assessment and collaboration with the State of California, Airbnb, and USC regarding housing and reasonable accommodation needs for DHS first responders and frontline healthcare workers who are engaged in COVID-19 Countywide response efforts.

Furthermore, DHS developed a strategy to best implement the Airbnb program and assisted the CEO Homeless Initiative, DMH, and Public Health with development of their strategies to make accommodations available to their frontline and affiliated workforce. As of December 31, 2020, there have been 59,129 accommodations confirmed for DHS frontline healthcare workers.

Persons Experiencing Homelessness (PEH) Response, Street Outreach Teams, Homeless Mortality Prevention

In line with Priority 2: *Reduction of Health Inequities,* the Departments collaborated to meet the needs of one of the County's most vulnerable populations, our PEH population. In partnership with DMH and Public Health, DHS has led medical sheltering during the COVID-19 pandemic that offers Isolation and Quarantine services. DHS operates 7 facilities with a capacity of 709 beds, including meals and onsite wraparound services, such as daily health evaluation and discharge planning. The discharge planning includes referrals and transportation protocols for all hospitals, homeless health care providers, and interim housing sites. Twenty-four-hour nursing is available at all locations with providers overseeing care (physicians, nurse practitioners, physician assistants). Since March 24th, 2020, 2,798 PEH have been cared for within medical shelters. Housing for Health (HFH) leads COVID-19 surveillance testing and infection control for PEH in sheltered and unsheltered settings. As of March 1, 2021, the following services have been completed:

- Sheltered Services
  - 91,771 COVID tests administered to PEH
  - 18,816 COVID tests administered to Staff
  - 2,009 cumulative positive for PEH: 2.2% overall positivity rate
  - 363 cumulative positive for Staff: 2.0% overall positivity rate
  - 305 shelter visits for initial assessment (clinical and programmatic)
  - 278 shelter visits establishing surveillance testing

- Unsheltered Services
  - 19,713 COVID tests administered to PEH
  - 4,117 COVID tests administered to Staff
  - 433 cumulative positive for PEH: 2.3% overall positivity rate
  - 88 cumulative positive for Staff: 2.3% overall positivity rate
  - 2,666 encampment wellness check and testing visit
  - 108,967 COVID services and referrals performed

Additionally, HFH launched a major food distribution initiative in response to COVID-19 that provides food to 5,000 unsheltered persons daily and 500 permanent supportive housing residents weekly to support these vulnerable individuals with staying in place and to address increased food insecurity during the pandemic. HFH also introduced a pilot hospice project that provides dignified and high-quality services to homeless and formerly homeless persons nearing the end of life.

As of February 23, 2021, 172 PEH and four people who were working in interim housing sites have died from COVID-19. PEH are especially vulnerable to COVID-19. They often don't have a safe place to shelter away from others, lack access to medical resources and may have multiple chronic health conditions. While PEH remain at risk for COVID-19 exposures in all settings, the number of cases among PEH remained below predicted levels during the early and peak stages of the pandemic. Since reaching a peak of cases around the Christmas holiday, there has been a significant reduction in cases among PEH, mirroring the overall decrease in cases in the County; from about 461 weekly cases to 26 from February 16 to February 22. At the peak of the surge, the County reported 17 deaths a week. From February 16 to February 22, there were 6 deaths.

This experience may be, in part, due to Public Health's work in partnership with DHS, HFH, and the Los Angeles Services Authority (LAHSA), to protect PEH from COVID-19 infections. Collectively they've supported the County's immediate and swift efforts to offer housing for PEH, including single-room facilities for the most at risk of serious illness, and for those needing to quarantine or isolate. Another contributing factor is Public Health's collaborative work with DHS, DMH, LAHSA, and other service providers to rapidly implement rigorous infectious disease protocols in shelters/interim housing and in other congregate settings where PEH live; investigate all COVID-19 outbreaks in homeless interim housing sites, homeless encampments, homeless service providers, and hygiene centers; as well as oversee contact tracing and data reporting across the County. As noted above, HFH's robust testing strategy for PEH in sheltered and unsheltered environments coupled with Public Health's contact tracing approach tailored to PEH may have also contributed to lower than expected cases among PEH thus far.

In addition, Public Health, in partnership with DHS, DMH, LAHSA, as well as various FQHCs, are bolstering efforts to decrease the number of COVID-19 cases and deaths among PEH by providing access to COVID-19 vaccines for currently eligible 65+ age group PEH and healthcare worker staff serving PEH. In consultation with the Board, the Departments are engaged with stakeholders in planning and carrying out strategies that take advantage of their collective experience in delivering care and services, including tested and validated prior vaccination efforts, as well as current COVID-19 disease control and testing interventions among PEH. In key partnership with HFH and its COVID-19 Response Teams, initial rollout efforts are leveraging established relationships with many shelters where surveillance testing and outbreak management have been performed. The effort has also engaged FQHCs that are already registered through myCAvax and have been vaccinating their communities. Vaccine administration models include satellite clinics and mobile outreach teams, and site selection is informed by risk of transmission within facilities or sites (congregate or unsheltered), mapped outbreak locations, risk of serious illness among PEH in specific locations (Project Roomkey sites), partner presence and reach, and the goal of ensuring adequate geographic coverage throughout the County. Public Health and Health Services have begun convening three regular workgroups—the COVID-19 Vaccine Policy and Coordination Committee, the Education and Engagement Workgroup, and the Vaccination Operations Workgroup—to coordinate vaccination work among identified partners. Vaccinations began during the first week of February with DHS providing 536 first doses of vaccine to PEH and healthcare workers at a range of sites, and L.A. Christian Health Center and JWCH administering vaccines to PEH in Skid Row and East L.A.

Furthermore, Public Health, in coordination with DHS, DMH, Chief Medical Examiner-Coroner (MEC), Chief Executive Office (CEO), and LAHSA, collectively referred to as the Homeless Mortality Prevention Initiative Workgroup (Workgroup), worked on data and methodological improvements and analyzed data for the second annual update of the L.A. County Homeless Mortality Report. This report is a follow-up to the first annual report of its kind, released in October of 2019, on trends in mortality rates and causes of death among PEH in LA County. The first report covered annual trends through 2018 and recommended that an updated report be released each year with additional data

from the previous year. Due to the ongoing response to the COVID-19 pandemic, the release of this year's report was moved to January to allow for a special preview of 2020 data so that the early impacts of COVID-19 on PEH could be examined and addressed.

In response to feedback from the Workgroup, this report presents results from additional analyses not included in last year's report, namely: 1) age-adjusted comparisons of cause-specific mortality rates among racial/ethnic and gender subgroups of PEH, 2) trends in overdose mortality rates by PEH age groups, and 3) an analysis of drug types most frequently involved in overdose deaths. One important finding from this report is that an early look at homeless mortality in 2020 revealed that COVID-19 had a smaller direct impact on PEH compared to the general population, but that overdose deaths, particularly those involving fentanyl, have increased significantly among PEH, particularly among Black and Latinx PEH, in LA County since the pandemic. The top five leading causes of death among PEH also include coronary heart disease, traffic injuries, homicide, and suicide. In addition to strategies to reduce these other leading causes of death among PEH, Public Health, in collaboration with Workgroup partners, are taking immediate steps to minimize drug-related mortality among PEH populations, including: 1) expansion of harm reduction services such as syringe exchange programs and distribution of naloxone and fentanyl test strips, 2) increasing access to supportive housing for PEH receiving substance use disorder services, 3) launch of Los Angeles County Methamphetamine Task Force to take a coordinated and comprehensive approach to addressing the methamphetamine crisis, 4) workforce training to promote the use of Medications for Addiction Treatment, and 5) development of a resource guide and mobile-friendly web application to facilitate access to substance use disorder treatment services. More information on the Workgroup's multiple strategies to reduce mortality among PEH amid the pandemic can be found in Public Health's October 23, 2020 progress report, "Analysis and Recommendations to Reduce Mortality Among People Experiencing Homelessness in Los Angeles County (Item 2, Board Agenda of October 29, 2019)".

COVID-19 Community Outreach to Address Highly Impacted Communities

In further support of Priority 2: *Reduction of Health Inequities*, DHS and Public Health have committed $7 million and $10 million, respectively, from allocated CARES Act and CDC grant funding to form the County COVID-19 Community Equity Fund to collaboratively develop a community-centered program to address disparities in COVID-19 outcomes. The fund serves communities disproportionately impacted by the COVID-19 pandemic through dedicated resources and prevention activities delivered by selected grassroots community-based organizations (CBOs) that possess cultural and linguistic expertise to reach historically under-resourced and hard to reach communities. In partnership, DHS and Public Health released an expedited solicitation by leveraging an existing DHS Board approved Master Agreement, which included a streamlined process for comparative review and analysis of all responses and resulted in Community Partners being awarded the contract as the fiscal intermediary for the fund on September 24, 2020 to support a community-centered outreach, engagement, system navigation, and contact tracing.

On October 16, 2020, Community Partners launched the CBO solicitation application. DHS and Public Health sought sub-contracted CBOs with deep connections within communities highly impacted by COVID-19 including Black, Latinx, Asian, Native Hawaiian/Pacific Islander, Indigenous, American Indian and Alaska Native, low-income, and justice-involved. When the solicitation closed on November 2, 2020, 250 applications were received for approximately 50 CBO funding opportunities. CP selected 51 CBOs and is currently finalizing sub-contracts with community-based organizations (25 CBOs to work with DHS and 26 CBOs to work with Public Health). Public Health and DHS have worked to overcome significant barriers posed by federal grant requirements and County insurance mandates that delayed contract execution. In particular, they augmented funding to CBOs to ensure that they could afford higher insurance premiums resulting from County requirements. Both departments worked nimbly and collaboratively to resolve this issue with their respective Contracts and Grants Divisions and will continue to explore approaches to address this issue for future initiatives. DHS-CBOs have executed all their sub-contractor agreement and 20 CBOs out of the 25 CBOs have completed all the SHSMA onboarding requirements to provide services. Of note, some organizations commenced service delivery in December. DHS anticipates completing all CBOs to meet onboarding requirements within the next month. DHS and Public Health have leveraged additional support for community-based efforts to address COVID-19 disparities by working closely with the County's Center for Strategic Partnerships. This has helped to ensure coordinated action with local and statewide funders who are interested in supporting COVID-19 response efforts. Recently, philanthropy has funded technical assistance to small CBOs who requested support in applying for the joint Public Health and DHS COVID-19 Equity Fund administered by Community Partners.

Various collaborative efforts are underway alongside community partners, with an emphasis on COVID-19 infection prevention, availability of COVID-19 testing, linkages to healthcare and other supportive services, as well as community education and engagement. Given the dangerous surge in COVID-19 cases, hospitalizations and deaths just ahead of the winter holidays — a time typically marked by gatherings and celebrations, DHS launched "Keeping Safe During the Holidays" a mini-campaign for the month of December 2020, focusing on how to stay safe and healthy for the holidays, how to access testing (regardless of immigration status and free of cost) and availability of community resources (including raising awareness on resource sites like 211 and One Degree).

A targeted public education campaign, COVID-19 Community Awareness and Education Campaign (Campaign) was created for highly impacted communities with Fenton Communications firm selected as the awarded contractor who began work in early December 2020. DHS has allocated $1.7 million of CRF funding to these efforts while exploring additional funding streams.

DHS partners with several community organizations as part of the Campaign. In December, DHS leveraged an additional $2.3 million in CRF funding to mobilize community-based organizations to engage and disseminate information to the priority populations mentioned above as a part of the "Keeping Safe for the Holidays" mini-campaign. By bringing the Los Angeles Regional Reentry Partnership (LARRP), Christ

Centered Ministries (CCM), AltaMed Health Services and Community Partners onboard as partners, a diverse group of over 220 community-based organizations across the region were recruited and coordinated to serve as trusted messengers. This coalition was composed of faith-based, racially and ethnically diverse, multilingual, health and social services, and regional nonprofit organizations across all supervisorial districts in Los Angeles County with strong community ties to COVID-19 highly impacted communities prioritized in the awareness campaign. The efforts around the "Keeping Safe during the Holidays" mini-campaign are informing the infrastructure of the community feedback loop that will amplify the reach and the relationships with community members during this critical time and over the next year.

In addition to mobilizing a coalition of over 220 community-based organizations, in partnership with Fenton, key stakeholders and community partners, DHS launched an integrated media campaign with Spanish-language media outlet, Univision, and a number of radio and newspaper outlets that have significant reach among Black and African American communities of Los Angeles County. These media outlets, who have proven significant reach and trust in the designated priority populations were intentionally selected to help carry the messages of the "Keeping Safe During the Holidays" mini-campaign. Of note, the media outlets have all served as impactful partners for previous community efforts including campaigns for the 2020 Census and voter outreach for the 2020 presidential election, and DHS leverages these outlets' abilities to reach communities in synergy with the coalition of community-based organizations.

