Los Angeles County Health Agency Strategic Priorities
Draft – September 4, 2015

Access to Clinical Services

Strategic Priority: Streamline access and enhance customer experience for those who need services from more than one Department, including by promoting information-sharing, registration, care management, and referral processes, training staff on cross-discipline practice, and increasing co-location of services.

Goal 1: Successfully implement DHS' Electronic Health Record (EHR) "ORCHID" at all DPH sites that deliver health care services suitable for ORCHID implementation.

Goal 2: Determine best short- and long-term course of action with respect to sharing clinical information on clients shared between DMH and DHS/DPH, including consideration of a Cerner Hub approach vs. potential shift to a single EHR with appropriate interfaces to contracted partners as needed to ensure efficient billing mechanisms.

Goal 3: Implement staff workflow processes and technical infrastructure necessary to ensure clients can access services in another Department without having to duplicate registration, financial screening, and eligibility/determination processes; where prudent, align Departments' financial policies governing eligibility and payment for services from self-pay individuals.

Goal 4: Develop joint care management plans for individuals served by more than one Department.

Goal 5: Implement Agency-wide referral processes and technical infrastructure and train staff on protocols through which clients can be identified and referred directly to services in or funded by another Department.

Goal 6: Expand number of directly-operated or contracted clinical sites at which individuals can receive co-located physical, mental, substance use, and public health services; train staff to effectively work within co-located sites.

Outcome metrics:

- Number of DPH sites that have completed ORCHID implementation
- Board-approval of short- and long-term method for sharing clinical information between DMH and DHS/DPH
- Adoption of common registration, financial screening and eligibility processes
- Increased number of staff cross-trained to properly identify and manage and/or refer individuals needing care within another domain
- Increased number of referrals between Departments that are appropriately dispositioned using a streamlined referral process; wait time to access services/programs post-referral
- Increased number of individuals with care plans incorporating more than one system
- Increased number of staff trained on effective care management practices within co-located clinical sites
- Increased number of individuals provided with multi-departmental services (directly operated or as contracted via the County) within co-located sites

Major organizational next steps:

- Map scheduling, registration, financial clearance/screening, and referral processes in each Department; convene a work group from the three Departments to determine how best to harmonize differences.

- Convene Health Agency IT Leadership Council comprised of technical and business leadership from each Department to ensure IT-related strategy and decisions made within each Department balance Agency-wide and Department-specific interests.
- Hire external consultant to perform a detailed, objective assessment of the best way to share information across the three Departments, understanding the needs of community partners and the complexity of financial/billing functions and responsibilities, including consideration of a health information exchange, interfacing existing applications, and implementation of an enterprise, single EHR for clinical functions.
- Convene a Health IT Task Force, including representation from DHS, DMH, DPH, Probation, Sheriff, CIO, and CEO, to assist consultants in the above evaluation, providing open access to their specific Departments resources, IT infrastructure, to ensure outcome of consultant's report outlines clear recommendations, to be delivered to the Board of Supervisors (BOS), regarding best short-and long-term strategy with respect to sharing/accessing clinical information; other County Departments (e.g., DCFS) should be consulted and involved as needed.
- Assess availability of space at all directly-operated clinical sites, including potential for space swaps.

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Homelessness

Strategic Priority: Develop a consistent method for identifying and engaging homeless clients, and those at risk for homelessness, across the three Departments, linking them with integrated health services, housing them, and providing ongoing community and other supports required for recovery.

Goal 1: Reconfigure housing and homeless services within the Agency and Departments to facilitate improved outcomes for homeless clients, including but not limited to the reduction/elimination of eligibility barriers and greater sharing of Departmental resources, to ensure that resources are available to all homeless clients needing assistance regardless of where they present.

Goal 2: Develop an accurate way to identify homeless clients, and those at risk of homelessness, currently served across the three Departments (e.g., development of a real-time unduplicated database; flag within shared client record) for the purpose of identifying priority clients who are determined to be likely to benefit from services from multiple Departments to regain health and residential stability.

