LOS ANGELES CITY

HEALTH COMMISSION REPORT

2015-16

2015-2016 Health Commissioners

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In Memorium: Bill Rosendahl – Commission President

Contact: Candy Rosales
(213) 978-1828
Candy.Rosales@lacity.org

Website: http://clerk.lacity.org/city-health-commission

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Chelsea Alexandra Schafer, Jonathan Watts, Joshua James G. Manlutac, Jen Marony, Dr. David E. Boyns, Dr. Bethany K. Wexler Rainisch, Fatima Lopez, Christopher Rogers, and Sarah Stembridge

Photos and Figures by Christopher Rogers

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This Report is Dedicated to the Memory of Councilmember and Health Commission President Bill Rosendahl

Contents

Introduction to Annual Report 2015-16

The Health Commission, as ordained by the people of the City of Los Angeles, aims to explore the health needs of the people, and report such information in an annual Health Services Plan. Mirrored after Henrik Blum's Model of Health (1983), with a focus on the social determinants of health, the following 2016 Los Angeles Health Commission Report provides recommendations and a strategic plan of action for addressing the most significant health issues in the City of Los Angeles: homelessness, healthy living, and medical care services. By demonstrating the need for strategic action, the Los Angeles City Health Commission is committed to improving the health and wellbeing for all those who reside in the City.

Environment is considered to have the most powerful effect on health, as our environment cultivates our community, and our community nurtures our health. The present Health Commission Report focuses on a salient environmental factor within the City of Los Angeles, Homelessness. To date, over 25,000 homeless reside in the City of Los Angeles, limiting thousands from access to medical care. This 2016 Health Commission Report demonstrates that significant action is needed to minimize the effect homelessness has on health, including addressing issues such as: affordable housing, housing for health, bathrooms, potable water and healthy food, sobering centers, and access to health care.

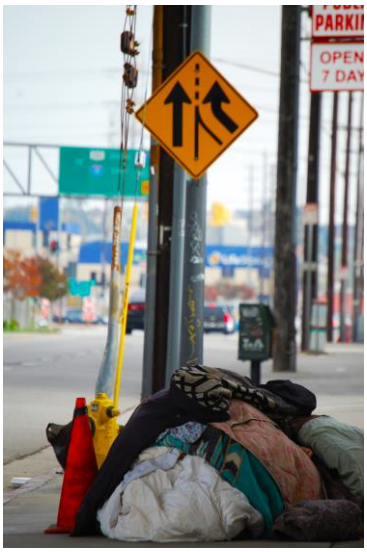
Lifestyle choices, behaviors, and attitudes, contribute greatly to health. For example, tobacco and alcohol use, insufficient opportunities for exercise, high cholesterol diets, and the consumption of sugary beverages among youth, all can have deleterious impacts on health.

Access to medical care services play an equally important role in affecting the health of residents in the City. The use of emergency ambulance services and other healthcare units (i.e., fast response, nurse practitioner, sobriety, and mobile mental health units) greatly impact access to care and patient safety.

The following 2016 Health Commission Report identifies much needed recommendations addressing lifestyle and medical care services concerns within the City, as well as providing a plan of action moving forward to address such recommendations.

Section I: Homelessness

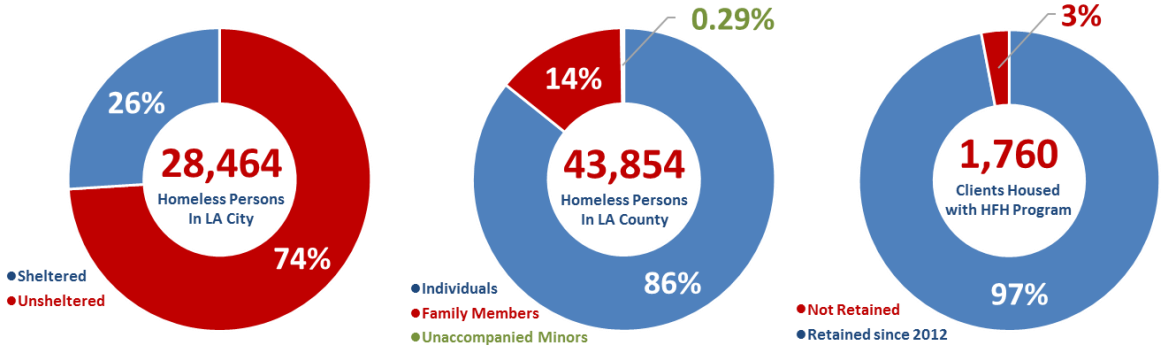
Introduction



According to the 2016 Homeless Count conducted by the Los Angeles Homeless Services Authority (LAHSA), Los Angeles County is home to approximately 43,854 homeless individuals on any given night. Approximately 28,464 of those homeless reside in the City of Los Angeles, and 74% of these individuals are unsheltered (LAHSA, 2016a).

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 (Zlotnick, Zerger, & Wolfe, 2013). Baggett**,** O'Connell**,** Singer, and Rigotti**, (**2010) found seventy-three percent of homeless individuals from a nationwide survey 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%). Furthermore, Nickasch and Marnocha (2009) found homeless populations face many barriers to accessing healthcare systems including financial barriers and a lack of medical insurance, an undersupply of services in impoverished communities, long wait times and limited hours of operation, provider hostility and resistance, cultural differences, and poor transportation. These factors contribute to an increase in the spread of infections, prevents homeless populations from accessing healthcare professionals, and inhibits obtaining and/or storing necessary medication (Badiaga, Raoult, and Brouqui, 2008). Homelessness is also linked with high rates of hospitalization and age-adjusted mortality (Ainslie, 2016).

A goal of the Los Angeles Health Commission is to improve health outcomes for homeless individuals through City Council action designed to reduce barriers to health access and housing. The Los Angeles City Health Commission recognizes the City and County homeless strategy plans and voters' adoption of proposition Help House the Homeless (HHH), and prioritizes new resources for the following recommendations:



Source: LAHSA, 2016a, LAHSA, 2016b

Housing for Health

Recommendations:

1. 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.
2. The City of Los Angeles should explore the implementation of a *Flexible Housing Subsidy Pool* (FHSP) to increase access to permanent affordable housing for chronic homeless populations with underlying health conditions.

Background:

The Los Angeles County Department of Health Services (LACDHS) Housing for Health (HFH) Program offers housing and supportive services for homeless clients with physical and/or behavioral health conditions, frequent users of County services, and other vulnerable populations. It is a C3 program (County + City +Community) with a goal to create 10,000 units of permanent supportive housing and reduce inappropriate use of expensive healthcare resources (LACDHS, 2016a).

HFH is modeled as a Housing First Program, which is defined by the National Alliance to End Homelessness (n.d.) as "a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible in addition to offering 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 Housing Subsidy Pool (FHSP), a program which circumvents the Housing Authority to provide a funding pool from the County General Fund, private foundations and other partners (LACDHS, 2016b). This supportive housing rental subsidy program is designed to break down barriers that homeless populations face going through traditional voucher-based programs (Smith, 2016). Included under FHSP is a master-leasing housing program, managed by Brilliant Corners, which creates a landlord/tenant contract between property owners and Brilliant Corners/ L.A. County. This alleviates the burden many homeless individuals face in traditional voucher programs, where they must find and qualify for housing from a private landlord (LACDHS, 2016b).