Together, this collaborative effort resulted in a broad impact:

- Increased reach for COVID-19 information by way of CBOs [reached approximately 160,000 residents both in-person (via door-to-door outreach and flyer distribution) and online (via texting, email and social media)],
- Partnered with Local and Hyperlocal Ethnic Media- a media partnership with Univision with preliminary results showing 21,960,000 impressions over the duration of the media campaign.
- Telethon helpline event- over 1,000 residents called the central helpline to access important and accurate information on COVID-19 from the comfort of their homes.
- Media campaign expanded to radio and print outlets- media partnerships were developed with radio and print outlets with a significant reach among the Black and African American communities on where to find COVID-19 resources and information, with preliminary results of more than 5,600,000 impressions.
- Expanded equitable access of health information- all materials, communication tools, trainings are shared with partners in the community including the community organization coalitions, faith-based organizations, community clinics and health plans in addition to County partners like OIA, Public Health and County Communications.

Given the constantly changing dynamics throughout the pandemic, the campaign has re-engaged prioritized communities by conducting three distinct learning opportunities:

1) Developed and deployed a communication needs and strengths assessment of over 150 community-based organizations highlighting the unique experiences of CBOs at the frontlines of sharing COVID-19 information and knowledge.
2) Completed a public opinion research report about perceptions of COVID-19, attitudes toward safety measures and resources.
3) Conducted 10 focus groups that reflect our most impacted communities to gain a better perspective on culturally relevant stigmas and attitudes among various diverse audiences.

The COVID-19 Community Awareness and Engagement Campaign will not only represent the diverse perspectives of LA County residents but will be co-created using a community-centered voice to reach under-resourced communities.

Public Health is also initiating communications efforts through related activities conducted as part of the Community Health Worker Initiative (CHW Initiative), described below.

Public Health's CHW Initiative supports COVID-19 outreach and education in prioritized populations highly impacted by the virus to amplify accurate and up-to-date information regarding COVID-19. This short-term initiative is building infrastructure for a community-based system of response and fostering collaboration across different peer outreach models, including violence intervention, promotoras, parent advocates, worker advocates, and others. The CHW Initiative is mobilizing more than 700 community health workers under an expedited timeline by building an in-house team of workers and contracting with the California Community Foundation (CCF) as a fiscal lead agency to coordinate community-based contracts to leverage existing networks of community health workers and other peer providers.

To date, Public Health deployed 60 community health workers and 14 supervisors in the field. Through CCF, Public Health is also partnering with 16 CBO partner agencies that have mobilized more than 900 community health workers and 154 supervisors overall to conduct healing-informed, grassroots community outreach in 82 priority communities countywide. More than 207,000 outreach activities have been completed, reaching more than 370,000 individuals, and conducted in multiple languages. Public Health and DHS are working together to ensure coordinated messaging and ongoing collaboration as part of these initiatives. The CHW Initiative has been extended through March 2021 using unspent CARES funds. A component of the CHW Initiative includes streamlined communications and coordination efforts with County CEO and other departments, including the Office of Immigrant Affairs.

To ensure that the Departments were able to reach highly impacted and/or difficult to reach communities, Public Health developed, released, and conducted an RFSQ solicitation and issued master agreement contracts for as-needed language assistance services effective for the period of February 1, 2020 through June 30, 2028, including: document translation, in-person oral interpretation, telephonic and video remote interpretation, simultaneous oral interpretation, and sign language interpretation. DMH and DHS have access to this pool of vendors. DMH also has sign language interpreter

services agreements available to DHS and Public Health. Thus far, in response to the COVID-19 response, Public Health has translated 331 distinct documents to increase its reach to all communities across the County.

Additionally, Public Health worked closely with community partners to develop and translate, where appropriate, culturally relevant materials for the African American, Latino/Latinx, American Indian, Alaska Native, Asian American, Native Hawaiian and Pacific Islander communities. Materials that have been translated into various languages (e.g., Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Japanese, Korean, Tagalog, Thai, and Vietnamese) include fact sheets, frequently asked questions, Health Officer Orders, compliance protocols, and other training materials. Translated materials that facilitate compliance and understanding of safety requirements have been well-received. For example, the training materials for the COVID-19 Safety Compliance Certificate Program have been used by more than 21,016 Los Angeles County business owners and employees representing various sectors ranging from office-based worksites to restaurants and personal care establishments.

DMH collaborated with Public Health in creating COVID-19 community resources that included practical public and mental health information addressing the impact of the pandemic, such as stress, anxiety, uncertainty toward the future, isolation, risks to gainful employment, and grief and loss, among many others. DMH also provided bilingual certified staff in all threshold languages to assist in the translation of Public Health's COVID-19 materials.

In May 2020, DMH implemented a Speakers Bureau which operates as a specialized public communication, clinical, and community intervention resource. Approximately 100 bilingual certified licensed clinicians serve as Subject Matter Experts to facilitate culturally competent interventions and assist communities in navigating the complexities often associated with access to competent care and resources, during and beyond the COVID-19 pandemic. DMH members of the Institute for Cultural and Linguistic Inclusion Responsiveness (ICLIR) members are also active members of the Speakers Bureau. All LA County threshold languages and more are represented in the Speakers Bureau. From July 2020 to November 2020, they held 52 virtual presentations/trainings/workshops and 47 media presentations, reaching a total of approximately 6,773 participants and 17,300,281 community members, respectively. Speakers Bureau activities included but were not limited to development and language translation of COVID-19 and other materials, participation in Town Halls and Board press conferences, and production of public service announcements. The cultural expertise of Speakers Bureau members represents communities experiencing health disparities as well as communities that have been historically and systemically oppressed and disempowered.

DHS has had a very active Patient Facing Communication Committee focusing on culturally sensitive and linguistically appropriate messaging during the pandemic. DHS internal Healthcare Interpreter Staff, in partnership with certified vendors, translate urgent health-related documents including COVID-19 information in all threshold languages for use in DHS healthcare facilities and for patients. The DHS Healthcare

Interpreter staff and translation vendors also support COVID-19 Community Testing translation needs as part of DHS' role as lead in LA County COVID-19 Community Testing. DHS' current focus is also on expanding access to remote interpretation language access services in clinical areas and for remote visits. DHS has deployed mobile Video Remote Interpreting (VRI) units to its Ambulatory Care Network (A.C.N.) that include Comprehensive Health Centers and clinics (over 25 health sites). Over 35 languages are available to patients via video interpreter including Sign Language to complement over 240 languages available by audio only. VRI deployment will continue through the first quarter of 2021 to DHS' remaining community health centers. In addition, DHS has incorporated audio and video interpretation services into its virtual patient visit experience. Finally, Telephonic interpreter services have also been made easier to access by minimizing the number of data prompts before an interpreter joins an in-person patient encounter.

Department/Union Coordination with Re-Opening Plans

In support of Priority 3: *Improvement of Organizational Effectiveness*, the Departments continue to meet collectively with their Union partners through the Labor Management Transformation Council (LMTC). Each has formed COVID-19 focused response teams with Union partners to address concerns with workplace safety, training, PPE, and policies and procedures. This continued partnership and vigilance has allowed the Departments to safely balance the needs of employee safety while fulfilling each Department's unique charge and scope. The communication efforts are ongoing.

Additionally, Health Transformation Advocates (HTAs), the designated employees by the Departments and Labor to advance LMTC sponsored work, launched wellness projects, such as the creation and delivery of care packages to staff on the front lines of the County's COVID-19 response. HTAs collected donations, created packages, and made deliveries to over 1,500 staff at DHS facilities. HTAs have completed the distribution of care packages for employees in DHS and DPH and are in the process of distributing them in DMH.

As the demands of the pandemic allow, the Alliance will resume coordination and integration work on other priority objectives, which will be further outlined in a future report.

ALLIANCE FOR HEALTH INTEGRATION

Los Angeles County Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell (Chair)
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Jaclyn Baucum
Chief Operating Officer
Alliance for Health Integration

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

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

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

313 N. Figueroa Street, Suite 1014
Los Angeles, CA 90012

"To improve the health and well-being of Los Angeles County residents by aligning and efficiently implementing Board-approved prevention, treatment, and healing initiatives that require the collaborative contributions of the three health departments."

TO: Supervisor Holly J. Mitchell, Chair
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

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

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

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

Jaclyn Baucum, Chief Operating Officer
Alliance for Health Integration

DATE: March 21, 2022

SUBJECT: **IMPLEMENTING THE LOS ANGELES COUNTY ALLIANCE FOR HEALTH INTEGRATION (ITEM NO. 13 OF THE FEBRUARY 18, 2020 BOARD AGENDA)**

On February 18, 2020, the Board of Supervisors (Board) directed the Departments of Mental Health (DMH), Public Health (DPH), and Health Services (DHS), together referred to as Health Departments, to:

1. Adopt the proposed structure, priorities, and accountability framework for the Los Angeles County (County) Alliance for Health Integration (AHI), which has been accomplished;
2. Instruct the Directors of DMH, DPH, and DHS to hire a Chief Operating Officer (COO) for AHI, as well as six staff to support AHI in achieving the proposed priorities and metrics; and
3. Further instruct the Directors of DMH, DPH, and DHS to implement AHI, refine objectives and metrics by continuing to engage with stakeholders as work on objectives begins, and to report back annually on progress of AHI, including updated priorities, objectives, and metrics.

As instructed in the Board motion, AHI *"will align and efficiently implement Board-approved health and social justice initiatives that require the collaborative contributions of the three Health Departments in a manner that supports departmental workforces, builds partnerships, promotes health equity, and respects each department's unique charge and scope."* To fulfill this work, the Health Directors jointly identify and agree upon the areas of focus that they want to move forward and ask AHI to *"facilitate effective collaboration across departments,"* as directed in the Board motion.

Collaboration and opportunities for integration among mental health, public health, and health care services require thoughtful planning and well-designed meetings to help groups think strategically and reach their goals. AHI staff functions as in-house collaboration and project management specialists, who coordinate all of the moving pieces of integration projects and serve as the centralized planning and strategy hub to help drive highly complex, high priority projects to completion.

AHI is responsible for:

- **Facilitating coordination efforts among the Health Departments and stakeholders**

  Coordination includes, but is not limited to, convening integration teams comprised of staff from the Health Departments and other key partners; developing planning tools, such as process maps and project timelines; and providing backbone support, such as meeting facilitation and administrative support.

- **Conducting in-depth analyses to support thoughtful, collaborative decision making**

  AHI staff works with a diverse group of stakeholders and integration teams to ensure alignment across the Health Departments on cross-departmental services and programs. AHI seeks to guide comprehensive solutions by first understanding the problem that needs to be solved, followed by intensive examination of potential solutions. Examples include, conducting landscape analyses; holding focus groups; completing root cause analyses; and researching policy impacts and legislation to understand gaps and opportunities to reduce barriers to care and improve health outcomes for County residents.

- **Facilitating collaborative discussions and decision making among the Health Departments to design strategies for service integration and implementation**

During the last year with staff of only five, AHI has supported a broad scope of work on topics that include behavioral health, California Advancing and Innovating Medi-Cal (CalAIM), Community Health Workers, chronic conditions, and labor management, to name a few. AHI's goal is to support implementation across the Health Departments, in order to meet the adopted priorities and associated objectives, strategies, and metrics. AHI's progress and accomplishments over the last year would not have been possible without the leadership and significant collaborations and contributions within the Health

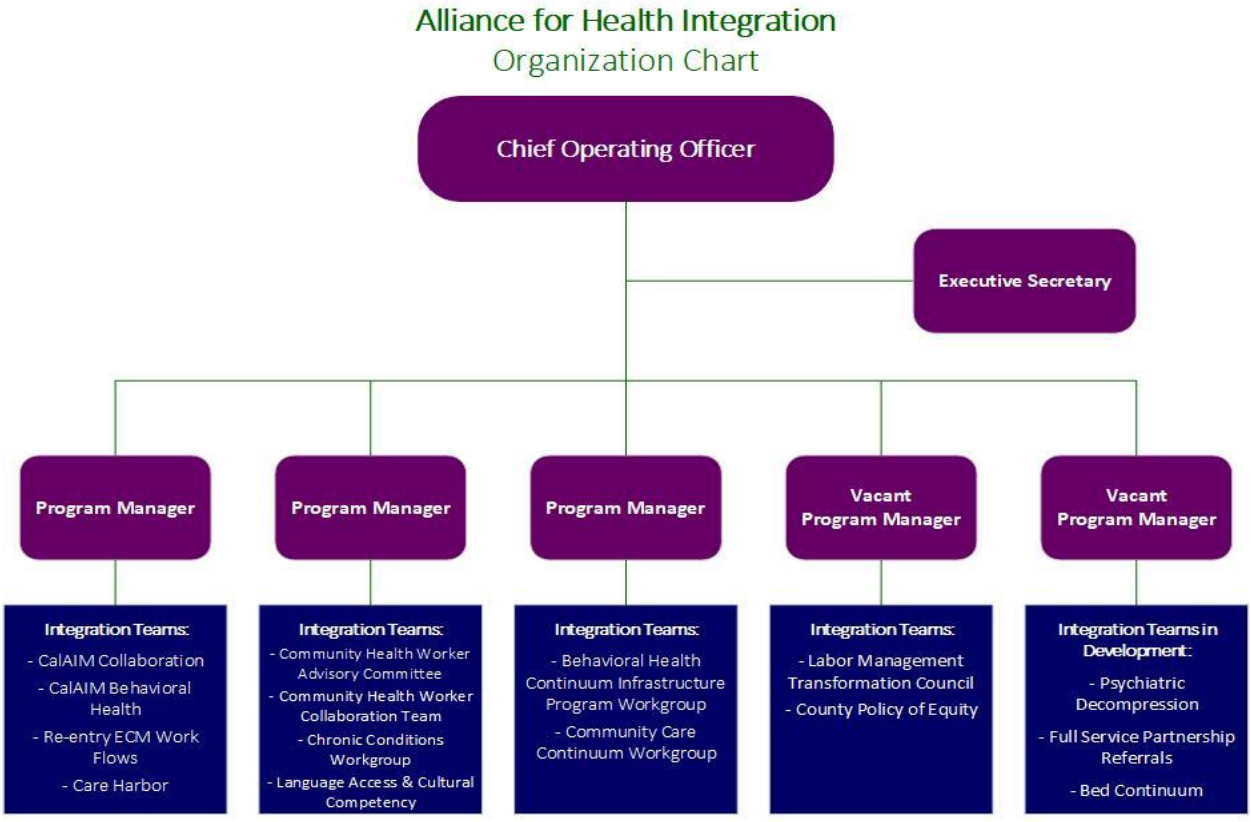
Departments. Additionally, many of AHI's priorities and Board initiated motions have required extensive collaboration with other County partners, including the Board; Chief Executive Office (CEO); Department of Human Resources (DHR); County Counsel; Workforce Development, Aging and Community Services; Department of Public Social Services (DPSS); Consumer and Business Affairs; Parks and Recreation (Parks); and many community-based organizations (CBOs). As AHI continues to advance work towards the three Board adopted priorities, the efforts to partner and collaborate with departmental colleagues and stakeholders will continue.