Goal 3: Develop and implement shared standards and practices for ensuring full range of housing, health, and prevention services are able to be delivered to clients based on client-specific needs.

Goal 4: Improve and expand upon multidisciplinary street engagement teams capable of effectively engaging homeless people living outdoors throughout the County with the express goal of securing interim and permanent housing.

Goal 5: Develop and open a range of "bridge" residential services that provide low-barrier, welcoming programs (e.g., sobering centers; day centers with showers, meals, and health services; recuperative care; detox centers; stabilization housing; congregate supervised living; and other effective bridges to permanent housing) for homeless people living on the streets with complex health conditions in high density neighborhoods such as Skid Row, Hollywood, and Venice.

Goal 6: Maintain a real-time inventory of available residential slots, funded and usable by all three Departments, that facilitates immediate placement of homeless clients into available interim and permanent residential options appropriately matched to various need indicators (e.g., accessibility, level of on-site services, neighborhood, age).

Goal 7: Obtain Medi-Cal coverage, when possible, and successfully link individuals, where clinically appropriate, to comprehensive, integrated health services that are delivered in a way that is tailored for the unique needs of homeless individuals.

Goal 8: Develop screening questions for those conditions that lead to homelessness that could be incorporated in all three Departments along with methods and plans to link to needed support and services as part of delivery of health care, mental health and public health services.

Outcome metrics:

- Increased number of families at risk for homelessness that are provided support services to prevent homelessness
- Decreased number of emergency department visits and ambulance transports of homeless personnel for non-emergency services
- Decreased rate of incarceration for non-violent offences related to being homeless

- Increased number of homeless individuals newly placed in permanent supportive housing (PSH), including breakdown by geography (e.g., Skid Row)
- Increased percent of individuals housed by the Departments who remain housed two years after initial placement
- Increased number of individuals incarcerated in LA County jails who are housed upon community re-entry (among those who otherwise would have been homeless upon release)
- Increased number of homeless clients able to be placed in interim or permanent housing on the same day they have been identified as willing to move into housing and/or receive services
- Among homeless individuals assigned to a DHS or community partner medical home, increased number with at least one primary care visit in the past 12 months
- Increased number of homeless individuals who are linked to physical, mental, and/or substance use services
- Increased number of homeless individuals assisted via street outreach efforts in areas in the county experiencing high concentrations of people living outdoors

Major organizational next steps:

- Analyze housing/homeless specific services in each Department to determine what level of further integration/consolidation would be useful toward achieving improved outcomes for homeless people, how these efforts interact with non-health related efforts, and any areas of additional funding needed to expand services.
- Explore with IT and other appropriate parties the most effective way to develop and maintain a real-time database/log of shared clients who are homeless.
- In partnership with other County Departments and non-County community partners, develop a priority list of types of residential programs that are most in need and develop a specific timeline for bringing them online.
- Work closely with CEO Homeless initiative coordinator to ensure other County departments (e.g., Sheriff, Probation, CDC, Fire, DPSS, DCFS) are working together to build a County-wide service system for homeless individuals.
- Work with DPSS and Community and Senior Services to create the correct program linkages and supports.

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Psychiatric Emergency Services

Strategic Priority: Reduce overcrowding of County Psychiatric Emergency Services (PES) and private hospital Emergency Departments (EDs) by those in psychiatric crisis.

Goal 1: Increase alternatives to PESs and private EDs by establishing additional psychiatric urgent care centers and crisis residential services, augmenting the spectrum of lower levels of care to include psychiatric recuperative care and additional crisis stabilization capacity, expanding access to structured outpatient services accessible to those at/before a time of crisis, and fully implementing the Alcohol and Drug Medicaid benefit.

Goal 2: Improve the utilization of inpatient services by ensuring that individuals who can be managed in a less restrictive setting are dispositioned appropriately and that those who are admitted to inpatient units are discharged as soon as they are clinically appropriate to leave.

