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Transcript

September 3, 2025, 4:02PM

Jack Arutyunyan started transcription

Room 140 2:07

Addition in here morning everyone.
I'm Jack Artunian from the chief executive office and I'll call the meeting to order now.
Note that the meeting will be muted for all participants.
You can unmute yourself using the teams app or by dialing *6 if you're calling into the meeting.
The as a reminder, public comment will be limited to two minutes and may be adjusted depending on the time we have available.
You will now start with introductions with our board offices going first.
2nd District before you go my second district, that's my personal your first district.
We can erase 4th district.
Tyler Cash, 5th district.
All right.
Thank you.
We'll do introductions of our board offices joining us virtually. Do we have any representatives from our first district joining us on the call?
Do we have any representatives from our second district joining us on the call?

Vera, Yolanda 3:07

Yolanda Vera, 2nd district.

Natalya Romo 3:11

Good morning, Natalia Romo, senior Justice Deputy, 2nd district.

Room 140 3:17
Do we have any representatives from the third district on the call?

Ayala, Angelica 3:22
That their district.

Fox, Aaron William 3:23
Aaron Fox, third district.

Room 140 3:24
OK.
Que do we have representatives from the 4th district on the call?
Do you have any representatives from the 5th district on the call?

Croxton, Sandra 3:39
Dandercon 5th district.

Gamino, Leslie 3:43
Plus, the Gamino 5th district.

Room 140 3:43
Very much.
Thank you very much.
We have representatives from countries on the call.
We have represented some County Council in the room anymore.
Thank you very much.
Do we have representatives from health services in the room?
Sanchez government relations.
Our Chief deputy director of health services, Katie Mathers, director of risk management services.
Thank you.
Do we have representatives from health services on the call?

Tim Belavich 4:20

Good morning.
This is Tim Belovic from Correctional health services.

Ferris Ling 4:25
Paris link DHS financed.

Allen Gomez 4:29
Helen Gomez, DHS, government relations.

Room 140 4:30
Thank you.
Much do we have representatives from public health in the room.
Represents from public health on the call.

Aneena Tellis 4:45
Hi, good morning, Annie.
Natalie's public health government affairs.

Yanira Lima 4:50
Good morning, Yanira Lima, also with the Department of Public Health, Bureau of Substance Abuse Prevention and control.

Room 140 4:56
Come on.
Thank you.
Do we have any representatives from mental health in the room?
Who do we have? Representatives from mental health on the call?

Otilia Holguin 5:13
Mental health Contracts Division Otilia Alguin.

Room 140 5:19
See, we have CEO budget on the call.
Do we have any other CEO staff on the call that like to introduce themselves?
We have representatives from ISD in the room.

Operating services.
Thank you.
That represents some ISD on the call.
You do.
We have representatives from Sheriff's Department in the room.
Represents from the Sheriff's Department on the call.
All right.
Thank you very much.
We will now proceed with today's meeting. The first item we have is a motion from SD4 maintaining Community health and safety through the Los Angeles County's Health Authority Law Enforcement Task Force.
Turn it over to SD 40.
This is my colleague Esther's motion.
She is running a tad late.
She just parked, so she should be here in a second.
I just texted her to find out, so I'm sorry about that.
Hopefully we can just wait a minute or two, if that's OK.
Do you have any?
What do we have after this?
Go to. You wanna go to the presentation item first?
That first, then, is I was asked to the presentation for all right, so we will move to the presentation item from CDHS Harbor UCLA Medical Center, underground storage tank replacement project approved project and budget appropriation adjustment and authorized internal services parks to deliver the proposed project using.
Track. We'll turn it over to the ISTD just.
You can sit up front there and do your.
Hi again. My name is Paige Bruin.
I'm from Operation Services Project management, section manager for the project management section.
This particular project is the replacement of a 25,000 gallon fuel tank that's meant for.
Find fuel for for emergency generators.
And the fuel tank was installed in 1996.
It is required to be removed and replaced because it is a single wall tank and is going to be covered under the $1.7 billion approved budget in April of 2022 to cover the

upgrades to the current facility.
Hospital is a level 1 trauma center.
And this particular fuel tank in these four generators supply all in case of a power outage, these would all power and comfort systems, lights, elevator, climate control, sterilization.
And and allow the hospital to remain functioning. These fuel tanks, also this fuel tank and those four generators also supply all power.
To all county buildings on a campus.
And so it's a very important replacement project it's replaced.
We'll be in compliance with.
Which is the local agency designated to handle California PPA requirements and that is monitored and implemented by the LA City Fire Authority.
Questions from our board offices.
But yeah, Victoria Gomez 2nd district.
Can you share an update on legislative efforts to propose or to postpone the AB 19 requirements?
Or.
The theismic act.
Required standard emergency standby power.
We have to normally standby power 72 hours, but because it's a level 1 trauma center and the amount of generators that it does supply the requirements, 96 hours of fuel, which is 18,000 gallons.
So the temporary fuel tank that will the the process would be to reinstall a temporary fuel tank.
25,000 gallons, 18,000 gallons is required for the 96 hours, but should the should an incident go past the 96 hours? There is capacity to pull 25,000 in the temporary fuel tank.
The temporary fuel tank after it's installed would allow EHS to empty the current tank, clean the current tank, remove the current tank air to the December 31st.
Deadline to have it removed. The new tank is also 25,000 gallons.
So we're replacing like with white, but for the fact that the new heel tank is double walled and it's expected to arrive in March, so they'll definitely be on temporary fuel from.
Whenever the process starts for them to remove the old tank up through March and then the installation of the new tank will take approximately 2 months.

OK.
Good question.
Questions.

Vera, Yolanda 10:45
It's gonna be a good day at work.

Room 140 10:47
Online questions from our board offices online.

Vera, Yolanda 10:48
Oh, thanks.
Yeah, I do, yeah.

Room 140 10:54
Thank you.
Do we have any public comment on this item?
Don't see any hands in the room.
The comment if you do, please raise your virtual hand or.
Dialing in.
All right, don't have any.
Comment on this item.
Thank you very much.
Move back to our motion.
For real estate, start at 9:30 and we'll take it to be early anyway, alright.
Thank you for your patience and thank you chair for the foundation. I'd like to introduce SD4's motion called maintaining Community health and safety through the Los Angeles County's Health Authority Law Enforcement Task Force. I think the health departments and the justice deputies are aware of.
Halt, you know? And and.
Reason why our office is bringing forward this motion is because we know that with some of the fiscal pressures on DHS, they've expressed that funding it solely is going to be really difficult for them.
The preamble talks a little bit about what halt does, but I do have Sergeant Van and Sergeant van.

I don't know if you want to come up to the front, but.
Just talk a little bit about what halt does and actually recommend our deputies here to.
Go on a ride along 'cause. I actually was not fully aware of halt until I started on this portfolio and I also want to congratulate halt on a really big operation that was conducted and I think you recovered over 18,000 counterfeit Miss branded pharmaceuticals valued at 7:00.

VY **Vera, Yolanda** 12:24
Yeah.

R1 **Room 140** 12:35
135,420 helping keep our community safe. But if you wanted to share a little bit of background.
Into Hal, that would be great.
Yes, of course.
Halt's been around since 1999.

VY **Vera, Yolanda** 12:46
Thank you so much.

R1 **Room 140** 12:47
It was created by the Board of Supervisors with the Rise of illicit pharmaceuticals and the streets of LA. It was started in East LA.
It was more focused on counterfeit pharmaceuticals from Mexico getting into the mainstream.
Community pretty much that people not wanting to go to the hospital or thinking that they could get medicine in other ways, making them sick and then having them go to the hospital.
So it started with 11 investigators approximately.
99 same budget as same exact budget that we have this year, so 25 years ago we've been working on the same budget. Unfortunately because of that we've gone from 11 investigators to two.
We're the only team in LA County that deals with healthcare related crime, misbranded pharmaceuticals, unlicensed doctors, unlicensed dentists, medical fraud,

insurance fraud, anything healthcare related.
My team.
It's me, Sergeant. Two detectives, a pharmacist and a health officer.
So it's a team of five DHS pays for all.
All of it $1,000,000 towards Sheriff's Department and about a half $1,000,000 towards DHS.
Like I said, we've been on the same budget for a long time.
Like Esther said, we just did.
This was 18th.
We did a search warrant in Riverside.
It was one of our largest seizure seizures of almost a dermal fillers and illegal Botox and stuff like that.
Went back to all 5 districts. We had evidence that this person was deploying misbranded stuff to every single district.
So yeah, we seized for $700,000 worth of stuff.
And there's no other team like us that does it with LAPD.
Not even with Sheriff's Department.
Nothing helps area.
It's basic, yes.
And you know, I know that we're gonna have back here next week for a more of a deep dive.
And you know, get what they do. And so I know I had planned on having this motion timed for that, but it is what it is so.
So part of you know, I think our office, the reason why we wanted to.
Put forward this motion is to ensure that Hall was still funded and I think the directive which asks that DHS work with CEO in collaboration and other relevant departments determined by CEO to figure out a more balanced and equitable funding plan to continue to support Hull, we believe.
That hull plays a very important role on the public health and public safety in our communities.
You know, and we already know that our first responder.
Response systems are very overlooked and we know that if someone gets injected by one of these, you know fake fillers or whatever else, right, they can end up in our systems.
And so this directive is really just simply, you know, having the relevant departments

work with each other to come up with a funding plan that doesn't have DHS solely physically responsible.
For halt, but we also want halt to be funded and continue to do the great work.
That they are doing in the community.
But folks have any questions.
Victoria. No, no, no.
You go first. Victoria Gomez, 2nd district.
I had a question.
So we're looking to make share costs equitably with other departments.
Would we, based on that, would we look to increase the budget?
Ideally that's in a perfect world, correct?
But I mean, I know every every.
Department or whatever is having financial issues.
Who's obviously, you know, the climate.
It's always been so. The MOU between the Sheriff's Department and DHS has always said read.
It's at minimum 3 detectives, one Sergeant and then a pharmacist and health officer.
So ideally, but like I said, it's been $1,000,000 for 26 years because of salary increases and stuff like that.
That's why it's gone down to two.
Right now, we're barely afloat with that $1,000,000 for.
New detectives and a Sergeant.
And a little bit of overtime because when we do operations, we need to reach out to other departments to help us with like operations like the search warrant or an undercover buy or something like that.
So to answer your question, ideally we would we would like more, but I feel like as long as we can get through the next few years at a kind of a a minimum that's better than not having the team at all.
And would the report back just solely focus on that directive?
So I just yeah, just in response to that.
So this motion, as much as I love halt and I wanna give them so much money, right?
We understand what the fiscal situation is and so this is really just to kind of maintain, OK.
So one is to maintain you know the budget that they have and the 2nd is that we wanna make sure that you know, is this supposed to be a task force between our

health departments and our law enforcement?
Right now, it's our health department that's taking on, you know, the.
Entirety of you know the health budget.
We wanna make sure that it's actually being so, yeah.
And just to be clear, I guess my my point was of the the team that you described, the only official DHS staff provided person is the pharmacist, correct? And and the health officer and the health officer. Yes, Sir.
Got it. OK.
And then the rest of the team is under the LASD. Sure. OK. And in the past, we've had LAPD and we've also had OIG. We've also had.
Roxana, we've had a lot of different and unfortunately it's fallen off because scaled down to just OK, just LASD and DHS got it.
We still do work with all those other agencies. Thank you.
And I guess this is a question for DHS. Does halt save DHS money?
Is it a program that there's any?
Yeah, is a great program.
Like important look, health public safety.
50 intervention.
There's no financial savings to accrued benefits that go to.
Not anything.
And I you know, I I I think the desire to continue to have it, but should be funded, law enforcement should.
Beneficiary of the funding then is.
So people are hurting for her.
He's crying.
OK.
It's a.
It's an important intervention. I think a lot of the the entities that were pulled out.
EDA sheriff, a variety of other law that's prioritized.
Can I ask you just speak a little louder? The folks online are saying they can't hear you.
Sorry.
Ask with the existing budget and team is your sense that you're working at capacity, like if you had an idea where you mentioned a larger team, does that mean you would?

