

LOS ANGELES CITY



HEALTH COMMISSION

2021



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Introduction to Annual Report 2021

The Los Angeles City Health Commission was authorized on July 2014 by Ordinance No. 183093 to determine the health needs of the people of the City of Los Angeles, assess whether those needs are being met, and identify cost effective ways of meeting those needs (Office of the City Clerk, 2020). Similar to the 2020, 2018, and 2015-2016 Annual Reports, the 2021 Annual Report is designed to advise and inform the City Council and the public on the health needs of people in Los Angeles. The 2021 and previous Health Commission reports follow the Blum's Model of Health (1983) by dividing information into three sections identified as key determinants of health: environment, lifestyle, and medical care. Due to the Coronavirus (COVID) pandemic, a new section is added to focus solely on information related to COVID in Los Angeles. This report is divided into sections with updated recommendations, backgrounds, and action plans of health programs and efforts conducted in the City.

The Health Commission fulfills its responsibility to provide public health information and recommendations to the people of Los Angeles; however, the Commission has not been heard or taken seriously by county and city government officials. The Health Commission provides annual health reports to the City Council and various government officials in Los Angeles but receives little response. Furthermore, the Commission runs almost entirely on a volunteer basis and receives no funding. The City Council should provide greater attention and financial investment in the Health Commission to conduct high-quality research and to advise the City with evidence-based health policies and interventions. An annual allotment of \$2 million is requested by the Commission to provide adequate funding for full-time staff and directed research. Since the Department of Public Health in Los Angeles County received an annual budget of over \$940 million, the Commission believes a portion of the budget should be allocated to the commission's personnel and projects that specifically address health issues in Los Angeles City, the largest city in the County. Support from the government is of crucial importance to the Commission's ability to accomplish its goals and duties.

Section I: Homelessness

Introduction:

In June 2020, the Los Angeles Housing Services Authority (LAHSA) published the 2020 homeless count, which identified 41,290 total individuals experiencing homelessness within the City of Los Angeles (LAHSA, 2020a). This number is a 16.1% increase from that of 2019 (LAHSA, 2020b). However, the 2020 count was conducted before the COVID-19 pandemic and subsequent homelessness relief efforts such as Project Roomkey, eviction moratoriums, and rent freezes; therefore, it is likely that these numbers have changed significantly since the collection of this data (LAHSA, 2020b).

Structural factors (systemic racism, an inadequate supply of low-cost housing, rising housing costs, a lack of available jobs, etc.) can interact with individual factors (mental health and substance abuse problems, limited social support, poverty, etc.) to increase the risk of homelessness. Individuals experiencing homelessness are disproportionately affected by infectious disease, chronic illness, violence, mental illness, and substance abuse. Consequently, mortality rates among the homeless are at age 51 for men and 48 for women (Kuhn et al., 2020). These risks are a public health issue not just for those experiencing homelessness but also for other housed individuals in those communities: individuals experiencing homelessness use emergency departments at higher rates, straining the health care system. They also have the potential for widespread disease transmission due to their higher susceptibility to symptomatic infection (Kushel et al., 2002; Culhane et al., 2020).

To understand the public health issue of homelessness, Nickasch and Marnocha highlight the four major causes of health disparities in the homeless population: lack of attainment of physical needs, healthcare affordability, health care provider compassion, and available resources (2009). To remedy the health disparities that arise with homelessness and to rehouse individuals experiencing homelessness, these four deficiencies must be addressed.

Our analysis of homelessness in the City of Los Angeles drew upon expert interviews, research, data analysis, and presentations given to the Los Angeles City Health Commission. In this report, the commission presents policy solutions that the Los Angeles City Council can implement to help reduce homelessness and improve the health and wellbeing of the City's homeless population.

Long Term Housing Solutions

Recommendations:

- 1) Continue funding Los Angeles City permanent supportive housing and housing first programs and establish a city council-controlled and funded organization to create more permanent supportive housing units.
- 2) Examine the current permanent supportive housing and housing first programs through government-funded comparative research studies, in order to determine overall efficacy and need for improvement.
- 3) Utilize any vacant units in the City, prefabricated modular housing, and adaptive reuse for use in permanent supportive housing with wrap around services where needed and Housing First programs.
- 4) Streamline the City processes and practices to expedite the building of housing for homeless and low income communities.
- 5) Implement the City goal of building 25,000 units of housing for the unhoused by 2025.
- 6) Evaluate proposals, aimed at addressing homelessness, from various organizations and/or government entities, such as ones that have been presented to the Commission in 2021.

Background:

Under Senate Bill 1380, all state housing programs in California are required to adopt the Housing First approach. This approach offers access to independent housing without requiring people experiencing homelessness to address their behavioral health problems or have met any other prior prerequisites. (Gulcur et al., 2003). The methodology is based on research that demonstrates better outcomes when giving individuals the choice of participation in supportive services (Einbinder et al. 2007).

One successful model that follows this approach is permanent supportive housing (PSH), which is a housing program for individuals and families with mental health issues, substance use disorders, chronic illnesses, or disabilities who have experienced repeated or long-term homelessness. PSH provides long-term rental assistance and supportive services and has a long-term housing retention rate of up to 98% (Montgomery et al., 2013). A majority of the clients who participated in PSH programs reported increased perception of autonomy, choice, and control, as well as higher usage of the optional supportive services. The clients who opt-in to these supportive services tend to be more likely to have greater housing stability, attend school, discontinue substance use, spend less time in the hospital, and participate in job training programs (Gulcur et al., 2003; Tsemberis et al., 2004). Another benefit of PSH is cost efficiency; housed individuals are less likely to use hospitals, jails, and emergency services in comparison to an unhoused individual. To quantify savings, Michael R. Cousineau, Associate professor of preventive medicine at the USC Keck School of Medicine, conducted a study that determined the cost of public services spent on four unhoused individuals to be \$187,288 over two years, a cost which dropped by \$20,000 per person when those same individuals were housed for two subsequent years (United Way, 2009).

Los Angeles has already implemented a number of programs that follow the Housing First approach and permanent supportive housing model. Housing for Health is one such program. In 2012, Housing First was established as a C3 program (County + City + Community) within the Los Angeles County Department of Health Services (DHS) to provide supportive housing to DHS patients experiencing homelessness alongside behavioral health and complex medical issues. Housing for Health has expanded its services since then to other vulnerable populations within the County (LACDHS, 2016a). The use of the Housing for Health program led to a reduction in the usage of legal and health services: 1) participants exhibited 52% fewer ER visits; 2) inpatient hospital stays were reduced by 44%; 3) mental health crisis service usage decreased by 47%; and 4) the average number of days spent in jail reduced by 52%. (Palimaru et al., 2020). Since 2012, 14,000 individuals experiencing homelessness have been housed with a 92% housing retention rate after 12 months. Intensive case management services with ongoing monitoring and follow-up have also been provided to 2,000 clients who were already provided shelter in other housing programs with insufficient services (LACDHS, 2021).

The Housing Authority of the City of Los Angeles (HACLA) was established in 1938 by City of Los Angeles Resolution No. 1241 and provided a large supply of housing to residents in the City of Los Angeles (HACLA, 2021). HACLA has helped 22,000 households of formerly homeless and chronically homeless individuals and families with their PSH programs (HACLA, 2021). Their homeless program and tenant-based supportive housing programs both partner with LACDHS to provide rental subsidies and supportive services for chronically homeless individuals and families (HACLA, 2021). The intensive support services enable individuals to stabilize their living conditions and remain housed.

As for the actual units required for Housing First programs and permanent supportive housing, the City of Los Angeles has 46,000 units in a state of non-market vacancy, which is equivalent to more than one for every unhoused person in the city. The Ace Institute's Vacancy Report has additionally documented 93,000 vacant units in Los Angeles, half of which are withheld from the housing market (Ferrer et al., 2020). Los Angeles can also implement the adaptive reuse of older commercial buildings in Downtown Los Angeles to obtain more housing units. Reuse of these buildings may outweigh the advantages of demolition and new development (Bullen et al., 2009). The use of prefabricated modular housing is also a cost efficient method in getting the units necessary for these programs. Prefabricated homes are houses that are partially built in an external site, shipped to the development site, and then placed on a foundation where the roof and exterior are to be finished (Lopez et al., 2016). These modular homes arrive on site and are usually about 95% complete. They only need to be fastened together with a crane when combining them together, taking workers a few days to complete (Lopez et al., 2016). Ultimately, this method of unit-building offers advantages such as a substantial reduction of construction time, higher quality control, and potential cost savings (Lopez et al., 2016).

Rise Together is a non-profit organization that has proposed a roadmap to solve homelessness. Their goal is to establish functional zero homelessness in the City of Los Angeles with this roadmap. Some of the roadmap's steps are to:

- Have a court-appointed and city-endorsed Homelessness Czar empowered to cut through red tape, with hiring and firing authority.
- Implement an expedited mapping program to determine: how many individuals are experiencing homelessness; real-time location mapping; and a classification of their needs
- Require non-profit organizations to participate in city-funded forensic accounting and public transparency requirements. For any project that has not yet broken ground, any PSH funds will be taken back and held on to by the City.
- Provide immediate housing with matched services. This means 20,000 shelter-based beds with semi-private rooms. The housing in residential locations should be populated at no more than 40 per site. This includes a shutdown of A Bridge Home sites.
- Create, between 6 weeks and 6 months, 13,000 emergency shelters for housing up to 1 year while awaiting intermediate housing options, 10,000 tiny/cabin homes with no more than 20 homes per site and one case worker per site, and 3,000 housing units in retrofit of 1200 State Street that will provide resourced-based assisted living with around-the-clock support services.
- Use, within 9 months, existing bids and offers currently in front of the city to house 12,000 individuals.
- Have, within 1 year, 90% of individuals experiencing homelessness in housing. For those who are considered low-need individuals, begin to transition them into long-term housing such as retrofit of city-owned homes and apartment buildings, supplemented master leases, roommate matching, family reunification, financial incentive program for anti-recidivism and efforts to supplement that.
- Establish, within 18 months, a permanent, real-time database of housing options and individuals experiencing homelessness. This includes a capacity at every site using a digital booking system.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to advance homelessness programs in Los Angeles.

Emergency Shelters and Transitional Housing

Recommendations:

- 1) Apply Housing First principles to emergency shelters and transitional housing.
- 2) Help transition individuals using COVID-19 emergency shelters into permanent supportive housing programs.
- 3) Transition congregate transitional housing and emergency shelters into non-congregate shelters.
- 4) Examine the LAC+USC Restorative Care Village and Project Roomkey through government-funded comparative research studies, in order to evaluate overall efficacy and improvement.

Background:

The prolonged process of rehousing chronically homeless individuals and increase in the number of homeless individuals gives need for emergency shelters and transitional housing programs. Homeless individuals who need PSH may experience delays in housing attainment (Kuhn et. al, 2020). The Substance Abuse and Mental Health Services Administration (SAMHSA) defines emergency shelters as a service people first turn to when experiencing economic shock, domestic violence, trauma, divorce, or any other life-destabilizing events. Transitional housing is a service that provides transitional residence of up to two years, with services that help people stabilize their lives (SAMHSA, 2021). Shelters and transitional housing programs are both designed to act as a safe short-term place to stay with access to services and resources for the homeless in the midst of attaining permanent housing. These facilities generally have showers, meals, case management, and beds. Access to facilities is usually dependent on the availability of beds at the site (LAHSA, 2019).

The necessity of transitional housing and emergency shelters is demonstrated by the analysis of Measure H's efficiency: during the 2018-2019 fiscal year, Measure H-funded emergency shelters helped 18,000 people move off the streets (LA County, 2021). This number is a significant increase from the prior fiscal year when 13,524 people were relocated off of the streets (LA County, 2021). Of those 18,000 people, 4,000 people left the shelter programs and were able to move into a permanent supportive housing program (LA County, 2021). Additionally, in the same fiscal year, 861 individuals experiencing homelessness were released from detention, 1,037 individuals discharged from hospitals, and 926 individuals were cleared from substance abuse treatment programs. All individuals were moved into transitional housing programs rather than onto the streets (LA County, 2021). In the 2019-2020 fiscal year, LA County helped 29,913 homeless individuals transition from the streets into transitional housing (Davenport, 2021).

The LAC+USC Restorative Care Village is a new transitional housing program being implemented by Los Angeles County that offers clinical care and other supportive services to individuals experiencing homelessness who are discharged from inpatient hospitals, County hospital emergency services, inpatient units, jails, and urgent care centers (Villasenor, 2021). The village has two components, a Recuperative Care Center and a Residential Treatment Program. The Recuperative Care Center has 96 beds that serve as immediate placement options for individuals who are discharged from an inpatient hospital and lack a supportive place to live (Villasenor, 2021). Administrative support, health oversight, case management, and resources that lead to permanent supportive housing programs are also provided at this Center (Villasenor, 2021). The Residential Treatment Program has 64 total beds and provides a short-term alternative to hospitalization in order to address mental health needs.

Project Roomkey is an emergency shelter program created by the County in response to the COVID-19 pandemic, serving thousands of unsheltered individuals in hotel rooms (LA County CEO, 2021). This program allows for the County to perform vast street outreach and provide COVID-19 vaccinations. LA County CEO reported that this program housed 8,000 unhoused individuals and enabled 30 hotels and motels to stay in business despite the economic downturn (LA County CEO, 2021). As Project Roomkey sites close, participants are then connected to permanent or temporary housing. Less than 4 percent of participants returned to living on the streets after exiting the program (LAHSA, 2021).

There is some reluctance from the unhoused population to enter emergency shelters and transitional housing programs. Individuals experiencing homelessness have cited ill-mannered shelter staff, a lack of autonomy, assault by shelter workers, small living spaces, too many surveillance cameras, a lack of promised services and food, and personal item theft as reasons for avoiding shelters (DeWard et al., 2010; LACHC, 2020). Additionally, stricter housing rules were associated with higher levels of depression in youth experiencing homelessness as well (Beharie et al., 2017). Due to these reasons, many individuals experiencing homelessness prefer to remain on the streets rather than use transitional housing programs. Kuhn (2020) suggests that the retention and efficiency of emergency shelters and transitional housing programs can be improved by implementing housing first principles, such as making the shelter open 24/7, not having people line up for a bed each night or leave early in the morning, allowing pets and other possessions, and removing drug and alcohol testing, criminal background checks, and income requirement.

Action Plan:

The Health Commission urges the adoption of the stated recommendations regarding emergency shelters and transitional housing in Los Angeles.

Encampment Sweeps and Hygiene

Recommendations:

- 1) Adopt the CDC recommendations regarding encampment sweeps and sanitation.
- 2) Reduce the use of law enforcement during encampment sweeps.
- 3) Follow the five key LAHSA principles when moving people from an encampment into housing.
- 4) Continue to fund the Mobile Pit Stop and Mobile Shower Programs so that the City can provide better sanitation stations and expand hours of operation to all day at additional stations.
- 5) Provide non-congregate options for temporary and permanent housing.
- 6) Provide regular weekly trash pickup for encampments.
- 7) Use service providers that specialize in harm reduction to engage people living in encampments.

Background:

Encampment sweeps are used by the City to increase street sanitation and the hygiene of individuals experiencing homelessness. They typically involve law enforcement, public works staff, department of sanitation, or a city-contracted cleanup crew posting an eviction notice next to an encampment in response to complaints or 911 calls (Goodling, 2020). Although these sweeps are meant to increase street sanitation and hygiene, they also may produce an opposite effect. Sweeps cause people to lose their survival gear, identification, and medications (Goodling, 2020). They also generate citations and fines, creating additional financial barriers to housing (Goodling, 2020), which can lead to warrants and arrest. According to outreach workers, the most frustrating and solvable source of delays regarding individuals experiencing homelessness gaining housing involve lost birth certificates, social security cards, and other identifying documentation- all of which are lost during sweeps (Kuhn et al., 2020). Some members of the homeless community have cited these sweeps as “traumatizing” due to the use of brute force by law enforcement (LACHC Homelessness Hearing, 2020). LAHSA has five key principles for performing encampment sweeps in a compassionate and equitable manner: 1) provide enough time to engage with the people living in the encampment during this transition; 2) ensure voluntary, client-centered, and trauma-informed care; 3) provide appropriate, adequate, and low-barrier resources; 4) identify an experienced service partner and let them lead; and 5) establish strong team coordination (LAHSA, 2021).

The CDC (2021) recommends that individuals in encampments should be left as they are: clearing encampments can cause people to disperse through the community and break connections with service providers as well as increase the potential for infectious disease spread. Additionally, the CDC (2021) recommends that the city ensures nearby restroom facilities remain open to people experiencing homelessness 24 hours a day and have functional water taps, bath tissue, and hand hygiene material. If toilets or handwashing facilities are not available nearby, portable latrines and handwashing facilities should be provided in their place (CDC, 2021).