Goal 3: Maximize federal funds available for the purchase of services or placements to support care to individuals in or recently in crisis.

Goal 4: Assess and redesign existing processes to improve audits of IMD utilization in order to reduce length of stay and thus reduce wait times for those in public and private inpatient psychiatric units.

Goal 5: Ensure law enforcement and community based mental health assessment teams are adequately trained on the wide array of options available for individuals in psychiatric crisis.

Goal 6: Increase the stock of private psychiatric inpatient beds by increasing rates and developing mechanisms to take advantage of changes in the IMD exclusion.

Outcome metrics:

- Decreased average morning census of those on involuntary holds in County PESs and private EDs
- Decreased administrative days as a percent of inpatient psychiatric days in public and private hospitals
- Increased number of visits to urgent care centers by individuals on involuntary holds and ultimate disposition type (e.g., home, PES/ED, inpatient admission, community-based placement, etc.)
- Decreased average length of stay in public and private EDs by those on involuntary psychiatric holds
- Increased number of new urgent care centers opened
- Increased number (and percent of total) of patients in psychiatric crisis in public and private EDs who are discharged to non-locked settings with medication and outpatient follow-up plans
- Increased number of alcohol and drug residential and detox services paid for by Medicaid
- Increased number of crisis residential beds available

Major organizational next steps:

- Assess current and anticipated future financial allocations from each Department toward individuals in psychiatric crisis, especially those on involuntary holds, so that resources can be maximally aligned toward services and placements most capable of responding to the needs of the target population.
- Align DHS, DMH, and DPH clinical, programmatic, and housing services to create novel placements for individuals who could be diverted from EDs or inpatient units.
- Open a 24/7 LPS-designated psychiatric urgent care at Olive View-UCLA Medical Center, on the Martin Luther King, Jr. campus, in Antelope Valley, and in the Long Beach area.
- Assess utilization of inpatient psychiatric units and IMDs to identify opportunities to improve flow.

Cultural Competency

Strategic Priority: Ensure access to culturally competent and linguistic appropriate care.

Goal 1: Implement mechanism to systematically collect and analyze Race, Ethnicity and Language (REAL) data and data for other culturally relevant factors (e.g., LGBTQ, physical disability) among consumers; use data to identify and report relevant health-related disparities and inform ongoing program design.

Goal 2: Systematically survey and publicly report client satisfaction with Departmental activities and services from a cultural perspective.

Goal 3: Design, establish, and implement core competencies for new employees and regularly train existing County workforce on providing culturally relevant care and customer service, including attention to the needs of specific race/ethnic groups, the disabled, veterans, LGBTQ, immigrant/refugees, the elderly, and other vulnerable groups within local communities.

Goal 4: Ensure clinical sites can provide real-time professional interpreter/translation services when required or requested by the client.

Goal 5: Ensure clinical sites have signage and written client materials available in the preferred primary languages of its local communities.

Goal 6: Share and coordinate existing culturally appropriate efforts across Departments that have been proven effective in reducing disparities, enhancing care coordination, increasing community awareness of health issues and have demonstrated positive health and behavioral health outcomes.

Outcome metrics:

- Disparities according to REAL and other relevant cohorts
- Results from clients/consumers/patients surveys
- Evaluation of impact and effectiveness of training programs related to cultural competency; number of individuals who have completed training
- Percent of total clinical sites that can provide real-time access to translation/interpreter services
- Percent of sites that have completed self-assessments and enhancements of signage and written materials that met the cultural and linguistic needs of individuals served

Major organizational next steps:

- Convene and/or evaluate existing Department-, program-, and/or facility-level cultural competency committees, comprised of consumers, their families, and front-line staff, to provide input on how to continually enhance cultural competency of existing programs.
- Perform cultural competency self-assessment using an externally validated tool appropriate to the size and diversity of the County.
- Create mechanism for formally survey clients/consumers/patients on cultural competency of services received/programmatic offerings.
- Engage organized labor on ways to formally enhance delivery of culturally competent care/services.
- Conduct inventory of currently available translation/interpreter resources/infrastructure, signage, and written client materials within each Departmental clinical site.
- Assess the ability of specific programs/facilities to care for special populations (e.g., use of peers/those with lived experience, family involvement) and take advantage of the strengths of each Department.