There are cases that maybe are not being investigated.
There's there's so many cases that either we get from we just got. We just had a meeting with the DEA.
About 3 weeks ago they brought.
They had a confidential informant bring about 13 or 14 illicit illegal medical swabs.
In Glendale.
And we and then about three other in the valley and we we have to pick and choose our our what we decide to invest because I mean to be non-stop surveillance you know surveillance leads to like a million hours in the back of a van in front.
Of these things, building our cases, so ideally we.
Ideally, in a perfect world, or at least.
It's better for. It would be for detectives and a Sergeant that would double our stats and double our the safety for the community in a perfect world.
But like I said, as long as we can just keep it 'cause, you know, everyone here has been around.
They know once a program like this goes away it it takes an active body to get back.
And so, but no, we we pick and choose our cases.
We prioritize them based on if there's a victim versus not a victim.
I mean, I can go online right now and find out.
June legal menswear or someone selling medicine out of back van. But when we eat a victim involved, that's our main priority.
Argument are you with LASD?
Yes. Oh, got it. Thank you.
Questions kind of related to that.
Of other departments that are named in here, been spoken to, are they interested in so they all have a copy of the.
Not a question from an helic.
Op.

AA **Ayala, Angelica** 22:12
Yes, hi.
Thank you so much.
I I just want to be clear.
So institute a funding plan that does not.

Does that mean that they have delegated authority to implement however they feel, or does that require board approval?

Room 140 22:30
So I think it's going to be up to CEO and how they present it back to the board.
But I think the the preamble and the directive is clear in that the the the complete funding of halt shouldn't rest solely on DHS. And I think the the intent of the motion is that the funding be distributed between health and Parish department.

Ayala, Angelica 22:57
And so that leads to my other question, which was at the core of this.
Do we have any concerns that maybe we will not be able to fund it again budget due to budget constraints and some of these other departments as well?

Room 140 23:11
So currently, DHS has been what funding this for last 26 years and I think that they've been using out of their budget the 1.5 mil right to support halt.
So if you know I am not a budget deputy, but you know if I'm seeing this, you know, and we want to just continue to fund Holtz where it's at not expand or increase the staffing even though we would like to.
I do think that there that the CEO can figure out.
Money transfer between DHS and the Sheriff's Department to continue funding all at the amount that it's that it's currently operating at.

Ayala, Angelica 23:53
Yeah. So just to clarify, I, I I think my question is more about given budget constraints at LASD District Attorney.

Room 140 23:58
OK.

Ayala, Angelica 24:03
Do do we have concerns that maybe those departments will not be able to pay their piece, their share?
And I'm not disagreeing that we shouldn't go in this route.

I actually think this makes a lot of sense. I just.
I just wonder, will that be an issue potentially?

R1 **Room 140** 24:17
I mean there are.
You know we can't fully account for every single issue, but like a possibly, but given that even with the.
Curtailment exercises right.
Like I think Halt is continuing to operate as is right.
Like, I don't think that the curtailments have affected all in terms of staffing or whatever else, right?
Doctor Galley DHS has not impacted by the county curtailments. OK, so the curtailments impact.
CHS for sure.
Are not subject to the county curtailments.
The DHS does not intend to continue funding the DSO for the shares.
We do plan to end it.
We would love the program to continue.
We're happy to work on a timeline for a transition.
There's two options, either the.
Doctor. Or do you mind just.
Either there's additional funding that's identified through the county to add to the appropriate budgets within the Sheriff's Department or other entities. I think the DA, some of the reasons that were just shared.
As a strong desire to continue to enter into support these cases as well as other parties, but even if it's a call for CEO to make in the board, ultimately the department's sheriff, the DA, they can choose to prioritize within their existing budgets if they believe these.
Crimes or alleged crimes are important community public safety threats. They can choose to prioritize within their budget the funding for the services DHS.
Our contribution to this, which you know to the extent DHS gets any financial benefit, which I don't know that we do, it would be more than made-up for by the fact that we continue to plan to fund the health piece for the time being to the great.
Extent possible knowing what's to come, but we have no plans to cease the pharmacist or the staff analyst.

That is a part of the project. We just can't continue to support the Sheriff's Department.
Financially, so that could be new money or it could be the Sheriff's Department choosing to prioritize within their existing budget.
We'd love it if other departments, DA, others, OIG, whoever wanted to. What's the financial cost for just the two DHS staff?
A little over 500,000, I think it was 505,000 last time I checked. OK.
So you'd be thinking from DHS currently, which is the 1.5 just down to 500,000 roughly.
A million sheriff piece slightly over and then we have like 1/2 a million.
Got it.
Didn't have any more questions online.
Anyone else?

AA **Ayala, Angelica** 26:52
Nope, that's it. Thank you.

R1 **Room 140** 26:55
Other questions from our board offices on this item.
Any public comment on this item?
Any hands in the room?
Don't see any virtual hands. I have one more question.
Go ahead, Mr. how do we get a ride along with you?
Just like, just like I told Esther, you guys are more than willing to come to any.
We did a an undercover 1.
So the one we did with her, there was this girl offering Botox. Whenever you see Botox for like $5 a unit or $7.00 a unit, don't do it.
That's it's not real.
So, so so we so.
I found this person online through Instagram.
She was offering these services.
We had one of my undercovers reach out and this actual undercover wasn't part of my team. So like I said, we always try to reach out to other like either LASD or LAPD. Whoever can help us this time. We reached out to another one of Major Crimes to. Help us.

She did a virtual.
Consultation 7.
Appointment. I actually paid her on Venmo because that's how they're doing it now.
That's another.
That's a hard thing to do anyway.
That's it.
And then we sent her in.
He was on a wire once.
She received once he received a consultation from someone that we knew that was not licensed.
We made entry knocked on the door.
It was actually. She had her own little like Med spa shop in a house, actually, in her parents house. Nice.
So Esther's with us. We we made an entry.
We detained.
Searched it, arrested her for crimes and so pretty much it was an undercover by turned into a search warrant.
That's and you guys are more than welcome to come to any if.
I usually like to have been pretty much reaching out to Sandra and Esther because I have only been my contacts with upcoming operations, but honestly, every one of those rooms will come to me. Any procedures?
Can I ask one more question?
Just thinking about your experience and what you've seen, how many of the folks that are out there hiding these services are also victims in themselves, who think that maybe they were licensed?
Because I I've heard of like these places that will provide you with licensing online, but those are also scams.
That's a great question.
That is a great question and we see it.
It's probably I wanna say about 25% now.
It's my.
It's at my discretion.
For OK, for instance, we did one in East LA.
And there was this lady's selling medication online.
You did.

A search warrant went in there.
She had all these like certificates posted, right?
Because she did the same thing.
We determined if she, he or she knows about it and based on that we will prosecute it on that case in East LA, we chose not to prosecute because she, in her mind was doing the right thing. And behind that case, there was no victim. So.
We my team's not all about like.
Prosecuting Airways more about educating and keeping that stuff out of hands.
So I use my discretion to determine if I'm going to prosecute based on. Like I said, victim or if they have knowledge of it. Now if I feel like they're, they say they didn't have knowledge, but I you can kind of prove they do.
Based off whatever we find, we'll prosecute him. But usually like 25%.
Thank you for the few extra questions.
Any public comment on this item?
Alright, thank you very much.
We now move on to our next item, which is a discussion item for health services financial challenges presented by our director.
Morning everyone.
Christina family, director of DHS Nina Park.
Deputies. Yes, I already.
Have you announced myself before you came?
Alright, thanks for allowing us to spend a little bit of time just doing a quick overview.
And and really, would love to just be open discussion and not share your thoughts and and do our best to answer questions about the status of DHS finances and what we're doing. I will say this is a different presentation than what you'll hear.
For the following week.
Fiscal outlook.
The fiscal outlook will go into much more detail that will be done by finance and by me and I'll go into detail on the numbers.
Why a certain revenue is going down and ask them all the questions you like about why it's this number and not this number and the timeline of some of the declines.
I'm not going to go into those details today.
I think what's important for the purpose of this conversation is that we do have a fiscal problem.

So as you'll see in the fiscal outlook, we closed the most recent fiscal year with $150 million budget deficit.
That's the first time that DHS has closed the books with a deficit in decades.
And that presents a real problem. The fundamental challenge there, and that deficit will grow to over a billion dollars in a few years, is that we have a huge mismatch between our costs and our revenue.
The costs are going up primarily due to labor. 2/3 of our cost to 3/4 of our costs in DHS are labor or labor related.
That's typical for a health system.
It's it's a labor heavy profession.
But when labor agreements are negotiated, there's the state minimum wage, there's benefits that increase every year. Those costs hit DHS really hard.
And I would say the benefits, it always feels somewhat unfair because.
The cost of healthcare goes up.
It's more expensive for us to provide health care, but at the same time, we also have to pay more for staff on their health benefits, costs that health benefits. Negotiation with county is 8% increase every year for three years for 24% increase over three years.
And that's really, I think should stick in your mind as reflective of how quickly the cost of healthcare goes up and that's what we're then faced with trying to manage.
On our own cost side and it's not just labor.
What's the cost of pharmaceuticals of medical supplies, of equipment of need, upgraded maintain facilities?
You heard a presentation earlier today on just one of numerous CAP projects that need to be done.
Maintain our facilities.
Just giving you some context for the costs, the recent for the the Labor agreement for the $5000 bonus one time bonus for Staff HS, which has to be paid by DHS.
Over $100 million just for one year.
I think there's often a misunderstanding among DHS staff as well as patients and the public that that money comes from the county.
And that the county's finances impact DHS or that the county will pay for the cost of those labor agreements or other associated cost increases.
They do not. Correctional Health Services, juvenile court health services.
Most of ODR and then leaving aside community programs and housing for health,

