SECTION I. HOMELESSNESS

INTRODUCTION:

According to the 2016 Homeless Count conducted by the Los Angeles Homeless Services Authority (LAHSA), Los Angeles County is home to approximately 48,854 homeless individuals on any given night. This same report documents that approximately 28,464 of those homeless reside in the City of Los Angeles and about 74% of those individuals are unsheltered.

Homelessness can be a cause and result of serious health issues, often detracting from regular medical attention, access to treatment, and recuperation, thereby lowering positive health outcomes compared to housed populations. According to the Centers for Disease Control, Homeless populations face many barriers to accessing healthcare systems. These factors contribute to an increase in the spread of infections, prevents homeless populations from accessing healthcare professionals and obtaining and/or storing necessary medication,.

The goal of the Los Angeles Health Commission is to improve health outcomes for homeless individuals through City Council action on the following recommendations designed to reduce barriers to health access and housing.

HOUSING FOR HEALTH:

RECOMMENDATIONS:

- The City of Los Angeles should explore opportunities to expand the County of Los Angeles Housing for Health program by providing financial and community support.
- The City of Los Angeles should explore the implementation of a Flexible Subsidized Housing Pool to increase access to permanent affordable housing for chronic homeless populations with underlying health conditions.

BACKGROUND:

The Los Angeles County Housing for Health Program (HFH) is a division of the Department of Health Services which housing and supportive services for homeless clients with physical and/or behavioral health conditions, high utilizers of County services and other vulnerable populations.

HFH is a C3 program (County, City and Community) with a goal to create 10,000 units of permanent supportive housing and reduce inappropriate use of expensive healthcare resources.

While HFH is modeled as a Housing First Program, which prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary supportive services as needed, it also provides innovative approaches to housing that make it one of the most promising housing programs in Los Angeles. Among these approaches includes housing funded through the Flexible Subsidized Housing Pool (FSHP) which circumvents the Housing Authority to provide a funding pool from the County General Fund, Foundations and other partners designed to break down barriers that homeless populations face going through traditional voucher based programs. Included under FSHP is the Master Lease housing program, managed by Brilliant Corners, which creates a landlord/tenant contract

between property owners and Brilliant Corners/ L.A. County, alleviating the burden many homeless individuals face in traditional voucher programs where they must find and qualify for housing from a private landlord.

Eligibility for the Housing for Health program requires that an individual meet the definition of chronic homelessness (homeless for one year or 4 -5 times within a four year period) and have visited a County hospital or clinic twice in one year. There is a streamlined process to determine eligibility which includes a 3-5 page application (1/4 the size of typical HUD applications).

To date, 1,760 clients have been housed through the HFH program with a 97% retention rate for those housed since 2012.

Along with positive health outcomes for homeless clients, HFH also realizes substantial cost savings by utilizing a Housing First approach. A study conducted by Michael R. Cousineau, associate professor of preventive medicine at the Keck School of Medicine of USC, found that the total cost of public services spent on four individuals during two years living on the street in Los Angeles was $187,288, a cost which dropped by more than $20,000 per person during two subsequent years spent in stable, permanent housing. Other studies have shown Housing First programs can save $20,000 to $30,000 per homeless client housed in Los Angeles by reducing costs from EMT runs, hospital stays, jail time and other costly programs. Along these lines, the State of Utah adopted a Housing First approach 10 years ago and recently reached a functional zero in chronic homelessness, saving $8,000 - $10,000 per homeless person housed.

Because of the overwhelming number of studies across the country showing cost savings connected to Housing First Programs, the California Governor signed into law SB 1380, which officially recognizes the State of California as a Housing First state, creating a Homeless Housing Trust Fund and Homeless Coordinating Committee to assist local governments in implementing Housing First programs starting in January 2017.

BATHROOMS

RECOMMENDATIONS:

- Adopt a policy to Increase the number of bathrooms available to homeless residents to 1 per 25 people homeless in the City of Los Angeles

BACKGROUND:

The World Health Organization recommends a minimum of 1 toilet per 25 users to maintain a sanitary environment.