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Diversion

Strategic Priority: Successfully divert corrections-involved persons with mental illness and addiction who may otherwise have spent time in County jail or State prison by placing them into structured, comprehensive, health programming and permanent housing, as tailored to the unique individual's situation and needs.

Goal 1: Establish the Office of Diversion with the capability to coordinate diversion efforts, create placements appropriate for the wide array of individuals who might be diverted and develop programs that support the recovery and improved health of these diverted individuals. The office will provide contracting, technical and evaluation support, and expansion of current evidence-based and successful diversion programs run by DHS, DMH, and DPH necessary for a successful County-wide intervention.

Goal 2: Establish priorities for the creation of comprehensive health (i.e., physical health, mental health, public health, and substance use) programming necessary to support clients and inform the Office of Diversion's work.

Goal 3: Work with Court 95 and the LA County District Attorney's Office to establish sufficient community placements to meet the relevant demand among Misdemeanants Incompetent to Stand Trial (MIST) deemed eligible by law enforcement for diversion.

Goal 4: Build the necessary administrative infrastructure necessary to rapidly place potential diversion candidates into housing, (e.g., possible creation of a Diversion Connection Access line with extended hour capabilities).

Goal 5: Develop diversion education and awareness campaign to heighten awareness of diversion opportunities and programs among County courts, prosecuting and defense attorneys, law enforcement and custody staff as well as mental health, substance use, and other relevant clinical staff.

Outcome metrics:

- Increased number of individuals diverted from jail, by intercept and offender category (e.g., MIST)
- Percent of diverted individuals who successfully complete diversion plan
- Percent of diverted individuals who have not re-offended within one year following completion of their diversion plan
- Average time spent in custody after diversion plan had been approved
- Increased number of diversion programs and housing units available for diversion clients
- Increased number of cases where diversion programs are the recommendation of the Courts

Major organizational next steps:

- Establish the organizational structure and key leadership positions within the Office of Diversion.
- Hire an Office Director and team with a sufficient leadership structure to create interface with the courts and custody as well as develop and identify providers for the required housing and programming.
- Build multi-department Diversion stakeholder group to guide Office priorities.
- Continue to build relationship and work with District Attorney's ongoing Diversion effort.
- Determine how DMH and Substance Abuse Prevention and Control (SAPC) programs and resources interact with and support a broad County diversion program.
- Align program metrics across each Department's current diversion programs.

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Substance Use Disorders

Strategic priority: Integration of adult and youth substance use disorder (SUD) treatment services into LA County's mental and physical health care delivery system.

Goal 1: Transition homeless and criminal justice-involved individuals receiving SUD residential treatment into appropriate Department housing programs as part of the SUD continuum of care.

Goal 2: Develop knowledge and skills of clinical staff in Departments' directly-operated and contracted primary and specialty care facilities on the American Society of Addiction Medicine's (ASAM) levels of care based on medical necessity, including the interaction of substance use disorders with physical health and mental health conditions, and how to appropriately screen and link individuals with SUDs into appropriate levels of care.

Goal 3: Advocacy with the State Legislature, Department of Health Care Services (DHCS) to have all drug treatment medications approved by the federal Food and Drug Administration (FDA) placed on the Drug Medi-Cal (DMC) formulary, and expand the use of these medications by both mental and physical health practitioners within LA County's health care delivery system.

Goal 4: Increase number of Departments' directly-operated and contracted providers that are DMC-certified.