those entities have separate funding streams and to some extent are paid for by the county.
CHS notably is entirely NCC funded, but DHS delivery system, which is what I'm going to focus on today.
Hospitals, the clinics EMS agency, which is a little bit separate but still we consider it part of the delivery system.
We did not receive extra money from the county when our office go up, so we have to be able to cover those costs with more revenue and then for all the reasons you'll hear about in the fiscal outlook that you already know about, our revenue is going down.
So I'll touch briefly on what we're doing on the revenue side, because people always want to know and they don't want to just hear about cost cutting understandably.
Already and you all are well aware.
Thank you for the board vote to increase the measure B parcel tax rate that brought in $54 million annually to DHS.
Starting this year, we are nearing the completion of a of implementing a rate increase for the Ihsss line of business. We'll bring in about $80 million.
Additionally, we currently lose about 100 and 1000 and $20 million a year on Ihsss slide of business.
So that $80 million will help fill in the gaps.
It doesn't and can't cover the.
Mou, the county's MOU, which for benefits has historically been paid for by DHS.
With the board action yesterday, there is no more room to raise the rate for benefits moving forward. We will have to look at benefit reductions, which would start those conversations to be able to further fill in the gaps.
We are doing advocacy efforts on a number of things.
We're working on trying to get the dish cuts extended.
Waiver renewal with the state and those things will continue. We have lobbyists that we are working on.
On some of the rules that are playing out in Washington, associated with the Big bill.
But a lot of those details are still to be developed.
Our amazing finance team is working on restructuring our supplemental payments, partly in light of the Big bill, and they'll continue that work.
We are always looking at opportunities to increase our base payments and have different negotiations with our health plans and thinking about ways to restructure

our health plan contracts.
Largely by increasing the base payments.
Because these payments are very low in California.
And so that work is ongoing.
They have a lot of work for billing, claiming to be able to not have as many write offs for insured and commercial pairs.
There's whole work streams on that we will.
We are in mid mid stream and implementing our project monarch.
We have our dictate, voice recognition, real time, voice recognition installed.
We're about to launch our computer aided coding.
We have real time provider documentation improvement support and then that will link in with our broader revenue cycle enhancements with a board letter going to the board this fall for awarding of a contract on a new revenue cycle system.
How much do you think the revenue enhancements will bring in hopefully?
100 million.
Ish. I mean, I think it remains to be seen.
DHS does not itemize Bill.
You know, we do have write offs. Those write offs are typically based on charges and they should not in any world be interpreted as the amount actual amount of money that is left on the table.
It's not all claimable, but there is money that could be claimed if we had a modern revenue cycle system, it will more than pay for itself to implement a new revenue cycle system.
Our current system is our quadrament affinity.
System which incredibly outdated and not capable of doing modern billing functions.
So we need a new one, but the revenue cycle and billing functions will not solve structural deficit.
We're working on other focused revenue enhancements, so we're trying to look program by program where there's losses in doing what we can to stem those losses.
Last year, years ago, we renegotiated our MOU with DMH for specialty mental health.
That is much improved.
Still opportunities for improvement, but it's much better. We do have losses for ODR on the ODR ward and all of you. We lose value a year on the inpatient ward at all of you. That is covered by DHS.
And not out of OD Rs budget. Looking at how we can improve operations there,

Kona, our nursing school which operates in part out of LA General is subsidized by DHS out of Medicaid managed care dollars. We're looking at models to increase tuition to be able to have it.
Be a break even operation and not trying to make money off nursing school.
But it needs to be able to be self-sufficient and fund itself.
Sorry, how much does that in order for us to break even?
On the number of hand, but we're putting together a sheet about Kona's operations.
I just don't have it yet.
And then happy to share it.
We are looking our recuperative care and our mobile clinics, both of those lose money.
They're fully subsidized by DHS managed care revenue.
Recuperative care is just to give you a flavor.
I think they were built with an understanding or expectation that there would be calane revenue from community supports for recoup that would fund largely fund those operations. The operations of the recruits.
Are annual.
Costs are about $27 million a year and we bring in about 1,000,000.
Dollars a year in revenue.
And we have done everything we can to maximize billing. Is that because of pre authorization requirements or the plans deny the patients they don't cover the number of days. Remember that day and the recoups for six months, patients don't transition to the community.
This eligibility criteria for their groups, according to the plan is exceedingly narrow.
And they're constantly denying patients based on who knows what.
It's very challenging.
So we're looking at alternative models for operation.
Or different contracting or patient eligibility criteria to make those work.
Same story in the mobile clinics.
There's really no revenue capture option through the mobile clinics to think about how we can best use those without having. Right now it's $11 million of losses.
Another revenue option that I'll raise that we're looking at is how we can try to get 340B pricing within our ACM clinics. If you recall, we only have a 340B pricing through our hospitals.
We don't have it through the ACN.

It is possible to get 340B pricing if we're an FQHC, so FQS have 340B pricing.
We are looking at whether or not we want to pursue FQHC status for our ACN clinics.
Some trade-offs there.
Or also other ways to be able to obtain 340B pricing for some portion of scripts written out of the ACN, and we're working with our Lsign Council in that regard.
They're just a few of the things we're working on.
There's a lot of things, I think.
What is important to keep in mind though is even if all of those things work, at most, that will stop the hemorrhaging on the revenue side.
But it will not be sufficient to raise revenue.
The manner needed to match our ongoing cost increases so.
Stemming a loss in revenue should not be confused as the same thing as revenue increases.
And what we need is both. We need to stem the loss of revenue on across the board and we actually need to bring in more revenue.
Otherwise, we have no way of trying to address the increasing cost that DHS faces every year.
So I'm going to spend the rest of the time today focused on cost.
So we are working first and foremost on a variety of efficiencies.
We consider it an efficiency if it's not a service reduction.
So efficiency defined broadly and there's lots of ways that we're doing this.
One of the biggest ones is obviously it has to be on the S and EB side or the labor side because again 2/3 to 3/4 of our costs are on that side.
We're looking at staffing productivity, staffing levels, where staff are assigned.
Does the workload match the staffing model?
Does it make sense to move people around?
What are the ratios that managers and supervisors where those aren't dictated? What are the staffing ratios where those aren't legislated?
We're looking at non clinical time that clinical people spend doing administrative tasks, reset our research protocol and expectations, particularly for physicians.
We already have long required physicians to do at least some portion of time on clinical activities, but we haven't had that same expectation for non clinical staff looking at extending that to all of our clinical staff.
We are looking at how we do standby pay.
For our physicians as well as efficiency of care in different settings like does that

make sense for these staff to be doing virtual work, video work or E visits? Or is it better for them to do in person visits, which is another means of getting productivity up as?
You all are aware we implemented a hiring freeze on July 18th. We had long before that.
Curbs a lot of map level and high level.
Hires. So back in late last year, even early this year as items were attrib.
Uted high level administrators, for example in our comp centers in HSA day OFTOWN and in other positions and several positions that historically been filled.
That will not be filled for the time being.
The hiring freeze is across the board.
There are no blanket exceptions to it.
It doesn't mean that there's not exceptions, though. What it is is that facilities and units have to submit staffing plans.
They need to hire according to the staffing plans. They do have expenditure caps.
They need to work within the expenditure caps and they it's an opportunity when items attrit to be able to revisit where the best use of whether it's really needed or whether there's different ways of.
Redistributing to work with the staffing to be able to maintain service levels.
With potentially fewer staff, ultimately, a hiring freeze is the most impactful way to reduce costs just because of the amount of money that is put into salaries.
Across DHS, and I know it's difficult and always difficult, but it is.
We've already seen an impact in terms of our expenditures and it is the fastest way that we can stop spending money and it will help overt layoffs.
And the goal is to avoid.
Way to quantify.
The hiring freeze as reduced your otherwise would have been expending.
Yeah, Allen's calculating those numbers and he should be able to share those with.
Doctor Galley, just to ask another clarifying question is.
In terms of the DHS expenses, salaries, I'm assuming are the largest expense you all carry. And are those mainly clinical like salaries?
Of physicians, are they the non clinical or mix of both?
It's a mix of both, but most salaries in DHS are OK.
Yeah, it's it's nurses, nurses, nurses, doctors.
There are lots of other staff in DHS, but if you were to just a lot of nurses and doctors

and their salaries are high, yeah. Doctor Galley, sorry if we can go back to the recruitment of care piece. I know you mentioned modifying like operating models and patient.
Eligibility. Can you like clarify what, like the impact of that would be like practically? What does that mean?
We don't know yet.
We're still looking at models and options, so we have to look at who's right now, admitted to the group.
We wanna change the eligibility criteria.
For who gets in based on what the reimbursement options are.
Do we wanna look at potentially contracting out a portion of the beds to a pair that's able to pay since we're not able to claim the money under Calais?
I have options.
Unclear. Get what the impact will be.
You mentioned staffing level.
Is there any way that you can share with standard practice staffing models look like? Typically they might compare to the county.
Currently, what do you see?
Particularly, you said that you're looking at staffing levels and there might be some areas where it seems like it's over staffed given the level of activity.
Can you share some examples? You don't have to do it now, but I'm just curious as to typically.
This to provide X number of patient visits.
You this type of staffing model but in these particular areas we have this type of staff, I'll give you just one example, but it is just one example.
I mean I have reclinic.
It's different.
Every service line is different, which is part of why this work is really hard and it's been done because it's really hard.
The patients are different. Features are different.
But like in an area that you might expect might be more standardized outpatient physical therapy.
The productivity.
Of our physical therapists and in heart varies because some of the staffing models are different.

Some use PT assistance or PT helpers, which is a different classification.
Some don't have that classification and they use just physical therapists. The number of patients that.
Our unit C vary widely based on number of visits per physical therapist.
Widely the supervisory ratio also varies widely.
So for the number of staff in rehab at one of our hospitals, the line level staff to supervisor ratios, I think 1 to 8 and in another hospital it's one to 26 and the one where it's one to 26 has far better productivity and far better.
Outcomes than the one that is 1 to 8.
It's not even that like.
You getting better outcomes with the richer staffing model.
So it's both in the management supervisor ratio.
But also the ratio of staff to workload on visits and volumes.
But there would be separate numbers for literally every single service line.
Not that there's one model.
We are looking at reducing registry. We've done a lot to reduce registry.
It is not always cost effective to reduce registry and it is not possible to eliminate registry. Sometimes registry is less expensive than county staff.
Sometimes it's just necessary because we need focused, specialized help in some highly specialized area, or we need it for a short period of time, or we need stop gap for surges and patient volume, and we need to kind of be able to modulate volume up and down.
But it often is less expensive to hire full-time county staff where we do need them versus registry.
But I think there's often a misconception about how much savings there might be from that.
So I'll give you just one example example.
Here I showed this one of you might have heard it recently in another setting, but so our our registry for RNS at the beginning in July of 2024.
A year ago, we had 785 RNS on registries.
We reduce that by June of 2025, July 2025, a year to 300.
So we did a lot of work to reduce our RN registry.
It's been a big initiative for us.
Those remaining 300 RN's where they were a month ago, I don't know where they're at now.