Since 2012, the HFH program has housed 1,760 clients, with a 97% retention rate. Eligibility for HFH 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 to 5-page application (1/4 the size of typical HUD applications) (LACDHS, 2016a).

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 (United Way, 2009).

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 in 2005 and recently reached a functional zero in chronic homelessness, saving $8,000 - $10,000 per homeless person housed. Due to 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 (Mitchell et al. 2016).

In addition, recuperative care is another resource that should be considered. It is 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." (National Health Care for the Homeless Council [NHCHC], 2014). According to the National Health Foundation (NHF, 2014), "recuperative centers provide hospitals a discharge option for homeless patients who are not sick enough to remain in the hospital, but too sick for a shelter. It is estimated that patients are kept up to four extra days in the hospital, due to insufficient availability of appropriate beds." Recuperative care is a cost-effective way to provide needed aftercare to homeless patients in a safe and clean environment to recover, receive medical oversight, support in attending follow-up appointments, connection to supportive services and housing options." Since 2010, among three locations in Los Angeles, the San Gabriel Valley, and Orange County, recuperative care centers have had 63 hospitals participate, over 2700 referrals submitted, 44% connected to transitional or permanent housing, and over $13.2M cost savings to hospitals (NHF, 2014).

Action Plan:

The committee urges the adoption of the stated recommendations to implement HFH.

Sobering Centers

Recommendation:

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

Background:

The American College of Emergency Physicians (ACEP, 2013) states: "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: 1) Provide better care for homeless alcohol-dependent persons and improve health outcomes 2) Decrease the number of inappropriate ambulance trips to the emergency department (ED) for homeless alcohol-dependent individuals 3) Decrease the number of inappropriate ED visits for homeless alcohol-dependent individuals 4) 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 (Eckstein, 2016). 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 No. 9 averages 30 calls per day, with an 18% increase in the call load between 2014-15 (Eckstein, 2016). This growth can be attributed to the continued increase in the homeless population. With costs for paramedics at approximately $1750 and EMTs at $850, sobering centers in all areas of Los Angeles can help reduce costs, while connecting serial inebriates to services where needed (Eckstein, 2016).

Action Plan:

The committee urges the adoption of the stated recommendations to implement sobering centers.

Bathrooms

Recommendation:

1. 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 homeless in the Downtown area. Unsanitary living conditions in this area contribute to significant public health concerns. 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. Such conditions are linked to outbreaks of tuberculosis, meningitis and staph infections, all of which can be fatal (Bales, 2016).

Based on the WHO's (2008) recommendations of a minimum of 1 toilet per 25 users to maintain a sanitary environment, there should be 400 toilets available in the Skid Row area with 24-hour access (Tiano, 2015). Currently there are only 5 toilets available (Bloom, 2016). 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.

Action Plan:

The committee urges the adoption of the stated recommendations to improve homeless access to bathrooms.

Potable Water and Food Assistance

Recommendations:

1. Increase availability of water through hydration stations.
2. Appeal to State and Federal Government to increase the Supplemental Nutrition Assistance Program (SNAP) funding.
3. Educate shelters and other feeding programs on the importance of increasing healthy food choices, including produce.
4. Explore with local food pantries increasing the number of times an individual can access any given food pantry.
5. 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.
6. Advocate that the Federal Government increase Cal-Fresh/SNAP benefit levels.

Background:

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 (Morier, 2015). 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 CalFresh (formerly known as food stamps) (Los Angeles Times Editorial Board, 2015). 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 each 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.

Action Plan:

The committee urges the adoption of the stated recommendations to address potable water and food assistance.

Health Access and Discharge Planning and Transportation

Recommendations:

1. Support shuttle system to County Hospitals and Clinics.
2. Expand transportation vouchers.
3. Expand access to consultants and other medical providers in areas with large homeless populations.
4. 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 (i.e., bed bugs) 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' recommendations.

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.

According to Dr. Sion Roy (2016), 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 Medi-Cal and quicker application processes would save hospitals more money (Roy, 2016).

For those who are discharged, there currently are no legal requirements for communication between a shelter accepting incoming patients and the discharging hospital (Roy, 2016). Patients may be assigned a caseworker at the hospital; however, caseworkers do not have an obligation to follow up after discharge, and it is typically difficult for someone who is homeless to get an appointment with frequently overloaded caseworkers, and due to lack of resources such as transportation. Nurse practitioners at the Union Rescue Mission Clinic affirm that families with children often encounter additional barriers related to access to transportation with children. The adoption of a transportation system between the shelter and the hospital would more adequately meet the needs of those who are homeless. In addition, transportation is needed for going back and forth between follow-up appointments and to pick up prescription medications.

Zlotnick, Zerger, and Wolfe (2013) reveal there are numerous factors that contribute to homeless individuals opting to use hospital emergency departments, instead of primary care providers. Restricted access to physicians and clinics is a tangible barrier that homeless individuals encounter (Zlotnick, Zerger, and Wolfe, 2013). For instance, clinics are located in non-central areas and hours of operation are limited (Zlotnick, Zerger, and Wolfe, 2013). Furthermore, in order to receive treatment at most clinics individuals must have a permanent address, insurance and identification to obtain services (Zlotnick, Zerger, and Wolfe, 2013). An additional barrier for homeless individuals is the treatment received at clinics (Zlotnick, Zerger, and Wolfe, 2013). Disadvantaged people may be susceptible to blatant prejudices, insolent attitudes and apathetic treatment from clinic staff (Zlotnick, Zerger, and Wolfe, 2013).

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 (CMS, 2015).

Action Plan:

The committee urges the adoption of the stated recommendations to address health access and discharge planning and transportation.

Affordable Housing

Recommendations:

1. Expand availability of homeless housing.
2. Prevent affordable housing developers contracting with the City of Los Angeles from excluding the homeless population in the application process.
3. Explore more transparency measures from non-profits contracted with the City of Los Angeles to provide housing for homeless individuals and families.

4. Reduce barriers for homeless individuals and families obtaining services from shelters and non-profits administering homeless set-aside vouchers.
5. Preserve rent stabilized and other affordable housing to prevent homelessness.

Background:

At the beginning of 2016, the Los Angeles rental vacancy rate fell from 3.8 percent to 2.7 percent as housing became more difficult to acquire (Huang, 2016). Approximately 43,854 affordable housing units are needed based on LAHSA's (2016b) total homeless count. There are currently 43,854 total homeless; 11,073 sheltered, 32,781 unsheltered; 37,601 individuals, 6,128 family members, and 125 unaccompanied minors (LAHSA, 2016b). Finding necessary housing can be significantly challenging as most rental applications require two to three years permanent rental history – even for government subsidized units.