The City has conducted encampment sweeps without following CDC guidelines; however, the City has provided portable latrines and handwashing facilities to homeless encampments. Unfortunately, many of these facilities have been described as “frequently inoperable, poorly maintained and inaccessible” and found without doors, locks, toilet paper, and sinks (Ares et al., 2017). During the COVID-19 pandemic, the City distributed 363 handwashing stations and 182 portable toilets at encampments as a response. City officials said they replaced 175 toilets and 94 hand-washing stations (LA Times, 2021). As a result, the City is currently opting to put more funding into its Mobile Pit Stop program, which serves as a public restroom service in densely populated and vulnerable areas within the City. One to two attendants typically stay on-site to prevent damage or stealing.

In January 2019, the Mobile Pit Stop Program was granted \$6.5 million from the State of California’s Homeless Emergency Aid Program to expand the program (Yu, 2019). This prompted the City to also create the Mobile Shower Program, which is funded by LAHSA through 2022 (LAHSA, 2020). Mobile shower facilities have individual shower rooms built into trailers that allow homeless individuals to take hot showers in private. Not only have they improved the public health and hygiene for those experiencing homelessness, but they have also provided opportunities for LAHSA outreach teams to engage with the unhoused and provide them supportive services and housing (LAHSA, 2020). Currently, evaluation of the Mobile Pit Stop and Mobile Shower programs has demonstrated that the program addresses the needs of the unhoused population and reduces the public health risks associated with various factors such as public urination and defecation (Yu, 2021).

Action Plan:

The Health Commission urges the adoption of the stated recommendations regarding encampment sweeps in Los Angeles.

Sobering Centers

Recommendations:

- 1) Make the Sobering Centers more accessible by removing certain restrictions.
- 2) Examine the efficiency of these centers in preventing medical and police service usage and create more sobering centers based on the results of the study.

Sobering centers are facilities that provide a safe, supportive environment for homeless or marginally-housed, publicly intoxicated individuals to become sober (ACEP, 2013). The goal of these facilities is to send serial inebriates to a place where they can be monitored rather than use police and emergency medical services (Exodus, 2017). Los Angeles opened the Dr. David L. Murphy Sobering Center on January 2, 2017, which has a capacity of 50 beds open 24 hours a day, with an expected 8,000 visits from 2,000 people.

Although the center initially experienced a slow start with only 2,463 visits in the first year of opening, the center saw 9,133 visits in 2018 (LA Downtown News, 2019). LAPD and LAFD's SOBER Unit, which comprises a firefighter, paramedic, nurse practitioner, and caseworker from the Sobering Center, has helped increase the number of patients seeking sobering treatment since the center first opened. Access to the Sobering Center requires a referral from a law enforcement officer, emergency personnel, or a designated outreach worker in the Skid Row area (Exodus, 2021). Lifting these restrictions may potentially help in increasing the usage of the Sobering Center.

Action Plan:

The Health Commission urges the adoption of the stated recommendations regarding sobering centers in Los Angeles.

Discharge Planning

Recommendations:

- 1) Continue to observe the LAC+USC Restorative Care Village and the effect it has on preventing patient dumping.
- 2) Pass a city ordinance that will fine hospitals for patient dumping.

Background:

Many homeless patients lack a place to go after hospital treatment. Hospitals struggle with the responsibility and finances required to relocate homeless individuals to proper locations. The LAC+USC Restorative Care Village is an attempt to remedy this and provides shelter for homeless patients discharged from inpatient hospital services and County hospitals. Additionally, Senate Bill 1152 requires hospitals, acute psychiatric hospitals, and special hospitals to: 1) “Establish a written process to make sure adequate post-hospital care arrangements are made for homeless patients;” 2) “Report patient housing and discharge information to the Office of Statewide Health Planning and Development;” 3) “Coordinate services and referrals with behavioral health, medical care, and social services agencies for homeless patients;” 4) “Maintain an accurate list of local homeless shelters, including their operation hours and admission procedures” (Institute for Health Policy and Leadership, 2018).

Action Plan:

The Health Commission urges the adoption of the stated recommendations regarding discharge planning in Los Angeles.

Food Insecurity and Assistance

Recommendations:

- 1) Evaluate methods to increase SNAP enrollment.
- 2) Increase SNAP funding.

Background:

There is a high rate of food insecurity among the homeless population (Morier, 2015). The United States Department of Agriculture provides two major categories of food insecurity, defined as:

1. “Low food security: reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake” (LACDPH, 2017).
2. “Very low food security: Reports of multiple indications of disrupted eating patterns and reduced food intake” (LACDPH, 2017).

For those on the street, meals are typically irregular, with limited or no nutritious choices. Emergency shelters are often unavailable to the general homeless population outside of the shelter system. Thus, many are left to buy food from high-priced, unhealthy fast food establishments. To combat this, CalFresh, or Supplemental Nutrition Assistance Program (SNAP), was established as a food stamp program to help lower-income individuals afford food products through allotments on an electronic benefit transfer (EBT) card. Most homeless individuals diminish their food stamp stipend within the first few weeks of their monthly allocation and are left to search for non-profit organizations that provide complimentary food. 1.2 million Los Angeles County residents benefit from CalFresh, with meals estimated to cost \$1.40 on average (Rosenbaum et al., 2018).

SNAP suffers from poor enrollment in California and Los Angeles County (TFT, 2018). The Food Trust released a report stating that 500,000 eligible individuals in LA County remain unenrolled (TFT, 2018).

Action Plan:

The Health Commission urges the adoption of the stated recommendations regarding SNAP in Los Angeles.

Disease Prevalence and Emergency Service Usage

Recommendations:

- 1) Extend evening hours of healthcare centers to homeless individuals.
- 2) Decrease theft among homeless individuals by providing places to store belongings during visits at healthcare centers and short-term storage during interim housing for the following.
- 3) Increase research efforts that assess barriers to healthcare services for those experiencing homelessness.
- 4) Utilize vacant buildings which could house those experiencing homelessness.

Background:

The homeless population suffers from preventable medical diseases that could be addressed with primary and secondary public health measures and education. Common medical conditions within the homeless population in Los Angeles are HIV, lung disease (bronchitis, tuberculosis, pneumonia), malnutrition, substance use, wound and skin infections, and rheumatic and musculoskeletal diseases (US National Library of Medicine, 2021, Seto 2021). Based on known prevalences of rheumatic and musculoskeletal diseases (RMSDs), a 2021 research study extrapolated that there are thousands of homeless with rheumatoid arthritis (RA), systemic lupus erythematosus, psoriatic arthritis, gout, and osteoarthritis (Seto, 2021). Further observations within this study found that the aforementioned musculoskeletal conditions were correlated with the following characteristics within the homeless: being an African American male, missing appointments, utilizing emergency services frequently, tending not to be on medications, and exhibiting severe disease (Seto, 2021).

The Los Angeles County Department of Mental Health reports that those experiencing homelessness are concerned for their safety during nighttime and thus sleep during the day in an effort to stay awake through the night. Moreover, Saban Community Clinic has a shower outreach program for the unhoused that offers healthcare services after showering; however, these services are not utilized by a significantly large percentage of those using the showers, despite the healthcare services being free of charge and readily available to them. Consequently, those experiencing homelessness have expressed that they are unable to use healthcare services that are available to them, as they do not have a place to safely store their belongings. For if they were to leave their belongings unattended, while they accessed healthcare services, there is a fear of theft of their belongings. As a result, with many of the unhoused sleeping during daylight hours and nowhere to store their belongings during healthcare visits, or even upon acceptance of interim housing, there is a decreased rate of both utilization of healthcare services and housing programs that assist those experiencing homelessness. To overcome these barriers, healthcare centers' hours of operation can be extended into the evening, offer a place of storage to securely place belongings, as well as, provide short-term storage for belongings that cannot be accommodated with interim housing placement for those unhoused. Employing such measures would not only overcome these particular challenges, but also help improve disease prevention by increasing the usage of healthcare services and acceptance of interim housing.

Furthermore, the University of California Los Angeles (UCLA) Fielding School of Public Health projected in late March of 2020 that COVID-19 would have a case fatality rate of over 4,000 within the homeless population. Among COVID-19 related hospitalizations, over 21,000 cases could be attributed to the homeless (Smith, 2020). With their reduced health status, the homeless may also experience severe illness and require critical care (Smith, 2020). Most homeless individuals are uninsured, creating a financial burden on the healthcare system. With the global pandemic, the need for housing, coronavirus testing, and vaccination mitigation heightens in urgency among vulnerable populations, like the homeless.

A retrospective study of emergency medical services utilization by the homeless population in Los Angeles, from January to December, was conducted. Within the twelve month study period, 355,411 incidents were related to 911 cases (Abramson et al, 2021). Of those incidents, homeless patients were involved in approximately 36,122 (10.2%) of the emergency situations (Abramson et al, 2021). Thus, in 2018, incidents for the homeless population occurred at a rate of 1155 per 1000 homeless residents or 14 times the rate of housed residents (Abramson et al, 2021). Of the 217,972 calls resulting in transport to the emergency department, 28,917 (13.3%) were from homeless patients (Abramson et al, 2021). The LA Fire Department also reported a 205% increase in EMS calls for homeless patients who experienced cardiac arrest but were found dead by the time paramedics arrived. The high number of EMS calls related to the homeless emphasizes the need for rapid interventions at city and county level.

The Commission extends its gratitude to Dr. Tanya Kondolay and Dr. Jingye Yang from St. George's University School of Medicine who provided insight to the Commission on this section of the report.

Action Plan:

The Health Commission urges the adoption of the stated recommendations regarding disease prevalence and emergency services among the homeless.

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Section II: Healthy Living

Introduction

This section of the report focuses on the impacts of the COVID-19 pandemic on Los Angeles' education system while considering the social and environmental influences on people's health.

Promoting healthy living remains a top priority for the Los Angeles Health Commission in order to prevent and stop the spread of COVID-19 among residents of Los Angeles City. Los Angeles has undergone major changes in the last year with business and school closures, state-mandated quarantine and self-isolation periods, and lifestyle modifications. With these changes, there have also been significant psychological and social consequences on individuals' health outcomes. Children, college students, front-line workers, and health workers have experienced the most exposure during the pandemic and have an increased susceptibility to post-traumatic stress disorder, anxiety, depression, and other variations of distress as a result (Saladino, Algeri, & Vincenzo, 2020). Past studies on pandemics reveal the psychological effects of contagion and quarantine, with heightened anxiety over contracting the virus, separation from loved ones, loss of freedom, uncertainty about disease advancement, etc. (Li and Wang, 2020; Cao et al., 2020).

In evaluating the effects of COVID-19 on our school systems, businesses, and the environment, the Commission is able to effectively advise stakeholders to allocate the necessary resources towards improving the health outcomes of vulnerable groups.

COVID-19 Transmission Among Students

Recommendations:

- 1) Require schools to implement multi-level prevention and response strategies to reduce SARS-CoV-2 transmission.
- 2) Use community transmission indicators to obtain levels of community risk.
- 3) Evaluate community transmission rates and alter phased prevention strategies accordingly.
- 4) Vaccinate teachers and staff as soon as possible.
- 5) Implement mask policies for all students, teachers, and staff, following the city ordinance's requirements.
- 6) Maintain distance in settings where masks cannot be worn, during activities with increased exhalation, and in common areas.
- 7) Alter classroom layouts to maximize distance between students. Face desks in the same direction and arrange desks in rows to minimize direct face-to-face interactions.
- 8) Decrease or eliminate nonessential in-person interactions between staff during meetings, lunch, and other situations that can increase the rate of adult to adult transmission.

Background:

As a result of the pandemic, education systems have undergone extreme modifications to tailor to the needs of educators, students, faculty, and staff. Schools play an essential role in building the infrastructure of a city's community. With a shift towards online learning at the onset of the pandemic, questions of when and how schools can safely return to in-person learning have taken precedence.

Dr. Alice Kuo is Associate Professor of Internal Medicine, Pediatrics, and Psychiatry and Biobehavioral Sciences at the David Geffen School of Medicine at UCLA, and of Health Policy and Management in the UCLA Fielding School of Public Health. At the onset of the pandemic, Dr. Kuo elucidated how COVID-19 is spread, and its future implications on community spread in education systems. COVID-19 is transmitted primarily via respiratory droplets. The virus is released in respiratory secretions when an infected person coughs, sneezes, or talks. Infection can also occur if a person touches an infected surface and then touches their eyes, nose, or mouth. Although surface spread of COVID-19 is certainly possible, regular hand washing and hygienic practices should reduce one's possibility of COVID-19 transmission through this mode of disease spread. Transmission commonly occurs during a prolonged duration of contact in closed settings. The Centers for Disease and Prevention (CDC) have recommended individuals maintain six feet of distance in populated and closed settings; the six-foot rule has also informed the CDC's guided recommendations for school reopenings and social distancing. It is worth noting that the six-foot social-distancing recommendation has been arbitrarily decided upon at the onset of the pandemic, and was not informed by studies measuring how far droplets travel in the air. Droplets, however, do not typically travel more than six feet and do not linger in the air.

A school based contact tracing study by the National Centre for Immunization Research and Surveillance (NCIRS) revealed how one student case led to zero transmissions to peers or teachers, and how five teacher cases infected only one student. In Italy, pediatric patients have made up 1% of all cases that are diagnosed, with 100% of all infected children surviving. By comparison, influenza in pediatrics kills 150 to 200 children annually in the US, with a vaccine readily available.

In general, children have milder respiratory symptoms and are less likely to develop a fever in comparison to adults. Acquisition of SARS-CoV-2 is less common in children than adults, based on household studies. Transmission among children is also less common yet still possible. Transmission in adults is greater with prolonged exposure in poorly ventilated spaces.

According to the Center of Disease Control's COVID-19 tracker, less than 10% of all COVID-19 cases in the United States have been linked to children and adolescents aged 5-17 years. Several studies conducted during the onset of the pandemic explain that incidence rates among children and adolescents are lower than adults. However, these low incidence rates may be explained by childrens' limited exposures due to school and daycare shut-downs, alongside a lower probability of being tested. (Reese, Patel, et al., 2020). Studies conducted during adolescent participation in camps, sporting events, and schools have shown that transmission does occur between adolescents. (Atherstone, Siegel, Schmitt-Matzen, et al., 2021; Chu, Yousaf, Chang, et al., 2020; Schwartz, Moorman, Makaretz, et al., 2020).

In comparison with adults, children infected with SARS-CoV-2 are more commonly asymptomatic or have non-specific symptoms linked to the vaccine (CDC, 2020; Davies, Klepac, Liu, et al., 2020; Laws, Chancey, Rabold, et al., 2021; Ludvigsson, 2020; Munro, Faust., 2020). Children are also less likely to develop severe illnesses or complications from contracting COVID-19 and experience a shorter duration of symptoms (JAMA, 2021). The long-term health consequences of adolescent infection remain unknown (Salamanna, Veronesi, Martini, et al., 2021).

Based on collected data, in-person learning has not been linked to substantial community transmission rates. Moreover, studies comparing COVID-19 hospitalization rates between counties with in-person schools and those with virtual classrooms have shown no significant effect of in-person learning on COVID-19 hospitalization rates when the baseline county hospitalization rates were low to moderate (Harris, Zieden, and Hassig, 2021). Recent data has illustrated that transmission, even amongst children, follows community transmission trends rather than augmenting them (Leidman, Duca, Omura, et al., 2020). Studies have shown that increases in case incidence among school-aged children and school reopenings do not appear to pre-date increases in community transmission. However, it remains unclear how case spikes can be attributed to school reopenings, as other factors play a role in community spread -- as schools reopen, gathering restrictions may ease and contribute to increased cases.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to thoroughly track the hospitalization and incidence rates of COVID-19 and to assess the safety of school reopenings.

Effect of School Time Reductions

Recommendations:

- 1) Upon school returns, evaluate the status of learning and identify learning gaps through formative assessment tools.
- 2) Identify and target students who possess gaps in education and provide specific learning support programs.
- 3) Maintain a beneficial relationship between students' academic, socio-emotional learning, and psychological health.
- 4) Make children aware of available support systems, such as hotlines and helplines, in case they require assistance as a result of the effects exacerbated by COVID-19.
- 5) Strengthen measures to sustain parental employment.
- 6) Provide income support to families with children living in poverty.

Background:

School closures have been an utilized tool to decrease the spread of the virus during the pandemic. A suspension of face-to-face learning has raised questions about its effects on student learning. Using data from a study conducted in the Netherlands, the effects of school closures on primary school performance can be evaluated. The Netherlands underwent a short lockdown of 8 weeks and has an equitable system of school funding with the world's highest rate of broadband access. Still, the results reveal a learning loss of approximately one-fifth of a school year. Losses are approximately 60% larger among students from less-educated homes. These findings imply that students made little to no progress while learning from home, with losses even greater in countries with weaker education infrastructures and longer school closure periods (Engzell, Frey, and Verhagen, 2021).

From a medical perspective, evidence suggests that children are less affected by COVID-19 in comparison to adults. However, the social and economic effects of COVID-19 impact children differently based on their socioeconomic status. Dynamic models of learning suggest how even small losses in education can accumulate into larger disadvantages for students over time (DiPrete & Eirich, 2006). Concerns about vulnerable students experiencing a greater learning loss, in comparison to students from higher economic backgrounds, inform the recommendations made. An investigation by PACE on COVID-19 and the educational equity crisis revealed a significant learning loss in the English Language Arts (ELA), with students in earlier grades being affected most (Pier, Hough, Christian, Bookman, Wilkenfeld, and Miller, 2021). Additionally, low-income students and English language learners (ELLs) experience a greater learning loss in comparison to others. The widening of educational disparities can also be attributed to a lack of support and resources for remote learning among lower SES students and students with disabilities.