We were to completely eliminate those registry RNS, but we need the work. So we would backfill it with county staff, would save less than $5,000,000 a year.
So that's a complete reduction complete, not just reduction, but elimination of RN registry.
So I think people often think, well, you know, you're just going to solve all of DHS's financial problems if you got rid of R3, it is it's it's not true.
We are looking at reducing overtime and over $100 million a year on overtime.
It's a lot of money.
It's money that people buy on and often have grown accustomed to.
So I understand that it's often difficult for staff.
But it's time that they could be doing other things, or if they wanted an outside employment, taking on another position. If they do need that income and it's very expensive us to operate over time make classifications, it's at time and a half and sometimes on double time.
Really just on that point, are there any things that you know leadership is doing to try to rest some of the overtime?
Yeah. Yeah, we have.
We put in place.
Well, start with management is looking at it a whole lot closer.
They're looking at some of the highest utilizers by name over time, sometimes just on numbers.
It's just the same people over and over again and then really looking at why is there a problem?
Is there a solution?
Sometimes it's time limited and it is what it is.
Someone's patient or whatever.
But sometimes there's other reasons, and those are being handled on a one off basis.
But there's also broader themes. Sometimes there's.
Just become a culture of that's just what you do.
You just stay for overtime and there's not an incentive to finish the work on time.
Sometimes there's actual workloads, staffing issues, and we can address those. We are in the process of shifting.
To all overtime must be prior approved.
So right now, that isn't necessarily the case across the board, and people can work the overtime and functionally and.

Offered.
And.
We are going to look at also all of our non clinical services. So we do have I want to safeguard patient care.
Have a lot of staff that work in.
HSA downtown a lot of those functions are absolutely necessary.
We have to have.
Supply chain. We have to have payroll.
We have to have finance.
We have to have it, but we still want to look at the staffing in those areas.
There's other units that we have that I would say are more values driven or strategically important, but not necessarily important for keeping the lights on and running the operations.
On a day-to-day basis. So we're taking a look at those.
And then finally, there will be an opportunity or needs to be an opportunity to look at contracting. I realize it's sometimes a difficult conversation, but sometimes cost contracting out is a more effective way to manage an operation and we have that ability through Prop Bay. So we're gonna.
Look at those options as well.
Briana, can you remind me how big?
The admin department is for DHS.
You say in terms of like budget and and staffing for HSA.
I can get it for you. I don't know it offhand. It's large.
It's large though, but in a bunch of stuff ends up having to get pulled out.
So, for example, the IGT that DHS pays for MLK Community Hospital is budgeted out of HSA.
That's a huge amount of money.
A lot of the other county department overhead is budgeted out of HSA.
We don't have an option but to pay that stuff so.
It's have to really look at how to separate out what's really kind of discretionary.
In that sense versus some of these costs that we still pay for, we still pay for with Medicaid dollars, but it's really not what people are thinking of as administration.
In terms of like reductions in cost like at the clinical level and on the admin side, how are you balancing?
Out or or how is that going into like the equation we will do everything we can to

safeguard patient care.
So we're looking at efficiencies and streamlining for those non clinical.
Little areas right now and trying to start making decisions about.
I mean, there's already been a high rate recently, but there will be.
There's certain areas in classifications where there's no exceptions to that hiring freeze, and not just some of those administrative areas. Some of those classifications that we know we don't need help ever at this point in time.
And a lot of the non clinical and more administrative.
We are doing a lot on the S&S side too.
We have projects to streamline supply chain purchases to really look at physician preference items and high cost implants for example.
There's variability that if we reduce the variability, it would save money.
We've reviewed all of our CAP projects in different projects and are only moving forward with the ones that we absolutely have to do either for safety issues or for regulatory compliance issues.
Doing a lot on lab Rev and pharmacy which unless you want to invite.
But just a lot to try to reduce the volume of testing that's done send out.
Look at protocols sites of infusion.
We are looking and changing the on site lab complexity for certain ACN sites.
Patients will still be able to get their blood drawn, but what we process on site versus send to another site might change.
On other SNS, we're looking at reducing the amount we provide for ourselves for transportation.
If a patient has Medicaid that's covered benefit, we often absorb those costs ourselves, mainly because it's such a pain to get them reimbursed through the plan.
But we don't have to.
Go through that process.
So we're going to defer to the plan and stop doing it ourselves.
We're looking at transfer protocols, health plan denials for things like transportation as well as Hospice, DME, Home health, home infusions and other things.
We're streamlining our IT applications and doing a comprehensive review of all of our applications and we have hundreds.
Of IT, applications that and then looking at memberships and subscriptions and other things.
Ask a little bit about the transfer protocols.

A little bit more about that are these transfer protocols of patients that DHS receives in its EDS that you're trying to transfer to a?
So we're looking at whether or not transferring more patients in where does it make sense to repatriate patients into DHS hospitals. Patients always have the choice for transfer, but sometimes from a financial perspective, it makes sense to to seek.
To try to transfer the patient in depending on the particular situation.
We are looking at our payments to other county departments.
For total, we now, DPW and the DPW numbers are not yet available.
We pay $161 million a year to other county departments, those to the auditor, the CEO.
DHR and ISD DPW numbers, as I said, are not available.
Vast majority of that is ISD for direct services, that's.
$98 million.
$99 million, but there are $50 million that DHS pays to other county departments for just overhead or based on our allocation, our portion of funding some system or some overhead. Half of that is for the auditor controller.
Can I ask questions about that?
Thanks for sending it around because I was.
I was looking to look at the chart that you sent to the deputies on it and there were different columns. Some were direct services.
Or allocations. Some were overhead admin fee and I was trying to understand the difference between those 3 categories.
It sounds like you pay whether or not you actually get a service worth that much overhead. The overhead, or it's it's it's DHS's portion.
And of paying for like a system that the auditor runs or that DHR runs. So we have to pay our share of that county system.
So that's an example of overhead.
Or it might not be an IT system.
It might be some program versus a direct service, which is think of it as fee for service.
We may not want to buy it from the other county.
We may prefer to do it ourselves or to outsource.
But the current county policy is it has to be performed.
On that part.
Many of these could you do on your own with your existing staff if you were given

the chance to do that.
I don't know.
We've started thinking about that, particularly for some of the larger items like DHR, which is I think the area where and and ISD where there is some opportunity already with our effort to insource our chalk contract effort.
We will save money there and that will help some of these Members to go down on the ISD front.
But I think there is more opportunity, but we haven't really dived into a lot of the details yet. The team these numbers from closing the books and then now they're trying to do more of a deep dive on some of the particular aspects in the things like the.
Auditor controller CEO.
I know it's a little bit less amount. Those sound like they're systems that you use.
You need to continue using.
No.
Oh, interesting.
I think particularly with the auditor, there's a lot of opportunity for streamlining.
Thank you.
We're also looking at some opportunities to restructure.
Care without affecting service levels. So I'll give you just a few examples.
So there's lots of ways this could play out.
Sometimes we might be looking at changing the hours of operation of a clinic, but there's a neighboring clinic that is still open at that time, and patients still have access.
We might be consolidating clinics, so a certain site might have like a multiple sclerosis.

A **Antonio Wu | Daley Strategies** 1:01:48
That's not science, the science.

R1 **Room 140** 1:01:49
Clinic on a certain day, at a certain time.

A **Antonio Wu | Daley Strategies** 1:01:50
Are you money up?

Room 140 1:01:52
It's not full neurology clinic, which is staffed by the same doctors, is on a different day and a different time and has capacity to absorb the Ms. patients. And so then we're just going to consolidate those two clinics so that we can be able to free up the.
Staff for that other day, patients still have the same care.

Antonio Wu | Daley Strategies 1:02:10
Hey, Izzy.
Oh hey.

Room 140 1:02:15
But sorry, thank you.
Patients still have the same access to care, but it's just.
Yeah. On a different day of the week or a different room number. We're looking on the inpatient side at some of our ward designations.
We do this regularly.
This is not new, but periodically we need to shift.
More designations just based on evolving patient demand, so that by Ward designation, I mean ICU versus PCU versus TELI versus Med search. All of those are staffed at different state mandated ratios and they all have different costs.
They all have different security, so we are looking at whether or not we need to make adjustments there, have an opportunity to make adjustments and then also looking at our utilization of observation.
Right then.
So those are examples of some of the work going on on efficiencies.
That's where largely we're focused right now with the exceptions that we'll get to.
Next category of of of actions taken really does get into the area of service reductions and service changes and they're much more complicated. And so I wanted to talk for a minute just about what the principles are about, how we think about the work.
So first I think it's important to say that we have to align the ongoing costs with the ongoing revenue to the greatest extent.
Possible. We're gonna do that on a line of business basis because revenue is specific

to the line of business, our lines of business are.
Met regular Medicaid, which is our biggest line of business.
Uninsured kind of gets thrown in there because of how the payment works.
Limited scope statement medical some of the other subsidies.
Are ihss past line of business, which I talked briefly about, so that one will have to get aligned on ongoing costs.
Ongoing revenue, we have our specialty mental health line of business, which is a contract with DMH.
Again, much improved with the current MOU.
Still, opportunities for improvement? We are the line of business currently DHS is subsidizing odr.
We're looking at how we can help address that.
It's all line of business specific.
Apart from that, then once we get within the lines of business, when we look at how we're affecting services, we wanna make changes.
In a way that is fair across the system, treating all patients the same.
In the sense that we're not trying to offer this service in this geography, but not this service in this geography. Like if a patient has access to a service, we want them to have access to the service and not have certain regions have more access to certain Serv.
And other, that doesn't mean there's not. There's always specialization of highly specialized services that are consolidated and highly specialized centers.
But the patients, even if they have to travel or if it goes to them, they still have access to the service.
What we're not doing is, you know, your eligibility and ability to act to use the service varies by where you live.
That said, we're also we'll. We'll also need to look at layering equity on it.
So when I say they have equal access to services.
It's not to say that we won't take into account equity, and we've already started looking at some equity measures.
And we aren't at the point yet of service reductions where we're starting to look at, you know, this service in this region needs to close. Which region do we pick for those types of decisions, we'll need to layer on an equity framework for that.
We need to as much as possible, preserve our core managed care services.
That's because that's how managed care is structured in California. That's Medicaid in

California.
We operate in a managed care system in California.
We have to be able to continue to compete in the Medicaid system as California has structured it and that requires maintaining core managed care services under Medicaid.
We want to try to maximize our services and the goal of all of the efficiencies. Now the goal of the hiring freeze. Now the goal of some of the service cuts now, which we'll get to are so that we can.
This much money.
And push off in time.
She'll service closures, facility closures and layoffs do have a fund balance. Alan will all about our fund balance when we're in the fiscal outlook discussion next week, but we have over a billion dollars in fund balance.
We did use some of that fund balance this year to close the books.
We have some fund balance that's still available to close the books this current year, which we will need because we will have a deficit.
Staff Fund balance will not be able to hold.
This longer, unless something mental changes for more than two more years.
So we have, but the more we can reduce our expenditures now.
Try to bring our costs under control.
Stop doing services that we don't need to do.
A longer we'll be able to have our fund balance last to be able to push us out in time so that.
Be a new administration will come and pass different laws.
Maybe, maybe.
We will have a different revenue source. You know, maybe the revenue cycle system implementation will yield $200 million, not just $100 million like there's a million different ways that this could play out in so many different uncertainties. But the goal is to push it.
Out. So if we didn't have that fund balance now, if our fund balance is down to zero, we would be doing layoffs today and doing facility large facility closures today.
The problem with doing large facility closures or large service cuts, it is very hard to cut your way out of a revenue problem.
So as one example, if we have a billion dollar mismatch between revenue and cost and say we.