The following reflects the progress AHI has made since March 2021 towards directives two and three.

DIRECTIVE TWO

As instructed in directive two, the Directors of the Health Departments, along with AHI's COO, have started building AHI's team and hired four of the six requested staff members since the 2021 report back. AHI's Executive Secretary was hired in April 2021 and three Program Implementation Managers (PIMs) were onboarded between August and December 2021. The new staff brings a wide range of experiences from other County departments, public health, preventative health, private sector health systems, non-profits, and government relations that all complement the challenging work set forth by AHI's priorities. Recruitment for the remaining two PIM positions is still underway.

Please see AHI's updated organization chart below for reference:



DIRECTIVE THREE

As formally adopted by the Board in February 2020, AHI's mission is to support alignment of the collaborative contributions of the Health Departments *"to improve the health and well-being of Los Angeles County residents by aligning and efficiently implementing Board-approved prevention, treatment, and healing initiatives."* Since the March 2021 report back, an extensive amount of work has been accomplished to advance the three priorities centered around AHI's mission statement.

AHI's priorities are:

- Priority One: Integrate and develop prevention, treatment, and healing services
- Priority Two: Reduce health inequities
- Priority Three: Improve organizational effectiveness

Over the last year, AHI has worked closely with the Health Department Directors to refine the objectives, strategies, and metrics (please refer to the index on page 13 to view the complete list). Per the Board's direction, the objectives and strategies continue to be refined, and AHI is currently facilitating an annual review of the priorities listed in this report. As such, AHI anticipates a refresh of the priority document in the coming months and will share these revisions with the Board when updated. The subsequent annual report back will align with those additions and adjustments. For any area that does not have clearly defined work, AHI will continue to collaborate with the Health Departments to clarify the projects to be pursued in the coming year.

Since AHI's PIMs have been hired within the last six months and having two vacant PIM items, the Health Department Directors and AHI COO have agreed that staff should focus on advancing the priorities only under their portfolio. Once fully staffed, metrics will be developed by the integration teams that reflect agreements among a full body of stakeholders. To date, AHI has supported efforts to establish the critical areas of shared work, launched integration teams, and developed specific metrics to track progress.

Below, AHI has listed work in development that corresponds to each priority.

PRIORITY ONE: INTEGRATE AND DEVELOP PREVENTION, TREATMENT, AND HEALING SERVICES

Behavioral Health:

On January 22, 2019, the Board approved a motion entitled, *Addressing the Shortage of Mental Health Hospital Beds*, which highlighted the need to remedy longstanding service gaps in the County's mental health system of care, with particular attention to treatment bed capacity. DMH was directed to provide the Board with a report that included a plan for the creation of mental health hospital beds, looking at potential sites, funding options, patient population, and assessments of current and future bed needs. Improving the public mental health and substance use disorder care system in the County is a massive

endeavor that involves the Health Departments; other County departments; and contracted providers, significant resources, and major systems improvements (Objectives 1.1 and 1.3). AHI is coordinating the Health Departments and CEO in their pursuit of the California Department of Health Care Services (DHCS) Behavioral Health Continuum Infrastructure Program (BHCIP) and California Department of Social Services (CDSS) Community Care Expansion (CCE) Program State grant funding. These State grants offer an unprecedented opportunity to thoughtfully plan, expand, and improve behavioral health and social services infrastructure across California. Success will result in minimizing client flow into hospitals, improving client flow out, and providing higher quality client care overall.

Since January 2022, AHI has set-up backbone and project management support for the BHCIP and CCE Workgroups to develop a County-wide plan to maximize BHCIP/CCE investments across departments, provider partners, and the remaining BHCIP/CCE grant rounds (Objective 1.1, Strategy 1.1.2). In support of submitting a comprehensive, system-wide County BHCIP/CCE grant application portfolio, the integration teams, with representation from DMH, DPH Substance Abuse and Prevention Control (SAPC), DHS, and CEO, have produced:

- Contract provider stakeholder network surveys (DPH SAPC, DMH)
- County BHCIP Resource Strategy that identifies a funding mix that balances resources for mental health and substance use disorder services, as well as key County infrastructure projects and contract provider safety net projects
- Project Review Criteria and Scoring Rubric used to assess County contract provider projects, so the County can provide the required letters of support for community applications
- Needs assessment of County bed-related needs and resources
- County Project and Building Portfolio

As the County has moved to address bed shortages with a comprehensive County-wide approach, AHI is supporting the Health Departments and CEO's efforts to contribute to the County-wide MAPP Goal 2.0, *Documenting the universe of County-funded beds for vulnerable populations: homeless, justice-involved, exiting institutions*. AHI attended the Bed Summit in December 2021 and has been an ongoing workgroup member to continue the effort. This work supports *Right Care at the Right Time* (Objective 1.1., Strategy 1.1.2), to prioritize projects, submitted through BHCIP and CCE applications, that expand bed and system capacity and leverage this funding resource.

Psychiatric Inpatient Care:

Before AHI was established, the Health Agency developed a set of priorities. Among those priorities was the effort to decompress our psychiatric inpatient beds. The Health Departments are aligned and have identified that this remains a critical need, and, as such, AHI will support efforts to ensure continued progress. During the COVID-19 pandemic, the psychiatric inpatient bed need peaked as the hospitals were overwhelmed with patients during the surges. DMH worked with DHS during the surges to help mitigate; however, the need to mitigate has not waned, and we continue to experience elevated

numbers within the psychiatric inpatient setting. Part of the strategy to step-down patients is dependent on bed capacity at the next lower level of care. There are bottle necks at many, if not all, levels of specialty mental health care that make movement challenging. DMH has worked to increase capacity with their contracted providers and within their own directly operated settings. There have been numerous challenges that have interfered with the ability to make measurable progress on this initiative. This effort relies on the success of the broader County-wide bed continuum endeavors (Objective 1.1, Strategy 1.1.3); strategic investments in the BHCIP/CCE projects and other funding opportunities (Objective 1.1, Strategy 1.1.2); success in healthcare hiring efforts, both in County positions and within our specialty mental health provider network (Objective 3.2, Strategy 3.2.2); and the Board's continued investment and support towards this goal. While the challenges with obtaining timely efficient flow through the behavioral health continuum has remained unchanged to date, AHI is working with DMH and DHS colleagues to identify the problems, map out solutions, build a project mapping tool to track all mitigation measures, support ongoing conversations, and foster a system for accountability to track progress. In addition to this effort, other utilization management and client flow challenges will be prioritized in the coming year.

CalAIM and Medi-Cal Reform:

CalAIM is a multi-year plan aimed at transforming California's Medi-Cal program. AHI supports coordinated preparation work and roll out planning for CalAIM among the Health Departments for County Medi-Cal beneficiaries. Alongside work completed and led by the Departments, AHI is providing the Board, County commissions, and other CBOs with information on CalAIM basics.

The following offers specific examples of AHI coordination and collaboration efforts to streamline services to County beneficiaries and reduce barriers to care:

Specific to AHI's Priority One, AHI has worked with the Health Departments to develop process flows and share information to support existing and new patient onboarding to CalAIM services. AHI and Health Department leads meet bi-weekly on CalAIM topics, which allows for timely and critical information sharing, identifying areas of shared interests, and coordinating advocacy to state agencies and health plans, as needed (Objective 1.2, Priority 1.2.1). AHI also facilitates monthly meetings with DMH, DPH, and DPH SAPC to discuss topics that require collaboration under the behavioral health scope. This includes preparation and coordination work around behavioral health payment reform and integration of systems and services. These efforts ensure that vulnerable populations have timely access to mental health, substance use, and physical health services (Objective 1.3).

While CalAIM launched on January 1, 2022, AHI is identifying opportunities for coordinated advocacy and escalating policy priorities in partnership with CEO Legislative Affairs (Objective 1.2, Priority 1.2.1). At the end of December 2021, AHI worked with DMH and CEO Legislative Affairs to gain urgent clarity from DHCS to ensure that DMH-assigned Whole Person Care (WPC) members remained under DMH management. Through these efforts, DMH patients remained under DMH's management and transitioned into 2022 without disruptions in access to care and services. AHI continues

to work closely with the Health Departments, other County departments, health plans, and the State to ensure access to coverage and benefits (Objective 1.1, Strategy 1.1.5).

Additionally, AHI is facilitating integration teams where CalAIM referral and linkage systems are critical to ensure timely access to services under County operations (Objective 1.1, Strategy 1.1.2). One of these integration teams is centered around defining cross-departmental referral systems for re-entry populations. Specifically, AHI is supporting the Health Departments to further build on existing processes and develop updated referral processes under new CalAIM frameworks for reentry populations.

Since August 2021, AHI has worked with the Health Departments to create joint presentations that are provided to the Board's Policy Deputies monthly, to keep the Board informed of new developments, opportunities, and any potential barriers that could impact patient access to care and services. Additionally, AHI supported the process for a joint Board letter among the Health Departments to ensure timely execution of CalAIM contracts with Managed Care Plans. Most recently, with additional Board Policy Deputies requesting access to CalAIM briefings and information, AHI is developing a set of webinars and tools to offer basic CalAIM training for the Board to access. Finally, as a way to track performance and outcomes, AHI will be working with the Health Departments to develop a performance dashboard that tracks shared key performance indicators.

PRIORITY TWO: REDUCE HEALTH INEQUITIES

Community Health Workers:

For several years, the Health Departments have integrated Community Health Workers (CHWs) into various programs and services, in both clinical and in community settings. Since the start of the COVID-19 pandemic, over 1,000 additional CHWs were brought onboard. Our current CHW workforce is a mix of permanent directly hired County staff, temporary contract workers, and CHWs employed by County-contracted CBOs. After many years of coordinating a network of internal and CBO CHWs, the Health Departments are eager to assess what is working well, what can be improved, how to better coordinate among the Health Departments, and how best to accomplish our goals by investing in CHWs as a critical step towards health equity.

To advance the Health Departments' strategic thinking and coordinate our CHW-related efforts across all Health Departments, AHI led several projects related to AHI's Priority Two, *Reduce Health Inequities* (Objective 2.6, Strategy 2.6.2). As an initial step to surface the strengths and challenges of our current efforts, AHI interviewed County departmental colleagues working with CHWs in October and November 2021. Based on these interviews, AHI produced an internal landscape analysis in February 2022 (Attachment A) that identified current practices and hurdles to hiring and training CHWs, opportunities to coordinate among the Health Departments, and potential strategies for strengthening our CHW infrastructure, both internally and with our CBO contractors.

Building on the rich ideas Health Department staff expressed in the landscape analysis for improving our CHW infrastructure, AHI designed a 12-month planning process (Attachment B) with input from departmental staff. Once we receive input from our CBO

contractors on the proposed process, AHI will launch this planning process with the Heath Departments and our CBO contractors in 2022. Key to this plan is engaging with our CBO contractors to understand what their CHWs, and their organizations, need to thrive and how the County can best help build the capacity of our contractors and their CHW employees. For this effort, AHI facilitates two ongoing integration teams which meet regularly to design the planning process and support the development of a written plan to strengthen our CHW infrastructure.

Together with, and guided by, the CEO Center for Strategic Partnerships and AHI sought funding in January 2022 from local philanthropies interested in supporting the County's investment in CHWs. These foundations are particularly enthusiastic about the efforts to collaborate with community partners in an interactive process to develop a plan for supporting our CHW workforce.