Furthermore, there needs to be more accountability on how shelters and non-profits, which are contracted with the City of Los Angeles, place clients on a list for permanent supportive housing. Housing vouchers are awarded to homeless individuals, but the process on how individuals are accepted into housing programs, and who gets tracked for housing within the nonprofit system remains unclear. The Housing Authority of the City of Los Angeles (HACLA, 2016) homeless set aside program has a distribution of 4,111 housing choice vouchers which serves to target homeless families and individuals who are residing in transitional housing, emergency shelters, and living on the streets (HACLA, 2016).

Since 2001, property owners have taken nearly 19,000 rent-controlled units across the city off the market using the Ellis Act, according to the Los Angeles Housing and Community Investment Department (Gross, 2015). The Ellis Act is a provision in California Law (Government Code section 7060-7060.7) that provides landlords in California with a legal way to go out of the rental market business. The Ellis Act was adopted by the California Legislature in 1985 after the California Supreme Court decision in the case of Nash v. City of Santa Monica (Los Angeles Housing and Community Investment Department [LAHCID], (n. d.). Gross (2015) asserts, "The city cannot truly address its affordable-housing crisis without eliminating or significantly amending the law, which allows landlords to evict tenants from rent-controlled apartments if the owners raze their buildings, convert them to condominiums, change the use from residential rental property or let them sit vacant for at least five years."

In 1995, the California Legislature passed and the Governor signed AB 1164 – a law that is known as the Costa-Hawkins Rental Housing Act. This law cleared the way for owners in rent control communities to establish market rental rates when there was a change in occupancy at a dwelling unit – a policy known as vacancy decontrol (California Apartment Association [CAA], 2006). The Costa-Hawkins Rental Housing Act poses an obstacle to affordable housing by allowing landlords to increase rents to market rates after one tenant vacates a rent controlled unit and another moves in.

Action Plan:
The committee urges the adoption of the stated recommendations to implement affordable housing.

Veteran Homelessness

Recommendations:
1. Increase Resources and Attention to Veteran Housing and Medical Services.
2. Expedite connections to services for Housing and Medical Care.
3. Expand access to housing and medical services and expedite service connections.

Background:
Recent data from the U.S. Department of Housing and Urban Development (HUD, 2014) show California represents nearly a quarter (24%) of the homeless veteran population nationwide. Many homeless veterans have mental health problems, alcohol and/or substance abuse issues, and other co-occurring disorders (National Coalition for Homeless Veterans, 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 (Ainslie, 2016). According to Ainslie (2016), veterans are twice as likely as other Americans to become chronically homeless.

Furthermore, Homelessness among female veterans is rising (Ainslie, 2016). Women veterans are four 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, 2005).

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 two 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, and connect to services for housing and medical care. One study, Gabrielian, et al. (2014), found that currently homeless veterans underuse many VA services relative to housed veterans. An increase in HUD-VASH vouchers can address this disparity by increasing access to housing. And, street outreach workers can provide the necessary referrals to primary care physicians.

Action Plan:
The committee urges the adoption of the stated recommendations to address veteran homelessness.

Heroin and Other Opioids

Recommendation:

1. Subsidize and provide wide spread availability of the drug Naloxone (also known as Narcan) for any groups working with homeless populations including, but not limited to, first responders, non-profit workers and government employees.

Background:

The population of active heroin users in Los Angeles among homeless populations is approximately 5,000 to 7,000 (Casanova, 2016). Narcan is an opioid antagonist designed to save the lives of heroin users who have overdosed. Between 1996 and 2014, 644 sites across 136 organizations provided Narcan kits to 152,283 laypersons and received reports of 26,463 overdose reversals (Wheeler, Jones, Gilbert, & Davidson, 2015). Narcan has reversed over 10,000 overdoses nationwide (DOH issues emergency regulations, 2014). According to the non-profit group Homeless Healthcare, Narcan has been responsible for 1,000 reversals of heroin overdoses in Los Angeles (Casanova, 2016).

Narcan is easy to administer through a medication pen and training is readily available. The cost per dose is approximately $4-$19 (Sullivan & Fiellin, 2008).

Action Plan:

The committee urges the adoption of the stated recommendations to address the use of heroin and other opioids.

References

Ainslie, N. (2016). A quick lesson about homeless veterans: United States Retrieved from https://www.ebscohost.com/assets-sample-content/Homeless_Veterans_US.pdf

American College of Emergency Physicians [ACEP] (2013). Sobering centers. *Clinical and Practice Management*. Retrieved from https://www.acep.org/clinical---practice-ew44management/sobering-centers/

Badiaga S., Raoult D., and Brouqui, P. (2008). Preventing and controlling emerging and reemerging transmissible diseases in the homeless. *Emerging Infectious Diseases. 14*(9). 1353-1359. Retrieved from https://wwwnc.cdc.gov/eid/article /14/9/pdfs/08-0204.pdf

Baggett, T. P., O'Connell, J. J., Singer, D. E., and Rigotti, N. A. (2010). The unmet health care needs of homeless adults: A national study**.** *American Journal of Public Health 100(7)* 1326-1333**.** Retrieved from http://ajph.aphapublications.org/doi/full/10.2105/AJPH.2009.180109

Bales, A. (2016). Personal communication. Phone Interview on September 19, 2016.

Benda, B. B. (2005). Gender differences in predictors of suicidal thoughts and attempts among homeless veterans that abuse substances. *Suicide and Life-Threatening Behavior, 35* (1), 106-116.

Bloom, M. (2016). There are just 5 bathrooms for the 1800 people living on Skid Row. *KPCC. Retrieved from* http://www.who.int/water_sanitation_health/hygiene/settings/ehs_health_care.pdf.pdf

California Apartment Association [CAA]. (2006). Rent control: An overview of California's Costa-Hawkins Rental Housing Act. *Issue Insights.* Retrieved from http://www.sfaa.org/pdf/CAA-Insights-Costa-Hawkins-Rental-Housing-Act.pdf

Casanova, M. (2016). Personal communication. Phone Interview on September 12, 2016.

Centers for Medicare and Medicaid Services [CMS]. (2015). Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies. *Department of Health and Human Services*. Retrieved from https://www.gpo.gov/fdsys/pkg/FR-2015-11-03/pdf/2015-27840.pdf

DOH issues emergency regulations on expanding use of narcan to prevent opioid overdose deaths. (2014). *Rhode Island Medical Journal (2013)*, *97*(4), 49. Retrieved from http://www.rimed.org/rimedicaljournal/2014/04/2014-04.pdf

Eckstein, M. (2016). Presentation on health-related costs, programs, and policies. Los Angeles City Fire Department. February 8, 2016. Audio Retrieved from: http://lacity.granicus.com/MediaPlayer.php?view_id=46&clip_id=15535

Gabrielian, S., Yuan, A. H., Andersen, R. M., Rubenstein, L. V. and Gelberg, L. (2014). VA health service utilization for homeless and low-income veterans: A spotlight on the VA Supportive Housing (VASH) program in greater Los Angeles. Med Care. 2014 May; 52(5): 454–461. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4714600/pdf/nihms751057.pdf

Gross, L. (2015). L.A.'s eviction game. *Los Angeles Times: Opinion Editorial.* Retrieved from http://www.latimes.com/opinion/op-ed/la-oe-0609-gross-housing-ellis-act-20150609-story.html

Hamilton, A., Poza, I., Hines, V., & Washington, D. (2012). Barriers to psychosocial services among homeless women veterans. *Journal of Social Work Practice in the Addictions, 12*, 52-68.