School closures were identified as causes of anxiety and loneliness among children, and negatively affected children's behaviors and psychological well-being. Studies reveal increased levels of emotional symptoms among children, and emotional fatigue reported in mothers.

Adolescent physical health has also been affected, as a longer duration of school closure and a reduction in daily physical activity led to higher than expected increases in childrens' BMI indexes. The effect of COVID-19 related school closure on obesity was larger for boys, non-Hispanic blacks, and Hispanics as compared to girls, non-Hispanic whites, and Asians (An, 2020). The most concerning issue among school closures is childrens' psychological well-being. A study showed that parents' personal distress levels and child rearing stress scores during school closures were significantly higher than before school closures (Hiraoka & Tomoda, 2020).

COVID-19 closures of childhood care facilities, schools, and after-school programs have exposed children from low-income families to food insecurity and poor nutrition as well. Students who were supported by the National School Lunch Program were found to obtain one third of their daily calories from school-prepared meals and drinks (Story, 2009). Upon school closures, children enrolled in these programs are more likely to eat less and consume less nutritious meals (Nord and Roming, 2006; Morgan et al., 2019). Weight gain for children may be perpetrated by home confinement and lower levels of physical activity during the day (Rundle et al., 2020). The pandemic has also exacerbated the contributing factors that lead to child maltreatment, including household poverty, household overcrowding, social isolation, intimate partner violence, and parental substance abuse (OECD, 2019). Therefore, the need for greater support and resources for families has increased. COVID-19 has already compromised the effectiveness of child protective services; with reduced face-to-face contact, it has become more difficult for child protection workers to work with vulnerable children who are at risk (Davidson et al., 2019).

Learning reductions also give rise to significant economic consequences. The Organization for Economic Cooperation and Development (OECD) released a study on the economic impacts of learning losses, elucidating how learning losses can give rise to long-term income losses. Additionally, national economies that possess a less-skilled labor force have lower economic growth which will subtract from the overall welfare of the nation's society. The value of education is significant as it equips people with the skills to enhance their productivity during work-related tasks, and provides the knowledge and skills that enable people to contribute to technological progress and overall economic growth. These negative impacts disproportionately affect disadvantaged households who are more susceptible to the effects of intergenerational poverty and are more likely to experience earning losses in future employment opportunities (Hanushek & Woessman, 2020). With these social and economic risks, the Commission strongly urges stakeholders to maintain access to services for children and young people with mental difficulties, at-risk home environments, and lower socioeconomic statuses. Additionally, schools and education systems must have programs to assess and mitigate the impact of learning losses. Targeted learning support programs are essential to avoid creating greater educational losses for disadvantaged children.

Action Plan:

The Health Commission urges the adoption of the stated recommendation the use of thorough education-gap targeting programs to identify learning loss in children. Afterwards, support programs to enhance childrens' education must be implemented.

When and How Schools Will Reopen

Recommendations:

- 1) Follow the mandated mask requirement for all K-12 students when indoors, with limited exceptions.
- 2) All teachers and staff must be vaccinated or submit to weekly COVID-19 testing.
- 3) Promote physical distancing during activities when masks are not being used, such as when students are eating or drinking.
- 4) Optimize ventilation in indoor spaces.
- 5) Frequently clean facilities, including the items, furniture, etc used by students.
- 6) Increase the rate of hand-washing throughout the day and raise awareness about proper hand-washing practices
- 7) Limit the sharing of school supplies.
- 8) Abide by the vaccine mandate released by Los Angeles Unified School District.

Background:

The County of Los Angeles Department of Public Health has released multiple statements regarding reopening protocols for K-12 schools in Los Angeles as students return to in-person classes in the Fall of 2021.

Within the protocol is an emphasis on the importance of vaccination as the first line of prevention. Schools are encouraged to adopt policies that will promote and facilitate the vaccination of all eligible individuals on campus. Indoor masking requirements will be enforced for all individuals at K-12 schools, regardless of their vaccination status. Students who opt out of wearing face coverings will be offered alternative educational opportunities. However, staff and students who are not granted exemptions must wear a mask indoors, consistent with the state mandate and recommendations by the U.S. Centers for Disease Control and Prevention. These recommendations may change in the future, depending on community transmission rates in Los Angeles.

Schools must promote certain workplace policies and practices to protect their staff and students. Schools are expected to have a COVID-19 Containment, Response, and Control plan that delineates a school's approach to preventing the spread of COVID-19. Compliance teams will be responsible for establishing and enforcing all safety protocols and ensure students and staff are regularly educated about COVID-19 and future developments. A member of this team will serve as a liaison to the Department of Public Health in the event of an outbreak on campus. The LA County Department of Public Health has also released protocols in the event of positive results among school officials or members of the school community, including faculty, staff, students, or visitors. These protocols advise self-isolation at home as the immediate isolation of the case from the school community.

On July 29th, the Los Angeles Unified School District (LAUSD) announced that every student and school personnel must participate in baseline and weekly COVID-19 testing upon returning to campus, regardless of vaccination status. Due to the shifting conditions of the pandemic and the introduction of variants, there has been a change in protocol, with stricter modifications to prevent the spreading of the Delta variant. Previously, those who were fully vaccinated would no longer have to undergo regular testing. However, the surge in coronavirus cases as a result of the Delta variant altered their response in preparation for the full return to in-person learning (CDC, 2021).

In addition to testing, LAUSD requires all students, 12 and older, to be fully vaccinated against COVID-19 by January 10, 2022 unless they have a medical or other exemption. The U.S. Food and Drug Administration has granted the Pfizer-BioNTech COVID-19 vaccine emergency use authorization for children ages 12 to 15. Research has proven that the Pfizer-BioNTech vaccination is 100% effective in preventing COVID-19 in children ages 12 to 15, and is 91% effective in preventing severe illness with COVID-19 in people ages 16 and older. The FDA has determined the safety and effectiveness of the vaccine through a study with more than 2,200 U.S. children ages 12 through 15. Approximately half of the children (1,005 children) were given the Pfizer-BioNTech COVID-19 vaccine, while the other half (968 children) received a placebo shot. A week after the second dose was given, there were no reported cases of COVID-19 in the children that received the vaccination. Of the 968 children that received the placebo, 16 reported cases of COVID-19. Pfizer and BioNTech have recently announced positive topline results from a trial of the COVID-19 vaccine in children ages 5 to 11 years of age. The vaccine has proven to be safe, well-tolerated, and shown neutralizing antibody responses (FDA, 2021). These results demonstrate that vaccines are one of the most effective ways to protect students, schools, and the greater community from COVID-19.

The COVID-19 vaccine is essential in preventing children from contracting COVID-19 and spreading the virus. mRNA COVID-19 vaccines do not use a live virus that can cause COVID-19, but rather, messenger RNA (mRNA). mRNA offers human cells' instructions on how to make a protein, or part of a protein that can trigger an immune response. mRNA is directed to the cells' ribosomes, the site of protein synthesis within the cell. It is worth mentioning that mRNA cannot bypass the nuclear membrane to enter the nucleus, and thus, is unable to alter the DNA within the nucleus. Instead, the mRNA 'instructions' will be used to produce spike proteins: a biological characteristic of the SARS-CoV-2 virus, as well as other viruses, that allow penetration into host cells and infection. Once the cell has produced the spike proteins, they will quickly be recognized by the immune system as foreign, and the mRNA (that 'coded' for the proteins) will be degraded within the cell. The immune system then produces specific antibodies and activates T-cells to destroy spike proteins. Antibodies protect the body from infection by recognizing specific pathogens and viruses and marking them for destruction. Once antibodies have been produced in response to the foreign protein, they remain in the body in order to respond quickly upon exposure to COVID-19 (CDC, 2021).

Action Plan:

The Health Commission urges the adoption and implementation of the reopening protocols released by the County of Los Angeles Department of Public Health.

Access to Digital Learning Devices

Recommendations:

- 1) Determine technology needs that match the curriculum and student needs.
- 2) Identify and provide technical assistance to families that may not have access to reliable, high speed internet.
- 3) Maintain technology inventory technology in schools, ensuring a 1:1 device-to-student ratio. Explore all possible funding sources to do so.
- 4) Develop training materials and technological support for families and students.
- 5) Design and schedule a safe distribution process for families.

Background:

Accessibility to digital learning devices, particularly during the pandemic, has created a substantive disparity in the quality of education received amongst students. California had a significant digital divide before the pandemic: rural residents faced barriers to internet access, and African American, Latin American, and low-income families lacked access to digital devices at home (Warf, 2012). With digital learning, the role of technology dramatically shifted with growing implications for marginalized students. The digital divide refers to a systematic inequality in access to technology and poses a multidimensional issue. The pandemic and remote learning further “exacerbated the academic consequences of the digital divide.” Studies reveal a direct correlation between the economic gap and the digital inclusion gap, leading to lower engagement rates for students in lower socioeconomic families (Kauffman Foundation). With a systematic direct relationship between access to technology and income, low-income households have the least access to technology. Additionally, empirical findings reveal a widening of the digital divide amongst racial and economic groups during the pandemic.

A Pew Research Center Poll revealed that one in five parents with homebound school-aged children state that it is very likely or somewhat likely that their children will not be able to complete their schoolwork due to barriers in accessing a computer at home (21%), or must use public wifi to finish their schoolwork due to poor internet access at home (22%). 29% percent of parents report that it is somewhat likely that their children will have to complete their schoolwork on a cell phone.

The Los Angeles Chief Executive Office has proposed a strategic planning approach, in partnership with County departments, cities, states, private partners, and other institutes. The approach utilizes sustainable solutions that can bridge the digital divide gap. The Los Angeles County Board of Supervisors has launched the “Delete the Divide” initiative, aimed at empowering youth and small businesses in underserved communities that are adversely impacted by the digital divide. The formed partnerships provide youth with an array of educational programs, technical certifications, job shadowing and mentoring, internships, academic scholarships, and pathways to high-paying careers.

California passed the 2017 “Internet for All Act” which attempts to assist 5 million California residents who lacked access to high-speed Internet services by allocating \$330 million dollars and extending the California Services Fund towards providing reliable internet in low income and rural areas (California AB No 1665, 2017). Despite these initiatives, barriers to internet access still exist. Partnership LA reports that of those families who do not have internet access: 41% of families are unaware of offers from internet companies that can assist students in obtaining internet access. An additional 15% of those families tried to obtain wifi through internet companies and discovered barriers in taking these offers.

In developing policies that increase accessibility to digital devices and Internet coverage, legislators must focus on three facets: universality, affordability, and reliability. Every resident has the right to connect to the Internet, regardless of their neighborhood location or socioeconomic status. Affordability is another barrier that must be acknowledged; low-income communities should be offered discounted and affordable access. Lastly, the provided internet access should be both secure, fast, and dependable (Sanders & Scanlon, 2021).

Action Plan:

The Health Commission urges the adoption of the stated recommendations to determine the technological needs of Los Angeles and provide affordable, reliable internet options to lower socioeconomic families.

The Four Day Work Week

Recommendations:

- 1) Encourage business owners to evaluate their workforces' productivity.
- 2) Evaluate the needs of employees working five days a week and measure employee and staff output instead of time spent working.
- 3) Implement a trial program to research how implementing shorter work weeks could affect employee productivity, engagement, empowerment, and health outcomes.
- 4) Determine and discuss the environmental impacts of a four day work week.

Background:

Andrew Howard Barnes is an esteemed entrepreneur, philanthropist, and founder of New Zealand's largest corporate trustee company, Perpetual Guardian. His movement in spearheading the four-day working week model has instigated discussions on innovation, management change, and productivity within the traditional business work environment.

Barnes was motivated to test and implement the concept of a four-day work week as he saw productivity dwindling in the workplace setting. When discussing the four-day work week, it must be placed in the context of developing a work-life balance. Within this model, Barnes pays his employees for their output instead of their time. Most businesses, regardless of their industry, use time as a surrogate for productivity. The biggest threat facing this model, however, is a misinterpretation of what it encompasses. Businesses should not view this model as a solution to cutting wages. There must be wage maintenance and an ability to share the benefits of an enhanced working environment.

He utilized an opt-in program for his employees, granting them the autonomy to choose which day or times they would work within the week. This is not to be confused with working four longer work days -- the concept behind this model is reducing the amount of time employees work. Before their pilot program launched, academics were brought in alongside the trial process to conduct qualitative and quantitative research on the impact on the business and staff. A key point, for the Perpetual Guardian and Barnes, was questioning if their employees would benefit from this program.

Upon reviewing their data, they found that employee engagement scores, including employee enthusiasm and empowerment, soared 40 percent to the highest levels researchers had ever seen in New Zealand. Stress levels reduced 15 percent and job performance was maintained. Overall productivity across Perpetual Guardians' offices and companies improved approximately 25 percent. It has become pressing to evaluate how businesses can maintain resilience during adverse circumstances, such as the COVID-19 pandemic. Upon the COVID-19 pandemic, Barnes' company and employees shared a common purpose in improving productivity, and the organization became far more creative and engaged.

There must be an acknowledgment of the levels of disruption that occur in the workplace setting. Statistically, in a traditional office setting, an employee will be disrupted every 11 minutes and will take 25 minutes to return to full productivity (Mark, 2008). At the micro-level, employees at the Perpetual Guardian became more collaborative, willing to help, and experienced significant levels of cross-training and upskilling. These changes were all critical to enhancing prior to the pandemic to ensure their readiness for change. When New Zealand entered lock-down, employees started working remotely for approximately 12 weeks. Over this time frame, the Perpetual Guardian had two months of record profit. This growth is because the four-day work week model was predicated on two main factors: understanding productivity and developing a high level of trust across the workplace. When shifting to remote work, company leadership knew that their employees were reliable to ensure the business could perform. One of the biggest challenges businesses faced during the pandemic was measuring productivity when their staff worked remotely. For the Perpetual Guardian, this concern was never an issue as the four-day work week model was critical for the post-COVID world.

In implementing this model, Barnes' recommended that it not be overthought: ask business staff and employees how they would implement this model and make changes to deliver the same or better outcomes. There must be a productivity focus and a structured format for this program's implementation. A trial period, prior to its full implementation, can evaluate the outcome and help in designing in a more permanent process. In addition to the trial period, Barnes and his team sought legal advice to ensure the model's compliance with employment legislation.

For the Perpetual Guardian, the four-day work week took approximately nine months to fully develop. This process included the initiation of a month prior to the trial with staff and team planning a two-month trial period, an evaluation period, and a subsequent month afterwards to design the four-day work week. This model has been permanent within the organization since November 2018, and currently, 75% of company staff opt towards having the four-day work week. While some workers opt to take an entire day off, others rearrange their schedules to alter the start and end times of their workdays. Additionally, as a measure to contain the spread of COVID-19, employees should be granted the opportunity to work from home. Working from home not only reduces one's chance of spreading or catching the COVID-19 virus, but also reduces transportation time and offers significant social and environmental advantages. In addition, decreased transit times and subsequent smog production may contribute to greater health benefits for the greater Los Angeles city population.

It is worthwhile for businesses to consider the strengths and benefits from the four-day work week program. These include more flexible working hours, improvements in mental health and upskilling, more efficient time management, enhanced productivity, and healthier outcomes for their employees. These benefits, however, are contingent on the results produced. The model was structured on a team basis -- if the team failed to reach their objectives, they face the potential of being asked to work five days a week. This further incentivizes employees to be more productive during working hours to receive the extra day off, creating a sense of personal responsibility for staff members.

The health benefits also bear significance. Work-related stress, anxiety, or depression accounts for 57 percent of all working days lost to ill health. These health issues equate to 15.4 million working days, which approximately costs 44-55.6 billion dollars per year. After program implementation, Perpetual Guardian staffs' days off split in half. Barnes' found that a large number of his employees used their time off to exercise, spend time with their families, educate themselves, and volunteer in the community. These are all factors that contribute to healthier and more fulfilling lifestyles for working individuals.

Aside from the health and productivity improvements, other significant incentives can encourage businesses to adopt the four-day work week. The FlexJobs 2019 annual survey provided statistics to demonstrate the appeal of flexible work schedules. The survey revealed that 30% of workers reported leaving a job because it did not offer flexible work options; 45% of respondents said they were interested in working an alternative work schedule; 74% of workers said that a work-life balance is a priority when evaluating a job; 80% of employees said they would be more loyal to their employers if they had more flexible work options. New Zealand Prime Minister, Jacina Arden, also suggested employers implement the four-day work week to boost the economy, encourage domestic tourism, and prioritize a healthier work-life balance.

Additionally, there are major shifts towards the utilization of transportation with the four-day work week model. Transportation is one of the main contributing factors to U.S. greenhouse emissions (29%,) with over 135 million Americans commuting to work. By reducing the work week, individuals are less likely to travel to work during traffic which can produce significant environmental impacts. In 2011, congestion cost the U.S. 5.5 billion more hours in travel time, 2.9 billion gallons of fuel at a cost of 121 billion dollars, and 56 billion pounds of carbon dioxide emissions. Reducing the amount of time people spend in traffic or commuting with the implementation of this model in Los Angeles can produce significant environmental impacts.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to encourage businesses to research ways to enhance productivity while improving the psychological, physical, and mental needs of their employees.