Cognizant of the need for stable, long-term funding to support our CHW workforce, AHI worked with the Health Departments and prepared a letter in response to the DHCS in support of Medi-Cal coverage for CHW services via the State's proposed CHW State Plan Amendment. To maximize the impact of this letter, AHI partnered with the CEO Office of Legislative Affairs and met with DHCS staff to emphasize the enormous health benefits that would result from Medi-Cal reimbursements for select CHW services. As next steps, AHI is continuing to work with CEO Legislative Affairs to identify additional channels to allow for other California Counties to sign-on to the County's recommendations (Objective 1.2, Strategy 1.2.1). The State is planning to roll out this new CHW Medi-Cal benefit in July 2022, pending submission and approval of the State Plan Amendment by the Centers for Medicare and Medicaid Services.

Chronic Conditions Initiative:

AHI is currently supporting efforts across the Health Departments to design an initiative to prevent and manage diabetes and hypertension. The ultimate goal is to implement an integrated chronic disease intervention that incorporates the Health Departments' successful strategies and best practices from other organizations, capitalizing on proven practices to prevent and manage diabetes and hypertension among County residents.

For several months, AHI has convened an integration team comprised of subject matter experts from the Health Departments to design this initiative (Objective 2.4, Strategy 2.4.1). Once departmental staff selected the initiative's outcome as the prevention and management of diabetes and hypertension, AHI organized a series of presentations for the integration team to review, together, best practices for preventing and managing diabetes and hypertension. These presentations have been conducted by internal staff directing programs within County departments, as well as subject matter experts from external agencies who have presented lessons learned from their efforts to lower rates of chronic disease. After this exploration phase is complete, AHI will facilitate the integration team through the process of initiative design, drawing from County programs' best practices as well as successful strategies implemented by non-County entities.

Care Harbor Mega Clinic:

On August 10, 2021, the Board appointed AHI as the County liaison for all Care Harbor Mega Clinic events moving forward. The Care Harbor Mega Clinic is a free clinic that provides under-resourced and underserved residents with essential health care services, such as primary care, vision, and dental care, in addition to access to social services through County partners, such as DPSS, DHR, DMH, DPH, DHS, Consumer and Business Affairs, Public Defender, and Office of Immigrant Affairs (Objective 2.6, Strategy 2.6.1). The Care Harbor Mega Clinic was held on March 4 through 6, 2022 at the Reef in Downtown Los Angeles. AHI worked closely with Care Harbor to provide public health inspections; solicit and coordinate participation from County partners, including volunteering to help on the days of the event; as well as offering on-site services, such as record expungement and in-person mental health counseling.

AHI also coordinated an on-site vaccine clinic at the Care Harbor event, administered by DPH to support increased acceptance rates of COVID-19 and influenza vaccinations among County residents and County workforce (Objective 2.5, Strategy 2.5.3). Residents were encouraged to get their vaccinations during their medical exams, and volunteers were also notified of the opportunities for COVID-19 boosters and influenza vaccines. In order to attend the Care Harbor Mega Clinic, County residents received wrist bands the weekend prior to the event, which served as entry tickets. By working with Parks, AHI helped to secure and reserve the wrist banding site at Ted Watkins Memorial Park, which is also a community vaccination site. This co-location also served as an opportunity for Care Harbor patients to receive COVID-19 vaccinations and boosters. In partnership, Care Harbor staff and volunteers helped to guide interested residents to the DPH vaccine clinic.

PRIORITY THREE: IMPROVE ORGANIZATIONAL EFFECTIVENESS

Labor Management Transformation Council:

Much of the work for Priority Three involves close collaboration with our labor partners in the Labor Management Transformation Council (LMTC). The LMTC is a collaborative approach to improve the quality of health services in the County through a labor-management partnership between the County's Health Departments, AHI, and the unions representing its employees, which includes American Federation of State, County and Municipal Employees (AFSCME) Local 2712; AFSCME Local 3511; Service Employees International Union (SEIU) Local 721; Committee of Interns and Residents (CIR); Union of American Physicians and Dentists (UAPD); and Teamsters Local 911.

The shared mission of the LMTC is to transform our communities to ensure optimal health and well-being for all residents in the County, by promoting prevention and aligning the healthcare delivery system to become a provider of choice and an employer of choice. The LMTC has prioritized projects and activities that are patient and client centered and that lead to staff empowerment and system outcomes (Objective 3.1).

AHI leads the coordination of departmental efforts within the LMTC, helping to coordinate agendas and work with the LMTC steering committee, LMTC workgroups, and the Health

Transformation Advocates. Recently, the LMTC has experienced changes in various leadership positions, including the LMTC coach retiring in September 2021. As such, AHI has partnered with Workers Education and Resource Center, Inc. to recruit a new contracted coach to work with the LTMC to advance the collective work. Recruitment is ongoing, but the hope is to fill the vacancy by the end of March 2022. To keep things moving, AHI is providing central administrative support to all corresponding LMTC activities and member groups. AHI also facilitated partnership for the LMTC in a Penn State Learning Collaborative to foster and strengthen partnership work. Presently, AHI staff, Health Department staff, and other LMTC representatives are serving on a Retreat Planning Committee to plan a late spring or early summer retreat, to help focus and reaffirm projects work moves into the next season.

Workforce Development:

In response to Board Chairwoman Holly J. Mitchell's Board motion, *Rebuilding a County Workforce that Can Respond to the County's Complex Healthcare Needs*, AHI facilitated the report back and coordinated the responses among the Health Departments to, first, address the healthcare workforce shortage and, second, identify solutions to decrease existing vacancies (Objective 3.2, Strategy 3.2.2). The second part of the report back is still pending final submission, but the list of recommendations will generate some areas of shared work to help address barriers to hiring and retaining staff. Specific AHI projects will be defined following the second report back submission and feedback from the Board.

The Health Departments share a commitment to work on a variety of shared human resources related projects, including, the identification of certain item classifications in need of revisions (Objective 3.2, Strategy 3.2.3); adapting mandatory training rules for a health-related environment (Objective 3.3, Strategy 3.3.2); and enhancing workplace culture through select County policies (Objective 3.3, Strategy 3.3.3). Due to the COVID-19 pandemic highly impacting the Health Departments, there has not been capacity to start new work in any of the abovementioned areas, with the exception of work towards the County Policy of Equity (Objective 3.3, Strategy 3.3.3). AHI worked with the Health Departments, DHR, Executive Office, and our labor partners to host a series of conversations about barriers, problems, and possible solutions. Through these meetings, the full group developed a grid of prioritized projects to work on together, including two pilot programs and the development of a frequently asked questions document. While not an explicit LMTC sponsored activity, it was done in collaboration with labor. This effort will continue and be constantly evaluated for areas of improvement.

OTHER: ADDITIONAL CONTRIBUTIONS

Board Motions:

Since AHI's last annual report back, AHI has been named in nine Board motions and has been asked to support two additional Board motions by the Health Department Directors. AHI led the coordination for the *Establishing Chief Well-being Officers and Promoting Workforce Wellness* report back and worked with the Health Departments to provide critical input and design for an effective Chief Well Being Officer role. AHI also worked with the Health Departments, CEO, and DHR to coordinate the first and second report

backs on *Rebuilding a County Workforce That Can Respond to the County's Complex Healthcare Needs.*

The complete list of AHI's Board motions are listed in the following table:

Board Motion	Tie to AHI Priority
Establishing Chief Well-being Officers and Promoting Workforce Wellness	Objective 3.3, Strategy 3.3.3
Participation and Support for the Care Harbor Clinic at the Reef Expo Hall in December 2021	Objective 2.6, Strategy 2.6.1
Addressing the STD Crisis in Los Angeles County	Objective 2.2, Strategy 2.2.1
Rebuilding a County Workforce That Can Respond to the County's Complex Healthcare Needs[1]	Objective 3.2, Strategy 3.2.2
Diabetes and Prediabetes Awareness and Prevention	Objective 2.4, Strategy 21
Proclaiming Alzheimer's Awareness Month and Encouraging Access to Mental Health Services for People with Dementia	Objective 1.3
Reinforcing Equitable Access to COVID-19 Boosters and Pediatric Vaccines	Objective 2.5, Strategy 2.5.3
Creating On-Site Behavioral Health Crisis Response Teams for Los Angeles County's Restorative Care Villages[1]	Objective 1.1, Strategy 1.1.1
Los Angeles County Social Connectivity Initiative	N/A
Strengthening Language Access in County Services	Objective 2.7, Strategy 2.7.1
Solidifying the Role of Promotoras de Salud in County Services	Objective 2.6, Strategy 2.6.2

SUMMARY

AHI is proud to have supported efforts across the Health Departments and valuable stakeholders to prioritize and advance its mission *"to improve the health and well-being of Los Angeles County residents by aligning and efficiently implementing Board-approved prevention, treatment, and healing initiatives that require the collaborative contributions of the Health Departments."*

Over the last 12 months, AHI has made significant progress around the three Board adopted priorities, under the leadership and support from the Health Departments. AHI's work is a reflection of the unique and meaningful contributions that come from each individual participant and their department or organization. Since AHI's inception in February 2020, the team has grown and taken significant steps to impact integrated care,

[1] Board motions where AHI was not cited, but assigned to AHI by the Health Department Directors

which would not have been possible without the contributions and support from the integration teams, several individuals from the Health Departments, and other organizations who have helped to develop and advance AHI's objectives and strategies. AHI would like to take the time to recognize and thank all of those participants for their partnership and continued support. Together, AHI will continue to carry forward the integration and coordination work that has started and expand the scope of work and projects, as appropriate, to reflect emerging priorities.

If you have any questions regarding this report back, you may contact Jaclyn Baucum, AHI COO, at jbaucum@ahi.lacounty.gov.

JB:ak

Attachments

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Department of Human Resources

INDEX

The following AHI Priorities are under construction and in review with the Health Departments. As a result, some objectives and priorities will be further defined and may be deleted.

[1] Examples of populations most in need include those with mental illness, substance use disorders (SUD) and/or those experiencing homelessness/housing insecurity, incarceration/re-entry, and Veterans.

Priorities	Objectives	Strategies	Page #
		such individuals with their assigned health care provider.	
	1.2 Coordinate advocacy efforts with local, state and federal entities to ensure timely access to physical health, mental health, and SUD services for our LA County residents.	1.2.1 Identify and address challenges from local, state, and federal regulations for shared clients.	6, 8
		1.2.2 Specific to CalAIM, escalate policy priorities as a unified County, as needed, to advocate for needs of LA County beneficiaries and their providers.	
	1.3 Ensure that vulnerable populations (such as those involved with DCFS system, persons experiencing homelessness, individuals post release from jail/prison, Veterans, and prenatal/perinatal women) have timely access to mental health, substance use, and physical health services.	TBD Specific strategies are still being determined but some of AHI's work are already in progress	5, 6, 11
	1.4 Increase and integrate prevention and healing services offered in the County.	1.4.1 Establish and expand programming in Healing and Trauma Prevention Centers to offer integrated clinical and emotional support for survivors and prevention-oriented activities for community members.	
		1.4.2 Expand and integrate prevention, treatment, and healing services at Student Wellbeing Centers through youth engagement and peer leadership opportunities, mental and sexual health services, substance use prevention, and teen development and	

Priorities	Objectives	Strategies	Page #
		health education programs for parents of youth at participating campuses.	
2. Reduce Health Inequities	2.1 Reduce racial/ethnic gaps in birth outcomes.	2.1.1 Offer appropriate home-based support for pregnant women with behavioral health needs.	
		2.1.2 Coordinate and enhance tobacco cessation services for women who are pregnant or plan to become pregnant.	
	2.2 Increase coordination and integration of STI/HIV services to decrease rates in LA County.	2.2.1 Increase chlamydia screenings amongst women.	11
		2.2.2 Increase HIV/viral suppression.	
	2.3 Identify and reduce impact from environmental exposures that contribute to poor health outcomes.	2.3.1 Coordinate outreach, enrollment, and remediation services to communities heavily impacted by lead paint exposure.	
	2.4 Address chronic health conditions that predispose people to negative health outcomes with a comprehensive and integrated community-based approach.	2.4.1 Design and implement a community-based initiative for all three health departments to integrate efforts in a location where DMH, DPH and DHS all serve residents, with the goal of preventing or decreasing diabetes and hypertension.	8, 11
	2.5 Decrease incidence of vaccine preventable illness.	2.5.1 Increase vaccine coverage of routine childhood immunizations.	
		2.5.2 Maintain geographically diverse and equitably accessible COVID-19 vaccination delivery infrastructure to ensure access.	
		2.5.3 Increase acceptance rates of COVID-19 vaccination and annual influenza	9, 11