Balance. You don't just cut a billion dollars in cost because when you cut a billion dollars.
That it costs you cut when you cut services, you cut revenue. And so when we seeking to close hypothetical numbers, a billion dollars in a mismatch between revenue and cost and we cut, we have to cut probably $2 billion worth of services to be able to make.
Up that $1 billion in mismatch.
It's incredibly hard to do.
It would decimate the system.
It would decimate care for lots of people that rely on us.
So our goal is to do everything we can.
That's why things like the halt presentation, while small, is really important, because a million of those examples each should not be painful.
It's a great program and it should continue.
But the Sheriff's Department should pay for law enforcement, Medicaid managed care dollars should not pay for it.
And we need to safeguard our Medicare managed care dollars for our services.
So that we can stop using our fund balance and try to avoid facility closures in the apps.
We're gonna do everything as one system across DHS.
I'm almost done.
So last general category.
So two things and and Nina will walk through these that we are already.
Made notice of termination is our enhanced care management and our non specialty mental health services.
Both are contracted with the health plan.
Nina will walk through why we're closing them.
I think the important thing before she starts to remind people is that the patients still have access to the service.
It is a benefit.
It is a benefit in Medicaid managed care, but it is paid for through fee for service through the plan of which we previously were a contracted provider.
We are losing money on it and can't break even and so we are going to end our contacted provider but the patient will still.
They just need to find another provider willing to take well. The past. The plans, yeah.

We'll be involved.
The first program is the PCM. The Enhanced care management. It's part of the Kaling program with the state and it's complex care management for our very high risk, high complex patients. And we have about 350,000 managed care.
Assigned lives.
Currently we serve about 2700.
ECM patients.
Where we utilize our care managers, RN care managers that manage their care and coordinate their services.
Provide education, coordinated referrals, navigation through the system.
And also connect them to any social you know service needs that type of thing. And we've implemented it. When Cali went live.
And since then?
And we've been trying to make make the program work.
It obviously is beneficial to our patients. Many of them actually will benefit by not, you know, getting sicker and being, you know, getting admitted to the hospital or going to the emergency room or having worse health outcomes, however.
The the rates that we get paid by the health plans actually doesn't cover our costs and over the years we've had lots of issues with our health plans.
In terms of continuing to increase all the administrative burden that comes with operating the program and so changes in in how we get, how we need to claim.
Information that we need to actually send to the health plan, such as care plans or authorization for a particular services.
Graduation sort of assessment.
Renewal assessment.
There's all kinds of things that's required by the health.
Plans and as you know, we contract with three different health plans for identity care, medical and each health plan. Most of the time they will try to sort of conform to like one way of doing things. However, there are differences and a particular plan might ask us to.
Do something different, like use a different screening tool or all of the the renewals actually have to be faxed for each patient.
It's not, not wouldn't accept it in a bulk file transfer for instance. And you know we have 2700 patients that we're caring for. And if you think about our care managers having to fax every single one separately to, you know, three different health plans,

there's just.
Lots of issues that we that was incurring a lot of cost and and sort of resource time for our staff.
And and we felt like there was just way too much of that in comparison to the amount of hours.
That our staff can actually spend on taking care of the patient and coordinating the care for that.
So we've been losing money ever since we started the program and by actually terminating the contracts that we have and allow the health plans to actually serve these patients through their network of ECM providers, we will be saving some additional costs that we're incurring right now.
So that's ECM.
Any questions on that one?
Are you able to like elaborate in terms of like additional like how much you anticipate you'll save?
ECM.
Yeah, we've actually calculated that out and we'll save over for 14,000,000 annually by allowing the the patients to actually access the health plan network.
So we are going through right now.
We have already informed our three health plans and so we will be for the next three to six months will be having conversations with them.
We definitely want to transition these patients appropriately to their new ECM provider.
So we're having weekly, monthly, you know, meetings with them to make sure that there is nothing.
You know, patients don't sort of fall to the cracks and the health plans actually are working with us to do a warm handoff to the new ECM provider.
The other program is the non specialty mental health and.
How many of you might be aware, but a couple of years ago when we did a new sort of revised staffing plan for our primary care medical homes in our clinics and at the hospitals, we've actually added some additional staffing licensed clinical social workers, substance use counselors, medical.
Case workers CHWS in order to actually in house.
Non specialty mental health services for our.
In panel patients.

Taking care of mild to moderate mental health services, depression, anxiety and whatnot and substance use disorders.
And we try to figure out how we can get some revenue for the services that we're providing.
And so we did a contract with our health plan vendors.
So responsibility of our physical health, managed care health plans in order to.
Instead of.
Mental health DMH, who is responsible for the specialty mental health services.
For, you know, healthnet LA Care and Molina are responsible for providing the mild to moderate or non specialty mental health services.
They actually contract this out to vendors that provide services for the patients and we we contracted with those vendors so that we could actually take care of our patients within our primary care.
However, the weights are.
All right.
Not very good.
It's too low for us to actually maintain the services and then on top of that.
There's lots of issues sort of challenges with billing and coding and and it hasn't worked out for us and this is something that we could continue to have our patients access, but they will be accessing through the health plan vendor.
So the patients will continue to receive the services, it just would have done within the primary care setting.
And we would be saving about.
The $1,000,000.
And what we plan to do with the existing staff that are performing these services, they will continue to serve our patients within our clinics. And so we will have a a little bit additional resources so that our patients can get services for social needs.
You know they will.
Be taking care of patients who need to be housing or transportation or other things.
So.
Clinical social workers and the medical case worker.
Me still be serving our patients. It would not be providing the nonspecific mental health services which now the patients will go to the Oakland and how many staff is that?
So you don't have a number, but I can.

I can get that to you. Thank you.
Those terminations, as Nina said, have already been shared with the plans.
We're working on transition with the health plan sometime between October and December.
There are other services that we're also looking at.
We're not.
No longer going to provide services in the school based health centers, there's a couple of school based health centers that we've historically provided services to.
Our facilities are in conversations with those.
To work on an appropriate transition plan.
And so that they have time to make make changes. Is there a possibility of transitioning some of them to a potentially interested fuhc?
Is that is that up to?
We have other areas that we're still looking at that we haven't made decisions on what we're going to do.
I'll just give you some examples.
Dental fee for service. It's not a Medicaid benefit. It's a wholly separate.
Dental is separate under managed care in California than physical health separate than specialty mental health.
We're looking at the finances on our dental services. When I say dental, that's for ACN based outpatient routine.
Dental is not for the more complex trauma on the fast services that are provided within the hospitals.
If we can't get 340B in the ACM pharmacies, we will need to look at whether or not it makes sense to continue to maintain the ACN pharmacies that would be on a case by case basis, and we would.
Need to go through a process abelimpon process. If we choose to go in that direction, but no decision has been made there, we're really.
First, looking at whether or not 340 B is possible to be able to cover our cost there.
There are elective services that DHS provides services that are not required, that are continued considered elective under managed care in California.
Some plastic surgeries.
Fertility services and fertility services, and we're looking at whether or not those should be continued. Those would also require balance and hearings and we would look forward to those.

Hearings. If we make a decision to cease those services, breath mobile services are provided again only in a couple of geographies. It goes against our principles that if services are available, they're available broadly to patients. We lose money on those. There's no billing for them.
We're looking at those that also would require.
We're also going to review all of our trading programs. We lose money on our training programs.
We don't enough caps to cover the number of residents.
Gme caps to cover the number of residents that we train, largely because we've increased the number of training programs we have over the years and then also which is is normal. The volume of procedures or the Acme expectations of training programs changes over time and often Times Now.
We're sending some of our residents out at a cost to DHS.
To receive training in other locations because we don't have the right mix of procedural exposure that is required to fulfill ACG requirements.
So in addition to losing money on the number of residents we have, sometimes we're actually then paying double the salary and paid for them to go out to other hospitals.
So we'll be doing a review of those training programs as well.
No specific decisions have been made on any of those residency programs.
Is the department have?
A lot.
There's 1500 residents.
OK, number of programs.
I don't know.
We are also going to look at consolidating services geographically.
These may require hearings in the future, depending on what specifically we do know. Specifically, decisions have been made.
I'll give you just a couple of examples.
So it's often highly specialized or very costly. Services that are low volume, speed, subspecialty, thoracic surgery, nuclear medicine.
Should we provided in five sites?
Three sites.
Two sites like what's the right mix of sites and you see this happening like Kaiser is incredibly efficient with what they choose to provide their services and this is how

health systems often are able to reap economies of scale is by consolidate by cost, low volume services.
We have already started presenting regularly at the hospital Commission and will continue to do those presentations.
And Brown and Patty.
And there's an opportunity.
Had a comment and observation during these meetings.
I've done 8 live town halls across DHS and will continue to do.
Calls.
Building basis, we're trying to figure out the schedule, but I think I just have one or two more that are scheduled really just and it's been really helpful to have staff have an opportunity to both hear where we're at. But also me have a chance of hear what?
On people's minds and what questions people have, and I think they've been helpful venues for discussion, all of our local CEOs are doing their own engagement with commun.
Ities patients, staff, especially as it relates to.
Facility specific efficiencies and measures that are being taken as specially with this in the setting of the hiring freeze.
How how they're managing through some of those changes, we will obviously do engagement with labor and HR as needed for staff reassignments as all of these changes go forward. And then as I mentioned.
We're in.
We'll do balance in hearings and if not belinden, then the SB 1300 notifications as required by law based on the advice of counsel and Brandy Council.
That's advising us.
Whether or not those hearings are going to be.
Doctor Galley, do you have any?
I know we asked a lot of questions during the conversation, but I don't know if there's any outstanding.
Yeah, I know. Like you're facing a lot of like fiscal challenges and difficult decisions ahead. And as you know, LA general over the last year hired a lot of staff due to changes in our MSAA with USC.
How are you ensuring that you're also protecting all of these newer but also critical staff, right as?
You're making some of these decisions.