Air Pollution during COVID-19

Recommendations:

- 1) Promote the switch to renewable energy and electrification of motor vehicles.
- 2) Invest in the planting and growth of trees that do not contribute to increased VOC emissions.
- 3) Increase ventilation and filtration systems in businesses to decrease nitrogen dioxide levels.

Background:

The relationship between air quality and health outcomes was further elucidated through the course of the pandemic (Lipsitt, Chan-Golston, Liu, et al., 2021). Studies found that Los Angeles County neighborhoods with higher rates of air pollution experienced the highest rates of COVID-19 cases and deaths, in comparison to their greater community. Air pollution, including traffic-related air pollution, is associated with many respiratory morbidities, including severe acute respiratory syndrome (SARS), and an increased risk of contracting respiratory viral infections.

In March and June of 2020, Los Angeles County Department of Public Health reported neighborhood-level COVID-19 cases, which allowed researchers to conduct spatial modeling research to compare how varying rates of pollution contributed to case numbers. In a study of COVID-19 in 3,122 U.S. counties through July 2020, scientists found an association between nitrogen dioxide levels and case-fatality rates. Specifically, Los Angeles County neighborhoods with the worst air quality saw a 60% increase in COVID-19 related mortalities, compared with communities with the best air quality.

With imposed lockdown measures during the beginning of the pandemic, Los Angeles' air pollution significantly decreased at the onset of the pandemic. Gas-powered vehicles directly emit carbon dioxide and nitrogen dioxide as combustion by-products. Carbon dioxide plays a significant role in global warming as a greenhouse gas. Nitrogen dioxide also plays an important role in triggering ozone-destroying reactions and breaking down the ozone layer within the atmosphere. With the introduction of lockdowns, traffic-related emissions dropped significantly. Yet, Los Angeles experienced one of the highest years of smog-production in decades in 2020. With the reduction of traffic-related emissions, scientists were able to determine its role in smog-forming pollution. While there were less carbon dioxide emissions due to a reduced number of cars on the road, carbon dioxide does not necessarily contribute to smog production (Ronald Cohen). Rising heat and temperatures in Los Angeles, especially during heat waves, can increase the amount of ozone and particulate pollution (University Corporation for Atmospheric Research). This is because an increase in temperatures can accelerate photochemical reaction rates, with implications for individuals' respiratory health.

Dr. Ronald C. Cohen is professor of chemistry and of Earth and Planetary Sciences at UC Berkeley. Dr. Cohen has shared the NASA Group Achievement Award and is an editor of the Atmospheric Chemistry and Physics Journal. At the Los Angeles City Health Commission's September 2021 meeting, Dr. Cohen shared his expertise on the creation of ozone and smog in Los Angeles.

In the past 40 years, gasoline use from cars and other electrical devices have primarily contributed to volatile organic compound (VOC) production. Upon being released into the atmosphere, VOCs react with nitrogen oxides (NO_x) to create ozone molecules. VOC levels are particularly higher in urban settings or countries with accelerated industrialization. In industrial and suburban areas, VOC levels can be higher due to the burning of fossil fuels and waste emissions. Alternatively, in large cities, VOC emissions are mainly due to mobile sources (Montero-Montaya, Lopez-Vargas, & Arellano-Aguilar, 2018).

Technological advancements have led to VOC reductions through decreased vehicle VOC emissions. Today, however, other sources of VOC production are equally as important; other sources of emissions stem from trees and volatile chemical products (VCP) such as household cleaning items, certain personal care products, and industrial chemicals. Nitrogen oxide is responsible for lending its color to the brown-haze recognized as smog. Photodissociation of nitrogen oxide, by sunlight, produces nitric oxide and ozone in the troposphere which is another component of smog (University Corporation for Atmospheric Research).

Ozone measurements are based on the ultraviolet (UV) absorption principle, which consists of measuring ozone's absorption of UV light. The measurements are recorded in parts per billion (ppb). In 2015, the U.S. Environmental Protection Agency (EPA) adjusted the National Ambient Air Quality Standards (NAAQS) for ground-level ozone to 70 ppb. In Los Angeles, ozone ppb is heavily dependent on the temperature. On September 10th of 2020, ozone pollution in downtown Los Angeles spiked to 185 ppb, according to South Coast Air Quality Management District Monitoring data. Temperatures, over Labor Day weekend, were greater than 120 degrees Fahrenheit. The average ozone-levels in downtown Los Angeles, over eight hours, were 118 ppb, which poses significant health and environmental risks for LA residents.

During Los Angeles' shelter in place order in March 2020, there were significant reductions in cars and truck quantities on the roads. These changes were also accompanied by the lower use of buildings and lower restaurant activity. Carbon dioxide, nitrogen oxide, and VOC emissions from vehicles dropped. Emissions of primary particles, from cooking, also dropped or were relocated to homes. However, during the shelter in place order, ozone levels remained high. The effects of higher temperatures may have contributed to this phenomenon.

Moving forward, the electrification of motor vehicles and trucks will reduce nitrogen oxide emissions and may lead to better ozone air qualities. Planting more trees can also assist in moderating urban heat, but these planted trees must be low in their VOC emissions. Other solutions such as filtration systems, which reduce indoor particle levels, may be beneficial for both the environment and public health. The Center for Disease Control has recommended the use of portable high-efficiency particulate air (HEPA) filtration systems to enhance cleaning, especially in high-risk or populated areas. Airborne transmission of COVID-19 often occurs as a result of inadequate ventilation in indoor spaces. In order to promote safety precautions, the CDC has recommended that restaurants and bars ensure that their ventilation systems are operating properly and increasing the use of open air through opened doors and windows.

Action Plan:

The Commission recommends businesses, in Los Angeles, to install ventilation systems to reduce COVID-19 airborne transmission rates and harmful indoor particulate matter. Additionally, the Commission also supports the city's investment into renewable energy and shifting towards the electrification of transportation vehicles.

Long-Term Care Facilities during COVID-19

Recommendations:

- 1) Ensure that all long-term care facilities have adequate access to personal protective care. equipment, COVID-19 vaccines, and other medical equipment that can slow the spread of the COVID-19 virus.
- 2) Improve nursing recruitment through increased funding of nursing education programs in the U.S.
- 3) Encourage the vaccination of all long-term care facility staff and personnel, and work to dispel concerns or misconceptions about the vaccine's effectiveness and safety.
- 4) Provide resources to long-term care facility staff to prevent burnout and promote more sustainable work-life balances.
- 5) Urge city council members and congressional representatives to advocate for increased funding to long term care facilities to maximize staff ratios and improve care facilities' pandemic responses.

Background:

Long-term care (LTC) facilities provide an array of medical and personal services to individuals who require assistance or are unable to live independently. According to the Centers for Disease Control and Prevention, it is estimated that one to three million infections occur every year in nursing homes, skilled nursing facilities, and assisted living facilities. Older individuals who reside in nursing homes, or assisted living facilities are at greater risk of being affected by viral diseases. Thus, the Commission supports a strong infection and control (IPC) program to protect long-term care facilities' residents and staff.

The CDC has recommended the training of one or more individuals in infection control to provide adequate on-site management of an IPC program. Facilities can consider staffing the IPC program based on resident population and facility services, or ensure that on-site ventilator and hemodialysis services are available. Additionally, the necessary medical supplies must be provided to LTC facilities. These supplies include, but are not limited to, alcohol-based hand sanitizer, personal protective equipment, and cleaning and disinfection supplies. Information about SARS-CoV-2 must be provided to both residents and staff through educational sessions and written materials. Through educational outlets, residents and staff should be informed of the actions they can take to protect themselves and their loved ones, when to physically distance themselves from other residents and staff, and how to promote hygienic practices. More information about the vaccine's efficacy and safety must also be provided to LTC residents, as people ages 65 years and older are at an increased risk for COVID-19 exposure and transmission.

The vaccination of skilled nursing facility (SNF) staff is similarly critical in the battle against COVID-19. According to a study conducted in June of 2021, SNF staff are increasingly hesitant to receive the COVID-19 vaccine due to beliefs that the vaccine had developed too fast or without sufficient testing (Harrison, Berry, & Gifford, 2021). Personal fears and mistrust of the government also play a role in vaccine hesitancy among SNF staff. However, vaccination of SNF workers is essential as SNF staff are often disadvantaged. Nursing assistants make up 53% of the SNF workforce, and more than 90% are women, 49% black or Latino, 44% residing in low-income households, and 36% are uninsured or on public health care (True, Cubanski, & Garfield, 2020).

Additionally, nursing assistants are at an increased risk of contracting COVID-19 through their work, and are more susceptible to developing severe infections as a result. Research findings show that SNF staff prefer to see local community members, who resemble themselves, receive the vaccination to improve their confidence about the vaccine's safety and effectiveness. Engaging staff in early conversations is critical to reducing vaccine hesitancy, especially in the midst of vaccine misinformation. Incorporating community members in the implementation of public health initiatives, and remediating trust between minority and scientific communities is important in reducing misinformation and personal concerns about the vaccine's safety and effectiveness.

A separate study gathered nursing home staff experiences during the COVID-19 pandemic. The study identified seven themes from staff experiences during the pandemic. The first theme is constraints on personal protective equipment and testing. During the pandemic's onset, access to adequate personal protective equipment was a concern for many staff members, many of which independently attempted to procure PPE with their own money and efforts. Many staff members also described a reliance on crisis standards for extended reuse of gowns and masks. Theme 2 included burdensome regulations and guidance, especially when there were frequent changes to regulations and guidelines. Reports reveal that staff members felt that local, state, and federal agencies' efforts were not coordinated and were contradictory at times. The third theme covered concern for self and family, relating to how SNF staff experienced greater levels of stress and fear about infection and spread to family and friends. Theme 4 revealed a concern for residents. Respondents cited the ongoing challenges of protecting the residents, under their care, while also attempting to socially distance and isolate themselves from residents. Theme 5 was burnout among SNF staff who reported feelings of mental and physical exhaustion due to Theme 4 and staffing shortages, increased workloads, and new responsibilities. Theme 6 was teamwork, communication, and flexibility. During the pandemic, many respondents were proud of how they coordinated efforts to ensure that leadership and staff were working together to coordinate resident care and fulfill multiple roles. Lastly, theme 7 was public blame and lack of recognition. Many SNF workers attested that public support for hospital workers, during the pandemic, heightened while SNF workloads and sacrifices were barely recognized. An evaluation of these arisen themes reveal the stressful and complex circumstances that LTC staff had to undergo during the pandemic (White, Wetle, Reddy, & Baier, 2021). These issues add onto already low-staffing levels and a declining quality of care present in U.S. nursing homes.

The COVID-19 pandemic significantly highlighted the vulnerabilities present in long-term care facilities. Assisted living facilities (ALF), a type of long-term care facilities, are designed for individuals who require varying levels of medical and personal care. Assisted living facilities are distinctly unique from nursing homes which provide a wider range of health and personal care services, focusing more on medical care in comparison to assisted living facilities. A study by the Centers for Disease Control and Prevention in October 2020 calculated morbidity and mortality rates of assisted living facility residents in comparison to the general population. The study included 39 states with available data, and demonstrated that the mortality rate among ALF residents with COVID-19 was 21%, compared to a 3% mortality rate among the general population with COVID-19 (Yi, See, & Kent, 2020). The disproportionate mortality rate may be due to increased risks of COVID-19 transmissions. ALF's tend to include more congregate areas and the nature of the setting may require close contact between staff members and residents. Additionally, community-acquired infections among staff members may also contribute to the introduction of COVID-19 into care facilities, which may severely impact residents due to their age and higher prevalence of chronic conditions.

The pandemic further revealed the nation's failure to invest in safe and effective long-term care facilities. Both Medicare and Medicaid have created incomplete social insurance programs for long-term care facilities and were never intended to pay for the majority of long-term care placements. Medicare funds long-term care temporarily by covering the cost of nursing-home rehabilitation following a hospital discharge. Medicaid finances more than half of long-term care for individuals who require assistance with daily activities, but remains available to individuals who have limited assets. Additionally, the financing of nursing homes by Medicare and Medicaid have declined. Despite the nation's aging population, nursing homes have seen decreasing occupancies because patients that require rehabilitation, after a hospital treatment, are being directly sent home. Throughout the pandemic, the number of short-stay visits following hospitalizations decreased due to fears of COVID-19. In addition, Medicaid has shifted a larger share of care into homes over the use of long-term care facilities which remain underfunded. Underfunded LTC's were also expected to respond effectively to a national emergency, such as COVID-19. Many had diverted resources to purchase personal protective equipment, COVID-19 tests for both staff and residents, and other materials that have already been provided. Due to greater amounts of spending, many LTC's may face the risk of bankruptcy and/or closure and a significant displacement of nursing home residents and staff (Werner, Hoffman, & Coe, 2020).

Action Plan:

The Health Commission supports higher U.S. minimum nursing staff standards to ensure adequate quality of long term care facilities. Policymakers must address the supply of staff through improved and effective recruitment and retention, provide resources to prevent burnout, and allocate increased funds to pay for nursing education and safer work environments.

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Section III: Medical Services

Introduction

This section of the report focuses on the prevention, surveillance, and control of major diseases as well as the emergency medical services (EMS) available in Los Angeles County.

As the second most populated city in the United States, Los Angeles harbors a wide range of infectious diseases that can transform into medical emergencies. The people of Los Angeles rely on the Los Angeles EMS system with over 18,000 certified EMR personnel to respond to medical emergencies (LACDHS, 2021). The Emergency Medical Service Agency of the Los Angeles County Department of Health Services provides regulatory oversight of the Emergency Medical Service (EMS) system and is advised by the Los Angeles County Emergency Medical Services Commission. Responsibilities of the EMS Agency include managing EMS data, overseeing finances of operations, designating medical centers and hospitals as EMS providers, implementing Advanced Life Support programs, authorizing EMS personal training programs, and establishing policies, guidelines, and procedures for EMS services (LAFD, 2021).

Over 85 percent of the Los Angeles Fire Department's emergency responses involve emergency medical services (LAFD, 2021b). LAFD responds to approximately 1,386 emergency calls and transports about 591 people every day (LAFD, 2021). As the primary provider of emergency care for the City of Los Angeles, the LAFD warrants the attention of the Los Angeles City Health Commission. We support the work of the LAFD by endorsing LAFD expressed recommendations to advance their services. These recommendations are described in the following sub-sections.

This section of the report will not cover COVID-19; please refer to the following section for information about COVID-19 in Los Angeles.

Emergency Medical Services (EMS) Calls

Recommendations:

- 1) Hire social workers to help navigate frequent EMS users through the local healthcare system.
- 2) Expand the number of field resources that can safely evaluate low acuity patients to avoid unnecessary ambulance transport to local emergency departments.
- 3) Expand the number of field resources that can safely clear patients with mental health emergencies and transport them to mental health urgent care centers.
- 4) Increase the number of Advanced Provider Response Units (APRU), Sobriety Emergency Response Units (SOBER), and Alternative Destination Response Units (ADRU).
- 5) Modernize City Ordinance No. 183807 to allow additional billing or updated billing for medical and health care services provided by EMS teams.
- 6) Report the location of traffic accident-related EMS calls to the LAFD and the Los Angeles Department of Transportation to identify areas of high risk.
- 7) Lobby the State to allow EMS teams to determine when a 5150 call would be appropriate.
- 8) Continue to support the managerial development of the EMS bureau by hiring an additional battalion chief to oversee Dispatch Medicine/MIH and an additional captain for project management and website communication.
- 9) Develop an opt-in location tracking system that enables EMS users to share the location of their mobile devices.
- 10) Increase compensation for clinicians working at the LAFD to increase retention.
- 11) Require all LAFD personnel to be vaccinated.

Background:

The LAFD has been receiving an unprecedented growth of 911 calls. An increasing load of calls stems from men and women in their 20-30s and their 50-70s (Sanko, 2021). A significant number of calls have also been reported among people with mental illness and trauma injury (Sanko, 2021). Interim Medical Director, Dr. Stephen Sanko M.D., FACEP, FAEMS stated that increased economic disparity, decreased access to primary and preventative care, poor coping, decreased access to mental health services, and food scarcity contribute to the surge of 911 calls. During the early part of the COVID-19 pandemic, the LAFD saw a 20% decrease in EMS incidents (Sanko, 2021). Despite the reduction in calls, there was an increased volume of high-acuity calls and calls involved with out-of-hospital cardiac arrest. Data also showed a sustained number of substance use disorder and mental health calls. Empowering EMS to determine when a 5150 hold would be appropriate would make the EMS system more humane as well as more efficient. During the pandemic, there was also a concerning 205% increase in EMS calls for homeless patients who experienced cardiac arrest but were found dead by the time paramedics arrived. This rapid increase in deaths is a serious concern and should be studied to identify causes and strategies that prevent future incidents.