Priorities	Objectives	Strategies	Page #
		vaccination among County residents and County workforce.	
	2.6 Partner with community-based organizations, philanthropy, private entities, and other stakeholders to identify and address health inequities.	2.6.1 Coordinate and facilitate Health Department involvement in hosting annual Care Harbor events for under-resourced and uninsured residents.	9, 11
		2.6.2 Strengthen the community health worker infrastructure in partnership with DMH, DPH and DHS, community organizations,	7,11
	2.7 Deliver culturally and linguistically appropriate care and communications to all patients, clients, customers, and community members.	2.7.1 Coordinate and advance cultural and linguistic competencies and best practices across the three health departments, including language assistance services, data standards, consumer satisfaction outcome data collection/reporting, employee resources and engagement, and equitable access to technology.	11
	2.8 Collaborate with the County's ARDI Initiative and labor partners to coordinate anti-racism work across the three Health Departments.	2.8.1 Partner with LMTC in supporting Anti-Racism, Diversity, and Inclusion effort county-wide.	
3. Improve Organizational Effectiveness	3.1 Further implement Just Culture in partnership with labor.	3.1.1 Identify and implement shared projects with the Labor Management Transformation Council (LMTC) for Just Culture implementation.	
	3.2 Partner with labor to improve employee engagement at all levels of each Department's organization to ensure high quality services, employee retention, and job satisfaction.	3.2.1 Through the LMTC, market and analyze Health Department employee engagement survey(s) and develop LMTC project to improve employee engagement	

Priorities	Objectives	Strategies	Page #
		3.2.2 Place holder: Developing a strategy around healthcare hiring	6, 10, 11
		3.2.3 Convene an HR Subject Matter Expert workgroup to identify the top 3 shared Health Department classifications where class specification revisions are most critical and collaboratively engage the Chief Executive Office to develop necessary revisions.	10
	3.3 Redesign and/or streamline contracting, contract monitoring, billing, IT, data integration, and Human Resources (HR) processes on an as-needed basis to enhance other cross-Departmental integration efforts and reduce burdens on contracted agencies.	3.3.1 Streamline process for executing contracts with vendors and community-based organizations (in a manner that also aligns with the aims of the County's ARDI Initiative).	
		3.3.2 Develop a proposal to provide to the Department of Human Resources and Board on modifying the mandatory County training rules and adapting them for a health-related environment.	10
		3.3.3 Develop a collaborative proposal for countywide policy changes to enhance the workplace culture within the Health Departments, including areas such as CPOE, PE, and Succession Planning.	10,11
		3.3.4 Enhance the efficiency and cost-effectiveness of IT operations at the three health departments through the implementation and use of shared technology platforms.	

County of Los Angeles Health Departments' Insights on Our Community Health Worker Infrastructure

Informal Internal Landscape Analysis

March 2, 2022

EXECUTIVE SUMMARY

Purpose of this Informal Landscape Analysis

The Departments of Health Services (DHS), Mental Health (DMH) and Public Health (DPH) have long valued the expertise of Community Health Workers (CHWs). For several years, the three Health Departments have supported the use of peer specialists, many with lived experience, in our clinics and in community settings. Since the start of the COVID-19 pandemic, over 1,000 additional CHWs were brought on board. Our current cohort of CHWs is a mix of permanent County staff, temporary contract workers, and CHWs employed by County contracted community-based organizations (CBOs).

The three Health Departments are at a key juncture. Much of the federal and state COVID-19 funding for our temporary and contracted CHWs is slated to end within the next couple of years. Further, after many years of coordinating a network of internal and community-based CHWs, the three Health Departments are well positioned to assess what is working well, what we can improve, and what we hope to accomplish by investing in CHWs.

As preparation for a larger discussion on how the County would like to invest in our CHW infrastructure, the Alliance for Health Integration interviewed 16 staff from the three Health Departments. The questions focused on current practices and challenges for hiring and training CHWs, how to best coordinate among the three Health Departments, and the overarching vision for the network of CHWs.

This document captures the insights that staff shared about our current CHW infrastructure and their ideas for how to strengthen it moving forward. The tables below summarize the key themes that emerged from these discussions with DHS, DPH and DMH employees.

Key Themes for Strengthening the Health Departments' CHW Infrastructure

Vision & Long-Term Goals

TOPIC	RECOMMENDATIONS to CONSIDER
Vision & Long-Terms Goals	*With Community Partners:* • Develop a vision, long-term goals and objectives for meeting these goals to strategically invest in our ***internal*** CHW infrastructure and in our ***community-based*** CHW infrastructure coordinated by CBOs

Internal Coordination and Strategic Integration of CHWs

TOPIC	RECOMMENDATIONS to CONSIDER
CHW Roles and Responsibilities	• Agree on a common definition of CHW that encompasses the breadth of roles our CHWs play and acknowledges that CHW can have many different functional titles, e.g. peer support specialist, peer specialists, parent advocates etc. • Conduct an inventory of the different roles played by CHWs/peer specialists hired by the three Departments and also integrated into contracted services. • Determine if there is a standard set of CHW roles (i.e. specific activities carried out by CHWs) we want to prioritize for CHWs across the three Departments.
Coordination	• Establish a steering committee or coordinating committee that brings together staff from all three Departments. • Develop a mechanism to coordinate our outreach/education by geography, topic and population to maximize impact and reach. • Identify strategic ways for our CHWs to collaborate across Departments in the same neighborhoods. • Establish an internal infrastructure so we can quickly coordinate deployment of CHWs in our three Departments for time-specific projects. • In addition to cross-Departmental coordination, designate a coordinator within each Department to streamline CHWs efforts intra-departmentally. • Learn from similar CHW efforts at other county Departments and in other communities to advance our own efforts.
Training and Peer Learning	• Develop a core curriculum, or modify existing local/national curricula, for training, onboarding and continuous improvement for the three Health Departments. Include opportunities for cross-training CHWs where appropriate. • Create a repository of training materials for all three Health Departments to use to supplement and customize the core training, as needed. • Develop in-person and virtual opportunities for CHWs to network and share best practices. • Invest in CBO partnerships to enhance existing CHW community infrastructure and capacity.

	• Provide trauma-informed capacity building for CBO and Department staff, for CHWs, their supervisors and other staff supporting CHW efforts. • Provide professional development for CHWs' supervisors and other staff working with CHWs so they know how to best integrate CHWs into care/work teams. • Create a certificate of completion for CHWs who are not certified at the state level (e.g. they are not certified under SB 803) but who complete the Health Departments' core curriculum. • Provide training and support to assist CHWs who want to become certified Peer Support Specialists as allowed by SB 803.

Internal Hiring and Contracting with CBOs

TOPIC	RECOMMENDATIONS to CONSIDER
Hiring CHWs	• Increase pay and expand promotional opportunities on the CHW career ladder within the County. • Pursue changes to the recruitment and hiring process across all three Health Departments to ensure inclusive hiring practices, including but not limited to removing any practices that could eliminate candidates who are usually excluded due to background checks, etc.
Contracting with CBOs	*With Community Partners:* • With our CBO partners, decide whether (and if applicable, how) to standardize and simplify the contracting process for CHWs based in CBOs. • With our CBO partners, pursue solutions to fair hiring, pay, promotional opportunities, adequate clinical supervision, and workforce development to encourage retention of CHWs and quality care.

Long-Term Funding & Policy Advocacy

TOPIC	RECOMMENDATIONS to CONSIDER
Stable Funding for CHWs	• Identify all opportunities for CHWs (broadly defined to encompass a wide variety of roles) to take advantage of Medi-Cal reimbursement through SB 803 and upcoming plans to reimburse CHWs through CalAIM and the State's CHW State Plan Amendment for Medi-Cal. • Identify other potential local, state and federal funding opportunities to support CHWs. Seek funding for care teams as a whole, as opposed to for only the CHW. • Engage in advocacy work to create policy change that will support CHWs, including but not limited to quality base pay and benefits.

1. VISION for COMMUNITY HEALTH WORKER INFRASTRUCTURE

Many staff at DPH, DHS and DMH reported that the three Health Departments and our community partners need a clear vision for how to invest in our CHW infrastructure over the long haul. Our vision could include clarification on when CHWs should be directly employed by the County, in what contexts it is more beneficial for CBOs to employ CHWs, and agreement on the priority services for CHWs to provide in clinical and in community settings. In the absence of a long-term vision, staff expressed that temporary investments, i.e. short-term contracts and hiring temporary contracted workers, are disjointed and do not necessarily help build trust and strong partnerships with CBOs, a view they said is also shared by some of our community partners.

One aspect of our vision that requires further discussion is what many staff referred to as our equity strategies. While many staff acknowledged the practicality of a hybrid hiring approach, with some CHWs directly employed by the County and others brought on through contracts with CBOs, staff input points to a potential philosophical difference of opinion over which equity strategy the Health Departments should prioritize: directly hiring CHWs as County employees or supporting CBOs to hire CHWs (see description below of the two equity strategies). Some staff asserted that one of the two strategies is more equitable than the other and that the Health Departments should not give them equal priority. Rather, these staff suggested that Health Departments should put in place some parameters to guide our contracting and hiring decisions in a more intentional manner.

Two equity strategies.

(i): Directly hire CHWs as County employees so they benefit from County jobs with good pay and comprehensive benefits;

(ii): Invest in communities by investing in CHWs employed by community-based organizations and acknowledge their unique role as trusted agencies in their neighborhoods.

2. ROLES & RESPONSIBILITIES OF CHWs

Current Roles and Responsibilities

Currently, CHWs in all three Health Departments carry out a wide variety of roles and have a broad range of responsibilities in the clinics and in community settings. While some CHWs may work in both the clinic and community context, many CHWs work entirely in one context or the other so Table 1 below is separated into these two settings.

Departments are using many different functional titles to refer to CHWs and are increasingly expanding the roles that CHWs play beyond clinical care team members and education/outreach

workers, for example, violence prevention "peer specialists" who conduct violence intervention and healing activities. Thus, some staff recommended that the definition of a CHW and our internal understanding of what constitutes a CHW be broadened beyond the general categories of "outreach/education" or "clinical care team members" to be inclusive of these additional roles, that are also critical to our goal of promoting equity. On a practical level, some employees shared that defining a standard set of roles is important because expected roles and responsibilities guide the multiple components of hiring, (e.g. supplemental questions, interview questions) and training.

Table 1: Summary of Current Roles & Responsibilities of Community Health Workers*

**Not an exhaustive list*

Roles & Responsibilities In Clinic Settings	Roles & Responsibilities In Community Settings
DMH (partial list)	**DMH (partial list)**
- Provide emotional support as a peer mentor/coach to people living with mental illness who are participating in DMH treatment programs, drawing from their own recovery experiences. - Provide emotional support to parents with kids who are involved with DCFS or Probation or to parents of children with special needs**.** - Teach parents how to advocate for their kids and access resources at school and in their communities. - Lead peer support groups in clinics. - Provide case management (and are members of the treatment team). - Link people to mental health services and other resources. - Provide therapeutic transport to take people to the hospital.	- Facilitate workshops in homes, schools, churches on mental health and available resources. - Link people to mental health services and other resources. - Conduct outreach in communities, including in areas adjacent to Peer Resource Centers to encourage drop-in visits to centers.
DHS (partial list)	**DHS (partial list)**
- Conduct a baseline needs assessment utilizing screening tools and works with patients/family and medical home team to create a comprehensive care plan. - Assist patients, and their support system in the development, tracking, and documenting of a care plan, which addresses the patient's	- Serve as care coordinator for home and field visitation services for pregnant/post-partum women. - Participate on behavioral health integration teams to outreach to patients at their homes to coach with medication adherence, disease

goals and any medical, behavioral health and/or substance use treatment needs. - Facilitate connection to and engagement with patients' primary care home. - Help patients with system navigation. - Support patients before, during, and after medical and social service appointments and accompany participants to appointments as needed. - Participate in team huddles, care conferences, and multidisciplinary team meetings and advocate on behalf of the patient to help them achieve health and life goals. - Assist patients/family around "transitions of care" as patient transfers from one care setting to another and promotes greater use of outpatient resources. - Provide health information and counseling around disease management, medication adherence, mental health, addiction, and self-care. - Assist patients to learn to advocate for him/her/themselves. - Represent CHWs on DHS-wide committees assigned to improve care coordination (such as Care Management or Social Determinants of Health work groups).	self-management, accompaniment to appointments, post-hospitalization care. - Gather and enter data to support/inform medical home teams or mobile care teams. - Provide care coordination, system navigation, mentorship to people leaving jail and people on probation/parole supervision. - Complete intakes for new clients experiencing homelessness (PEH), provide general support for accessing benefits and services, and provide education to encourage COVID testing, vaccination. - Engage community members in education on health topics. - Go door-to-door to educate one-on-one - Provide outreach in the community as assigned by attending local community fairs, events, and or community-based meetings. - Build and maintain trusting and open relationships with community organizations, leaders and resources.
DPH (partial list)	**DPH (partial list)**
- Transport patients to appointments at public health clinics and other County facilities. - Assist with oral and written translation (must be on bilingual bonus pay). - Assist with patient check-in and support patient flow to appropriate staff for care. - Support registration and scheduling functions in electronic medical records.	- Conduct education/outreach at health fairs to engage community members on various topics, including COVID-19 and other infectious diseases (flu, West Nile, etc.). - Go door-to-door to homes and businesses to educate residents and business owners one-on-one on public health topics. - Support community engagement and healing activities to promote public safety.