We're not doing layoffs, pardon. There's a lot of hard things about layoffs.
Layoffs are horrible across the board, but they are a very blend instrument that really does not suit the needs of anybody. In addition to being incredibly painful for the individual that is laid off and then often leads to cascading of multiple other individuals that have to get moved.
Around the system, the other hard part about layoffs is that it's on civil service rules.
Almost entirely.
There are exceptions.
And seniority based.
So a lot of the times the newer staff that we hired are the ones that are impacted by layoffs.
Now there's ways to layer on some specialty knowledge and these things, but it's just part of the the challenge.
So the fact that we're not doing layoffs right now is the biggest protection against those really hired staff.
And beyond that?
Their staff and part of the DHS team, just like anyone else, and our goal is to be able to work on efficiencies.
Bubbles and we need them to provide that excellent clinical service that they've I did and we are motivated to sufficient as possible to bring in the revenue so that we can stabilize the system in the face of a lot of these external threats, so that.
Beyond them, thanks for this sobering.
Wonder if if there is in some ways a timeline.
Arc of catastrophe.
And for lack of a better word cycle, you know what?
They used to have it in global warming.
That but but for what? So what is?
O'clock, what is our our clock for the various?
The various painful things we might be I don't see that we will.
To do and I know the LA Times and other publications have talked a lot, we are not.
Repeated this in every town hall that is, there is no planning happening to close facilities. There is no planning happening to do layoffs.
Like I think that message has gotten a little.
Exaggerated, I think.
What we're doing is working on efficiencies and the revenue capture thing and we're

we select service cuts where we can maintain service levels like with what Doctor Park shared.
So that in doing the hiring freeze, which is huge, so that we can extend out that fund balance fund balance. If you look at the current fiscal forecast.
We'll see in a week or so.
Our fund balance is good for 2:00-ish years.
Now there are so many assumptions at outlook that fiscal outlook assumptions about rules that have yet to be released by HHS rules, assumptions about waivers and renewal or non renewal assumptions about costs and hiring assumptions about.
How many different things? So what we do and the fiscal outlook is every six months for a good reason is that we have to then see where we're at.
See our efforts on overtime reduction.
I mentioned all of the facilities including HSA have expenditure caps, 3% expenditure.
They have reduction 3% reduction. So they all have to and which which the hiring freeze is not contributing to that's being taken out.
Work on those efficiencies and targets to hit so that we but then we have to see where we're at.
And continuously.
Revisit, can't underestimate with, like the Big bill, how much there is still to be worked out with the rules that have to be issued still by HHS. But you could expedite slowdown, which could expedite or slow down, make worse, make better.
If all in the detail of how those rules are written and then whether or not particularly for state directed payments, whether or not the particular structure of our directed payments, how they're impacted by how that rule is written.
So we're just in a wait and see right now.
And it would be, I think, especially since we do have a fund balance which hard to build up.
It's allowing us the time to wait, see where that goes.
So there's not really a timeline. I would say there's an every six month revisit the fiscal outlook, I would say in a year, we'll know a lot more than we do today about how we're doing, trying to balance the revenue and the cost.
I think though, even with all that said, we have to bring our cost down because the rate of increase in the cost of Labor and the other costs of just healthcare going up, they go up 345678 percent a year. Revenue streams don't go.
Up by that and the county doesn't give us money.

So we can't pull in additional revenue.
They'll have a structural deficit.
We'll run that.
And how are we monitoring?
Sure. We don't mean advertently as we're becoming more efficient, inadvertently reduce the level of services.
Have a lot of metrics that we follow following them, access metrics, quality metrics, clinical quality, medical access.
We also have patient experience, patient engagement, grievances, all that.
For reporting.
Errors and events.
We need to monitor all of that information and data and and pay attention to it.
It is a. It is a risk.
That's not what we're doing and we've really tried to message.
Which that's not what we're doing.
And I think there are efficiencies in the organization as efficiencies where you can just do the same work with less. But sometimes I think do better work.
Because you really have a chance to work on your workflows and really think about where you're putting people and really work on training people to know their job so that they can do it better.
I think that there's benefit there, but it's a risk and we'll have to continue to watch the the data.
Questions from deputies in the room.
Please ask the folks online if they have any questions.
Any deputies joining us online have any questions.
Do we have any public comment on this item?
The room.
Chris Fragon, American physicians in Dennis.
Unfortunately, we have to hear about these ideas at DHS has in these public meetings instead of being partner in, in letting us know. I mean, I granted, you know, the LMTC doesn't exist anymore.
Unfortunately.
But you know, we we have concerns about a lot of the talk about contracting out.
We have a concerns about reducing.
Consolidating staff etc.

Like that, you know, as you know, that's how a lot of the lawsuits happen.
Historically, so we do have concerns and hopefully the department will be open to at least talking to us about this before a public.
Thank you.
Do you have any other public comment in the room?
Have a public comment online. Go ahead.

DM **Dr. Esroruleh Mohammad** 1:32:36
Good morning.

R1 **Room 140** 1:32:36
President Mohammed.

DM **Dr. Esroruleh Mohammad** 1:32:39
Good morning. For the record, I'm doctor Israd, Ala Mohammed, clinical psychologist currently on ADA medical leave and also the author of the Bureau of Care to custody Cemetery pipeline and the BDC 3A pipeline prevention model, which was entered into the county record this past April under US.
Copyright law.
Today's agenda, especially the presentation by Doctor Raley and Dr. Park, shows clear convergence with the core categories of the Bureau. Care to custody cemetery pipeline.

R1 **Room 140** 1:33:10
Doctor Mohammed, as I said in my comment to you, if your comment is not specifically related to the DHS budget discussion, please hold your comment for public comment and we will call on you then. Thank you.
Do we have any other public comment on this item?
Thank you very much, Doctor Galley.
We will move on to our next discussion item, which is a joint presentation by.
HSHS and LASD prioritizing dignity in life in the Los Angeles County jails back on motion from 13,025 item 21.
And I will share the presentation.

TB **Tim Belavich** 1:34:01

Hi, good morning.
This is Tim Belovic and Dr. Henderson is also with me from Correctional health services.
So we just have a a brief PowerPoint, we'll walk through and then take questions. Or if you have questions as we go along, just just feel free to to ask as we go.
So we can go to to the next slide.
Yeah. One of the things that that we have been speaking about for for several years is the fact that our patient population is getting older and it has more chronic medical conditions. We've also seen since the COVID-19 pandemic, an increase in both the proportion of the pop.
That.
Has been diagnosed with the mental illness in the jail, but as well the absolute number of individuals.
Diagnosed with mental illness in the jail has also has also gone up over the last several years and we have a couple of graphs that that will show that.
We continue to have concerns obviously with the amounts of of fentanyl and substance use that occurs and is one of the the causes of deaths in the jail and continues to be.
And.
Doctor Henderson will talk a little bit more about that when we get to the third to the third topic.
So the three things we want to talk about with this motion are mental health treatment and suicides in the jail.
Medication assisted therapy.
And substance use and chronic medical conditions. So we can go to the next slide.
This is a slide year over year causes of death.
From deaths in the jail related to the medical examiner's findings and that this motion will go for us through July 1st of this year.
So obviously you only have a partial year reporting, but one of the things.
That we wanted to point out was, for example, last year we had a total of 8 overdose deaths.
That's this year.
By July 1st, we had a total of 7 overdose deaths. So so obviously we are on track.
Unfortunately to have a larger number of deaths overall, but also due to things such as suicide and overdose.

In this coming year, next slide.
Again, this is one of the things we shared prior in some of our meetings.
It just reflects that the the increasing jail population currently with mental illness.
Currently we estimate 46% or 45% of the jail population is participant in mental health services system. And so that would be anything from our acute inpatient unit to our fifth step down.
In our HOH and MOH housing to general population.
Incarcerated individuals who take psychiatric medications.
I think this slide is one of the most telling slides and this was also recently utilized in our annual suicide prevention.
Suicide Prevention meeting held just within the last couple of weeks and you can see that from 2016 to present we see a significant decrease in the overall patient population, but we see an absolute increase in the mental health population and this is one of the things that.
That we had forecasted and predicted.
Years ago and it is partially also related to the the need for enhanced and robust Community services when we release people so that we have either places where people can go in lieu of coming to the jail or where patients can be released to receive treatment so that.
Eventually returned to the jail.
And we can go to the next slide.
And the next three slides are a summary of what we've been doing and focusing on and what we what we feel we need to to increase our services and to increase our care.
So I think many of you are aware of the FIPS step downs.
Those have continued to expand.
We have a total of 21 fit step downs.
We have also increased our functional.
Latterman Petra.
Short beds where we can do forced medications.
And we were able to rearrange the licenses of the beds so that we didn't have to get additional licenses, but we were able to increase the functionality of the beds to 52 lbs beds in addition to some non LP's licensed beds that are in our in.
Unit. This has been a positive step for us and has virtually eliminated.
The wait list for those who need inpatient care for mental health issues in the jail.

We've also over the last couple of years developed the acute intervention module, which is a licensed LP's module housing 10 beds where we provide more urgent care and shorter term stays for individuals who may be stabilized there and can be returned to housing. And if they are.
Not able to be stabilized there. They can go into.
A.
Into a Fitbit.
So those are all positive developments in addressing the mental health issues and and preventing suicide in the jails.
One of the things that we continue to need.
Is.
Our goal has always been to catch people at the door and catch them early so that we can get them treated and medicated, and we've done a good job in building up resources in the inmate reception center so that they can see a psychiatric prescriber and get their.
Medications.
Prescribed and administered more quickly.
We have sought funding for additional services, both in the immediate inmate reception center, but also in the Supplemental Assessment area, which is where individuals go when they when they potentially have a crisis or when they're initially identified as needing a higher level of care, and that is staff.
By psychologists, social workers and psychiatrists.
We we think that that needs to be expanded.
Just because the expansion of the population to right size, what we're able to do, we feel that getting people earlier and early identification will go a long way to helping us to stabilize individuals so they don't eventually have a mental health crisis, while while with us in the.
Jail another.
Another thing that we seek funding for, and it is related to Department of Justice.
Agreement or decree is a medication refusal.
Team. So when individuals refuse medication or they go off medication, we're required to do a a follow up with education and to better understand why they're not wanting to take their psychiatric medications.
We're not.
We're not able to fully fully do this with the staffing we we have and so the

medication refusal team would be comprised of clinicians who would be able to fulfill this function.
And then lastly, something I mentioned earlier is an increase in Community health resources to both.
To divert people from the jail, but also as a prevention for them, returning to the jail if they're able to receive treatment in the Community.
We.

R1 **Room 140** 1:42:00
Doctor Bellavich is Tyler.
Can I ask a quick question on the what we're doing under the beds, the LP's bed expansion?

TB **Tim Belavich** 1:42:03
Sure, sure.

R1 **Room 140** 1:42:07
The 52 license beds we talked about the the acute intervention beds, those are separate, right?
Your even though they're both PS, OK.

TB **Tim Belavich** 1:42:13
Yep.

R1 **Room 140** 1:42:15
So it's 52 plus, so 62 beds then?

TB **Tim Belavich** 1:42:15
Yeah, yeah, yeah. We've got close to 80 beds between the licensed and non licensed.
So the the LP's licensed beds in the CTC are licensed hospital beds.
The acute intervention module is is licensed by the state and it it was one of the first ones. They they did about three years ago for us where they licensed.
A.
A housing unit in twin towers. And so that's why it is it it it, it does not look like a

hospital.
Settings. So we have we keep people for a much shorter length of stay there.

Room 140 1:42:52
Thank you.

Tim Belavich 1:42:52
But we, but we we do staff it to the LP's requirements in terms of our our healthcare staffing, those those ratios are maintained in that unit as well.
Does that answer it?

Room 140 1:43:09
Yeah. Now, thank you for clarifying.

Tim Belavich 1:43:09
OK.
Great. OK, great.
We can go on to the next slide please.
Overdose deaths again, and this is a program that really falls large gender Doctor Henderson. So I can talk about it a little bit and then he may want to follow up with some of the things that I may have missed.
As I think most of you are aware, we have a very strong and robust MAT program.
That the the board is funded.
For several years.
We also have a very strong naloxone program.
Where it is, it is in as many places within the jail as we can have it.
Our staff carry it.
The custody staff carry it.
It is taped to walls in dorms so that naloxone can be used to prevent an overdose.
And it's been very successful.
We also have introduced harm reduction vending machines.
Which are for visitors who come to to see incarcerated individuals, and they can also get naloxone and fentanyl test strips. We also have the vending machine available when individuals are released from our custody, they can take naloxone home with them as well. And we think all of these.