Skid Row represents the largest homeless population in Los Angeles, with 8,000 – 11,000 people living homeless in the Downtown area. This area has often been subject to public health concerns attributed to unsanitary living conditions. In 2012, the Public Health Department found the City of Los Angeles in violation of county health codes after an inspection in which 90 piles of human waste were found in a 10-block radius encompassing skid row. The conditions there have been linked to outbreaks of tuberculosis, meningitis and staph infections, all of which can be fatal

By the World Health Organization's recommendations, there should be 400 toilets available in the Skid Row area with 24 hour access. Currently there are only 5 toilets available.

Other areas within the City of Los Angeles with concentrated homeless populations, such as Venice, The San Fernando Valley and South Los Angeles, have similar to smaller ratios of toilets per person unhoused.

POTABLE/ DRINKING WATER AND HEALTHY FOOD

RECOMMENDATIONS:

- Increase availability of water through drinking fountains
- Increase the number of bathrooms with sinks
- Appeal to State and Federal Government to increase food stamp funding
- Educate shelters and other feeding programs on the importance of increasing healthy food choices, including produce.
- Explore with local food banks increasing the number of times an individual can access any given food bank
- Appeal to the County of Los Angeles to increase the General Relief stipend to a level whereby individuals can afford the basic necessities to sustain life.

As the City of Los Angeles began to remove drinking fountains from parks and closed public bathrooms, the availability of free, public water to the homeless population diminished. As a result, people living in shelters or on the streets who lack easy access to potable water continue to be at risk for dehydration.

In addition, there is a high rate of food insecurity among the homeless population. Whether living in shelters or on the street, meals are typically irregular, with limited to no dietary choice. Emergency shelters are typically closed during daytime hours, leaving homeless individuals to find food programs outside the shelter system. Homeless individuals are also not able to store food in many instances, leaving them to buy from high priced unhealthy fast food establishments. As a result, most homeless individuals will diminish their food stamp stipend within the first two weeks of the monthly allocation, leaving homeless individuals to find non-profit organizations that can provide enough food for subsistence.

General Relief, which has been set by the county at $221 per month for several years, is often used to supplement Food Stamps. But with the low stipend rate of both these programs, there is a growing need to find food through private non-profits.

In addition, many food banks have maximum caps on the number of times they can be accessed by an individual in a given month. This leaves homeless individuals no other choice but to travel farther away from their area to seek food, potentially having to make a choice of leaving their belongings unattended on the street or looking for a meal.

In less concentrated areas of homelessness, where food programs are scarce, many people must resort to begging if they have no access to funds or have exhausted their food stamp and GR allocations.

SOBERING CENTERS:

RECOMMENDATION:

The City of Los Angeles should explore supporting the expansion of sobering centers throughout all areas of Los Angeles.

BACKGROUND:

Sobering Centers are facilities that provide a safe, supportive, environment for mostly uninsured, homeless or marginally housed publicly intoxicated individuals to become sober. Sobering centers provide services for alcohol-dependent individuals that may have secondary problems such as drug abuse/dependence, mental illness and/or medical issues. Stated goals for sobering centers include:

- Provide better care for homeless alcohol-dependent persons and improve health outcomes
- Decrease the number of inappropriate ambulance trips to the emergency department (ED) for homeless alcohol-dependent individuals
- Decrease the number of inappropriate ED visits for homeless alcohol-dependent individuals
- Create an alternative to booking individuals arrested for public inebriation

According to the Los Angeles Fire Department, frequent EMS Super Users are typically homeless, male and have chronic alcoholism. Many homeless individuals are untreated or underdiagnosed with diabetes, hypertension, COPD and sometimes have a combination of substance abuse and mental health issues.

The Skid Row area of Los Angeles represents the Smallest district (one square mile) of the county which receives the largest number of calls in a 24-hour period. Engine company nine averages 30 calls per day, with an 18% increase in the call load between 2014-15. This growth can be attributed to the continued increase in the homeless population.

With costs for paramedics at approximately $1750 and EMT's at $850, sobering centers in all areas of Los Angeles can help reduce costs while connecting serial inebriates to services where needed.