- Assist with patient engagement and support as part of hospital violence intervention programs. -	- Provide violence intervention, including incident response, peace maintenance, informal mentoring, and system navigation for survivors of violence - Teach educational and skill-building classes (e.g. hands-only CPR, etc.) at County wellness communities. - Assist with system navigation and link people to care and resources. - Provide additional educational and operational support at County-run vaccine and public health response events. - Connect people to services at County resource centers during emergencies such as fires, toxic exposures. - Conduct home visits to pick up specimens to be tested in lab.

3. COORDINATION AMONG THE THREE HEALTH DEPARTMENTS

Staff offered the following observations and suggestions for better coordination among the three Health Departments and in some cases, with external partners:

Geographic Coordination

- Sometimes CHWs from different Departments conduct outreach in the same neighborhoods on the same topics which is triggering "education saturation." We should avoid this duplication of efforts (see cross-training below).
- Develop mechanisms to coordinate CHWs who are doing outreach in the same communities for different purposes, for example, street violence intervention and health education outreach promoting vaccines.
- We need better partnerships with funders to coordinate outreach where there is geographic overlap. For example, if California Community Foundation invests in outreach in Antelope Valley, we need to coordinate with them so our CHWs are not doing outreach in the same area as their other funded partners.

Cross Training (see also section #4 on "Training" below)

- Cross train all CHWs so they can promote the services provided by each of the three Health Departments. For example, train DMH and DHS' CHWs how to connect clients to substance use disorder treatment and train DPH's CHWs how to link clients to mental health and personal health care.

- For CHWs working in a more clinical context, train them in new skills such as taking blood pressure, diabetes management, and other chronic diseases so they can take on additional roles. Or if more appropriate from a regulatory perspective, train CHWs to support the client to take their own blood pressure or blood sugar with their own equipment and to instruct the client to call the appropriate contact for abnormal values.
- Train CHWs in trauma informed resilience-oriented practice and field safety, including self-care to prevent burnout.

Strategic Integration of CHWs

- The Health Departments should be more strategic with how we integrate CHWs into workforce teams to maximize their impact.
- Rather than placing so much emphasis on door-to-door outreach to residences (where most people are not home during workweek hours) and businesses, CHWs should meet community members where they are, e.g. schools, parks, faith institutions, etc. (Note, not all three Departments are using the door-to-door outreach strategy).
- CHWs have expressed that the door-to-door work is too physically tiring when visiting homes and businesses all day, five days a week.
- We should target certain neighborhoods with high levels of mental and personal health issues and CHWs should be encouraged and supported to jointly partner with faith institutions and other community organizations to help people access care.
- Establish more impactful tracking and data collection mechanisms. For example, in addition to tracking the number of homes or locations visited by CHW's when doing community outreach, document the impact of their exchanges with people.
- To maximize CHWs who can speak specific languages, create a roster of which languages are spoken by CHWs so the three Health Departments can work jointly to deploy CHWs where there is a language need.

Infrastructure for Regular and Rapid Deployments

- We need an internal infrastructure, perhaps a centralized coordinating committee with representatives from each of the three Departments, to coordinate deployment of CHWs in our three Departments, in general, but also for time-specific projects, such as upcoming enrollment in expanded Medi-Cal. This committee could also produce communication about different initiatives and develop mechanisms to quickly hire CHWs to meet urgent needs.

Internal Communication and Key Messaging for Clients & Community Members

- Each Department needs to have an awareness of the core role and responsibilities of CHWs in the other two Health Departments
- Develop key, standardized messaging and communication materials for CHWs in all three Health Departments to use with clients.

Coordination with other County Departments

- Coordination of CHW efforts extends beyond our three Departments. As county initiatives focused on equity increasingly include CHWs/peer specialists, there is an opportunity for further coordination and learning with Departments outside of DHS, DMH and DPH.
- Some Health Department programs with CHWs would benefit from better communication and coordination between their CHWs and staff in other County Departments, for example, with medical case workers in the County jail in order to better serve clients currently incarcerated.

4. TRAINING & PEER LEARNING COMMUNITY for INTERNAL CHWs

Staff in all three Health Departments expressed strong agreement that coordinating training and other capacity building opportunities (e.g. learning collaboratives, conferences) for CHWs would be very beneficial. Due to length, training is discussed in this separate section even though it could also be placed under "Coordination," above.

Previous Efforts to Develop a CHW Core Curriculum and Learning Network

Before the COVID-19 pandemic began, a group of staff from DHS, DPH and DMH convened a cross-Departmental workgroup with the goal of developing a standardized core training curriculum for CHWs in DMH, DHS and DPH by building on their existing training efforts. This group led two training webinars for CHWs and established a cross-Departmental learning network for CHWs to learn from each other and be connected to the broader CHW workforce. To facilitate peer learning and support, they set up a SharePoint website called "The CHW Connect" for County-employed CHWs to share resources and pose questions requesting peer responses. When COVID took hold, this group stopped meeting, and was unable to complete a standardized training though they had begun to inventory existing training modules developed by the three Health Departments. The pandemic also has prevented staff from actively engaging through the CHW Connect SharePoint site.

At this point in time, staff are interested in reviving all these efforts once their workload allows it. It is also worth noting that staff at the three Health Departments have conducted some training for CHWs in each other's Departments so there is a history of cross Departmental collaboration though it has not been systematic.

Broad Desire for Core Curriculum

Across all three Health Departments, there is a continued strong interest for a core training curriculum for CHWs. Examples of content that all CHWs should learn include resources available for people to access, navigation skills, and motivational interviewing skills. Beyond the core

curriculum, each program within a Department would be free to add modules to supplement and customize the training to the particular needs of that program.

Each of the three Health Departments has developed key training materials that will be helpful to the development of a core curriculum. DMH has a 72-hour training curriculum that they developed with Children's Hospital Los Angeles and UCLA for mental health peer specialists in clinic settings. DHS Whole Person Care established an approximately 40-hour core curriculum which includes training on the core competencies identified in the national Community Health Worker Core Consensus Project and program-specific needs. DPH's Office of Violence Prevention has developed a peer-to-peer violence prevention curriculum that includes trauma informed practices for peer specialists.

Repository of Additional Training Modules and Professional Development

Each Department has already developed a variety of training modules. Many staff suggested that the Health Departments create an online repository of additional modules and other training materials for program staff in any of the three Departments to access and modify. These additional modules could be used to supplement a core curriculum or to use for ongoing professional development.

Staff from all three Health Departments reported insufficient ongoing professional development opportunities for CHWs. If a repository of training materials were created, staff suggested that some of the additional training modules outside the core curriculum could be used to provide ongoing professional development for CHWs to expand their skillset. For example, DHS has training modules to build supervising and mentorship skills that the other Departments could use as professional development for CHWs. Other topics for professional development could include more in-depth teaching about resources to promote wellbeing. CHWs could be facilitators for some of these trainings.

Training Methodology

Finally, staff also emphasized that the training methodology itself is important. Some DPH, DMH and DHS programs that employ CHWs have adopted a highly participatory training approach that builds upon the expertise that CHWs bring to the table to create knowledge collaboratively. This training format engages participants in a variety of activities, avoiding the more traditional lecture-style format. Several staff expressed a strong desire that the core curriculum and add-on modules utilize this interactive approach with opportunities for hands-on learning.

Aligning Training with State Training Requirements for Medi-Cal Reimbursement

State Bill 803: Peer Support Specialists Certification (slated to begin in spring of 2022)
SB 803, approved in 2020, will enable California to expand the behavioral health workforce by allowing certification of Peer Support Specialists, a new provider category under Medi-Cal. Peer Support specialists are intended to work in a county's Medi-Cal mental health and substance use disorder delivery systems and will provide specific reimbursable peer support services to people living with mental health and substance use disorder conditions. They will mainly be clinic-based, but they are allowed to visit clients at home, board and care facilities and in hospitals. At this point the State has not yet finalized the specific Peer Support Specialist activities that will be reimbursable.

DMH and DPH-Substance Abuse Prevention and Control (SAPC) have been actively involved in SB 803. Both DMH and SAPC are planning to send many of their CHWs through this certification program once it begins and are permitted to use Mental Health Services Act dollars to pay for the program. After participating in the training, participants take an exam to become certified.

CHW Medi-Cal State Plan Amendment (slated to begin in July 2022)
Staff recommended that our efforts to develop a core curriculum also be informed by reimbursement requirements that will be established for the CHW State Plan Amendment Medi-Cal benefit, currently under development. In order for the County to take full advantage of this Medi-Cal funding source, staff suggested that we align our core CHW curriculum with training requirements that the State ultimately enacts for CHWs' services to be billable under Medi-Cal.

Certificate of Completion for our CHWs
Several staff would like CHWs to receive a special certificate of completion for finishing the CHW core training curriculum, especially for CHWs who are not able to get certified in any of the State peer worker training programs. Such a certificate would recognize completion of our training as an important milestone and assist CHWs in their professional development.

5. TRAINING FOR CHWs at COMMUNITY BASED ORGANIZATIONS

At the present time, each of the three Health Departments typically provides training for our contracted CHWs, sometimes provided by CBOs and sometimes provided by Health Department personnel, depending upon which organization has the necessary content expertise. According to staff, our CBO partners have a wide range of capacity, with some CBOs providing additional detailed training to their CHWs and other CBOs providing limited training only.

Several staff reported that they would like the Health Departments to do more to help CBOs build the capacity of their CHWs. They conveyed that is particularly important to provide

comprehensive support to ensure the success of CHWs for whom this position is their first formal job in their life (see also "supervision" section below).

Staff working with CBO-based CHWs highlighted some key training and support needs. Since many community-based CHWs are still processing their own trauma and have only recently entered recovery or a post-incarceration re-entering phase, staff underscored that it is especially important for them to learn self-care practices. These practices should help them process the stories they hear during the workday from peer clients that they are supporting. Their work can be emotionally taxing. Training and other supports need to be in place at the organization to help them re-charge each day and avoid being overwhelmed by the complex challenges their clients face.

Some employees suggested that the Health Departments should foster a network among the CBOs for their CHWs to share resources and cross train one another, similar to the network started by DPH, DHS and DMH for County-employed CHWs. In the event this network does get established, staff recommended that participation and reimbursement be woven into contracts to make sure CBOs are compensated for their time.

6. CHW HIRING PROCESS at the THREE HEALTH DEPARTMENTS

Career Ladder: Insufficient Number of Promotional Opportunities

The primary payroll items for current community health workers/peer specialists employed by the three Health Departments are those in the Community Health Worker ladder:

- Community Health Worker
- Senior Community Health Worker
- Supervising Community Health Worker

Though the Senior and Supervising CHWs items are approved as official payroll items, many staff reported that there is an insufficient number of these two items that have been allocated to the three Health Departments. For example, one Departmental program has approximately 40 CHWs, but has no Supervising CHW or Senior CHW items allocated so there are no promotional opportunities for these 40 CHWs at this program.

To further develop long-term opportunities for CHWs at the County, several staff support creating additional payroll items to the Community Health Worker ladder, beyond the current positions. Other staff recommended that the County identify other internal career pathways for CHWs, in addition to the CHW ladder, to provide leadership opportunities for people with lived experience.

Pay for CHWs

Further, several staff stated that the pay is too low for CHWs, Senior CHWs and Supervising CHWs and that the County hourly pay is not high enough to compete with larger organizations outside the County (see pay range in chart below).

Staff reported that an unintended consequence of the lower-paying CHW career ladder coupled with the small number of Senior CHW and Supervising CHW items is that some CHWs leave their positions to pursue County administrative-track jobs with higher salaries. The Health Departments then lose their unique contributions as peer specialists in programs that directly benefit from their expertise.

Below is a chart with salary information for four Los Angeles County CHW classifications:

Position	Starting Salary (mo/yr)	Ending Salary (mo/yr)
Community Health Worker	$2,899.00 *($34,788)*	$4,334.64 *($52,016)*
Senior Community Worker I *(Not commonly used)*	$2,998.82 *($35,986)*	$4,487.46 *($53,850)*
Senior Community Health Worker	$3,329.74 *($39,957)*	$4,909.46 *($58,914)*
Supervising Community Health Worker	$3,512.55 *($42,150)*	$5,268.00 *($63,216)*

Sources: 1) Los Angeles County Class and Salary Listing, Oct. 2021, accessed online on 1/17/22: https://file.lacounty.gov/SDSInter/lac/1043266_alpha.pdf; 2) County Class Specifications accessed online on 3/1/22: https://www.governmentjobs.com/careers/lacounty/classspecs

Standardized Hiring Processes for County-Employed CHWs

Many staff expressed that we need an exam process that is not geared towards the one department that is posting the exam. Under the current system, applicants who do not have experience working in the department posting the exam are likely to receive a lower score. Instead, many staff would like the exam process to value experience in all three Health Departments.