Strategies have been very successful.
We also partner with our community based referrals.
And this year alone have referred several several 100 individuals upon release.
What we continue to need is, unfortunately, more funding the, you know, the cost of medications go up and those those coming into the jail.
Needing needing substance use treatment services as also has also gone up gone up and when our funding stays the same from year to year.

R1 **Room 140** 1:45:03
Thank.

TB **Tim Belavich** 1:45:04
We're actually able to treat fewer people because of the increased costs and so so this has been a challenge we find ourselves with a with a wait list for individuals requesting MAT services when they come in. They are all offered MAT services and if they they accept those.
Services that they qualify and accept those services, they can be seen somewhat quickly, but if they.
Wait, and they request them.
Later on, there tends to be a lot.
There's a longer wait up weeks to up to months to get those individual services, and that's just because of of bandwidth of our resources and both staffing and and the medication.
And as well, you know the last bullet there really points to something. I think that LASD will talk about more is, you know, interventions to decrease the introduction of substances into the jail.
Are absolutely needed and I think that there's some strategies that they they will talk about there that we we fully support obviously any anything we can do to keep the substances from from coming into the jail will go a long way in preventing preventing overdose. Dr. Henderson did.
I hit everything.
Or is there anything you want to add?

SH **Sean Henderson** 1:46:23
Oh, you did? You did it.

Tim Belavich 1:46:23

Got it.

Cool. Thanks.

And then we can go to the last slide, please.

And the last slide, this is the natural causes category.

We continue to do compassionate release letters.

We continue to identify individuals who should not be in our care and you know from a healthcare standpoint are not, you know, are not well served by being in the jail. And we ask for their release.

Those go to the court.

And you know, we are able to have some success with that.

But unfortunately, I think many of the individuals, either they are refused based on charges from being released or they they pass away before the court is able to make a determination.

What we are are asking for in terms of treating those with our chronic illnesses and our the more medically, those who are suffering from the medical issues in our care is an automated.

Room 140 1:47:18

Yeah.

Tim Belavich 1:47:31

Health service request form.

So right now, in correctional health services, if an incarcerated individual has a health need, they have to fill out a paper that gets triaged by a nurse and then the nurse will either see the patient or set up an appointment for follow up care. We get over 10. Thousand of these papers every month so.

The inefficiency of trying to understand 10,000 individual health care request needs. Makes it a very inefficient system. There are automated systems that are often part based on kiosks, or if the if the jail has tablets that the incarcerated individuals.

Have that there are ways that they can submit health service requests in that way and one it will help us to see them more quickly and to triage more quickly.

But it it is something we we need.

We needed.

We asked for funding in the past. We've received some funding in the past for this system, but it has not been enough to to maintain the system.
So we have not been able to implement that the health service request system.
And then the the.
The second thing that we are seeking, which is nothing new.
Is the primary care model.
It was discussed a little bit earlier in one of the presentations as well. You know, having a primary care team who cares for the patient.
We we have submitted this in the past and we again you know feel that we we need this model.
In order to to treat the the severity of the medical conditions that are.
Patients are presenting with and then last is universal screening and treatment on the CDC recommends this this program for individuals in carceral settings, and it would help us with better identification, but also it would allow, you know, to identify those with hepatitis C and then we would be.
Able to treat them, which we are not able to treat.
As many individuals with hepatitis C as an example that we as we.
Excuse me in the past.
So I think that might be the last one. There might be one more slide.
Is that? Nope, that's it.
So Doctor Henderson, before we ask for questions, is there anything that you wanted to say about the medical or primary care model that I may have glossed over?

SH **Sean Henderson** 1:50:02
No, I think you've touched on all of it.
It's in the letter in greater detail.
I don't think we have to.
It's just a it's a question of the two things at the end there is trying to move to a proactive.
Method of providing care IE getting to the patients and following them proactively supposing to be being reactive and then the universal screening is to.
Try and get to some of the chronic disease states. Infectious disease states, sorry.
That we sometimes can't get to because we can't move fast enough and then people get released with the same infection that they came in with and take it back out into the community and in in that way we don't.

We don't serve the greater good when we can't treat them. For what?
What ails them? So? But you did a great job.
Thank you, doctor Belovich.

Tim Belavich 1:50:49
Thank you.
So I guess we can turn now for questions.

Room 140 1:50:56
Esther, thank you.
Thank you, Doctor Bailey.
And Henderson for being on and you know this. This motion opposite came from our office.
So I have several questions.
I'm just gonna go through them.
You start with identifying that we have a different patient population, specifically that our population is now older. And given that you know, we kind of know this, how has or whether it's maybe staffing or the way that we engage, how have we changed at all?
How we deliver medical care or how we engage the patients knowing that we have this profile of?

Sean Henderson 1:51:35
Well, I think we OK.

Tim Belavich 1:51:36
Yeah, I well go ahead.

Sean Henderson 1:51:37
I'm sorry.
Well, we do.
We have. It's the.
It's the primary care model that's the problem.
We know they're older.
They're not older like in they didn't all turn 60.

They're in.
They went from an average age in the mid 20s to an average age in the low in the high 30s.
So they're aging and we've got a higher number of people over 50, but we are trying to get to them as fast as we can.
We need to be able to put a system in place that allows us.
To treat them in a prospective fashion instead of a reactive fashion, we just don't have this staff or the positions yet to put that those models in place. We are developing population health models using AI and hopefully roll those out in the next couple months. Diabetes is going.
1st but.
I don't really have an answer for you, except that we we know it's there and we got to get to it.

TB **Tim Belavich** 1:52:30
Yeah.
Yeah, I think a good example, Esther, is. So we have a medical outpatient population namash that that everyone's aware of. We we set up a program to have individuals in the mosh receive rounding by a physician once every two weeks, and we were successful with that for.
A while.
But we were not able to continue the funding for it and so we had to curtail that. And so that's no longer occurring.
So so some are getting some are getting it but we are not doing as well at it as we were when we when we were using other funding for that.
So that that would be an example where with a primary care model that could ensure that that was going on.

R1 **Room 140** 1:53:15
With the primary care model Doctor Village, can you just kind of talk through, I guess, really in specifics in terms of what does it look like, you know, what's the current staffing and if we wanted to bring in the primary care model like what are we talking about?
How many more staff like the budget for it?
That kind of thing.

Tim Belavich 1:53:32
We yeah.
Doctor Hemsen will may have probably more details, but this is ABR 7 we've submitted.
I think it's been five years.
And it's it's been changed every year because it it, you know obviously the patient population changes, doctors do have.
Do you recall what the last primary care model BR7 was for?

Sean Henderson 1:53:51
Oh yeah, I don't know the exact numbers, but it's somewhere in the neighborhood of about $70 million.
None of the stuff that is CHS was really funded from. We had proposed this when Jackie Clark was here about having CMA's and clinics with physicians providing care and patients being moved proactively we.

Room 140 1:53:58
Thank you.

Sean Henderson 1:54:15
Fund our optometry services. Our Podiatry services, our physical therapy services, all that's funded.

Room 140 1:54:18
What's the weather?

Sean Henderson 1:54:22
By freezing psychiatry positions, for instance. So we never received funding for any of those proactive kind of WellCare items. The diabetics demand a foot exam we're paying.
You know we have registry Podiatry because we never received items.
The Johnson lawsuit demands that we do physical therapy.
We pay for that out of frozen items.
We were never funded for.

Actually taking care of a population long term and you and you all know as well as I do.
Our AB109 population numbers in the thousands and they're not going anywhere.
I have 3 to 4000 AB 109 folks, and they're going to be here for the duration of their sentence, often greater than a year, so.
That that chronic care is necessary. And I I don't.
I mean we do.
We we provide it, but we provide it by, you know, borrowing from Peter to pay Paul and it's it's, you know it's a juggling act.

TB **Tim Belavich** 1:55:22
Esther, I think a good way to think of it is really the terms of Doctor Henderson used earlier.
It's proactive versus reactive right now.
We are reactive.
Most people get care because they raise their hand.
They submit a health service request and say I have an issue.
The primary care model lets us identify you, assign you to a team that follows up with you and knows what's going on, and they are the ones who are then reaching out to do follow-ups and to, you know, to ensure that.

R1 **Room 140** 1:55:54
No, no. I mean I, you know, recall Jackie Clark talking about the primary care model way back way back in the day.

SH **Sean Henderson** 1:55:59
Yeah.

R1 **Room 140** 1:56:00
So you know, the mere fact that it's still something that that you two, you know, inside the jails and leadership, you know, recognize that this is still an issue.
It's obviously a concern that we have it figured out a way to implement it, you know.

TB **Tim Belavich** 1:56:13
The.

Yeah.
I was just gonna say, and there have been times in instances where we've been where we've had temporary funding where we've done things that are part of it, such as, you know, making sure everybody in the mosh does get the rounding as an example. But then, if that funding's not permanent, obviously that may not stay so.

R1 **Room 140** 1:56:37
I want to move over to the suicide piece.
I know part of your, you know, one, you know, really glad that fit stepped down, you know was mentioned.
You know it's it's a.
It's a program that we think is incredibly important, especially, you know, with the mhas who are there, right?
Providing kind of the peer support and and guidance.
With the medical refusal team, I know this is something that you indicated as a as a need so.
You know, if someone refuses medication, right?
You do the you know, education and whatever else have we also considered?
Medication refusal teams not just that medication, but also, you know when appointments are missed.
I know that this is something that you know you and I have talked about that sometimes folks don't, you know, go to their appointments and it could either be that they, you know, really don't want to go or it's other factors such as, you know, either alac staff.
Thing.
Break or we're not double checking to make sure that it's actually the person, the patient who's refusing and not some other kind of factor. And so is that something, you know, a possible solution or strategy that the team is also looking into, not just medication refusal, but also.
You know, appointment refusals.

TB **Tim Belavich** 1:57:54
Sure. So within if if we differentiate mental health from non mental health appointments, the mental health appointments generally are occurring on the units. So the clinicians are going to see the patient to see if they want to have their their

session and so they would refuse to the to the clinician if that if they decide not to hold the the the session for the non mental health. If someone refuses an. Appointment. There is a protocol to to have healthcare staff.
Receive that refusal.
And to educate the individual so they're aware of the the risks of them not attending their appointment. So there, there was a protocol in place for that for that as well for the non mental health appointments. But the mental health ones generally are the refusal are having with.
The clinician who's going to hold the session.

R1 **Room 140** 1:58:42
And given that you know there's there's at least some engagement with, you know, whether it's medical or mental health staff with the patient, are we getting a sense or are we collecting any sort of data as to why folks are refusing medication or why folks are refusing to?
Go to their appointment like for example. You know, if I am a patient and I have to have, you know, mental health services that's not in a confidential space and you know and and.
Things like that, right?
I mean those are maybe you know some of the reasons.
As to why I'm refusing, and I know that this is something that DOJ has pointed out, right?
You know, you all have pointed out that you know the jails don't have a lot of confidential treatment spaces, but are we, as you know, CHS?
Collecting some sort of data in terms of why these refusals are happening, and if so, how we're actually addressing that.
Is it just through, you know, education? And then they'll take their medication? Or is it just, you know, or they'll go to their appointments?