As of September 2021, EMS incidents and transportations are about the same volume as before the pandemic (Sanko, 2021). The LAFD must now adopt innovative approaches to address the overwhelming number of 911 calls. LAFD is implementing new technologies such as the Los Angeles Tiered Dispatch System, which was created to effectively and accurately ask questions and deliver emergency instructions to 911 callers. As a result, fewer resources were needed to provide adequate EMS care. In addition, LAFD is using a new electronic health record system and telemedicine system to expand on-scene decision-making and to increase the exchange of patient information among health providers. The Health Commission commends the LAFD's development in intervention systems that can respond to EMS calls in a timely and efficient manner.

Action Plan:

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

Increase Use of Fast Response Vehicles (FRV)

Recommendations:

- 1) Modernize City Ordinance No. 183807 to allow billing for medical services other than transportation.
- 2) Provide additional Fast Response Vehicles.
- 3) Improve and/or reduce "wall time" response referrals to minimize gaps in lapse time in which paramedics and EMTs cannot leave an emergency situation until a patient is transferred. Potential solutions for incentivizing expedient service or reducing "wall time" include:
 - Penalizing hospitals for excessive wall time.
 - Finding funding for less expensive health care service providers at Emergency Departments.
 - 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 and staffed by two firefighters/paramedics on patrol, located in busy EMS demand areas, will allow for quicker responses to calls and initiate faster care, pending the arrival of an ambulance. This approach can eliminate the need to dispatch a fire engine, cut response times, and summon the appropriate ambulance, if necessary. This program is, with County EMS approval, undergoing evaluation (M. Eckstein, personal communication, 2016).

Action Plan:

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

Expansion of Response Programs

Recommendations:

- 1) Expand the number of Advanced Provider Response Units (APRUs).
- 2) Continue the development, implementation, and expansion of the Sobriety Emergency Response Unit (SOBER).
- 3) Expand the number of Alternative Destination Response Units (ADRU).
- 4) Increase the number of psychiatric beds in public hospitals.
- 5) Encourage the use of the Los Angeles Network for Enhanced Services (LANES) to allow healthcare providers safe access to patient information.
- 6) Continue the LA City's Innovation Fund to financially support LAFD projects that can improve the efficiency and effectiveness of their services.

Background:

The APRU was a 12-month pilot project approved by the County in which a paramedic and a nurse practitioner respond to calls in an ambulance to treat, consult, create an action plan, and release patients to appropriate sources of medical care (LAFD, 2021b). Since then, the LAFD has received funding to build and use four APRU units and one SOBER unit (Sanko, 2021). This process should be continued to increase the number of APRUs throughout the City. The APRUs have three primary missions:

1. Treat and release low acuity patients to avoid unnecessary and costly ambulance transport to EDs.
2. Medically clear patients with mental health emergencies or public inebriation and transport them to Mental Health Urgent Care facilities or Sobering Centers instead of EDs.
3. Help EMS super-users navigate the healthcare system to reduce their dependence on the 911 system to address chronic medical problems.

The LAFD SOBER Unit is an ambulance staffed with a firefighter/paramedic, a nurse practitioner, and a caseworker. They medically clear publicly inebriated patients and transport them to the DHS Sobering Center on Skid Row. This alternative destination avoids unnecessary ambulance transport to an ED and offers patients an opportunity to detox and enter transitional housing. The SOBER Unit was assessed and led to a decrease in ambulance offload delay, the amount of time patients cannot be transferred from paramedics to the hospital. SOBER Units “beneficially impacted for a nearby emergency department, particularly during the summer months” (Kashani et al., 2019) .

Furthermore, behavioral health emergency department visits are increasing at a faster rate than total acute care emergency department visits. Currently, Los Angeles County has 96 hospitals, 35 of which are Lanterman Petris-Short designated hospitals (Garcia, 2020). The lack of hospitals with psychiatric beds contributes to the overall shortage of beds for patients with mental illnesses. The national average number of psychiatric beds is one bed for every 4,383 people; however, California hospitals face a shortage of psychiatric beds with one bed for every 5,834 people (Garcia, 2020; Torrey et al., 2008). “Experts estimate [the] need for (minimum) one public psychiatric bed for every 2000 people with serious psychiatric disorders” (Garcia, 2020). Thus, the expansion of psychiatric beds remains a priority for the Health Commission.

When patients arrive at treatment centers, the EMS system confronts care coordination problems due to the lack of effective health information exchange. The Los Angeles Network for Enhanced Services (LANES) is an electronic health record that hospitals and providers update, access, and use to share medical records of Medi-Cal and uninsured patients, which may serve as an effective tool for the EMS department to navigate patient health records safely.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to continue the development, implementation, and expansion of response programs.

Expansion of County Hospitals and Funding

Recommendations:

- 1) Urge Los Angeles County to purchase and integrate Saint Vincent Medical Center into the Los Angeles County health system.
- 2) Lobby for an increase of Medi-Cal reimbursements to all providers in hospitals and medical centers.

Background:

On August 31, 2018, Verity Health hospitals filed voluntary petitions for relief under Chapter 11 of the United States Bankruptcy Code (United States Bankruptcy Court: Central District of California, 2019). Saint Vincent Medical Center, a general acute care hospital founded in 1856, with 381 beds, over 480 attending physicians, and 22,991 annual ER visits, is one of the hospitals included under Verity's bankruptcy petition (Verity Health, 2020).

In January 2020, Verity Health closed St. Vincent Medical Center. Due to the COVID-19 pandemic, the Center was reopened in April 2020. The County of Los Angeles, Dignity Health and Kaiser Permanente led a joint effort to repurpose the St. Vincent Medical Center into a COVID-19 treatment center (Dignity Health, n.d.). Governor Newsom approved the temporary leasing of this Center with no specific date of termination. Thus, the future of the St. Vincent Medical Center is uncertain post-pandemic. The Commission believes the Center provides valuable medical services to the people of Los Angeles and should be acquired by Los Angeles County. A similar case was seen in 2019 when two hospitals and one health center under Verity Health, O'Connor Hospital in San José, St. Louise Regional Hospital in Gilroy, and De Paul Health Center in Morgan Hill, filed bankruptcy petitions. Santa Clara County purchased and subsumed the medical centers into the County's Health System for \$235,000,000 (County of Santa Clara, 2019). The Health Commission urges a similar acquisition of the St. Vincent Medical Center by the Los Angeles County Department of Health or, alternatively, that the facility be transformed into a mental health hospital as well as a health center in order to assure the provision of health services to Los Angeles residents.

From 2009-2018, five general acute care hospitals within the City of Los Angeles have closed (OSHPD, personal communication, 2020):

- Los Angeles Metropolitan Medical Center
- Pacific Alliance Medical Center
- Promise Hospital of East Los Angeles-East L.A Center
- Shriners Hospital for Children
- Temple Community Hospital

In 2021, Olympia Medical Center closed but was bought by UCLA Health to be renovated and repurposed in the future.

To prevent the closure of additional hospitals, the Commission believes Medi-Cal reimbursements must be increased to prevent hospital bankruptcy. Closures can be counteracted through additional payments to hospitals covering Medicaid patients. The Health Commission urges the allocation of government state funds for MediCal reimbursements.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to maximize the use of existing medical centers and provide adequate funding toward critical health services.

Affordable Care Act (ACA) Implementation

Recommendations:

- 1) Increase awareness and education about the California individual health insurance mandate.
- 2) Identify ways to increase health insurance coverage in LA City and strengthen the use of insurance and medical care by City residents.
- 3) Request the Los Angeles County Department of Health Services and the State Department of Health Services to report city-specific data on uninsurance rates.

Background:

In January 2020, an individual health insurance mandate was issued in California (California Franchise Tax Board, 2021a). This requirement builds upon the goals of the ACA to make healthcare accessible and affordable. By law, residents in California must be enrolled in a minimum essential coverage plan. If a resident does not have coverage and does not qualify for an exemption, he or she is required to pay at least \$800 per adult and \$400 per dependent as a penalty when filing state tax returns (California Franchise Tax Board, 2021b; Covered California, 2021b). In 2020, Covered California, California's state health insurance marketplace, "established a COVID-19 special-enrollment period, which allowed any eligible uninsured individual to enroll" (Covered California, 2021b). The enrollment period extension helped Californians gain access to healthcare during the COVID pandemic. In March 2021, the American Rescue Plan (ARP) was passed and provided funding to expand national health insurance coverage. With ARP funds, California Covered maintained open enrollment all year (Covered California, 2021a). For 2022 coverage, open enrollment for California Covered started on November 1, 2021. Deadlines for Special Enrollment are different for people who experience a qualifying life event.

According to the 2019 US Census, an estimated 12.8% of people under the age of 65 in Los Angeles are without health insurance (U.S. Census, 2021). A priority of the Los Angeles City Health Commission is to convene with key City departments to increase health coverage in Los Angeles by promoting Covered California, Healthy Way LA, and MediCal expansion. Unified efforts at the county and city level should be implemented to identify ways to strengthen the use of insurance, navigation of medical care, and specific advocacy requests on behalf of city residents.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve the dissemination of ACA implementation and city-specific information.

Communicable Disease Response

Recommendations:

- 1) Enhance outreach at airports on communicable diseases. Increase communication on travel restrictions pertaining to 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.
 - Encourage COVID-19 testing before and after travel.

Background:

The Los Angeles County Department of Public Health oversees the Communicable Disease Control and Prevention Division with the stated mission to “reduce the risk factors and disease burdens of preventable communicable diseases for all persons and animals in Los Angeles County, in partnership with others, through providing the health promotion, surveillance, investigation, laboratory, and disease prevention and control that meet quality standards” (LACDPH, 2021c). Services and efforts aim to provide wide-spread disease surveillance, quick turnaround times, and education outreach to control infectious diseases.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to help promote the mission of the Los Angeles County Department of Public Health.

Meningitis Outreach and Education

Recommendations:

- 1) Perform antimicrobial susceptibility testing (AST) of all meningococcal isolates.
- 2) Urge health departments in LA County to submit all meningococcal isolates to the CDC for AST and whole-genome sequencing.
- 3) Encourage health departments in LA County to report any suspected meningococcal treatment or prophylaxis failures.
- 4) 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.
 - Increase awareness about Meningococcal vaccination recommendations among MSM regardless of risk and HIV status.
 - Increasing awareness of safe sex practices.
 - Developing and implementing a community plan for providing immediate access to vaccines during a meningitis outbreak.
 - Utilizing electronic social networks such as TikTok, 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 with regards to outbreak alerts and emergency response.
 - Include public-private partnerships 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 one in 10 patients, is spread through saliva or respiratory droplets. It can be easily transmitted by the exchange of saliva and being in close proximity to an infected person who is sneezing and coughing. It is a severe infection that can cause brain infection and/or bacteremia (blood infection), leading to death (LACDPH, 2021). 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 homosexual (and bisexual) men were disproportionately represented among those infected. Rates of meningococcal disease have decreased since the 2016 outbreak, with 10 cases in 2017 and 8 cases in 2018 as of June 29, 2018. Recently, there has been an increase in penicillin- and ciprofloxacin-resistant meningococci in the United States. The CDC sent out an alert to caution the public about 11 cases of meningococcal diseases during 2019-2020 containing a blaROB-1 β -lactamase gene conferring penicillin resistance and a mutation in a chromosomal gene (*gyrA*) that causes ciprofloxacin resistance (Los Angeles County Health Alert Network, 2020; McNamara et al., 2020).

One of the isolates was detected in California. To surveil the resistance of meningococcal disease to antimicrobials, the CDC “is recommending that clinicians perform antimicrobial susceptibility testing (AST) of all meningococcal isolates to determine susceptibility to penicillin before changing from empiric treatment to penicillin or ampicillin. In addition, in states with ciprofloxacin-resistant isolates identified in the past 2 years, the CDC recommends that clinicians consider performing AST on meningococcal isolates to inform prophylaxis decisions. The initiation of prophylaxis with ciprofloxacin, rifampin, or ceftriaxone should not be delayed for AST” (Los Angeles County Health Alert Network, 2020). State and territorial health departments are advised to send all meningococcal isolates to the CDC for AST and whole genome testing. If there are suspected cases of Meningococcal disease or any failed prophylaxis attempts, health departments are also advised to report these incidents.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve public health control over Meningitis transmission.

Typhus Outreach and Education

Recommendations:

- 1) Implement stricter stray animal controls and promote community rodent control programs to eliminate food sources, harborage conditions, and pest infestation.
- 2) Continue the collaboration of the DPH Veterinary Public Health Program with Downtown Dog Rescue and Inner-City Law Center to provide flea prevention education and services to homeless people living with pets in Skid Row.

Background:

Typhus is an infectious disease caused by rickettsia or orientiacteria. This disease is transmitted by fleas, mites, lice, or their feces and causes various degrees of symptoms including fevers, chills, headaches, coughing, muscles aches, and rashes. Fleas often take refuge on animals such as stray cats, dogs, and pets that can lead to human exposure and transmission of Typhus (CDC, 2020). In 2010, only 31 cases of Measles were identified; however, in 2020, 92 cases of flea-borne Typhus were reported (LACDPH 2021a). The number of cases in LA County has almost tripled over the past decade (LACDPH, 2021a). As of November 23, 2021, 83 cases were reported in 2021. The cause of rising typhus cases is uncertain, but may be due to travel, relocation of animals, weather changes that are advantageous for flea survival, increased testing, and increased homelessness. There is a higher risk of contracting Typhus for people who experience homelessness, reside in crowded housing, and have poorer hygiene and toiletry habits (LAHSA, 2019). Environmental controls should be implemented to reduce harborage conditions for fleas.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve public health control over Typhus transmission.

Hepatitis Outreach and Education

Recommendation:

- 1) Improve accessibility and quality of public restrooms (one toilet per 20 users as recommended by the WHO (Adams et al., 2008)) by increasing funding towards the Pit Stop Mobile Toilet Program.

Background:

Hepatitis A, B, and C are the most common types of viral Hepatitis that cause inflammation in the liver. Symptoms include fatigue, fever, loss of appetite, nausea, vomiting, jaundice, abdominal pain, dark urine, and joint pain. Infections can lead to cirrhosis or liver cancer (CDC, 2021).

Hepatitis A (HAV) is highly contagious and usually contracted through food and feces contamination or sexual contact. Due to high false-positive rates, routine testing is not recommended (Balter & Gounder, 2019). HAV is usually not serious and can be overcome in a couple of weeks, but some cases last several months. While there are no specific treatments for HAV, supportive treatment of symptoms is recommended (CDC, 2021).

During 2017-2018, the counties of Los Angeles, San Diego, and Santa Cruz announced outbreaks of HAV that primarily affected individuals experiencing homelessness, drug users, and MSM populations. To reduce exposure, the Los Angeles County Department of Public Health (LACDPH) recommends immediate reporting of any homeless person, IDU, or MSM with symptoms of HAV instead of waiting for anti-HAV Immunoglobulin M (IgM) test results. LACDPH encourages post-exposure prophylaxis (PEP) and vaccinations for people at risk for HAV or in close contact with those who were infected (Balter & Gounder, 2019).

Hepatitis B (HBV) is spread through exposure to blood and contaminated bodily fluids. People who are at risk of contracting HBV include mothers who can transfer fluids to their babies and people who engage in unprotected sex and IV needle sharing. HBV symptoms often last for several weeks, but some cases become persistent and are labeled chronic HBV. Vaccines are available for Hepatitis B (CDC, 2020b).

Hepatitis C (HCV) is the leading global cause of chronic liver disease and cirrhosis and the primary cause of liver transplants in the United States (Mohamed et al., 2015). Similar to HBV, HCV is spread through the transfer of blood or bodily fluids. People with HIV infection, organ transplant before 1992 or clotting factor concentrates before 1987 are at risk of HCV. People who are using IV drugs and children of HCV-positive mothers also have increased HCV risks. Unlike Hepatitis A and B, there are no vaccinations for Hepatitis C; however, chronic HCV can be treated with oral medications (Mayo Clinic, 2021).

On February 29, 2019, LACDPH investigated and reported six HCV cases from patients who received care from Westside Multispecialty Medical Group. Approximately 500 patients who received injections, infusions, or procedures from this clinic were notified to obtain HCV testing (LACDPH, 2019). All cases of Hepatitis should be reported in order to help LACDPH respond swiftly and effectively. To find HCV-related resources, the [Hepatitis C Task Force for Los Angeles](#) compiled a list of HCV testing and treatment sites, vaccination sites, support groups, needle and syringe programs, patient health navigators, and education resources and counseling throughout Los Angeles County for both patients and providers.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve public health control over Hepatitis transmission.