Housing Authority of the City of Los Angeles. (2016). HACLA homeless initiatives. *Housing*

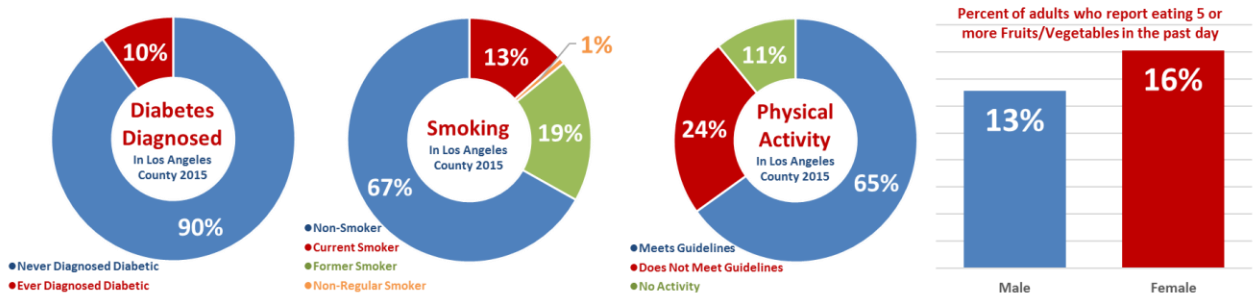
programs: Section 8 housing. Retrieved from http://www.hacla.org/homelessinitiatives
Huang, J. (2016). LA rents: Vacancy rate falls to 2.7 percent as area's rental market tightens Further. *Southern California Public Radio.* Business and Economy. Retrieved from http://www.scpr.org/news/2016/01/28/57103/la-apartments-rental-vacancy-rate-fall-to-27/
Lee, H., Iglewicz, A., Golshan, S., & Zisook, S. (2013). A tale of two veterans: Homeless vs. domiciled veterans presenting to a psychiatric urgent care clinic. *Annals of Clinical Psychiatry, 25*(4), 275-282.
Los Angeles County Department of Health Services [LACDHS] (2016a). Housing for health overview. Retrieved from http://file.lacounty.gov/dhs/cms1_217171.pdf
Los Angeles County Department of Health Services [LACDHS] (2016b). Flexible housing subsidy pool. Retrieved from http://file.lacounty.gov/SDSInter/dhs/218377_FHSP082614(bleed--screenview).pdf
Los Angeles Homelessness Services Authority [LAHSA] (2016a). 2016 Greater Los Angeles homeless count data shows significant drops in veteran and family homelessness citing focused investment. Retrieved from https://documents.lahsa.org/Communication/2016/2016HomelessCountResultsRelease.pdf
Los Angeles Homelessness Services Authority [LAHSA] (2016b). 2016 Greater Los Angeles homeless count data. *Service Planning Area*. Retrieved from https://www.lahsa.org/homeless-count/service-planning-area
Los Angeles Housing and Community Investment Department [LAHCID]. (n. d.) Ellis Act information. Retrieved from http://hcidla.lacity.org/Ellis-Act
Los Angeles Times Editorial Board. (2015). Could you live on $221 a month? Opinion/Editorial. May 15, 2015. Retrieved from http://www.latimes.com/opinion/editorials/la-ed-adv-general-relief-20150513-story.html
Mitchell, S., Santiago, A., Alejo, A., Allen, S., Campos, A., Chiu, A., Hertzberg, S., Liu, S., Lopez, A., Thurmond, A., Wieckowski, S. (2016). SB-1380 Homeless Coordinating and Financing Council. California Legislative Information. Retrieved from http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB1380
Morier, D. (2015). Rising Food Insecurity in Los Angeles County. County of Los Angeles Public Health, Office of Health Assessment & Epidemiology. Retrieved from http://www.publichealth.lacounty.gov/ha/reports/LAHealthBrief2011/FoodInsecurity/Food_Insecurity_2015Fs.pdf
National Alliance to End Homelessness. (n.d.). Housing first. *Solutions*. Retrieved from http://www.endhomelessness.org/pages/housing_first
National Coalition for Homeless Veterans (NCHV). (n.d.). Background and statistics. Retrieved November 4, 2015, Retrieved from http://nchv.org/index.php/news/media/ background_and_statistics/
National Health Foundation [NHF]. (2013). Recuperative care center. *Current Programs.* Retrieved from https://www.nhfca.org/ProjectDescCurrent.aspx?PID=75
National Health Care for the Homeless Council [NHCHC] (2014). Proposed Minimum Standards for Medical Respite Programs. Retrieved from http://www.nhchc.org/wp-content/uploads/2011/09/standards_public_comment.pdf
Nickasch, B. & Marnocha, S. (2009). Healthcare experiences of the homeless. *Journal of the American Academy of Nurse Practitioners, 21*(1), 39-46.

Roy, S. (2016). Personal communication. Phone Interview on November 8, 2016.
Russell, L. M., Devore, M. D., Barnes, S. M., Forster, J. E., Hostetter, T. A., Montgomery, A. E., ... Brenner, L. (2013). Challenges associated with screening for traumatic brain injury among US veterans seeking homeless services. *American Journal of Public Health, 103* (S2), S211-S213.
Smith, D. (2016). How L.A. is housing thousands of homeless long before Proposition HHH units get built. *Los Angeles Times*. Retrieved from: http://www.latimes.com/local/california/la-me-ln-marc-trotz-question-answer-20161125-story.html.
Sullivan, L. E. and Fiellin, D. A. (2008). Office-Based Buprenorphine for Patients with Opioid Dependence. Ann Intern Med. 148(9): 662–670
Tiano, S. (2015). Lack of bathroom access puts public health at risk. *Off the Freeway*. University of Southern California. Digital Journalism Media Project. Retrieved from http://offthefreeway.com/2015/community/stiano/
United Way. (2009). Homeless cost study. *United Way of Greater Los Angeles*. Retrieved from http://homeforgoodla.org/wp-content/uploads/2015/01/Homeless-Cost-Study.pdf
U.S. Department of Housing and Urban Development (HUD). (2014). The 2014 Annual Homeless Assessment Report (AHAR) to Congress: Part 1 -- Point-in-Time Estimates of Homelessness. Retrieved November 4, 2015, from https://www.hudexchange.info/resources/documents/2014-AHAR-Part1.pdf
Utah Department of Workforce Services. (2016). Comprehensive report on homelessness. *State of Utah Housing*. Retrieved from https://jobs.utah.gov/housing/scso/documents/homelessness2016.pdf
Wheeler, E., Jones, T. S., Gilbert, M. K., Davidson, P. J. (2015). Opioid overdose prevention programs providing naloxone to laypersons — United States, 2014. *Morbidity and Mortality Weekly Report.* 64(23);631-635. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm
World Health Organization [WHO]. (2008). Essential environmental health standards in health care. J. Adams, J. Bartram & Y. Chartier (Eds.). World Health Organization. Retrieved from http://www.who.int/water_sanitation_health/hygiene/settings/ehs_health_care.pdf.pdf
World Health Organization. (2009). *Water, sanitation and hygiene standards for schools in low-cost settings*. J. Adams, J. Simms, Y. Chartier, & J. Bartram (Eds.). World Health Organization.
Yuan, A. H., Gabrielian, S., Andersen, R., McGuire, J., Rubenstein, L., Gelberg, L. (2014). What medical care needs of homeless and housed veterans are served by the VA? *Drug and Alcohol Dependence* 140 (2014) e169–e251. Retrieved from http://www.sciencedirect.com/science/article/pii/S0376871614007418
Zlotnick, C., Zerger, S., and Wolfe, P.B. (2013). Health care for the homeless: what we have learned in the past 30 years and what's next. *American Journal of Public Health*. 103(S2). S199-S205. Retrieved from http://ajph.aphapublications.org/doi/ref/10.2105/AJPH.2013.301586