Recruitment and Support for Candidates to Apply for County CHW Jobs

Some staff mentioned how onerous the application process can be for CHW candidates. They thought it would be beneficial if there were a program or entity to help potential CHWs gain the skills to write a resume and cover letter, apply for jobs, and prepare for interviews. The Worker Education & Resource Center (WERC), a nonprofit organization and labor-management partnership with the Service Employees International Union Local 721, has provided helpful application support to some of DHS's CHWs, according to DHS staff. Further, other staff voiced support for the apprentice model, where CHW candidates are given stipends and trained for a few

months (as opposed to hours) and provided field exposure. WERC has also successfully developed apprenticeship programs for some County CHWs.

Additionally, some staff recommended that Departments invest in a recruitment strategy to encourage diverse applicants to apply for CHW positions. Recruitment strategies could include disseminating employment opportunities to CBOs via email and asking them to share with their networks and partnering with CBOs to host informational sessions on CHW job openings. These sessions could focus on educating potential candidates about the County's hiring process, in order to demystify the multiple steps involved in applying for County positions.

Use of Standardized Supplemental Questions

As we pivot to hire more staff with lived experience, some Departmental employees conveyed that our exams do not adequately value the lived experience that applicants bring and that some applicants receive lower scores, or do not pass at all, if they do not have a certain type of experience or formal education. Staff would like the exam process to consistently include standardized supplemental questions so candidates can demonstrate their experience more broadly. Sometimes supplemental questions are not a part of the exam process and applicants have less opportunity to explain their expertise.

Utilizing Subject Matter Experts as Exam Reviewers

Rather than assigning Human Resources (HR) employees to review applications and supplemental questionnaire responses, some staff suggested it would be more effective to use non-HR subject matter experts. This would enable the County to consider people's lived experience and work experience in a more culturally appropriate manner.

Longer Exam Submission Periods & Standardized Core Interview Questions

Sometimes the CHW exams are open for only a short amount of time in order for HR to generate a list of eligible candidates quickly, to expedite the hiring process. As a result, some candidates are not able to apply during the brief application submission window, particularly if the window is during the workday. Some staff requested longer windows to allow more time for people to submit their applications and that we find other methods for expediting eligibility lists. Lastly, staff suggested that detailed interview guides with assessment criteria be developed for all three departments to use when interviewing CHW candidates.

7. CONTRACTING WITH COMMUNITY BASED ORGANIZATIONS

Simplifying and Changing the Contracting Process

Contracting with the County typically requires a significant investment of staff time. Not only does responding to a County Request for Proposals (RFP) require a considerable amount of effort but applicants must meet various administrative requirements, e.g. minimum insurance coverage.

Further, once contracts are approved, a variety of additional administrative requirements kick in, e.g. report writing and annual audits. The administrative aspects of contracting can be challenging for CBOs especially for smaller ones. Staff in the three Health Departments strongly suggested deepening our use of intermediary agencies and allowing these intermediaries to subcontract with community organizations which would then be freed up to focus more on the outreach, education and other deliverables for CHWs.

Staff expressed appreciation for the added flexibility to contracting offered by the Master Agreement for Community Engagement, managed by DPH. This contracting tool is also accessible to DHS and DMH, along with all County departments. Some staff mentioned that the application process to get on the Master Agreement's pre-approved list of vendors, while less onerous than responding to a RFP, is still too difficult for many CBOs. In addition, there is currently no mechanism to link CBOs that are potentially interested in subcontracting with intermediaries applying for particular projects (via Work Order Solicitations). The result is that intermediaries might subcontract with the same set of CBOs for various projects.

Increasing the Pay for CHWs

Given that a substantial number of CHWs are hired via contracts with CBOs, many staff stated that standardizing parts of the contracting process would benefit both our partners and the three Health Departments. Staff are concerned about the wide range of pay among contracted partners, with larger organizations paying a higher salary to their CHWs than smaller agencies. However, staff are aware that requiring minimum salaries for CHWs based in our contracted agencies could raise internal parity issues. For example, if our Health Departments require contractors to pay their CHWs $30 an hour, this may be equal to - or more than - the salaries of peer colleagues or higher-level staff in the same organization. Thus, any pay requirement that the three Health Departments were to impose needs to be mindful of community-based organizations' internal pay scale. Regarding promotional opportunities, ideally CHWs based in CBOs would have opportunities to advance to senior or supervisory positions.

8. SUPERVISION of CHWs

Quality supervision for CHWs is a critical component of setting up CHWs for success. To provide excellent supervision CHWs' supervisors must receive adequate training in how to best support CHWs. More broadly, hiring CHWs means as a program, agency, and department, you are committing to a robust workforce development initiative and carving out time from skilled program managers and clinical supervisors to specifically invest in the CHW workforce. Staff at the three Health Departments and CBOs alike need to be given the training, funds and support to make these investments.

CHWs' Unique Situation

For some CHWs, this is their first job, and they might require significant support to succeed. For example, they might have limited computer skills or need to strengthen communication skills. In addition, many CHWs cope with their own trauma that can be triggered by their job responsibilities, e.g. interacting with clients whose trauma is similar to a CHWs personal trauma. And, for some CHWs, they may be currently experiencing mental health conditions or may have only recently re-entered their community after incarceration.

Quality Supervision for CHWs

Many of the clients supported by CHWs have complicated needs, for example they may be suicidal, face other severe mental health challenges, and/or reside in communities that experience significant stress and trauma due to historical oppression and systemic racism. To provide the best support to clients, some staff expressed that CHWs working in certain clinical contexts need supervisory guidance from an experienced clinical staff person. These staff reported that some of the Supervising CHWs do not have sufficient clinical expertise to guide CHWs working with patients who live with extreme challenges. While some CHWs working in clinical settings are currently supervised by clinical staff, this is not always the case.

Below are additional recommendations that staff shared to help institutionalize quality supervision for CHWs. Supervisors:

- Should conduct an assessment of CHWs during their onboarding to identify what skills and supports they need to succeed, e.g. computer skills, communication skills.
- Need skills to support CHWs as CHWs cope with their own trauma that can be triggered by their job responsibilities.
- Should help CHWs receive the support they need to heal from their own personal trauma and history.
- Should receive training in trauma informed resilience-oriented practice to support clients and peers in a culturally responsive and sensitive manner.
- Should be trained in how to support CHWs to use their "lived experience" in ways that are helpful and healthy for both themselves and their clients.
- Develop a stronger career ladder for CHW supervisors for all the reasons outlined above.

9. LONG-TERM FUNDING

Staff reported that long-term, dedicated funding sources are key so that three Health Departments do not hire and contract with CBOs on an ad-hoc basis, impeding the long-term stability of the CHW infrastructure and impacting care for clients and community members.

The Health Departments are involved in discussions and planning for three long-term state and federal funding sources for peer specialists: State Bill 803, CalAIM and fee-for-service Medi-Cal.

State Bill 803: Peer Support Specialists Certification

SB 803 creates Peer Support Specialists, a new provider category under Medi-Cal. Peer Support Specialists will provide specific reimbursable peer support services to people living with mental health and substance use disorder conditions. They will mainly be clinic-based, working in the Medi-Cal mental health and substance use disorder care systems, but they are allowed to visit clients at home, board and care facilities and in hospitals. According to DMH staff, the State has not yet finalized the specific Peer Support Specialist activities that will be reimbursable.

Peer Support Specialists will primarily provide emotional support to DMH and DPH-SAPC clients who receive mental health and substance use disorder services by serving as a mentor/coach and sharing their own recovery stories with clients.

Medi-Cal

There are potentially two new funding streams to reimburse CHWs for their services through Medi-Cal. The California Advancing and Innovating Medi-Cal (CalAIM) initiative creates financial mechanisms for managed care plans to contract with community-based organizations and other providers to support patients through Community Health Workers.

In addition to these reforms under CalAIM, the State of California is seeking approval from the Federal Centers for Medicare & Medicaid Services (CMS) via a CHW State Plan Amendment to use federal Medicaid funds to reimburse for certain services provided by CHWs to Medi-Cal beneficiaries.

Other Potential Funding Sources

Further, there might be other funding mechanisms included in the Affordable Care Act (ACA) that the three Health Departments should explore to be sure we are taking full advantage of all opportunities to fund CHW services. In some instances, it may be necessary to train CBOs to bill Medi-Cal for reimbursable services and to set up the infrastructure for meeting reporting requirements.

Beyond Medi-Cal and the ACA, many staff would like the three Health Departments to proactively advocate for policy changes at the state and federal levels that would create stable funding sources for a broad range of CHW/peer specialist services.

10. CONCLUSION

The insights presented in this document from staff at DPH, DMH and DHS shed light on the current CHW infrastructure and provide a crucial context for upcoming discussions about strengthening our CHW workforce. Staff in all three Health Departments are deeply committed to CHWs and are

ready to put in place the supports, practices and administrative solutions to facilitate CHWs' success on the job and their career advancement. Across DMH, DHS and DPH, colleagues are eager to work collectively to address the issues highlighted in this report and equally enthusiastic about collaborating with community partners while planning for a vibrant, successful CHW workforce.

Attachment B

Rev 3/2/22

Key Phases to Develop a Plan to Strengthen the Community Health Workers (CHW) Infrastructure

This plan includes CHWs hired by the three Health Departments and employed by our community-based organization partners with the goal of:

1) Developing a permanent and coordinated CHW network;

2) Creating an aligned strategy with flexibility for each Department to operate as needed;

3) Building out the workforce development opportunity for CHWs in the County and in partner organizations.

Nov 2021 – May 2022

1

Phase I: Initial Preparation

- **Stage 1: Internal Discussions**
- **Stage 2: Landscape Analysis**
  - *Internal Staff Input*
- **Stage 3: Hire consultant for CBO assessment**
- **Stage 4: Commit to Next Steps**

June – Dec 2022

2

Phase 2: Consult with CBO Partners

- **Stage 5: Assessment with CBOs**
- **Stage 6: Internal County Staff Assessment/Discussions**
- **Stage 7: CBOs & County Commit to Next Steps**
- **Stage 8: Develop a Framework**

Jan - Mar 2023

3

Phase 3: Develop a Plan & Implement Changes

- **Stage 9: Develop a Plan**
- **Stage 10: Implement the Plan**
  - *Ongoing consortium for shared learning*

OUR HEALTH · OUR COMMUNITY · OUR LOS ANGELES COUNTY

ALLIANCE FOR HEALTH INTEGRATION

313 N. Figueroa Street, Suite 1014
Los Angeles, CA 90012

"To improve the health and well-being of Los Angeles County residents by aligning and efficiently implementing Board-approved prevention, treatment, and healing initiatives that require the collaborative contributions of the three health departments."

TO: Supervisor Janice Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Lindsey P. Horvath
Supervisor Kathryn Barger

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

Lisa H. Wong, Psy.D., Director
Department of Mental Health

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

Jaclyn Baucum, Chief Operating Officer
Alliance for Health Integration

DATE: March 23, 2023

SUBJECT: **IMPLEMENTING THE LOS ANGELES COUNTY ALLIANCE FOR HEALTH INTEGRATION (ITEM NO. 13 OF THE FEBRUARY 18, 2020 BOARD AGENDA)**

On February 18, 2020, the Board of Supervisors (Board) directed the Departments of Mental Health (DMH), Public Health (DPH), and Health Services (DHS), together referred to as Health Departments, to:

1. Adopt the proposed structure, priorities, and accountability framework for the Los Angeles County (County) Alliance for Health Integration (AHI), which has been accomplished;
2. Instruct the Directors of DMH, DPH, and DHS to hire a Chief Operating Officer (COO) for AHI, as well as six staff to support AHI in achieving the proposed priorities and metrics; and
3. Further instruct the Directors of DMH, DPH, and DHS to implement AHI, refine objectives and metrics by continuing to engage with stakeholders as work on objectives begins, and to report back annually on progress of AHI, including updated priorities, objectives, and metrics.

As directed by the Board motion, AHI *"will align and efficiently implement Board -approved health and social justice initiatives that require the collaborative contributions of the three Health Departments in a manner that supports departmental workforces, builds partnerships, promotes health equity, and respects each department's unique charge and scope."* To fulfill this work, AHI has facilitated collaboration on jointly identify and agreed upon areas of focus, as instructed by the Board adopted priorities authored by Health Directors.

On March 1, 2023, AHI's team transitioned to DMH to assist in responding to the current mental health crisis throughout the County. To ensure that critical work continues, AHI has worked with the Health Department Directors to develop transition plans for all projects. Although AHI's portfolio will change, Health Integration will continue to be a Board priority.

The attached AHI annual report reflects the progress that AHI made since the March 2022 report to the Board. Due to the AHI transition, future annual Board report backs will be suspended.

AHI's work towards Health Integration has been a reflection of the unique and meaningful contributions that come from each individual participant and their respective department or organization. AHI would like to recognize and thank the Department Heads, staff of the three Health Departments, and all other participants and stakeholders for their partnership and support during AHI's tenure.

If you have any questions regarding this report back, you may contact Jaclyn Baucum at jbaucum@dmh.lacounty.gov.