HEALTH ACCESS/ DISCHARGE PLA NNING AND TRANSPORTATION

RECOMMENDATION:

- Support Shuttle system to County Hospitals and Clinics
- Expand transportation vouchers
- Expand access to consultants and other medical providers in areas with large homeless populations.
- Explore working with shelters to provide 24 hour access

BACKGROUND:

Homeless individuals have heightened exposure to communicable diseases and parasites easily spread in crowded conditions, such as shelters. For example, untreated lice infections and insect bites frequently lead to serious, even life-threatening, systemic infections such as cellulitis among people who are homeless. Lack of permanent housing complicates basic self-care and treatment adherence. For example, the inability to store medications makes it difficult to keep pills intact or to meet doctors.

Limits on shelter stays during the daytime and competing needs to seek food and employment also interfere with regular administration of medication as prescribed, as well as scheduled follow-up visits with health care providers. On the whole, poverty remains a powerful social determinant of poor health, and persons struggling to survive without stable housing are particularly vulnerable.

Tangible access barriers to doctors and clinics, such as limited hours, noncentral locations, and intake requirements of identification, insurance, and a permanent address and less obvious barriers, such as disrespectful attitudes, apathetic treatment, and overt prejudices toward impoverished people, all contributed to this substitution of the emergency department for the primary care provider.

According to Sion Roy, cardiologist at UCLA Harbor Medical Center, there is a lack of resources for inpatient discharge to a safe place for those who are homeless. Those without families or other support systems are particularly vulnerable. Homeless patients typically need long-term care facility or a sub-acute nursing facility Easier access to medical and quicker application process would save hospitals more money.

For those who are discharged, there currently is no legally necessary communication between the shelter and the hospital. Patients may be assigned a caseworker, however caseworkers do not have an obligation to follow up after discharge and typically it is difficult for someone who is homeless to get an appointment with the caseworker due to lack of resources

We need to more adequately transfer these patients through a shuttle system from the hospital to a shelter. In addition, transportation is needed going back and forth between follow-up appointments and pick up prescription medications.

In November 2015, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule to modify hospital discharge requirements. The Council has submitted comments in response to these regulations, suggesting a number of steps that should be taken during the critical period of hospitalization to ensure that patients are not discharged into homelessness.

- Vouchers: Awarded to homeless individuals for a place to reside.
  - The Housing Authority of the City of Los Angeles (HACLA) has committed permanent supportive housing (PSH) assistance to more than 16,800 households of formerly homeless and chronically homeless individuals and families through the following rental assistance subsidy programs:
    Waiting List Limited Preference: Homeless Program
    The goal of the program is to provide permanent affordable housing for homeless individuals and families while insuring them access to supportive services to maintain independent living. The Homeless Program's allocation of 4,111 housing choice vouchers, targets homeless individuals and families living in transitional housing, emergency shelters, and the streets.
    http://www.hacla.org/homelessinitiatives

- Recuperative Care

defined by the Health Resources and Services Administration as "*short- term medical care and case management provided to persons (generally homeless) recovering from an acute illness or injury, whose conditions would be exacerbated by living on the street, in a shelter or other unsuitable places. This unique set of clinical and non-clinical services, often referred to as a recuperative care program, is offered to treat patients with conditions that have an identifiable endpoint of care for discharge from a facility/setting designed for such purpose.*" http://www.nhchc.org/wp-content/uploads/2011/09/standards_public_comment.pdf

AFFORDABLE HOUSING

Recommendation:

- Expand homeless housing,
- Prevent affordable housing developers contracting with the City of Los Angeles from excluding homeless population in application process
- Explore more accountability from non-profits contracted with the City of Los Angeles to provide housing for homeless individuals and families
- Reduce barriers for homeless individuals and families obtaining services from shelters and non-profits administering homeless set-aside vouchers

Background:

- Housing barriers – rental applications (Photo) /
    - LA rents: Vacancy rate falls to 2.7 percent as area's rental market tightens further
  - Approximately 43,854 affordable housing units needed based on
    - Total homeless count: 43,854; 11,073 Sheltered, 32,781 unsheltered; 37,601 individuals, 6,128 family members, 125 unaccompanied minors
    - Rental applications require 3 years permanent rental history – even for government subsidized units
  - Vouchers: Awarded to homeless individuals for a place to reside.
    - The Housing Authority of the City of Los Angeles (HACLA) has committed permanent supportive housing (PSH) assistance to more than 16,800 households of formerly homeless and chronically homeless individuals and families through the following rental assistance subsidy programs:
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    - More accountability on how shelters and non-profits track clients for housing.
    -

Veterans

Recommendation:

Expand access to housing and medical services and expedite service connections .

Background:

- Substance Use Disorders (SUD), mental illness and multi-morbidities were more common in both homeless Veteran groups (Veterans Affairs Supportive Housing [VASH], homeless) than for housed (low income, other). Department of Housing and Urban Development (HUD) HUD-VASH Veterans had the highest % reporting ≥ 1 of the following: SUD (31%, 16%, 6%, 3%), mental illness (54%, 28%, 19%, 23%), chronic physical illness (70%, 38%, 57%, 52%), tri-morbidity (20%, 6%, 2%, 1%), respectively. Controlling for demographics, HUD-VASH Veterans had higher odds of drug disorders (AOR = 8.78) and alcohol disorders (AOR = 6.07) than general housed Veterans

- California has the highest number of homeless veterans, representing 24% of the total population of homeless veterans, followed by Florida (9%), Texas (5%), and New York (5%) (HUD, 2014). Many homeless veterans have mental health problems, alcohol and/or substance abuse issues, and other co-occurring disorders (NCHV, n.d.). TBIs were found in 47% of homeless veterans who sought services at a VA hospital (Russell et al., 2013).
- The main causes of veteran homelessness are poverty, mental health issues, substance abuse, disabilities or other physical ailments, and a lack of support from family and friends › Veterans are twice as likely as other Americans to become chronically homeless › Homelessness among female veterans is rising. Women veterans are 4 times more likely to be homeless than non-veteran women (Hamilton et al., 2012). Homeless female veterans are more likely than homeless male veterans to be thinking about suicide (48.7% versus 44.4%) and to have attempted suicide in the past 5 years (36.5% versus 26.7%) (Benda, 2005b) › Homelessness is linked with high rates of hospitalization and age-adjustedmortality › Homeless veterans have higher incidences of suicide attempts and self-harming behavior when compared to veterans with housing. In one study 47% of homeless veterans were found to have attempted suicide versus 27% of domiciled veterans; 33% had self-harmed or engaged in reckless behavior in the previous 2 weeks compared to 18% of domiciled veterans (Lee et al., 2013) › Street outreach is still considered to be an important way to reach homeless veterans. Veterans living on the streets who normally avoid shelters and medical assistance are more likely to be chronically homeless than those veterans who are referred by a medical provider or who are self-referred (Tsai et al., 2014) https://www.ebscohost.com/assets-sample-content/Homeless_Veterans_US.pdf

- Clinicians and researchers who work with homeless populations may benefit from knowledge about health care utilization patterns among Housing First program participants. This study suggests that currently homeless Veterans underuse many VA services relative to housed Veterans and that HUD-VASH addresses this disparity through housing and primary care referrals. Though we hoped that HUD-VASH case management led to less acute care (ED and inpatient) and preventable

hospitalizations, we found no such effects. Future studies are needed to explore longitudinal changes in utilization with HUD-VASH participation, incorporating non-VA services. Differences in health outcomes among Veterans by housing and income status are also important for study, along with barriers and facilitators to acute, primary, and other ambulatory care use for Veterans in these groups. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4714600/pdf/nihms751057.pdf

- **Seventy-three percent of the respondents reported at least one unmet health need**, including an inability to obtain needed medical or surgical care (32%), prescription medications (36%), mental health care (21%), eyeglasses (41%), and dental care (41%).

HEROINE OVERDOSE:

RECOMMENDATION:

- Provide wide spread availability of the drug Narcan for any groups working with homeless populations including, but not limited to, first responders, non-profit workers and government employees.