Goal 5: Implement SUD Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol in Departments' directly-operated and contracted clinics and programs.

Outcome metrics:

- Increased number of eligible homeless and criminal justice-involved individuals referred to DHS and DMH housing programs upon completion of their SUD treatment
- Increased number of SUD homeless and criminal justice-involved patients with co-occurring SUD mental health and/or physical health conditions housed in DHS and DMH programs
- Increased number of clinical personnel in directly-operated and contracted County clinics trained to accurately identify substance use disorders, provide medical assisted therapy (MAT), and make referrals for SUD treatment based on medical necessity as determined by ASAM criteria
- Addition, by California DHCS, of all FDA-approved addiction treatment medications to the DMC formulary without a TAR requirement
- Increased number of Departments' directly-operated and contracted facilities that are DMC certified
- Increased number of Departments' directly-operated and contracted clinical personnel trained in SBIRT
- Increased percentage of Departments' clients in directly-operated and contracted clinics receiving an annual screening for substance use in the past year

Major organizational next steps:

- Prepare and submit the DMC Organized Delivery System (ODS) implementation plan required under the 1115 Waiver's DMC ODS Special Terms and Conditions to obtain BOS approval to opt into the Waiver.
- Upon BOS approval, submit the DMC ODS implementation plan to DHCS and Centers Medicaid and Medicare (CMS) for approval as required under the STCs.
- Establish workgroups comprised of DHS, DMH, DPH, other County departments, and key external stakeholders to execute the DMC ODS Waiver implementation plan once approved by DCHS and CMS.
- Provide technical assistance, training and infrastructure investments for the three Departments and their provider networks to build administrative, clinical and workforce capabilities and capacity to meet the increased demand for SUD services under the DMC ODS Waiver.

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Children in Foster Care and Transitional Age Youth

Strategic Priority: Improve the County's ability to link children in foster care and Transitional Age Youth (TAY) to comprehensive health services (i.e., physical health, mental health, public health, and SUD services).

Goal 1: Develop comprehensive individualized treatment plans, including placements able to provide integrated mental health, substance use, and physical health services, for children in foster care that are "difficult-to-place" due to health-related issues.

Goal 2: Develop and implement new approach to community outreach and engagement to high-risk TAY (e.g., those with HIV/STDs, LGBTQ).

Goal 3: Continue to develop and evolve a comprehensive health services package (i.e., physical health, mental health, substance use, public health) available to Commercially Sexually Exploited Children (CSEC) in LA County.

Goal 4: Develop a package of comprehensive aftercare services, including mechanisms for appropriate referral and linkage, for youth in Probation Camps and Juvenile Halls and TAYs in the adult corrections system.

Goal 5: Create or adopt an externally available mobile tracking and communication tool usable by TAY to help gain access to educational and service information.

Outcome metrics:

- Increased percent of "difficult-to-place" youth in DCFS system that are successfully linked with comprehensive treatment services and receive timely, appropriate residential placement in a home-like setting where feasible
- Decreased number of children/youth with physical and/or mental health challenges who experience placement disruptions
- Increased number of high-risk TAY newly linked to and receiving mental health and/or SUD services
- Increased number of CSEC youth using services from an agency Department
- Increased number of youth and TAY leaving the correctional system with an aftercare plan addressing mental health, substance use and/or physical health needs
- Increased number of youth/TAY with full implementation of the aftercare plan
- Increased number of TAY who use such an electronic tool to "stay in touch" with service providers, DCFS social workers, Probation officers or other parts of their community

Major organizational next steps:

- Establish a working partnership between the Agency and the County's Office of Child Protection
- Evaluate current models of integrated treatment teams in place (e.g., Child and Family Teams implemented by DCFS and DMH) and determine their applicability and potential scalability for improving management of target population(s).
- In partnership with DCFS, clearly define "difficult to place" youth appropriate for Goal 1 interventions.
- Convene workgroup, involving entities outside the Agency as needed, to develop a mechanism (e.g., utilize a common data collection system) to ensure that all Department programs that may interact with CSEC have a way to identify individuals and employ consistent methods to capture relevant information.
- Convene an agency-level CSEC workgroup to enhance Department collaboration on health-related issues; participate in County-wide CSEC workgroups as appropriate.
- Identify funding to create and/or implement the mobile tracking and communication tool.