JB:gh

Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Department of Human Resources

ALLIANCE FOR HEALTH INTEGRATION
ANNUAL BOARD REPORT BACK
MARCH 23, 2023

OUR HEALTH · OUR COMMUNITY · OUR LOS ANGELES COUNTY
ALLIANCE FOR HEALTH INTEGRATION

Health Services
LOS ANGELES COUNTY

COUNTY OF LOS ANGELES
Public Health

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

1 PRIORITY ONE: INTEGRATE AND DEVELOP PREVENTION, TREATMENT AND HEALING SERVICES

Objective 1.1 Provide the right care at the right time to those most in need of County and County-contracted services.

Strategies

☑ 1.1.3: Leverage Federal, State, County, and other opportunities to address gaps in the behavioral health continuum (e.g., Behavioral Health Continuum Infrastructure Program-BHCIP and Community Care Expansion-CCE).

Key Accomplishments

- ✓ The State awarded $383.6M to County and community providers in behavioral health capital infrastructure funding to add and preserve mental health, substance use disorder and residential care capacity. (As of February 2023)
  - $49.3M has been awarded to County projects at the LAC+USC, Martin Luther King and Rancho Los Amigos campuses in BHCIP Rounds 3 and 4.
  - $241.3M has been awarded to behavioral health community providers in Los Angeles County through CCE Expansion and BHCIP Rounds 3 and 4.
  - $93M in CCE Preservation funds were awarded to DMH for the preservation of the existing residential care network.
- ✓ The County has supported community behavioral health providers to apply for BHCIP and CCE funding to expand community-based care.
  - The County issued 91 BHCIP letters of support to behavioral health community providers applying for funding in Rounds 3, 4 and 5.
  - The County has executed 31 CCE Partnership Agreements to support community residential care operators in their applications to the State for funding.
- ✓ Completed 3 in depth campus site visits to assess BHCIP grant alignment with RCV master plans.
- ✓ Supported DMH in the submission of the CCE Preservation Implementation Plan to CDSS/AHP for approval.
- ✓ Completed the County Behavioral Health Framework Report commissioned through HMA using BHCIP Round 2 Planning Grant funds.
- ✓ Supported DMH in commissioning a Behavioral Health Forecasting Tool and expanded Forecasting Model to support Double MH Bed Shortage Board Motion through Round 2 Planning Grant funds.
- ✓ Collaborated with the state, AHP, board offices and Health Departments to do strategic BHCIP and CCE outreach to behavioral health provider networks via email, 3 website landing pages, and 2 county webinars.

1 PRIORITY ONE: INTEGRATE AND DEVELOP PREVENTION, TREATMENT AND HEALING SERVICES

Objective 1.1 Provide the right care at the right time to those most in need of County and County-contracted services.

Strategies

☑ 1.1.4: Coordinate and enhance pathways to address psychiatric system decompression.

Key Accomplishments

- ✓ Convened 6 DMH root cause meetings and 4 DMH/DHS meetings to do an in-depth analysis of psychiatric decompression issues.
- ✓ Created a comprehensive list of psych decompression issues representing DMH and DHS perspectives.
- ✓ Produced a root cause analysis of DMH and DHS contributing causes related to psychiatric decompression and prioritized solutions to address these causes.

PRIORITY ONE:
INTEGRATE AND DEVELOP PREVENTION, TREATMENT AND HEALING SERVICES

1

Objective 1.2 Coordinate advocacy efforts with local, state and federal entities to ensure timely access to physical health, mental health, and SUD services for our LA County residents.

Strategies

- ☑ 1.2.1: Advocate for policies at the state and federal level that support the community health worker (CHW) workforce.
- ☑ 1.2.2 Specific to CalAIM, escalate policy priorities, as needed, to advocate for needs of LA County beneficiaries and their providers.
- ☑ 1.2.3: Engage with chronic disease workgroup to advocate for local, state, and federal policies that will prevent and manage chronic disease.
- ☑ 1.2.4: Support and provide coordinated input and advocacy to the State and their third-party administrator, Advocates for Human Potential (AHP) for the BHCIP and CCE grant opportunities through grant completion (see next slide for accomplishments).
- ☑ 1.2.5: Ensure that countywide legislative agendas for Sacramento and DC include priorities defined by the Health Departments (see previous slide).

Accomplishments

- ✓ Advocated for equitable compensation for CHWs directly employed by the County.
- ✓ Advocated for State policies to support CHWs including the new CHW Medi-Cal benefit:
  - Submitted formal comments to the State and met with State Administrators to advocate for additional reimbursable activities for the CHW benefit.
  - Created and distributed a summary document explaining new Medi-Cal benefits (for CHWs and beyond) for all Health Departments.
- ✓ Submitted questions and synthesized feedback to the State around CalAIM Justice Involved Populations of Focus as the State was developing their 90-day pre-release services and policies

PRIORITY ONE:
INTEGRATE AND DEVELOP PREVENTION, TREATMENT AND HEALING SERVICES

1

Objective 1.2 Coordinate advocacy efforts with local, state and federal entities to ensure timely access to physical health, mental health, and SUD services for our LA County residents.

Accomplishments *(cont'd)*

- ✓ Briefed AHP grant review team and sent DHCS the County Behavioral Health Framework with highest priority DMH mental health and SAPC SUD levels of care for consideration in the BHCIP Round 5 grant award process.
- ✓ Co-authored an advocacy letter to recommend revisions to the BHCIP grant processes, elevate the impacts of award decisions on the County and build a more collaborative relationship with DHCS/AHP.
- ✓ Collaborated with the state and AHP to improve and promote the letter of support process in BHCIP Rounds 3, 4 and 5 by increasing outreach to prospective community providers through state e-blasts a joint webinar (with 60+ attendees) and direct communication and referrals between the County and interested applicants.
- ✓ Proactively initiated a coordinated strategy with the County, CDSS and AHP to expand outreach to eligible residential care operators to ensure CCE Expansion funding is fully realized in Los Angeles County.

2

PRIORITY TWO:
REDUCE HEALTH INEQUITIES

Objective 2.2: Increase coordination and integration of STI/HIV services to decrease rates in LA County

Strategies

- ☑ 2.2.1: Ensure all women of child-bearing age are screened for syphilis, including in ED's (both DHS and beyond).
- ☑ 2.2.2: Work with programs that serve women of childbearing age who are experiencing homelessness to ensure screening and treatment for syphilis.

Accomplishments

- ✓ All DPH and DHS sites are screening for STI/HIV.
- ✓ Conducted key Informant interviews with subject matter experts at the Health Departments to identify potential solutions for preventing STI/HIV.
- ✓ Facilitated data sharing between DHSP and DMH for a DPH-DHSP's Mental Health Assessment for People Living with HIV.
- ✓ Participated on the *Responding to Los Angeles County's Sexually Transmitted Disease Crisis* motion (August 2022) workgroup.

2

PRIORITY TWO: REDUCE HEALTH INEQUITIES

Objective 2.3: Identify and reduce impact from environmental exposures that contribute to poor health outcomes.

Strategies

☑ 2.3.1 Coordinate outreach, enrollment, and remediation services to communities heavily impacted by lead paint exposure.

Accomplishments

✓ The Lead Free Homes LA Program offers free lead paint hazard remediation to high risk families throughout Los Angeles County. As of March 3, 2023, the Program has received 1,838 applications, countywide (1,499) and Exide area (339). The total number of households enrolled is 1,189, countywide (943) and Exide area (246).

- Of the homes tested, the total number of units with lead-based paint hazards is 804, countywide (678) and Exide area (126). A total of 228 homes have completed the lead paint hazard remediation process, countywide (146) and Exide area (82).

✓ As an enhancement to the Lead Free Homes LA Program, the Department of Public Health (Public Health) entered into a partnership agreement with Quest Labs.

- Under this agreement, Quest offers free blood lead level testing to those who are enrolled in Lead Free Homes LA. This new project launched in February 2023 and Public Health is encouraging participation and scheduling the appointments.

2

PRIORITY TWO:
REDUCE HEALTH INEQUITIES

Objective 2.4: Address chronic health conditions that predispose people to negative health outcomes with a comprehensive and integrated community-based approach.

Strategies

- ☑ 2.4.1 Support stroke prevention services across the Departments.
- ☑ 2.4.2 Engage with chronic disease workgroup to advocate for local, state, and federal policies that will prevent and manage chronic disease. (see 1.2.3)

Accomplishments

- ✓ DPH, in partnership with DHS, secured a grant for $500,000 from the USDA National Institute of Food and Agriculture to conduct a Produce Prescription Pilot Project at two DHS clinics. This program is expected to begin in spring of 2023 and will provide 350 DHS patients with $40 electronic benefit cards each month to purchase fresh fruits and vegetables from local supermarkets for six months. Eligibility criteria for this program include enrollment in Medi-Cal, diagnosis of diabetes or prediabetes, and food insecurity. Food insecurity status, fruit and vegetable consumption, and health impacts will be measured.
- ✓ Conducted key Informant interviews with subject matter experts at the Health Departments to identify potential solutions for preventing strokes.
- ✓ Organized eight presentations by County and non-County subject matter experts on chronic disease prevention and management best practices to identify potential gaps in services at the Health Departments.

2

PRIORITY TWO:
REDUCE HEALTH INEQUITIES

Objective 2.6: Partner with community-based organizations, philanthropy, private entities, and other stakeholders to identify and address health inequities.

Strategies

☑ 2.6.1: Coordinate and facilitate Health Department involvement in hosting annual Care Harbor events for under-resourced and uninsured residents.

Accomplishments

✓ Served as County Liaison for the Spring 2022 Annual Care Harbor Free Clinic that served 870 residents with medical, dental, vision and social services.

- 109 County employees volunteered for the three-day free clinic;
- 9 County Departments hosted educational kiosks and provided necessary services including DHS, DPH, DMH, Public Defender and Alternate Public Defender, DPSS, Registrar-Recorder/County Clerk, Office of Immigrant Affairs, and Housing and Community Development.
- Additionally, the Department of Parks and Recreation provided space at Ted Watkins Memorial Park that allowed 450 residents to obtain entrance tickets, and the Superior Courts provided adjacent parking over the weekend event allowing 950 clinic volunteers and attendees free parking.

✓ Served as County Liaison for the Spring 2023 Care Harbor Focused Care Clinic, which was a smaller scale free clinic event that targeted the unhoused population.

2

PRIORITY TWO:
REDUCE HEALTH INEQUITIES

Objective 2.6: Partner with community-based organizations, philanthropy, private entities, and other stakeholders to identify and address health inequities.

Strategies

☑ 2.6.2: Strengthen the community health worker infrastructure in partnership with DMH, DPH and DHS, and community organizations.

Accomplishments

- ✓ Organized 12 listening sessions with 95 staff people at 57 CBO partners that provide contracted CHW services to the Health Departments, commissioned through Vision y Compromiso, to identify what current practices that are effective and what could be improved to best support the Health Departments' community-based contracted CHW workforce.
- ✓ Conducted 6 listening sessions with a total of 60 staff from DHS, DPH and DMH to identify strategies to support the Health Departments' directly-hired CHW workforce.
- ✓ Developed a draft CHW Workforce Action Plan, based on input from CBO partners and internal Health Department staff, to strengthen the CHW workforce and infrastructure (career ladder, training, professional development, supervision). Goal is to finalize this plan by May 2023 and begin implementation.

See Board report backs related to the "Solidifying the Role of Promotoras de Salud in County Services" motion, for additional information on CHWs at the Health Departments. Microsoft Word - Document1 (lacounty.gov)

2

PRIORITY TWO:
REDUCE HEALTH INEQUITIES

Objective 2.7: Deliver culturally and linguistically appropriate care and communications to all patients, clients, customers, and community members.

Strategies

☑ 2.7.1: Increase the quality of language access services (interpretation and translation) provided through the Master Agreement by gathering feedback from Health Department staff on vendor performance

Accomplishments

- ✓ Developed and began piloting a vendor performance survey for Health Department staff to provide feedback on quality of services provided by translation and interpretation vendors secured through DPH's Language Access Services Master Agreement. Survey results will be used to improve the quality of translation and interpretation services.
- ✓ Provided feedback to the County's Office of Immigrant Affairs on the draft countywide language access plan.

3

PRIORITY THREE:
IMPROVE ORGANIZATIONAL EFFECTIVENESS

Objective 3.1: Redesign and/or streamline operations to enhance other cross-Departmental integration efforts, on an as-needed basis . Scope includes contracting, contract monitoring, billing, IT, data integration, and Human Resources (HR) processes.

Strategies

☑ 3.1.1: Streamline and accelerate the Health Departments' hiring process.

Accomplishments

- ✓ Convened a workgroup comprised of staff from the Health Departments, CEO and DHR to implement directives in the Board Motion "Investing in Strengthening the Healthcare Workforce."
- ✓ Submitted a list of recommended changes to the Civil Service Code to accelerate the hiring process to DHR.
- ✓ Submitted requests to CEO for new classifications and updates to existing classifications that would facilitate hiring.

See Board report backs related to the "Investing in Strengthening the County Healthcare Workforce" motion for additional information about these activities. 1128695_RebuildingCountyWorkforce90DayReportBacksecured.pdf (lacounty.gov); 1128694_RebuildingCountyWorkforce60-DayReportBack.pdf (lacounty.gov)