According to non-profit group Homeless Healthcare, the drug Narcan was responsible for 1,000 reversals of heroine overdoses. Narcan is an an opioid antagonist designed to save the lives of heroine users who have overdosed. The population of active heroine users in Los Angeles among homeless populations is approximately 5,000 to 7,000.

Narcan is easy to administer through a medication pen and training is readily available. The cost per dose is approximately $19.

DRAFT

Los Angeles City Health Commission

Medical Services Work Group

Background

The Los Angeles Fire Department (LAFD) responds to over 350.000 calls for emergency medical service (EMS) every year and transports about 220,000 patients to emergency rooms. Since the LAFD was designated as the sole provider of public emergency ambulance for the City of Los Angeles in 1970, this vital service has grown to constitute about 85% of the workload of the department at an annual cost of over $185 million dollars. This emergency care is the largest direct health care service provided by the City of Los Angeles. As such, it warrants the attention of the Los Angeles City Health Commission, an entity created to assess the health of the city with particular focus on the relationship between the County of Los Angeles Health Agency and the City of Los Angeles. In 1964, the city closed its own department of public health and agreed to have the County take responsibility for public health services in the city.

Today many of the EMS tasks in the County of Los Angeles are overseen by the Emergency Medical Service Agency of the Department of Health Services advised by the Los Angeles County Emergency Medical Services Commission. The LAFD must meet EMS performance and training standards established at the state level and evaluated and enforced by the County EMS Agency.

In order for the newly established Los Angeles City Health Commission to understand the Emergency Medical functions of the LAFD, the LA City Health Commission has met with the leadership of the Emergency Medical Services Bureau of the Fire Department and endorsed their recommendations aimed at making the service more efficient.

Health Commission encourages the Fire Commission to take up the first five recommendations.

Recommendation 1

Fast Response Vehicle (FRV) – a pick-up truck size vehicle equipped with limited fire-fighting capability and a full range of EMS equipment staffed by two firefighter/paramedics on patrol in busy EMS demand areas and able to respond quickly to calls and initiate care pending the arrival of an ambulance. This can eliminate the need to dispatch a fire engine, usually cuts response time, and can summon the appropriate ambulance if necessary. This program is, with County EMS approval, undergoing evaluation.

Recommendation 2

Nurse Practitioner Response Unit(NPRU) – a 12 month pilot project approved by the County in which a paramedic and a nurse practitioner respond to calls in an ambulance, particularly from "super-users" to try to treat and release the patient and arrange a more appropriate source of medical care.

Recommendation 3

Nurse Practitioner at Dispatch—a soon to be implemented program to supplement the LAFD's recently improved 911 EMS response protocol whereby a low acuity caller would be referred to a nurse practitioner in the dispatch headquarters after screening by a trained dispatcher. The nurse could take the time to determine the caller's needs and offer a clinic referral, dispatch of the NPRU, dispatch of a Basic Life Support (BLS) ambulance staffed by EMTs rather than paramedics or even dispatch of a taxi to transport to a clinic.

Recommendation 4

Sobriety Emergency Response Unit(SOBER)—a BLS ambulance with a trained counsellor who could determine if the patient required detox and sobering and an EMT to check basic medical needs allowing transport to a Sobering Center rather that an emergency room. The County in cooperation with the City is developing the sobering centers, particularly near "Skid Row". This program is in development.

Recommendation 5

Mobile Mental Health Unit—an ambulance staffed with a Nurse Practitioner and an LPS Certified Social Worker able to evaluate patients with mental health crises, determine any medical needs and, if clear medically, transport if necessary to an LPS-designated mental health facility rather than an emergency room. This program is currently in development.

Recommendation 6

Assistance with "super users" EMS calls- Although the Los Angeles City Health Commission has no operational responsibility for LAFD EMS, the volume of health service provided by the agency certainly warrants attention from a commission charged with reviewing and addressing health needs in the City, especially those that are carried out in concert with the Los Angeles County Health Agency.