STI/HIV

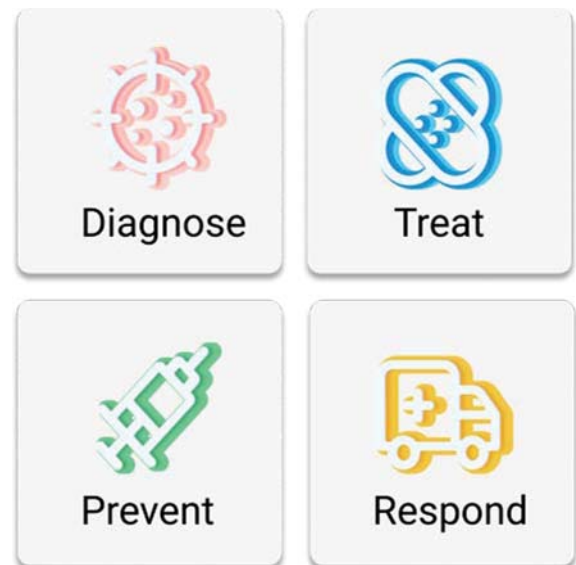
Recommendations:

- 1) Support the implementation of the Ending the HIV Epidemic Plan for Los Angeles County.
- 2) Increase STI screening at programs for people with SUD and at correctional facilities and field outreach events for the homeless.
- 3) Utilize electronic social networks such as Facebook, Instagram, Twitter, TikTok, Tinder, Grindr, and other technology/social media platforms to provide education on STIs.
- 4) Increase funding to HIV prevention programs like AIDS Project Los Angeles (APLA) in order to reduce the spread of STIs.

Background:

In 2019, the CDC announced the national initiative, Ending the HIV Epidemic (EHE) in the U.S., to reduce new HIV infections by 75 percent by 2025 and by 90 percent by 2030 (CDC, 2021b). To reach this goal, The CDC established four pillars:

- “1) Diagnose people living with HIV as early as possible;
- 2) Treat people living with HIV rapidly and effectively to achieve viral suppression;
- 3) Prevent new HIV transmissions using proven interventions, and;
- 4) Respond quickly to HIV outbreaks and deliver prevention and treatment services to people who need them” (LACDPH, 2021a).

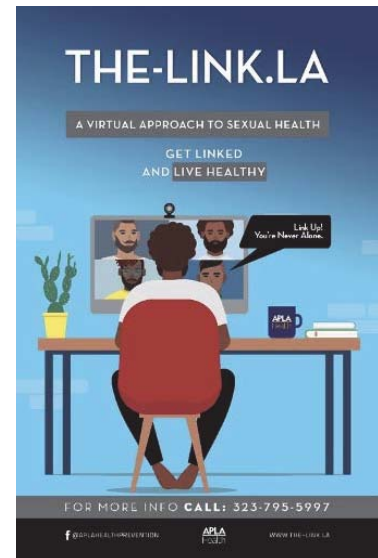


LA County aims to meet the nation’s goals with its own EHE Plan for Los Angeles County with specific strategies and goals (LACDPH, 2021a). HIV remains a serious health risk in LA County since approximately 58,000 people are living with HIV in LA County and 1,700 new infections occur each year (LACDPH, 2021a). The Commission supports the EHE Plan for LA County and urges county-wide adoption.

During the pandemic, access to HIV resources became a growing challenge. To reach all members of the community, virtual HIV programming may serve as a solution. One virtual outreach program was created by APLA: The-Link.LA, a digital platform that enables people to be screened for HIV, linked to care services, and provided transgender and substance abuse support services. APLA also launched the Swab and Chill initiative to increase HIV testing by mailing people at-home testing kits (Pulsipher & Smith, 2021). If people are diagnosed with

HIV, they can take antiretroviral therapy to suppress their viral load and prevent STI transmission. “People with HIV who take HIV medicine as prescribed and get and keep an undetectable viral load (or stay virally suppressed) have effectively no risk of transmitting HIV to their HIV-negative sexual partners” (CDC, 2020b).

Cases of gonorrhea and syphilis, the most common type of STIs in LA County, are also rising in LA County. In 2018, 96,342 people were diagnosed with STIs; 66% percent were chlamydia and 26% gonorrhea (LACDPH, 2019a). The California Department of Public Health (CDPH) announced that the numbers of disseminated gonococcal infections have been increasing during the pandemic (CDPH, 2020). These numbers may be rising due to a lack of screening, testing, and treatment during COVID-19. Routine STI testing should be implemented in high-risk communities to prevent the spread of STIs. Women from 15 to 44 years of age should be screened for syphilis at least once, and pregnant women should be screened as early as possible. Testing and providing care to mothers who have syphilis should be a priority for the City since “two thirds of the women giving birth to newborns with CS received no or late prenatal care” (Los Angeles County Department of Public Health & Division of HIV and STI Programs, 2020). To increase testing, social determinants that could inhibit groups of people from utilizing STI resources must be addressed. STI prevention and treatment should be continuously promoted and monitored to protect the people of Los Angeles.



Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve public health control over STI transmission.

Source: APLA

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Section IV: COVID-19 Surveillance and Control

Introduction

County and city health departments continue to report on the latest public health information and strategies related to COVID-19 in Los Angeles.

Since the start of the pandemic, the Los Angeles Health Commission has researched and developed health promotion and disease prevention strategies to help Los Angeles City residents safely and slowly transition back to a pre-COVID era. Our recommendations are based on an analysis of COVID-19 trends, essential health services, and public health guidelines supplemented with research, government-reported data, and presentations delivered at the Commission. The Health Commission believes city-wide policies and interventions are needed to control and prevent the spread of COVID-19, especially among at-risk populations.

Encouraging local communities to follow COVID-19 guidelines is a critical goal of the Commission. The continuously changing mask mandates, quarantine restrictions, and business reopenings have been enforced by city and state governments, but still require greater public attention. COVID-19 measures disproportionately affect disadvantaged groups, “who are living in overcrowded and under-resourced settings, and depend on daily labour for subsistence” (World Health Organization, 2021a). Data reported in this section on COVID-19 cases, deaths, and vaccinations in Los Angeles captures health disparities faced by different socioeconomic groups. The commission aims to provide policy solutions that address health inequities and reduce the transmission, infection, and deaths from COVID-19 among Los Angeles City residents.

COVID-19 Data Reporting

Recommendations:

- 1) Provide inclusive and accessible data for all racial/ethnic groups.
- 2) Acknowledge the discrimination experienced by underrepresented communities.
- 3) Translate documents into all threshold languages, as suggested by the Los Angeles County Department of Public Health.

Background:

Understanding data trends and disease patterns are of great importance to ensure equitable access to healthcare services and resources (Los Angeles County Department of Public Health, Chief Science Office, 2020). Los Angeles County provides COVID-19 data disaggregated by race/ethnicity and socioeconomic status. Cumulative data from LA County reveals that cases among the Los Angeles County Hispanic population outnumber any other race/ethnicity group by more than 500,000 cases (Los Angeles County Department of Public Health, 2021f). Additionally, the highest percentage of cases are among adults between the ages of 30-49, nearly twice the rate of cases compared to other age groups.

Area Poverty	N	%	Age-Adjusted Rate per 100,000	95% CI
<10% area poverty	4,327	23.9%	136.8	(132.7-140.9)
10% to <20% area poverty	6,144	34.0%	169.5	(165.3-173.8)
20% to <30% area poverty	4,453	24.6%	213.1	(206.8-219.3)
30% to 100% area poverty	3,166	17.5%	262.6	(253.4-271.7)
Unknown/Missing*	1,426			
*Area poverty level data were missing for 7.3% of cases.				

Table 1: Confirmed COVID-19 Cases by Census Tract Poverty Level, Age-Adjusted Rates, through April 26th, 2020. Source: (Los Angeles County Department of Public Health, Chief Science Office, 2020).

Table 1 displays confirmed COVID-19 cases in 2020 by area of poverty, or “the percent of residents below the federal poverty level (FPL) in the census tracts where the home addresses of confirmed cases were located” (Los Angeles County Department of Public Health, Chief Science Office, 2020). The greatest number of cases originated in areas of 30% to 100% area poverty. The number of COVID-19 related deaths follows a similar trend, with increased deaths in high poverty areas in 2021. Causes of higher-than-average COVID-19 rates in high poverty areas may be due to a lack of access to COVID-19 educational resources (i.e. symptoms, prevention strategies, quarantine guidelines, vaccine education, etc.), proximity to testing sites, and other social determinants of health that bear significant effects on low socioeconomic health outcomes.

Age-Adjusted Death Rates due to COVID-19 per 100K December 2, 2021		
Los Angeles County Total		Mortality Rate
Race/Ethnicity	Asian	172
	Black/African American	253
	Hispanic/Latino	397
	White	142
Area Poverty	<10% area poverty	142
	10% to <20% area poverty	256
	20% to <30% area poverty	338
	30% to 100% area poverty	453

Figure 1: Age-Adjusted Death Rates due to COVID-19 per 100k December 2, 2021 Source: (Los Angeles County Department of Public Health, 2021)

Deaths among vulnerable, impoverished communities have drastically risen with COVID-19 cases. Figure 1 illustrates the significant mortality gap, through an age-adjusted death rate, between different socioeconomic groups. A majority of deaths can be observed within higher poverty areas. Increased population vulnerability may be due to high levels of pre-existing conditions, limited transportation to vaccination and testing sites, and an overall lack of healthcare services, insurance, and education. Possible solutions to limit the spread of COVID-19 in these areas include distributing free masks/PPE, installing additional temporary hand washing stations, and expanding designated quarantine spaces in homeless shelters.

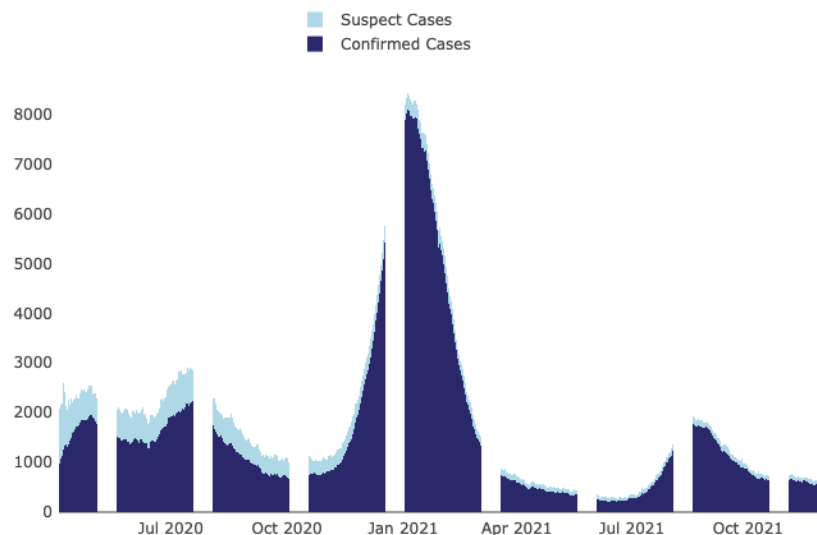


Figure 2: Hospitalized Confirmed and Suspect COVID-19 Cases Source: (Los Angeles County Department of Public Health, 2021g)

Figure 2 presents confirmed and suspected hospitalized COVID-19 cases among individuals in LA County since the beginning of the pandemic. As of late 2021, hospitalization rates have significantly decreased, possibly due to a greater understanding of how individuals can protect themselves through mask-usage and increased vaccination rates. This could have alleviated the burden and stress on healthcare workers, and contributed to the reopening of Los Angeles restaurants and businesses. However, winter surges such as that of January 2021 may return once again, especially with increased transmissibility of variants. In order to keep hospitalization rates low during the winter months, serious precautions, especially vaccination guidelines, must be taken.

The Commission also evaluated the state of vaccinations in LA County. According to the California Department of Public Health, a person is considered fully vaccinated for COVID-19 if they are two or more weeks out of receiving the second dose in a 2-dose series (Pfizer-BioNTech, Moderna, or another WHO-approved vaccine) or two or more weeks after they have received a single-dose vaccine, such as Johnson and Johnson (California Department of Public Health, n.d.).

Race/Ethnicity	5-11	12-17	18-29	30-49	50-64	65+
American Indian/Alaska Native	1.6%	73.1%	72.6%	76.8%	62.5%	67.1%
Asian	1.8%	87.9%	82.0%	77.7%	77.4%	81.7%
Black/African American	0.4%	41.3%	38.7%	51.3%	60.4%	69.4%
Latinx	0.3%	54.0%	51.8%	57.1%	68.2%	76.1%
White	1.8%	67.2%	66.5%	69.7%	65.9%	82.0%

Table 2: Percent of Population Fully Vaccinated in LA County Disaggregated by Race and Age Group Source: (Los Angeles County Department of Public Health, 2021d)

Table 2 presents the percent of population vaccinated by age groups among specific race/ethnicity divisions. Although fairly high among 65 and older age groups, vaccinations continue to vary among younger age groups, as vaccine rollout is being approved for children ages 5-11.

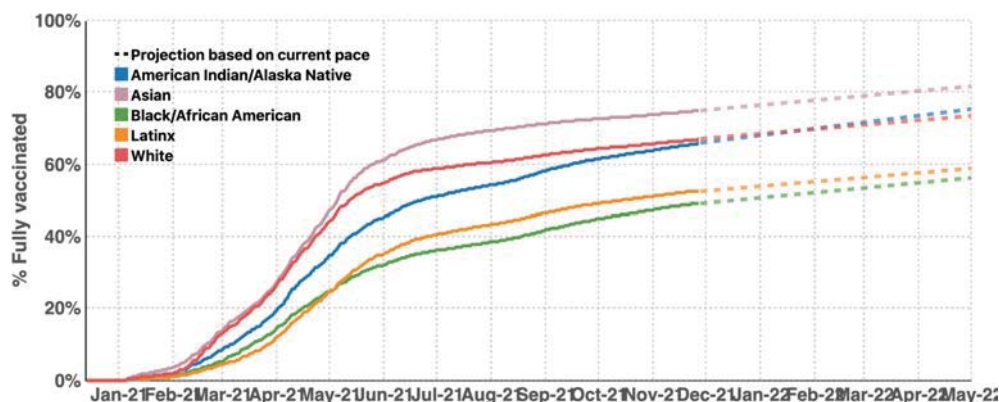


Figure 3: Projected Estimate of Percentage of Population Fully Vaccinated Disaggregated by Race/Ethnicity Source: (Los Angeles County Department of Public Health, 2021d)

The graph above shows current and projected vaccination trends by race/ethnicity. Based on these projections and rising vaccination rates, there may be a decrease in the number of total hospitalizations in LA County. Vaccinations and booster shots will continue to play a vital role during upcoming COVID-19 surges. According to a recent study from the CDC on the Delta variant, a person is 29.2 times more likely to be hospitalized if unvaccinated in comparison to someone who is vaccinated (Jennifer B. Griffin et al., 2021). Regardless, in the case of any variant, vaccinated individuals will be less likely to spread COVID-19, reducing overall infection than unvaccinated individuals (Shamier et al., 2021).

Action Plan:

The Health Commission urges the implementation of recommendations mentioned in the plan above to limit the spread of COVID-19 and reduce severe cases of infection.

Coordination and Planning

Recommendations:

- 1) Follow face mask requirements in public.
- 2) Actively encourage and support symptomatic, infected, or exposed individuals to quarantine at home, isolated from their workplace.
- 3) Follow self-isolation instructions in the case of exposure to COVID-19.
- 4) Increase ventilation and frequently clean and disinfect work environments.
- 5) Support hand hygiene by providing handwashing facilities for employees.
- 6) Continue, where feasible, to offer telework options for employees, especially for those who are at higher risk of severe illness.

Background:

In the Commission's 2020 Annual Health Report, symptoms of the COVID-19 virus are reported as "fever, cough, and difficulty breathing" (Los Angeles Health Commission, 2020). However, the virus is continuously changing through mutation, causing new variants of the virus to surge (Centers for Disease Control and Prevention, 2021). The symptoms of the new Alpha and Delta Variants are similar to that of the earlier forms of COVID-19, but may cause more severe and long-term infection that can spread "faster than earlier forms of the virus that causes COVID-19" (Centers for Disease Control and Prevention, 2021).

The Commission strongly encourages residents to remain updated on the COVID-19 pandemic through the California Health Alert Network, the Los Angeles County Department of Public Health, and other educational websites. Additionally, residents in LA City should limit unnecessary travel. LACDPH should continue to spread awareness about the transmission of COVID-19 and provide data focusing on the highly-impacted populations and minority populations. Specifically, reduced transmission and infection can be aided by improving access to complimentary testing and vaccination sites, especially in high poverty communities. LA City is currently following CDC recommendations to control the spread of new variants. The CDC states that individuals greater than 2 years of age who are not fully vaccinated "should wear a mask indoors in public at all levels of community transmission," whereas "people who are fully vaccinated should wear a mask indoors in areas of substantial or high transmission" (California Department of Public Health, n.d.). Masks are not required in outdoor areas, but are recommended in crowded outdoor settings and situations in close contact with unvaccinated individuals as a precaution. The CDC also encourages the public to receive FDA-authorized COVID-19 vaccines to prevent serious illness.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to mandate all residents to follow the guidelines set by the CDC and remain alert for updates regarding COVID-19 testing, vaccines, and mask mandates.

Essential Health Services

Recommendations:

- 1) Encourage country leaders to take practical action at national and local levels to maintain access to safe, high-quality, essential health services.
- 2) Promote increased vaccination levels among those who are still unvaccinated to prevent cases of severe infections.
- 3) Ensure that, following a positive COVID-19 test, individuals receive testing and follow self-isolation guidelines.
- 4) Educate the greater community on safety measures and the importance of COVID-19 vaccines.
- 5) Verify all sources releasing guidelines and information on COVID-19 to ensure the validity, reliability, and accuracy of sources to prevent the spread of misinformation.
- 6) Reallocate resources to increase funding to hospitals and schools in high-poverty communities.