Section II: Healthy Living

Introduction

The Los Angeles Health Commission's goal is to prevent major chronic diseases among the residents of the City of Los Angeles, such as cardiovascular disease (CVD), cancer, pre-diabetes, diabetes, heart disease, and transmittable infectious diseases. Diabetes, along with pre-diabetes, are growing chronic disease epidemics that are progressing to affect more and more populations due to vastly influential social and economic factors. An additional alarming statistic states that the prevalence rates for diabetes is higher than cancer prevalence rates in the Los Angeles County (Los Angeles County Department of Public Health [LACDPH], 2012). Furthermore, alcohol and tobacco abuse among residents desperately need to be addressed due to the corresponding short and long term health defects they cause. The City of Los Angeles has adopted effective tobacco control and prevention policies, but the status of implementation is unknown, particularly regarding more recent electronic-cigarette restrictions (LACDPH, 2016). The plight of individuals living among food deserts, having limited access to fresh food, high-priced healthy food, and hype from the media has been vastly consistent. It is up to healthcare workers, policy makers, and stakeholders to create a positive impact in improving healthy decision making within the Los Angeles community.



Source: LADPH, 2015

The following recommendations are offered by the Los Angeles City Health Commission. These recommendations propose changes with the overall goal of reducing chronic diseases (i.e., cardiovascular, stroke, cancer, diabetes, prediabetes, and heart disease) by adopting and implementing preventive policies and programs, and by creating an environment that encourages and supports healthy living. Overarching objectives are:

1. Lessening the abuse of alcohol and tobacco; increasing healthy eating and physical Activity.
2. Directly reducing diabetes and pre-diabetes, whose rates are growing and are more prevalent than other diseases.
3. Prevention of infectious disease transmission.
4. Ensuring health equity by reducing population-level economic, racial and social disparities.

The Commission recommends that City and County leaders take three major actions to achieve this goal.

The three major actions include:

1) Accelerate progress to achieve the objectives in the city's Plan for A Healthy LA and county's Community Health Improvement Plan;
2) Accelerate progress on actions proposed by community stakeholders during Health Commission meetings;
3) Build on the strong relationship between city departments and the county departments of public health, health services and mental health.

Plan for A Healthy LA and Community Health Improvement Plan Objectives

Recommendations:

1) Determine the extent of progress toward these objectives.
2) County Public Health plans to publish a status update in February 2017.
   - City Planning is not actively tracking progress. LA City Council and Mayor Garcetti have adopted new laws to implement actions recommended in Plan for A Healthy LA, such as to increase farmers' markets availability to CalFresh (food stamp) participants, enacting the Clean Up Green Up ordinance to improve air quality near polluting businesses and to increase funding for new parks. One of the Plan's key actions is incomplete: *Annually track the Plan for a Healthy Los Angeles core indicators and objectives and prepare an updated Health Atlas Report in five and ten years from Plan adoption to evaluate community health and wellbeing*.
3) Identify obstacles to Plan recommendations that have not moved forward.
4) Health Commission to facilitate discussion with LAUSD about how the City of LA can support creation of Healthy Kids Zones around schools.

Background:

These goals were founded on a vision of health that was articulated with the assistance of residents, community leaders, and staff from various City and County departments, and other local government agencies. A vision of a healthy Los Angeles includes:

- Complete neighborhoods that meet residents' basic needs, including:
  - Access to health-promoting goods and services, which include affordable grocery stores, comprehensive medical services for both physical and mental health, park space, and childcare, among others.
- Community design that promotes healthy living for people of all ages, income levels, cultural backgrounds, and geographies.
- Access for individuals with disabilities and across the age spectrum.
- Use of community resources such as schools and underused assets to promote health and well-being.
- Access to affordable and safe opportunities for physical activity, particularly for park poor communities.

- Safe and just neighborhoods that are free of violence, where residents feel safe pursuing healthy activities, promote trust between law enforcement and local stakeholders, and where every resident has access to economic and educational opportunities that help support public safety in all neighborhoods.
- A balanced, multi-modal, and sustainable transportation system that offers safe and efficient options for all users.
- Access to affordable, healthy, and safe housing for residents of all ages and income levels.
- Access to healthy and sustainable environments with:
    - Clean air, soil, and water.
    - Tobacco- and smoke-free environments.
    - Ample green and open space, including a robust tree canopy in all neighborhoods and opportunities for urban agriculture.
    - Minimized toxins, greenhouse gas emissions, and waste.
    - Climate resilience that protects residents from the public health effects of climate change.
    - Opportunities for economic, educational and social development, including:
        - A thriving economy that provides all residents with the opportunity to access good jobs that offer the financial resources needed to lead healthy lives.
        - Educational resources and workforce development that prepares residents for the jobs of the future at every stage of their lives.

The Plan for A Healthy LA prescribes 88 separate actions that, if fully implemented, would substantively improve the health status of Los Angeles residents.

Action Plan:

The committee urges that the aforementioned recommendations, if fully implemented, would substantively improve the health status of Los Angeles residents. In addition, it would accelerate the progress to achieve the objectives in the city's Plan for a Healthy LA and county's Community Health Improvement Plan.

Community Stakeholders

Recommendations:

1) Strengthen implementation of policies and programs to improving access to affordable, nutritious foods and proximity to park spaces.
    - All city departments fully implement Good Food Purchasing Policy.
    - Incorporate Healthy Food focus as part of efforts to streamline new business opening. Focus on the Healthy Food Incentive zones identified to close food access disparities.
    - Support policy to improve beverage choices in kids' meals at fast food restaurants.
    - Set a target to increase breastfeeding rates at workplaces, beginning with city departments.
    - City of LA should rapidly and fully implement the revised Quimby Park Fee Ordinance (Council File 16-0529) to ensure increased resources from the updated fee structure reach

the most park-poor residents. City of LA should use resources generated by LA County's Measure A, recently passed by voters on November 8, 2016, to implement priorities identified in the 2016 Countywide Parks and Recreation Needs Assessment.