Another rationale for the Health Commission to understand the work of the agency providing EMS in the city is that each call for emergency service represents a failure to provide an optimally healthy environment. Each homeless serial inebriate found lying in the street is a prime example of failed prevention and inadequate shelter. Individuals with chronic illness who repeatedly call 911 for relief illustrate failures in our basic health care system. Every preventable injury accident, every gunshot wound, and every serious behavioral assaultive incident reflects near term failure of prevention efforts. The thousands of EMS calls for cardiorespiratory and stroke incidents in many cases are the result failed prevention efforts and limitations of the health care system.

Recommendation 6

LA City Health Commission to convene key city departments that supported ACA implementation in Los Angeles by promoting Covered CA, HealthWay LA and MediCal expansion (HCIDLA, LAPL, LAFD, Mayor's Office and community health insurance advocates) to identify ways ot strengthen use of insurance, navigation of medical care and specific advocacy requests on behalf of city residents.

Emergency Ambulance Services (EMS)

- Represent failure of other medical services (e.g. superusers)
- Dr. Epstein has additional info from Los Angeles Fire Department (LAFD)
- Serial inebriates – transfer them to a sobering center and offer to work with them.
- Help LAPD expand SMART Crisis Response Team
    - Need to respond appropriately to situations (e.g. police car and handcuffs vs. ambulance and stretchers)
- Associated costs with medical Services
    - City is not reimbursed for sober center drop-offs. This is a political issue.
    - Estimated $185 billion in costs
    - Arrangement with Kaiser – if a patient is being transported to a medical center and there is a Kaiser within a reasonable distance, then patient goes to Kaiser.

Nurse Practitioners' Unit at Dispatch

- Develop new approaches in delivering educational information that is disseminated.
- Propose something new or instate an existing idea.
- Expand Smart Team and Nurse Practitioner Unit (to no longer be a pilot).

Health Education Outreach at Airports

- Increase awareness on safe sex practices
- Include public-private partnership
- Message on kiosk screens and other low costs methods
    - Alerting people of prevalence and CDC recommendations
    - Include health messages/ alerts of disease(s) on itinerary or ticket and give airlines an incentive to implement this method. This could also become a policy or requirement for airlines.
    - Text message alerts/ include in emergency alert system.

Meningitis Outbreak

- County lacking outreach to LGBT community
    - Need to provide outreach and vaccines
    - Outreach to electronic social networks
        - Grindr "hook-up" website, twitter, and other technology platforms
    - LA Health Commission started due to lack of outreach for Meningitis

Transgender Youth – Advisory Committee

- Connect with another process underway in the city
- Reach out to schools
    - Parents unaware of their kids who may identify as transgender

Affordable Care Act (ACA)

- Refers everything to non-profit organizations
- Two issues with ACA
    1. Getting patients enrolled + afford monthly premium
    2. Getting access to doctors local to patients

Health Disparities Worker (Female Speaker)

- Increase number of mobile units
- People are afraid of going to certain areas at certain times

- Benefits of healthy population is for all taxpayers worldwide.
- 14 locations of wellness centers in LA schools to serve non-students as one of the least expensive ways to expand medical coverage
    - Family medical care to individuals not affiliated with school.
    - Separate entrance from rest of school around the perimeter of campus.
    - LAUSD now has medical doctors.

<u>Research for Alex and Jonathan</u>

- Get a better fix on number of and cost of *superusers*
    - Call Drs. Epstein and Sanko and Fire Chief Corey Rose for LAFD stats. Lt. Bixler for LAPD.
        - All operations of LAFD are estimated at $632,940,936 for 2016.
        - Published in 2012-13, ASEP Review of the top 40 *superusers* in 2011 and their number of unique incidents found charges of $2.4 million. Of this amount, only $231,000 was actually paid for/reimbursed.
    - Also mention "wall time" (paramedics and EMT cannot leave until patient is transferred) and how this can be improved/reduced.
        - Bakersfield (or Kern) County penalize hospital for keeping patients for too long. Incentivize expedient service.
        - United Kingdom and parts of Scandinavia looking to experiment ways to "hurry up".
        - Leaving one paramedic with several patients – an idea that has issues.
- Zika Virus # of cases in Los Angeles
    - 81 cases reported as of November 4, 2016 (*http://www.cdph.ca.gov/HealthInfo/discond/Documents/TravelAssociatedCasesofZikaVirusinCA.pdf*)

October 31, 2016

Los Angeles Fire Department (LAFD)

Interview with Dr. Stephen Sanko

Background

Statistics on the cost of *superusers* of the LAFD's medical services for support of the expansion of the SMART (crisis response) team and broader implementation of the nurse practitioner unit.