Background:

With the possibility of vaccinated and unvaccinated individuals developing severe infections from COVID-19 variants, there has been an increased demand for healthcare services, consequently adding more stress to low-staffed and low-capacity healthcare facilities. Additionally, it is possible that widespread misinformation has contributed to the increased demand for healthcare resources. Although not confirmed, the WHO predicts that misinformation “can result in a significant change in health-seeking behavior amongst the general population” (WHO, 2021). They also encourage support for health service delivery in vulnerable settings that may already have low capacities and a lack of medical equipment.

Baseline Characteristics of People Who Died Due to Covid Infection May 1 st – September 5 th , 2021		
	Fully Vaccinated Deaths (n=101)	Unvaccinated* Deaths (n=978)
Mean age (range)	72 (32-100)	65 (10-104)
Male	61%	59%
At least one chronic condition	99%	88%
Hypertension	77%	47%
Diabetes	60%	38%
Cardiovascular disease	46%	27%
Chronic pulmonary disease	34%	27%
Immunocompromise	21%	11%

Table 1: Characteristics of People Who Died Due to Covid Infection May 1st - September 5th, 2021. Source: (Los Angeles County Department of Public Health, 2021c)

Characteristics of Hospitalized COVID Cases 16+ by Vaccination Status		
	Unvaccinated/partially vaccinated	Fully vaccinated
	May 1 – August 18, 2021*	
Median age (IQR)	51	66
Proportion admitted to ICU	17.7%	14.9%
Proportion intubated	7.0%	5.8%
	Unvaccinated/partially vaccinated	Fully vaccinated
	(April 1 – June 3, 2021)**	(March 1 – August 5 th , 2021)**
Comorbidities among patients hospitalized for Covid or a potential covid-related complication:		
No comorbidities	19%	8%
3+ comorbidities	32%	48%
Diabetes type II	37%	51%
High blood pressure	47%	71%
Neurologic/neurodevelopmental disorder	5%	17%
Cancer (ever)	4%	16%

Table 2: Characteristics of Hospitalized COVID Cases 16+ by Vaccination Status. Source: (Los Angeles County Department of Public Health, 2021c)

Access to critical hospital resources like respirators, ICU beds, and anesthesia machines has been a challenge throughout the pandemic, especially for patients requiring acute care. To optimize the utilization of resources, hospital staff may be forced to select patients for immediate treatment based on who requires greater medical attention and is more likely to benefit from treatment. In this state of “crisis” care, a facility is inevitably overwhelmed with patients and may not be able to provide an adequate standard of care (Los Angeles Department of Health Services, 2021).

An increasing number of sources have also revealed that hospitalized COVID-19 patients with comorbidities may extend their length of hospitalization and ventilation use. This is especially true for patients with abnormally high body mass indexes (BMI). A study from the CDC described that obesity increases risk of severe illness from COVID-19 and may triple the risk of hospitalization due to a COVID-19 infection, as it is linked to impaired immune function. Increasing BMIs are causal factors in risk of ICU admittance and death. Obesity itself plays a significant role in respirator availability because it is known to decrease lung capacity and reserve, especially for those under age 65 who are unvaccinated (Centers for Disease Control and Prevention, 2021).

	No. hospitalized	No. with ICU stay	% with ICU stay	No. intubated	% intubated
<i>Age</i>					
0-4	579	79	13.6%	23	4.0%
5-11	320	50	15.6%	21	6.6%
12-17	597	77	12.9%	33	5.5%
18-29	6944	663	9.5%	267	3.8%
30-49	20768	3009	14.5%	1429	6.9%
50-64	27881	6305	22.6%	3564	12.8%
65-79	27128	7506	27.7%	4471	16.5%
80+	16790	3772	22.5%	1930	11.5%

Table 1: Hospitalizations by age group in LA County from the beginning of the pandemic through 08/08/21. Source: (Los Angeles County Department of Public Health, personal communication, 8 August 2021)

LA County data has revealed hospitalizations by age groups since the onset of the pandemic. A majority of confirmed hospitalizations and ICU stays were among residents ranging from 65-79 years of age, suggesting that senior populations are more vulnerable to disease due to weakened immune systems, underlying medical conditions, or exposure to workers and/or caregivers. This trend is shown through an increasing number of hospitalizations and longer ICU stays with older age.

However, new research reveals several discrepancies within County data. In their study, Dr. Jennifer Tsai and her colleagues “randomly selected a set of hospital discharges reported to LAC Public Health from August to October 2020 for a clinical diagnosis of COVID-19 or a positive SARS-CoV-2 test result” (Tsai et al., 2021). Among the 13,813 discharges from 85 hospitals reported to LAC Public Health as COVID-19–associated hospitalizations from August to October 2020, 346 were randomly selected and reviewed” (Tsai et al., 2021). The study revealed that “SARS-CoV-2 detection was incidental to the reason for hospitalization in 12%,” or 43 out of 346 patients involved in the study. In addition, a total of 13% of the patients who were believed to have positive COVID-19 tests were incorrect, due to “coding errors or economic incentive of hospital administration to err on the diagnosis maximizing revenues” (Tsai et al., 2021).

Breakdown of type of COVID cases for hospitalized patients under age of 18 discharged between May 2020 and June 2021 as of 8/5/2021 (N=34)		
	n	%
Likely COVID	6	18%
COVID Associated	18	53%
Incidental	10	29%

Table 2: Breakdown of type of COVID-19 cases for hospitalized patients under age of 18 discharged between May 2020 and June 2021 as of 8/5/21. Source: (Los Angeles County Department of Public Health, personal communication, 8 August 2021)

The table above illustrates a breakdown of the type of COVID-19 cases for 34 hospitalized patients under the age of 18 between May 2020 and June 2021. This data discloses that nearly 29% of cases of hospitalization were incidental, while likely COVID-19 or COVID-19 associated cases made up 18% and 53%, respectively. Another area of concern is the number of reported patients requiring critical care. The study revealed that a total of “47 (<1%) discharges were from a non-acute care hospital,” in which patients did not require acute care hospitalization (Los Angeles County Department of Public Health, 2021b). This presents clear limitations to data gathering and reporting within LA County. These limitations can include, but are not limited to false-positive COVID-19 test results, presymptomatic or asymptomatic infection, and “prolonged shedding of nonviable virus” (Tsai et al., 2021). Studies from JAMA Network have also shown that individuals who recovered from COVID-19 may still test positive for SARS-CoV-2 RNA (Flora Marzia Liotti et al., 2020). These results emphasize a need for consideration that hospital-reported data might be overestimating the effects of COVID-19 hospitalizations when using hospitalization data as a resource (Daniel P. Oran & Eric J. Topol, 2020). Health departments must be aware and account for incidental SARS-CoV-2 detection in city and county COVID-19 hospitalization rates, which would improve the accuracy of the reports by public health policymakers.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to increase access to critical health services and ensure timely, accurate data collection and tracking of COVID-19.

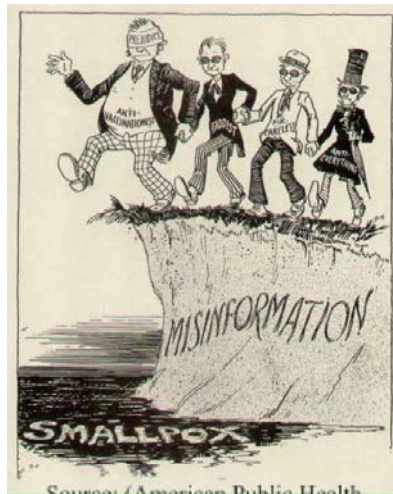
Infection Prevention and Control

Recommendations:

- 1) Encourage mask use in the listed community circumstances to limit the spread of the COVID-19 virus: communal areas in health care facilities, crowded public areas, public transportation vehicles (cars, taxis, buses, airplanes, etc.), indoor gym facilities during intense physical activity, and public settings such as schools and workplaces.
- 2) Increase access to medical resources that can help prevent the early transmission of COVID-19, such as surgical masks (N95 masks). Gloves, goggles, face shields, and gowns may also be needed.
- 3) Ensure available and easily accessible testing for every person with symptoms of COVID-19.
- 4) Guarantee paid sick days for staff that present any COVID-19 symptoms or have been actively exposed to someone who has tested positive for COVID-19.
- 5) Utilize face-coverings for all staff and necessary students in school-settings.
- 6) Enforce space and distance protocols in public areas, decrease class sizes in schools, space desks apart, and limit congregations in crowded school areas.
- 7) Increase outdoor learning and eating areas.
- 8) Provide hand washing and sanitizing stations for all staff and students.

Background:

Since the beginning of the COVID-19 pandemic in late 2019, infection prevention and control (IPC) has been a priority in policymaking, as it has proven to be one of the most effective methods of combating the spread of COVID-19. However, a lack of personal protective equipment (PPE) has also presented a serious challenge in providing medical resources to health care facilities as well as vulnerable populations (i.e. minority groups, areas with 30% to 100% poverty, or people with immune deficiency diseases) (WHO, 2021).



Source: (American Public Health Association, 1930).

Increased accessibility to vaccines has made infection prevention and control more attainable. The FDA authorized a booster dose of the Pfizer-BioNTech vaccine for everyone ages 16 and older. Booster shots from Moderna and Johnson & Johnson's are for adults 18 years and older. The Commission urges the CDC recommendation to deliver booster shots to anyone older than the age of 18. The need for booster shots reflects a time when "the immunity and clinical protection has fallen below a rate deemed sufficient" in a population (World Health Organization, 2021b). Booster shots can preserve

vaccine effectiveness. In distributing booster shots, high levels of susceptibility and critical health conditions should determine vaccine and booster shot allocation.

Due to school reopenings and a return to in-person education, medical professionals and policymakers carefully identified precautions LAUSD schools must take to prevent outbreaks. Dr. Alice Kuo (2020), a Professor of Pediatrics and Internal Medicine at the David Geffen School of Medicine and Chief of Medicine-Pediatrics at UCLA, discusses appropriate school policies designed to protect both children and adults in educational settings. She indicates that individuals under 18 years of age make up less than 10% of the overall cases in the United States (Centers for Disease Control and Prevention, 2020). Dr. Kuo also offers information to assess the actual risk to students when returning to school. She notes that data from household studies have proven that COVID-19 transmission and acquisition is less common in children than adults. Young children are also reported to have “milder respiratory symptoms and less fever” (Kuo, 2020). Additionally, return to in-person schooling this fall semester has been eased by FDA approval for vaccination in children ages 5-11 in late October (U.S. Food & Drug Administration, 2021).

It is also important to consider the benefits of an in-person education for a child’s emotional and social wellbeing. The “indirect costs of COVID-19 on children” have resulted in poor educational and psychological outcomes, according to JAMA Pediatrics. With students being forced to attend school virtually, there have been limitations to frequent “well-child visits,” “denied opportunities for social and emotional development,” and “under-reporting of child abuse.” Furthermore, distance learning has also limited children’s academic development. In urban districts, elementary school students have reportedly lost 30% of their reading skills. These consequences are especially harmful to low-income students, who may not have access to an internet connection, tutors, or other technology to complete their mandatory school work. Consequently, there is a “widening gap between the ‘haves’ and ‘have-nots’ resulting in inequities” (JAMA Pediatrics, 2020). Without infection control or prevention methods, these inequities will continue to widen.

Another area of importance that has arisen is the possibility of long-term symptoms from a COVID-19 infection. Dr. Alirez Atri, a neurologist with specialty focus in memory and cognitive disorders, revealed persistent neurologic symptoms and cognitive dysfunction that appeared in previous COVID-19 patients, otherwise known as “long haulers” (Graham et al., 2021). Comparing the 50 patients that tested positive for COVID-19 to another 50 patients that tested negative for COVID-19, researchers recorded the frequency of neurologic symptoms and analyzed patient-reported quality of life measures and standardized cognitive assessments. They discovered that patients with COVID-19 performed worse in “attention and working memory cognitive tasks compared to a demographic-matched US population.” Along with other comorbidities, both sets of patients experienced neurologic symptoms that included “brain fog (81%), headache (68%), numbness/tingling (60%), dysgeusia (59%), anosmia (55%) and myalgias (55%).” Anosmia, the partial loss or complete loss of the sense of smell, was more frequent in COVID-19 patients. Thus, COVID-19 “long haulers” may experience long-term “brain fog” and fatigue that can affect their overall cognition and life quality.

Action Plan:

The Commission encourages community education programs on vaccinations, routine testing, adherence to masking, and contact tracing among students, parents, and staff to increase preparedness for in-person learning. The Commission also encourages the adoption of the state recommendations to increase hygiene amongst students and staff.

COVID-19 Response

Recommendations:

- 1) Urge individuals above the age of 5 to receive a COVID-19 vaccination unless they have a medical exemption.
- 2) Encourage the proper use of a mask in indoor gatherings with individuals outside of one's household, at crowded or outdoor mega-gatherings, and in crowded outdoor settings.
- 3) Ensure that one's mask properly covers the nose and mouth and fits snugly against the sides of the face and nose.
- 4) Encourage children to wear masks on playgrounds and outdoor settings if social distancing is not possible.
- 5) Promote the use of respiratory masks or double masks during prolonged close contact with unvaccinated individuals.
- 6) Check for proof of full vaccination, or negative COVID-19 viral test against a photo identification for all attendees (≥ 18) of outdoor mega events - events with over 10,000 attendees like concerts, sports games, and parades.
- 7) Support research that studies the longevity of T-cell and B-cell immunity against COVID-19.

Background:

COVID-19 has placed enormous pressure on policymakers, researchers, and government officials to publish up-to-date information and policies. The Los Angeles County Department of Public Health, Office of Los Angeles Mayor Eric Garcetti, and various other county departments have been leading collaborative efforts to create guidelines and policies that address COVID-19. The following timeline lists major responses to COVID-19 in Los Angeles City:

- January 26, 2020 The Los Angeles County Department of Public Health confirms the first case of COVID-19 in Los Angeles County (LACDPH, 2020).
- March 4, 2020: California Governor Gavin Newsom declares a State of Emergency (Office of Governor Gavin Newsom, 2020); Mayor Eric Garcetti declares a local emergency for the City of Los Angeles (Garcetti, 2021).
- March 13, 2020: Los Angeles Unified School District (LAUSD) announces the cancellation of classes for two weeks (LAUSD, 2020).
- March 19, 2020: Governor Newsom issues a state-wide stay-at-home order; Mayor Garcetti issues the "Safer at Home" emergency order that requires all City residents to stay home and limit their activities to only those completely necessary (i.e. grocery shopping, securing medical necessities, caring for family, etc) (Newsom, 2020).
- April 7, 2020: Mayor Garcetti issues an emergency order requiring "essential workers" to wear face coverings, which is soon followed by an order for customers to also wear face coverings (Newsom, 2020).
- April 24, 2020: Mayor Garcetti mandates COVID-19 testing at skilled nursing facilities (Garcetti, 2020).

- August 28, 2020: California adopts a four-tier color-coded system to determine how counties can reopen their businesses (Office of Governor Gavin Newsom, 2020b).
 - The tiers include purple, red, orange, and yellow, with purple being the most severe and yellow being the least.
- November 19, 2020: Governor Newsom orders an overnight curfew (10 p.m. - 6 a.m.) for all California counties in the purple tier, including Los Angeles (November 21 - December 21) (Office of Governor Gavin Newsom, 2020c).
- November 22, 2020: Los Angeles County shuts down outdoor dining (excluding restaurant takeout and delivery) (Los Angeles County Department of Public Health, 2020).
 - Long Beach and Pasadena restaurants remain open despite other closures.
- December 12, 2020: FDA authorizes use of Pfizer vaccines (U.S. Food and Drug Administration, 2020a), which is soon followed by the approval of the Moderna (U.S. Food and Drug Administration, 2020b)
 - Available first in hospitals (Sandra Shewry & Erica S. Pan, 2020, p.1).
- January 13, 2021: California allows those age 65 and older to get vaccinated (California Governor's Office of Emergency Services, 2021).
- March 15, 2021: California allows high-risk individuals ages 16 to 64, to receive the COVID-19 vaccine (California Department of Public Health, 2021).
- March 25, 2021: Governor Newsom expands eligibility for the COVID-19 vaccine to all residents over the age of 16, on April 15th (Office of Governor Gavin Newsom, 2021a).
 - Residents that are 50 years and older are eligible beginning April 1st.
- April 6, 2021: California announces to lift all state COVID-19 restrictions on June 15th (Office of Governor Gavin Newsom, 2021b)
 - The mask mandate is not included in this, however.
- April 26, 2021: LAUSD campuses reopen (AB-86 COVID-19 Relief and School Reopening, Reporting, and Public Health Requirements, 2021).
 - Students are given the option to attend school in-person or continue virtually.
- May 10, 2021: The FDA authorizes the use of Pfizer's COVID-19 vaccine for use in 12 to 15 year olds (U.S. Food and Drug Administration, 2021).
- June 15, 2021: California reduces masking and social distancing requirements for vaccinated people only (Office of Governor Gavin Newsom, 2021).
- Late June, 2021: Delta Variant arises in California and a surge of cases hits Los Angeles County (Los Angeles County Department of Public Health, 2021a).
- July 16, 2021: LACDPH requires all individuals to wear a mask in indoor public settings and businesses, regardless of vaccination status (Tomás J. Aragón, 2021)
- September 9, 2021: Los Angeles Unified announces they will require all students 12 and older to be vaccinated against COVID-19 by January 10, 2022 (Los Angeles Unified School District, 2021).
- October 6, 2021: Mayor Garcetti requires individuals to be fully vaccinated on November 26 when entering restaurants, bars, gyms, sports arenas, nail salons, and all indoor City facilities (Office of Mayor Garcetti, 2021).
- October 29, 2021: FDA authorizes Pfizer COVID-19 vaccine for emergency use in children 5 through 11 years of age (U.S. Food & Drug Administration, 2021).
- December 2, 2021: Los Angeles reports first case of the Omicron Variant (Los Angeles County Department of Public Health, 2021e).