TB **Tim Belavich** 1:59:42
If we're focusing on mental health appointments, usually what will happen Esther is the patient may be offered an out of cell appointment to go and speak, but you're absolutely right.
There's no, there's no closed offices, there's no, you know, obviously confidential space to have that appointment. So that if the individual then refuses to do to do

that, our clinicians then.
Then generally will do a cell side which is also of limited value.

Room 140 2:00:12
Sorry.

Tim Belavich 2:00:12
You know, because you're then yelling through a door and it's probably much briefer.
And they're and they're checking in.
You're not getting as much, you know, probably as much value from that.
So so there could be any number of of. So usually what will happen like I said, is if they refuse the actual appointment, then the the clinicians will, you know, will will adjust how they provide the treatment as well.
But we we don't wanna provide any treatment through cell doors.

Room 140 2:00:40
Yeah, especially as someone is, you know, feeling suicidal.
It's not something that you want to yell at on the tier.

Tim Belavich 2:00:45
Absolutely.

Room 140 2:00:49
The.
So the IRC psych services you have mentioned that also as a need.
What is that expansion look like, right?
Because you know some of that stuff is being done in very limited way, but you want to expand what that looks.

Sean Henderson 2:01:07
No, it's it's not actually so.

Room 140 2:01:07
So what is that?

Tim Belavich 2:01:07
Yeah, yeah.

Sean Henderson 2:01:12
In the IT was taken out of hide. We created it.
About two or three years ago.
The idea was to push that first hello with psychiatry, specifically to get you on your meds.
There was a bridge medj program with the nurses. If you have extend, you know if you had existing meds, the nurse would would do it.
But there was often a time when there was either uncertainty or there was a need for.
A decision.
To be made or orders to be placed, and so we pushed psychiatry staff down to the IRC and to the SA into the SAT.
They didn't exist.
So once again, this is like Doctor Belovic mentioned, this is a program that we felt was important, kind of critical in intervening.
We never received funding for it, so we, you know, somebody goes on medical leave and all of a sudden our success rate, which was 88 percent, is now 72% or 65% because.
It's relying on, you know, individuals.
To do the right thing, we don't have a robust.
Hello, psychiatry service.

Room 140 2:02:15
Well.

Sean Henderson 2:02:15
And we really believe, I mean it takes the load off of everyone else as well. If you've got your meds and you're stable, then MCJ it doesn't have to jump on you quite as quickly and they can go up north to PDC, into the mosh housing up there.
A lot more smoothly and they don't have to be seen as quickly by Doctor Ochoa.
So there's just this.
It's this trickle down effect.

Tim Belavich 2:02:37
Yeah.

Sean Henderson 2:02:37
That, you know, putting the, putting the focus on the hello, especially with the mental health population and I'll be quiet now. Doctor Belovic knows them much better than I do. But I think that was the goal.

Tim Belavich 2:02:46
Yep.
Yeah, it's just the the quicker we can get them stabilized on their meds, the the better they'll do in in you know in the setting.
Why make somebody wait? And there were times where people would have to wait a week, two weeks, several weeks, to see a psychiatrist.
Our goal is to front load psychiatry in the IRC so that as many people as possible coming there can get their evaluation and start earlier.
So we just want to stop the wait.

Room 140 2:03:17
Thank you.
And then on the overdose, I'm gonna move over to the overdose piece.
You know, we have obviously really great.
Programs inside our inside our jails like Matt and Alexon and the harm reduction vending machine and and everything else.
I mean, despite this, right?
I mean, you've obviously listed, you know, LASD needs to do a better job of ensuring that drugs are not coming in through in through our jails. And you, you know, added that you need more additional mat and staff.
You know, I I think that the board had approved funding right for for more.
Services inside the jails.
So doctor relevant, I mean what you know?
What additional staffing you know cost, I mean I I get it right in order, if we're gonna fix this and address this and we need more funding and more staff and a lot of my questions are around what does that actually look like?

Tim Belavich 2:04:15
Yep.

Room 140 2:04:19
How much is that gonna cost?

Tim Belavich 2:04:22
I I think we're looking for about 6.5 million more.
In most of its medication, I want to say I want to say that one and a half million is staffing and the the rest is in medication cost.

Sean Henderson 2:04:28
Right, so you're right.
Yeah.

Tim Belavich 2:04:35
They're expensive medications, obviously, so I I want to say it's about 6.5 million.
Yeah, and. And also just to go back to the primary care model for some of what we're asking for for the primary care model are BR7 ask I think was about 10 million.
I think some of the other things can can run up the cost to 70, but some of the staffing was initially about 10 million for the primary care model.

Room 140 2:05:02
And then you also mentioned the wait list. How long is?
How many people around there?

Tim Belavich 2:05:09
Doctor Henderson, can I ask you?

Sean Henderson 2:05:09
Select.

Tim Belavich 2:05:11
I know you had the numbers for me last week, I don't think.

Sean Henderson 2:05:12

I know there are 200 as of today. There are 255 people with open referrals.
The longest waiter is 55 days.
There are two classifications of waiters.
This is subtle, but it's important if you've never talked to us before and you're experiencing symptoms of opiate use withdrawal, we will. That that weight is about 20 days and there are about, I don't know, there are 255 of them. If you've seen us before.
But you keep quitting the program for one reason or the other.
We will respect your request to be returned to the program, but you have to go to the back of the line behind the people that are just entering.
With acute symptoms, this is a maintenance medication. The way we give it, we put you on it and you stay on it through your the entire time of your incarceration.
We're trying to avoid that vulnerability that comes upon an unexpected release and you don't have any medication on board.
So right now there's 255 new people that have asked for.
To be put on the map program and the longest waiter is about 30 days, 20 days, 20 to 30 days.

Room 140 2:06:22

And then can I ask, when is staff engaging with the patient about about bat services? Is that done during intake? If they indicate that they have a history of substance?

Sean Henderson 2:06:32

So two different scenarios, if you're willing to speak to the nurse on arrival, it's in the M&M. What you know is it the M&M?
The MMHS if you say yes to opiate use, you are immediately routed to a provider who will offer you MAT and actually will administer your first dose of Suboxone right there in the IRC.
You'll start on the program right off the bat.
Those are.
That's the best route for those folks.
And prevents this await. If you choose instead to go quickly to your bed and do not want to be bothered by the M&M.

Then you then submit an HSR downstream and as soon as we get the referral, a clinical pharmacist will come visit you and speak to you about the program. And if you're willing to start it and you understand how it's going to go, then we put you on the.
List and as soon as your number comes up, we'll put you on the medication.

TB **Tim Belavich** 2:07:21
And Esther, that's after that second way is is one of those 10,000 sheets of paper we talked about.

R1 **Room 140** 2:07:21
So with the latter.

SH **Sean Henderson** 2:07:26
Right.

R1 **Room 140** 2:07:27
Yeah, Esther can't. Can't. Can't say sorry. We're coming up close to time. And these are great questions. But I would ask deputies real quick that we'd be respectful because we have to move this room to the next cluster. And if there's additional questions for Doctor Belavitra Henderson, we.
Could just reach out to them directly.
Then let me just move really quickly to the the health service request form, right?
I mean, this is a really annoying thing that whether it's health or whether it's other grievances that the department has not been able to like quite figure out. And I know that you know, you were talking about, you know, an iPad kiosk, a Sheriff's Department has also done.
The iPad kiosk.
So are you asking for a whole separate kind of system, or is there because my understanding is that the LASD kkios?
You know, would be more folks to put in their medical request and their, you know, non medical request in that same system and then it's routed to the respective areas you know.

TB **Tim Belavich** 2:08:28

It it could be on the same kiosk.
That's really not the I think the the overall driver of cost here.
It's about the software and the, you know, the the software that manages all of those requests. And so they're also not kiosks in every housing unit, which we would end up needing.
So it would be a big expansion.

R1 **Room 140** 2:08:50
So I mean.
I mean pill call is done 3 * A You know three times a day something you know in some of these in some of these modules have we, you know, thought of having nurses as administering, you know, their medication, you know, because they're they're probably engaging going self.
Front. You know, asking if they have any additional requests and maybe you know routing that way versus using. You know one of the 10,000 pieces of you know like triple click.

TB **Tim Belavich** 2:09:17
Yeah.
So pill call is so, so involved and and our nurses are administering, I think about 120 individuals per pill call which is which is huge to do anything but that in pill call would exponentially.
Take more time and it would take more staff because pill call has to happen in a 2 hour window.
So in order to get pill call done, we would just need to to to add a lot more staff.
To do that.

R1 **Room 140** 2:09:52
I will edit there and I'll follow up with you, Doctor Belvich on the service request form.
Thank you.
Thank you, Esther. If else has any really important questions, I I guess it could wait, but just wanted to share the 2nd District team. Did tour men central jail last week or two weeks ago, we went to two dorms.

TB **Tim Belavich** 2:09:57
Sure.

R1 **Room 140** 2:10:10
So have questions and comments related to that that I could follow up with.
OK.
Thank you so much.
Presenters and the deputies for the questions.
We have any public comment on this item.
See any hands in the room?
See any?
We do have one virtual hand.
We had.
Delaney Stewart.

TD **Tia Delaney-Stewart** 2:10:41
Hi everyone.

R1 **Room 140** 2:10:41
Right.

TD **Tia Delaney-Stewart** 2:10:42
This is just a statement after listening to the presentation, which I thought was great, and I know there are a lot of barriers to care and a lot of the systems that we have.

R1 **Room 140** 2:10:49
Yeah.

TD **Tia Delaney-Stewart** 2:10:51
But my statement really is about intentionality.

R1 **Room 140** 2:10:53
Mm.

Tia Delaney-Stewart 2:10:55

And you know, it's defined as the fact of being deliberate and doing things on purpose.
And I don't know the name of the woman who was asking the majority of the questions just now.
But the questions that she asked.
Really about intentionality. If you look at it at the end of the day, what's taking so long?
How come this hasn't been implemented?
Have we thought about this?
And I'm a nurse.
I've been a nurse a very long time and just from the lens of a nurse in community, I just heard a lot of reasons and ideas, but not a lot of intentionality. And so I guess I'm still stuck at why we are really grasping how to pilot and.
Implement.
And evaluate a primary care, a model system, something that tracks our metrics.
Something that we can make adjustments to doesn't have to be perfect.
And you know any conversations about reaching out to other jurisdictions to talk about best practices so that we can improve and adjust these systems of care for those who are incarcerated and provide them some quality care and put in systems that are sustainable and successful. So just think.
About intentionality. As we continue to move forward, because whether you're incarcerated or not from our lens, I think everyone deserves to have quality.
And ethical care so.

Room 140 2:12:14

Thank you very much.
Any other public comment on this item?
Right we will.
We are going to push the next present discussion item for DMH to a further date to be determined.
And so we don't have that presentation coming up.
We don't have anything else for calendar besides public comment, general public comment.

This this is now the time for general public comment on today's agenda.
Reminder that the general public comment will be limited to two minutes if we have multiple, we may have to reduce it to one minute.
Any general public comment on today's agenda?
Right. We don't see any hands in the room.
I don't see any virtual hands either.
We'll now move to adjourn the meeting.
Thank you everyone for participating in the rest of your.

Jack Arutyunyan stopped transcription