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Chronic Disease and Injury Prevention

Strategic Priority: To align and integrate population health with personal health strategies by creating healthy community environments and strengthening linkages between community resources and clinical services.

Goal 1: Expand access to chronic disease prevention programs (e.g., National Diabetes Prevention Program (NDPP)) for priority populations.

Goal 2: Scale and spread the use of team-based care approaches in Los Angeles, such as community health worker (CHW) and pharmacist-led medication therapy management (MTM) programs, for persons with chronic health conditions.

Goal 3: Expand access to evidence-based tobacco cessation treatment for priority populations.

Goal 4: Reduce youth violence through targeted community-level strategies, building on the Parks After Dark (PAD) model to incorporate gang intervention and safe passages; integrate DHS, DMH and DPH services and outreach into community-based youth violence efforts.

Goal 5: Reduce youth violence through broad social determinants of health strategies, including promotion of a school climate that ensures adequate access to high-quality and coordinated social, medical, and behavioral health services for students and families (e.g., a coordinated school health model).

Goal 6: Encourage high-risk populations (e.g., those prescribed atypical anti-psychotics) to engage in exercise and movement.

Outcome metrics:

- Increased number of at-risk persons enrolled in the chronic disease prevention programs (e.g., NDPP) in LA County
- Increased number of organizations/providers offering formal chronic disease prevention programs (e.g., NDPP) in LA County
- Increased number of at-risk persons with controlled blood pressure and/or chronic conditions (e.g., heart failure, diabetes) in LA County
- Increased number of and level of client satisfaction with CHW and MTM programs in LA County
- Increased number of healthcare providers in LA County trained in the provision of evidence-based tobacco treatment interventions
- Increased number of LA County residents screened by health care providers for tobacco use
- Increased number of tobacco users referred to evidence-based cessation treatment; number who contact 1-800-NO-BUTTS
- Increased number of schools with wellness policies that adopt and integrate elements of a coordinated school health model
- Increased number of PAD parks in communities with high rates of violence that include co-located social, physical, behavioral, and public health services
- Increased number of serious and violent crimes and gang-related crimes in PAD park communities relatives to comparison sites
- Increased number of trauma-related ED visits and hospitalizations

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Major organizational next steps:

- Develop assessment tools/methods for collecting needed baseline and ongoing performance/progress data for above initiatives.
- Perform baseline inventory and assessment of existing CDC-recognized NDPP providers in Los Angeles; develop and implement outreach and provider engagement strategy to promote and support broader provider participation.
- Perform baseline inventory and assessment of select existing team-based care models (e.g., community pharmacies screening programs; MTM programs); develop and provide technical assistance to agencies and providers interested in expanding participation.
- Establish standards of care for the delivery of evidence-based tobacco interventions; revise or update standards to address the assessment and treatment of tobacco dependence.
- Develop necessary education objectives, curricula, evaluation tools, and training schedules to enhance tobacco cessation efforts; train providers to deliver evidence-based tobacco cessation treatment.
- Analyze trauma-related data to better tailor and target prevention interventions.
- Conduct baseline inventory and assessment of existing violence prevention, social service, health and behavioral health resources in PAD park communities with a goal to develop a cross-referral system; convene key partners to develop and implement targeted strategies to facilitate referrals and coordination between organizations, provide technical assistance, and evaluate impact of initiatives.
- Analyze available data and assess impact of current programs targeted at social determinants of youth violence (e.g., diversion programs, Teen Court programs) to understand gaps and priority opportunities for future intervention.

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