2) Ensure adequate funding and full implementation of the City of LA's Vision Zero plan to improve safety of walking and biking.
   - Metro to provide sufficient resources to support safety improvements to the most accident-prone corridors and intersections.
   - City Council to accelerate active transportation projects in areas facing greatest risk to pedestrians and cyclists giving priority of implementation when the area of concern overlaps with the most disadvantaged areas of the City as identified in the Plan for a Healthy Los Angeles' Community Health and Equity Index.
   - Recommend to Mayor and the City Council to pursue legislation to support Automated Speed Enforcement. Make speeding tickets from speed cameras more like a parking ticket (i.e. lower fines, no point on your license, civic adjudication process, etc.) and dedicate any revenue from the program back to safety improvements, not the City's general fund (to prevent any appearance that this is just a revenue generating project).
   - City Council to actively seek, encourage and promote community participation to raise awareness, educate and offer residents an opportunity to shape their own environment and strengthen partnership with community based organizations such as Vision Zero Alliance.
   - Support Open Streets program

Background:

The City of LA directly influences residents' health by shaping the environment through land use and zoning, providing municipal services that improve residents' quality of life, and through its allocation of public resources. City departments are responsible for building and maintaining parks, providing sanitation services that keep communities clean, enforcing the City's codes, ensuring the quality and safety of housing, and maintaining public safety, among many other services that influence and promote health for Angelenos.

The City can help promote good health by increasing access to health promoting resources through its own departments and by stimulating economic development that creates jobs, increases commercial resources in areas that lack services, and increasing access to affordable and healthy housing. The City also works with other governmental entities, such as the Los Angeles Unified School District and Metro, among others, to help promote access to health resources, quality education, and improvements to the built environment.

The relationship between individual habits and healthy choices reflects the built environment. Environmental and

community factors are fundamental to ensure the future health outcomes of city residents. Recognizing this, the creation of the Health and Wellness Chapter of the LA City General Plan (Plan for Healthy LA) has been fundamental to committing the city to improving community health, supporting environmental and prevention efforts. It is important to recognize the manner in which state and regional government affect the health of the population. Both state and regional government take on an oversight role on a variety of the environmental factors that contribute to health of the residents of Los Angeles.

Obesity is a national epidemic that requires prompt action by national and local government agencies. In terms of tracking, obesity incidence and prevalence data is more accessible and available to collect. For instance, data on diabetes and pre-diabetes is not as obtainable. However, diabetes rates are best known through an understanding of the fundamentals of obesity rates, including health promotion and environmental interventions.

Environmental factors that adversely impact health must also be targeted in an attempt to impact the current rates of obesity and diabetes (Ershow, 2009). Addressing factors in our built environment such as access to healthy nutritious foods and tobacco cessation can help to improve community-level health (Ershow, 2009).

Action Plan:
The committee supports the aforementioned recommendations to accelerate the progress on the actions proposed by community stakeholders.

City and County Department of Public Health, Health Services, and Mental Health

Recommendations:
1) Health Commission to survey City Council offices and City departments to confirm they have adequate contacts with County health departments to resolve policy and community issues.
2) Health Commission to coordinate annual briefing for City Council and Mayoral staff to learn about the latest health status data and recommendations from County health departments for City consideration.
3) Health Commission to convene a joint hearing with County's Healthy Agency Integrated Advisory Board to identify areas of mutual priorities, collaboration and research.

Background:

The mission of the County Department of Public Health is to develop programs and services that serve in protecting health, preventing disease, and promoting the health and wellbeing of all individuals in the County of Los Angeles. The relationship between DPH and the City of Los Angeles is facilitated through analysis, health education, communicable disease control, food and water inspection and other environmental health services. DPH promotes health through its chronic disease and injury prevention programs. These programs work in partnership with cities, schools, businesses, and communities to promote policies, systems and environmental change that create safer and healthier places and provide City residents with greater opportunities to adopt healthier lifestyles. For example, DPH has collaborated with the City on efforts to reduce smoking and secondhand smoke exposure, provided support for active living events like CicLAvia, and assisted with City initiatives designed to increase access to active transportation and healthy food.

County Department of Health Services operates 19 health centers and four hospitals (three operating in the City). DHS annually cares for 670,000 unique patients, employs 19,000 staff, and has an annual operating budget of $4 billion. The Department provides health services to youth in the juvenile justice system and specialized medical services to children in foster care. Through academic affiliations with the University of Southern California (USC) and the University of California, Los Angeles (UCLA), DHS hospitals are training sites for physicians completing their graduate medical education, as well as settings to improve housing and services for unhoused DHS patients upon.

County Department of Mental Health operates programs in more than 85 sites, and providing services via contract program and DMH staff at approximately 300 sites co-located with other County departments, schools, courts and other organizations. DMH contracts with more than 1,000 organizations and individual practitioners to provide a variety of mental health-related services. On average, more than 250,000 County residents of all ages are served every year. In the City of LA, DMH works with Police, Fire and others to respond to residents experiencing mental health distress. DMH is core to the City's Homeless Strategy, identified in multiple recommendations from training first responders to supporting street outreach teams.

Action Plan:

The committee supports implementing the aforementioned recommendations to build on the strong relationship between city and county departments of public health, health services, and mental health.

References

Ershow, A. (2009). Environmental Influences on Development of Type 2 Diabetes and Obesity: Challenges in Personalizing Prevention and Management. Journal of Diabetes Science and Technology. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2769972/

Los Angeles County Department of Public Health [LACDPH] (2012). Trends in Diabetes: Time for Action. Retrieved from http://publichealth.lacounty.gov/wwwfiles/ph/hae/ha/Diabetes_2012_FinalS.pdf

Los Angeles County Department of Public Health [LACDPH] (2015). Health survey 2015 dataset Retrieved from https://dqs.publichealth.lacounty.gov/query.aspx?d=57

Los Angeles County Department of Public Health [LACDPH] (2016). Tobacco Control and Prevention Program. Retrieved from http://publichealth.lacounty.gov/tob/

Los Angeles County Registrar-Record. (2016). LA County Election Results. Retrieved from: http://www.lavote.net/election-results#year=2016&election=3496