- What is the current budget for the department?
  - **Operational cost of LAFD is $632,940,936.**
- Analysis of *superusers*
  - The total number of people that called-in reached more than six times annually.
    - [insert exact number]
    - Review attached publications in email from Dr. Sanko.
  - The number of times the top 100 *superusers* called:
    - **Published in 2012-13, ASEP Review of the top 40 *superusers* in 2011 and their number of unique incidents found charges of $2.4 million. Of this amount, only $231,000 was actually paid for/reimbursed.**
  - The true economic impact of these individuals analyzing their payer mix multiplied by the charges attributed to each paramedic run:
    - **Exact figures difficult to assess at this time.**
    - "If I recall each run costs $1850 about 30% had MediCal that only pays a fraction of that and some people had Medicare that also does not pay the whole costs. The overwhelming majority were uninsured so LAFD takes a million and a half dollar loss just on these 100 individuals let alone the total number of superusers." - Howard "Howie" Mandel
    - **This loss is estimated to be larger than $1,850.00.**

Summary

The overall cost of *superusers* is still unknown due to both the dynamic nature of *superusers* and lack of data. It is difficult to quantify the effectiveness of LAFD-based Emergency Medical Services (EMS). The current budgeted cost for all operations of LAFD are $632,940,936.00. In 2011, of the top 40 *superusers* reviewed by ASEP, their number of unique incidents found charges of $2.4 million. Of this amount, only $231,000.00 was actually paid for and/or reimbursed. EMS reimburses Centers for Medicaid and Medicare (CMS) only if a patient is transferred to an emergency department. In Los Angeles, mobile integrated healthcare with the use of a nurse practitioner for low acuity issues are not bound by the same rules as EMS. Selecting appropriate destinations for patient populations (e.g. sobering center, psychiatric urgent care) as opposed to default of emergency room is the current focus.

Challenges & Recommendations

- Continued promotion of new departments within LAFD. For example, EMS recently modified oversight from division to bureau.

- Presently, LAFD EMS Bureau is underfunded and understaffed. Only 1% of calls serviced by LAFD are for traditional fires. We have seen an explosive growth in 911 calls being made. Affordable Care Act (ACA) signaled growth in the total number of EMS runs from 1-2% prior to its implementation to an increase of over 4% in 2013-14 following its implementation. At this rate, a doubling of emergency calls each year is not sustainable.
    - Analogy: School cafeteria line. Even if the process of getting students through the line is more efficient than ever, adding more students to the line can make it seem longer than ever in spite of it being the most efficient it has ever been.
    - In addition, LAFD is a safety net for other emergency services. New partnerships are underway with a variety of community partners to meet the increased demand and coverage for service expansion, including Housing for Health (HFH), the Veterans Association, LA Department of Mental Health, LA Department of Transportation and the jail system among others.
- Currently, each emergency call uses the 25 off-shelf dispatch system involving scripted questions, pre-arrival, to send the correct resources.
    - LAFD wants to implement a "Home Grown Dispatch System" which can:
        - Decrease call process.
        - Improve efficiency and reduce the over and under usage of triage and average number of resources used per call.
- Further development of the Nurse Practitioner Unit.
    - This can add a supplemental degree of judgment at the dispatch level and on-scene response. It is important to invest in a Nurse Practitioner program, at the public health level within LAFD EMS Bureau, SMART Team embedded within Nurse Practitioner Program. Eager for proactive, data-driven methods to help better navigation of services and allocation of resources
- Implementation of Upstream Model Units: The further upstream you consider your decision, the more cost effective it will be along with higher customer satisfaction.