Section III: Medical Services

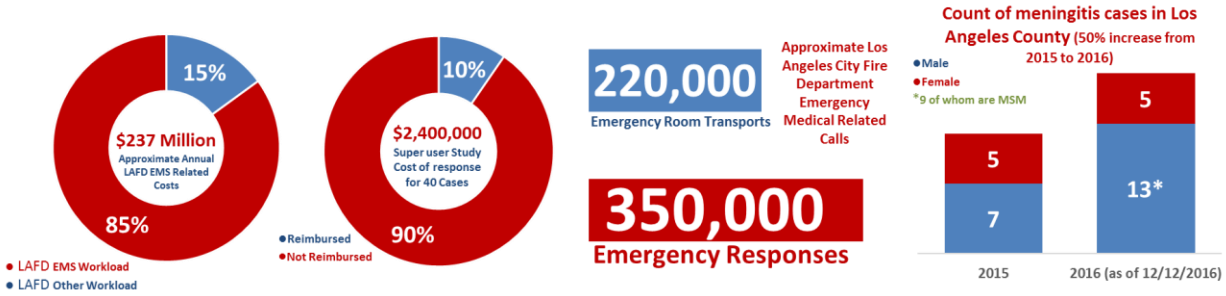
Introduction

The Los Angeles Fire Department (LAFD) responds to over 406,088 calls, with 339,379 of those for emergency medical service (EMS) every year while also transporting up to 220,000 patients to emergency rooms (LAFD, 2016) (Eckstein, 2016). In 2013, there were 867,027 fire department responses, 705,786 of those responses were for EMS (LAFD, 2016). Since the LAFD was designated as the sole provider of public emergency ambulance for the City of Los Angeles in 1973, this vital service has grown to constitute more than 85% of the workload of the department at an estimated annual cost of $237 million based on the fiscal year 2014-2015 (LAFD, 2016) (Board of Fire Commission, 2014). All operations of LAFD are approximately $729 million (Board of Fire Commission, 2014; Sanko, 2016). 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.

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. Coordinated emergency response is maintained through the Incident Command System (ICS), which is impetus in the multi-coordination of tactile operations and system implementations. This system functions in partnership with seven organizations including:

1. California Division of Forestry (CDF)
2. Governor's Office of Emergency Services (OES)
3. Los Angeles County Fire Department
4. Los Angeles City Fire Department
5. Ventura County Fire Department
6. Santa Barbara County
7. U.S. Forest Service California Region

To fully understand the Emergency Medical functions of the LAFD, the Los Angeles City Health Commission met with the leadership of the EMS Bureau of the Fire Department and endorsed their recommendations to make services more efficient.



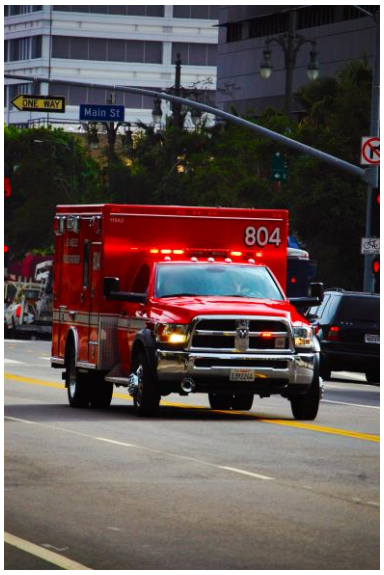
Source: LAFD, 2016; Eckstein, 2016; Board of Fire Commission, 2014; LADPH, 2016

Emergency Medical Services (EMS) Calls

Recommendations:

1) Elevate the importance of medical services over policing regarding EMS Calls.
2) Transfer "super users" or serial inebriates to sobering centers and assist in connecting with services through the continuum of provider care.
3) Expand the SMART Crisis Response Team within the Los Angeles Police Department.

Background:



Assistance with EMS "super users" calls can be supported with the guidance of the Los Angeles City Health Commission. Although the Los Angeles City Health Commission has no operational responsibility for LAFD EMS, the volume of health services provided by the agency warrants attention from a commission charged with reviewing and addressing health needs in the City, especially those that are carried out in relation with the Los Angeles County Health Agency. In 2011, approximately $2.4 million was spent on "super user" incidents. Of this amount, only $231,000 was actually paid for/reimbursed.

Each missed 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 or 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 of failed prevention efforts and limitations of the health care system.

Action Plan:

The committee urges the adoption of the stated recommendations to improve response to EMS calls.

Increase Use of Fast Response Vehicles (FRV)

Recommendations:

1) Provide more Fast Response Vehicles.
2) Establish hospital agreement to transport patients to the nearest hospital within a reasonable distance.
3) Improve and/or reduce "wall time" response referrals to minimize gaps in lapse time in which paramedics and EMT's cannot leave an emergency situation until a patient is transferred. Potential solutions for incentivizing expedient service or reducing "wall time" include:
    - Penalizing hospitals for keeping patients too long.
    - Leaving one paramedic alone with several patients.

Background:

An FRV is a pickup truck sized vehicle equipped with limited fire-fighting capability. Providing a full range of EMS equipment staffed by two firefighters/paramedics on patrol, while located in busy EMS demand areas, will allow for quicker response to calls and initiate faster care, pending the arrival of an ambulance. This can eliminate the need to dispatch a fire engine, cutting response time, and can summon the appropriate ambulance, if necessary. This program is, with County EMS approval, undergoing evaluation (Eckstein, 2016).

Action Plan:

The committee urges the adoption of the stated recommendations to implement FRVs and address wall time.

Expansion of Response Unit Programs

Recommendations:

1) Implement and expand the Nurse Practitioner Response Unit (NPRU).
2) Implement and expand the Nurse Practitioner at Dispatch program.
3) Continue the development, implementation, and expansion of the Sobriety Emergency Response Unit (SOBER).
4) Continue the development, implementation, and expansion of the Mobile Mental Health Unit (MMHU).

Background:

NPRU is 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 (Eckstein, 2016).

The *Nurse Practitioner at Dispatch* is 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 being screened by a trained dispatcher (City of Los Angeles, 2015). The nurse could take the time to determine the caller's needs and offer a clinic referral. Additionally, this program would help determine if dispatch of the NPRU is needed for such low acuity calls; or if a Basic Life Support (BLS) ambulance staffed by EMTs is ideal rather than paramedics; or the dispatch of a taxi to transport the caller to a clinic.

The LAFD SOBER program is a newly initiated unit in which a BLS ambulance paired with a trained counsellor determine if the patient requires detox and sobering; and provides an EMT to check basic medical needs. The program also allows transport to a Sobering Center rather than an emergency room. The County in cooperation with the City is developing the sobering centers, particularly near "Skid Row". This program is in its early pilot stage (LA32NC, 2016).

A MMHU is an ambulance staffed with a Nurse Practitioner and an LPS Certified Social Worker who are able to evaluate patients with mental health crises and determine any medical needs. If the patient is cleared medically, the ambulance will transport the patient to an LPS-designated mental health facility rather than an emergency room. This program is currently in development.

Action Plan:
The committee urges the adoption of the stated recommendations to continue the development, implementation, and expansion of Response Units Programs.

Affordable Care Act (ACA) Implementation

Recommendation:
1) Referrals to non-profit organizations equipped with resources to provide medical services (including mental, alcohol and drug, and physical health).

Background:
Los Angeles City Health Commission is to convene key city departments that support Affordable Care Act (ACA) implementation in Los Angeles by promoting Covered CA, Healthy Way LA and MediCal expansion (HCIDLA, LAPL, LAFD, Mayor's Office and community health insurance advocates). The mission should be to identify ways to strengthen use of insurance, navigation of medical care and specific advocacy requests on behalf of city residents.
Two issues with ACA dissemination that still need to be addressed include:

a. Enrolling patients in health plans with an affordable monthly premium.
b. Gaining access to doctors who are local to their patients.

Action Plan:
The committee urges the adoption of the stated recommendations to improve dissemination of ACA implementation.

Zika Virus and Other Communicable Disease Response

Recommendations:
1) Enhance outreach at airports for Zika virus and other communicable diseases. Increase communication for travel restrictions pertaining to Zika virus and other infectious diseases by:
    - Increasing frequency of messages on kiosk screens.
    - Increasing awareness of safe sex practices.
    - Alerting people of prevalence and CDC recommendations.
    - Including health messages/alerts of disease(s) on itinerary or ticket (with incentives for airlines to implement this method) and in baggage claim areas.
    - Including text message alerts as part of emergency alert systems.

Background:

The California Department of Public Health reports 472 travel-associated cases of Zika virus infection in the state since 2015; 106 of these cases were in the County of Los Angeles. Among these cases in California were 73 pregnant women, and three children born with birth defects, including microcephaly. The County of Los Angeles Public Health reports that as the amount of infections among U.S. travelers is expected to potentially increase, viral introduction and local spread via Aedes mosquitos within the U.S. is possible (LACDPH, 2016). Turnaround in response time is needed to effectively increase communication, action, and delivery of information among residents. Education of travelers is imperative to stop the spread of Zika virus transmission, as is more information about safe sex practices.

Action Plan:

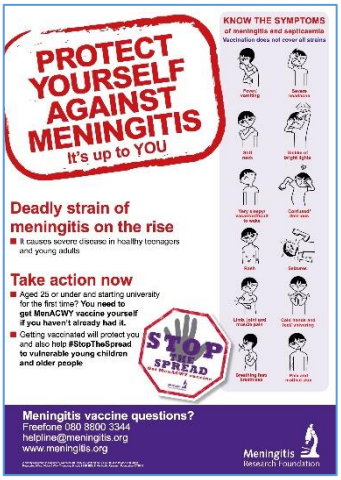
The committee urges the adoption of the stated recommendations to improve Public Health Education for Zika Virus and other communicable diseases.

Meningitis Outreach and Education

Recommendations:

1. Increase outreach and health education regarding Meningitis Outbreaks by:
    - Increasing awareness among vulnerable subpopulations (i.e., gay and bisexual men) utilizing LA Pride parades and similar festivals for LGBT communities.
    - Increasing awareness of safe sex practices.
    - A community plan for providing immediate access to vaccines during a meningitis outbreak.
    - Utilizing electronic social networks such as Twitter, Tinder, Grindr, and other technology/social media platforms to provide outreach, education, and connect to sexual partners potentially exposed to the virus.
    - Initiating collaboration between the City and County to roll out health education plans earlier, especially in regards to outbreak alerts and emergency response.
        - Include public-private partnership in order to disseminate information.

Background:



Meningococcal disease (meningitis) is caused by a type of bacteria known as *Neisseria meningitidis*. The disease, which is fatal in about 1 in 10 patients, is spread through saliva, by close contact with an infected person. It can be easily transmitted by kissing, by unprotected anal or oral sex, and even by close proximity to an infected person who is sneezing and coughing. It is a serious infection that can cause brain infection and/or bacteremia (blood infection), and can lead to death (Los Angeles County Public Health, n.d.). Since 2013, there have been two outbreaks of meningitis in Southern California. The first in 2013-14 led to the death of two Los Angeles men in the gay community. During the recent outbreak in 2016, 27 cases were reported resulting in two deaths as of August, 2016. In each case, the number of gay (and bisexual) men were disproportionately represented among those infected. Quick response times from the County of Los Angeles in providing health alerts to the community, and access to vaccines, are a critical component in preventing the spread of the disease. Bridging the gap in health education outreach should be a priority of utmost concern to meet the needs of the people. Outbreaks of meningitis in Los Angeles have been of particular concern to the members of the LGBT community and require greater City efforts at prevention education.

Action Plan:

The committee urges the adoption of the stated recommendations to improve Public Health Education for Meningitis.

References

Eckstein, M. (2016). Presentation on health-related costs, programs, and policies. Los Angeles City Fire Department. February 8, 2016. Audio Retrieved from: http://lacity.granicus.com/MediaPlayer.php?view_id=46&clip_id=15535

City of Los Angeles. (2015). Mayor Garcetti Unveils Los Angeles Fire Department Innovations to Improve Emergency Response, Patient Care. Retrieved from: https://www.lamayor.org/mayor_garcetti_unveils_los_angeles_fire_department_innovations_to_improve_emergency_response_patient_care

Sanko, S. (2016). Personal communication. Phone Interview on October 31, 2016.

Los Angeles County Department of Public Health [LADPH] (2016). Invasive Meningococcal Disease: 2016 Los Angeles County Epidemiology Report December 12, 2016. Retrieved from http://publichealth.lacounty.gov/acd/docs/IMD2016.pdf

Los Angeles Fire Department. (2016). History of LAFD. December 13, 2016. Retrieved from: http://joinlafd.org/index.cfm?section=historyoflafd

Los Angeles Fire Department. (2016). Los Angeles Fire Department A Safer City. Strategic Plan 2015-17. Retrieved from: https://issuu.com/lafd/docs/262609736-lafd-strategic-plan-2015-?e=17034503/13744980

Los Angeles Fire Department. (2016). Our Mission. Retrieved from: http://www.lafd.org/about/about-lafd/our-mission

Los Angeles Fire Department. (2016) Emergency Medical Services. Retrieved from: http://www.lafd.org/about/emergency-medical-services

Board of Fire Commission. (2014). Emergency Ambulatory Service Fee Increase. Retrieved from: http://clkrep.lacity.org/onlinedocs/2014/14-1693_MISC_11-24-14.pdf

Board of Fire Commissioners. (2015). Proposed Fiscal Year 2016-17 Budget. Retrieved from: http://www.uflac.org/images/shared/Documents/ProposedBudget.pdf

Emergency Medical Services Agency. (2016) EMS Annual Data Report. Retrieved from: http://file.lacounty.gov/SDSInter/dhs/248671_2016EMSAnnualDataReport.pdf

Emergency Management Services. (2016). About EMSI. Retrieved from: http://www.emsics.com/about-emsi-cqn6

Los Angeles County Department of Public Health. (2016). LAC DPH Health Update: Zika Virus Infection. Retrieved from: http://publichealth.lacounty.gov/eprp/Health%20Alerts/LAHAN%20Zika%201%2028%2016%20FINAL.pdf

Los Angeles County Department of Public Health. (n.d.). Meningitis. Are You Sick? Retrieved from: http://publichealth.lacounty.gov/ip/DiseaseSpecific/dontswap.htm

Los Angeles LGBT Center. (2016). Health Services. Meningitis Vaccine – Los Angeles. Retrieved from: https://lalgbtcenter.org/health-services/medical-services/vaccine

Conclusion

In this report, the Los Angeles City Health Commission proposes recommendations related to three primary areas of concern: 1) homelessness; 2) healthy lifestyles; and 3) medical services. The Commission offers specific recommendations for action by the City, and urges the City to take a more direct and active role in addressing these areas of concern. The Commission believes that by adopting the recommendations in this report, the health and wellbeing of the people of Los Angeles will be significantly improved.