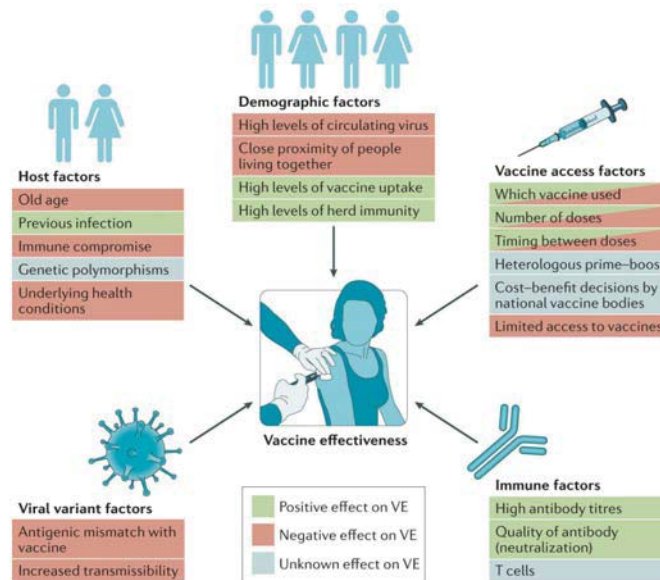


Figure 1: Factors Determining Vaccine Effectiveness Source: (Tregoning et al., 2021)

Over the course of the pandemic, vaccine effectiveness has proven to be dependent on several factors (see Figure 1). With the rise of new variants, Los Angeles health departments and organizations continue to monitor COVID cases and respond with new guidelines and strategies. The Health Commission supports COVID-19 related research efforts to better understand arising variants and to slow the spread of the virus. Marc Hellerstein, professor of medicine at the University of California San Francisco, presented his research to the Commission on vaccine longevity. Hellerstein elucidated the two types of protective immunity: “antibodies (serologic) and cellular (T-cells).” Early data on SARS-1 infections show how T-cells, a type of white blood cell that attacks foreign pathogens, have longer lifespans and lead to less severe disease responses than antibody responses (Hellerstein, 2021). However, in natural infections, the half-life of antibodies and T-cells are only a few months long; memory B-cells -- white blood cells that remember and respond to re-exposed pathogens -- last slightly longer (Dan et al., 2021; Turner et al., 2021; Van Elslande et al., 2021). Another study by Dr. Monica Gandhi, professor of medicine at the University of California San Francisco, placed an equally important emphasis on T cells and memory B cells, which are responsible for antibody production. T-cell reactivity was similarly high against variants in case of natural infection or mRNA vaccination (Alison Tarke et al., 2021). Antibodies developed from vaccinations also demonstrated comparable life spans to that of natural infections, but the longevity of T-cells generated from vaccines remains uncertain (Hellerstein, 2021, Doria-Rose et al., 2021). Greater research is required to fully understand the durability of vaccine-generated antibodies, T-cells, and memory B-cells against COVID-19 and its mutants. This information is crucial to our understanding of the longevity of COVID vaccines, and policy decisions regarding the requirement of booster shots for long-term protection.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to support the City’s response to COVID-19.

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Conclusion

The Los Angeles City Health Commission aims to provide policy recommendations in this report to address homelessness, healthy lifestyles, medical services, and COVID-19 surveillance and control in Los Angeles City. The recommendations are based on research, interviews, and presentations recently collected from experts and stakeholders in the Los Angeles community. The Health Commission also encourages the City Council and public health community to adopt the recommendations contained within this report to improve the health of Los Angeles residents. The Commission's work lies almost entirely on the dedicated work of volunteers. In order to produce high-quality research and effective recommendations for major public health concerns, the Health Commission requires financial support. An annual allocation of \$2 million would provide adequate funding for full-time staff and directed research, which the Health Commission believes is necessary to accomplish its goals and objectives.

2021 Los Angeles City Health Commissioners



HOWARD C. MANDEL M.D., FACOG

President (Council District Five)

Howard C. Mandel MD, FACOG is a practicing Obstetrician Gynecologist who has dedicated his life to the practice of high-quality health care and assuring access to such care. To this end, Dr. Mandel's extensive leadership in political advocacy and his education of the public has spanned over 35 years. He has held positions and chaired the Board of Directors of several not-for-profit and educational institutions, served on advisory panels and councils, and has received recognition for his leadership locally, statewide, and nationally.

Born in Brooklyn, New York, Dr. Mandel received his degrees from Johns Hopkins University and New York University School of Medicine. His exposure early on to the medical care of the indigent at both Johns Hopkins Hospital and Bellevue Hospital bonded him to the defense of those who could not help themselves. As a volunteer at the Saban (Los Angeles) Free Clinic for three decades, Dr. Mandel has advocated for equal access to health care for women, children, the homeless and the working poor.

Dr. Mandel currently advises Senators Michael Bennet and Mark Warner on health care policy. He also serves as the President of the City of Los Angeles Health Commission. He has advised the House of Representatives serving on the National Physicians Council for Health Care Policy and has previously served on "Obama for America Health Policy Advisory Committee." He was a National Co-Chair of Run Biden 2016 and was an advisor to Vice President Biden on health care issues during his 2007/2008 presidential campaign. Likewise, he has served on several local and statewide governmental advisory panels, assisting Assembly members Burt Margolin, Barbara Friedman, Susan Davis, Wally Knox and Paul Koretz. He was an early supporter of Governor Howard Dean's 2004 presidential campaign, a member of the "Dean's List" and a founder of "Doctors for Dean". He later was one of three founders of "Doctors for Kerry" and served on the then California Attorney General, Kamala D. Harris' "Smart on Crime" Health Committee.

In addition to teaching and lecturing on topics such as Ob/Gyn Emergencies, Umbilical Cord Blood Banking, Menopause, Women's Health and Health Care Economics, he has appeared as an expert on numerous television news and informational programs on NBC, ABC, CNN, KTLA, KCOP, E!Entertainment and UPN, and has made appearances on The Dennis Miller Show, The Mo Show, Strange Universe, Borderline and Medically Incorrect.

Dr. Mandel has been recognized for his leadership and public service by the State of California, County and City of Los Angeles, The Johns Hopkins University (Distinguished Alumnus Award 2015), Jhpiego (The Elyse Bila Ouedraogo Award 2015), The Oakwood School (Charles Haas Award 2011), Temple Israel of Hollywood (2007), the Saban (Los Angeles Free) Community Clinic (Lenny Somberg Award-1996 and Leo D. Fields Volunteer Award-1996), Los Angeles Committee on Philanthropy (1995), and the American College of Obstetrics and Gynecology (President's Community Service Award 1994), American Association of Gynecologic Laparoscopists (1985), Cedars-Sinai Medical Center (Leo G. Rigler Award 1985), New York University School of Medicine (Frederick C. Holden Prize 1981 and the James Constantine Award 1981). Most recently he was selected as one of the Top Three Gynecologists in Los Angeles by threebestrelated.com.

Currently Dr. Mandel is a member on the Board of Directors of the Friends of the Saban (Los Angeles Free) Community Clinic, WomenStrong International, Big Sunday, the UCLA School of Nursing Dean's Advisory Board and he Chairs the International Advisory Board of Jhpiego. He also serves on the Johns Hopkins University Krieger School of Arts and Sciences Advisory Board and her School of Education's National Advisory Council. He has previously served on the Boards of Trustees of the Johns Hopkins University, of Temple Israel of Hollywood, Oakwood School and the Boards of Directors of Century City Hospital and the Los Angeles Free Clinic and its Hollywood Endowment Corporation as well as the Los Angeles Advisory Board of Children Now. He has served on the Performance Improvement Committees of Cedars-Sinai Medical Center, Century City Hospital and Century City Doctors Hospital. He was the Chairman of Surgery as well as Chief of Gynecology at Century City Doctors Hospital and served twice in that role at Century City Hospital. He represented Century City Doctors Hospital to the American Medical Association, California Medical Association and the Los Angeles County Medical Association and previously did the same for Century City Hospital. Dr. Mandel lives in Los Angeles with his wife Dr. Susan Mandel and has two children, Spencer, age 34 and Mallory 32.

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MATTHEW GRIMMIG

1st Vice President (Council District Four)

Matt Grimmig currently serves as a National Field Ambassador for Myriad Genetics and is an integral part of helping doctors discover their patient's invisible genetic risk that places them squarely in the crosshairs of cancer. Over the past 15 years, Matt has been a representative of multiple medical corporations that operate in the Women's Healthcare space in the greater Los Angeles area. During that time, he has been an essential part of bringing access to family planning medication and life-saving genetic testing to impoverished and lower-income patients who would otherwise be without the care every woman should be afforded.

Born and raised in a military family, Matt learned the importance of service and, after graduating from Florida State University, has accepted leadership roles on several boards related to healthcare. He currently serves as the Vice President on the board of directors of the Angeles Community Health Center in downtown Los Angeles. This Federally Qualified Healthcare Center (FQHC) has been a fundamental part of expanding necessary healthcare to low-income patients across the City.

As 1st Vice President of the Los Angeles City Health Commission, Matt strives to lend his expertise to expand essential medical care to those who need it most and tackle the most difficult health issues that affect our City.

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SHAMIKA OSSEY R.N., B.S.N.

2nd Vice President (Council District 15)

Shamika Ossey graduated with a Bachelor of Science Degree in Nursing from Mount Saint Mary's University, in 2005, and began her Public Health Nursing career in 2007 with the County of Los Angeles. She has been an emerging leader in the community earning several awards, and recognition from local elected officials, the Federal Emergency Management Agency and the White House. Ms. Ossey enjoys community engagement, promoting emergency preparedness, and has been a volunteer with the American Red Cross Los Angeles Region since 2014 as a Community Ambassador. As an Instructor and Co-Program Manager of the Watts Community Emergency Response Team (CERT) Program Ms. Ossey volunteers her time engaging the community in emergency and disaster preparedness education and training. Ms. Ossey currently serves as a SEIU 721 Union Steward, Co-Chair of SEIU 721's Bargaining Unit 311 (LA County Registered Nurses), SEIU Nurse Alliance of California Steering Committee Member, Co-Chair of LA County Department of Public Health's RN Joint Labor Management Committee, and Commissioner on the City of Los Angeles Health Commission.

2021 Los Angeles City Health Commissioners



LORRAINE ESTRADAS R.N., B.S.N., M.P.H.

Commissioner (Council District One)

Ms. Estradas, a native Angeleno, developed a keen interest in health care, particularly health services for the medically underserved vulnerable populations at a very early age. She volunteered as a Candy Stripper at Los Angeles County USC Medical Center where she later worked as a nurse's aide. Her commitment to health care propelled her to earn a Bachelor of Science degree in Nursing as well as a Master's degree in Public Health, both from UCLA.

While pursuing an education, Ms. Estradas continued advocacy for access to quality health care for the poor and medically underserved in Los Angeles. Her experience included hospital and community public health nursing at UCLA, the Regional Center for the Developmentally Disabled, the State Department of Health Services, Farm Worker Health, and the Federally Qualified Community Health Center. She learned how health policy, legislation and advocacy impacts health care delivery and has served on various health care Association Boards and Committees.

Ms. Estradas currently serves as the Chief Executive Officer of Arroyo Vista Family Health Center. Under Ms. Estradas's leadership, Arroyo Vista has experienced significant growth from a small storefront clinic to a healthcare delivery network of four health centers and a mobile medical clinic serving the healthcare needs of medically underserved families of Northeast Los Angeles. Services span the five-stage life cycle and include medical, dental, optometry, imagining, including the Ruby Cedillo Breast Care and Imaging Center, specialty services, health promotion and disease prevention. All are welcomed and cared for at Arroyo Vista Family Health Center regardless of ability to pay. Arroyo Vista is accredited by The Joint Commission and certified as a Primary Care Medical Home and is affiliated with local universities as a clinic preceptor for medical residents, graduate nurse practitioners and medical students.

She continues to participate in leadership roles in the area of health policy and advocacy to improve health care outcomes, expand health care access and decrease community health disparities. She believes that healthy children and healthy families, lead to healthy and empowered communities.

2021 Los Angeles City Health Commissioners



JOHN HISSERICH M.P.H., DrPH.

Commissioner (Council District Two)

John Hisserich spent 34 years at the University of Southern California retiring in 2005 as Associate Vice President of Health Affairs. He then joined the staff of Assembly member then Councilmember Paul Krekorian addressing principally health and public safety issues. He holds Master's and Doctoral degrees in Public Health from UCLA and a BA in Government from California State University Los Angeles. He served three years on active duty with the U.S. Army and has served as a Reserve Los Angeles County Deputy Sheriff for 41 years.

2021 Los Angeles City Health Commissioners



MICHAEL SIROTA

Commissioner (Council District Three)

A resident of Los Angeles since 1965. A proud homeowner for over 50 years and a successful business leader for more than 40 years. Michael Sirota was President of Woodland Printing, located in Canoga Park for thirty years. Well known in the San Fernando Valley for generosity and commitment to the betterment of the community. Mr. Sirota is presently the President of the Canoga Park Improvement Association. Which is the administrator of the Canoga Park Business Improvement District, (BID). He is also CEO of Sobriety Connection. Sobriety Connection is a nonprofit organization with a mission to solve the homeless crisis.

Michael Sirota has an impressive resume of community activism and an equally strong list of charitable accomplishments. He served as a Commissioner for the City of Los Angeles Quality and Productivity Commission for eight years. He served as President of the Winnetka Chamber of Commerce, for three years and a Board Member and Vice-President of the Canoga Park-West Hills Chamber of Commerce. Michael Sirota has donated his time and resources for more than ten years, as President of the LAPD West Valley Jeopardy Foundation, which is a successful gang diversion program, operated in conjunction with the LAPD. Michael Sirota served as Club President and Valley Regional Chair of the Lions Club, part of the 1.45 million Lions giving service to those in need.

His civic participation earned him an elected position to the Canoga Park Neighborhood Council Board, serving from its formation, for ten years. As a member of the Board of Directors of Main Street Canoga Park, he has played an important role in bringing about the economic revitalization in Canoga Park. Which was one factor, leading up to his community receiving the nationally prestigious All-American City Award-June 2005.

Past community and professional involvement include serving on the boards or committees of the Guadalupe Center, the Los Angeles Free Clinic, the Canoga Park Memorial Day Parade Committee, the West Valley Evening Optimist Club (past President), the California Association of Commercial Printers, and the Canoga Park-West Hills Job Fairs (Chair), which attracted 15,000-20,000 job seekers at each of its annual events. Mr. Sirota has been general manager of a large manufacturing company in downtown Los Angeles (400 employees), a teacher and a college instructor teaching marketing classes, and founder and administrator of the Los Angeles

Free University, which offered college training to 800 students at no charge. His daily application of sound business policy and practice, together with his dedication to improving the quality of life and sense of community in the City of Los Angeles, makes him well suited to serve as a Health Commissioner.

2021 Los Angeles City Health Commissioners



Brian Gavidia M.P.A

Commissioner (Council District Seven)

Brian Gavidia is the son of hard-working parents who immigrated from El Salvador and Guatemala. Currently, he holds the position of Government and Community Relations Manager at Northeast Valley Health Corporation, a federally qualified health center. There, he advocates to increase healthcare access for uninsured and underinsured residents of the San Fernando and Santa Clarita valleys. Previously, Brian proudly led constituent outreach efforts in the San Fernando Valley as the East Valley Area Representative for Los Angeles Mayor Eric Garcetti, and as Field Representative for U.S. Representative Tony Cárdenas. Brian holds a Master's degree in Public Administration from the California State University Northridge, and two Bachelor's degrees in Latin American, Iberian Studies and Spanish Language from the University of California Santa Barbara.

2021 Los Angeles City Health Commissioners



NOMSA KHALFANI M.A., Ph.D.

Commissioner (Council District Eight)

Nomsa Khalfani, Ph.D. is the Executive Vice President at Essential Access Health, where she leads key initiatives in support of Essential Access' strategic priorities, to further the growth and position of the organization. In this role, Ms. Khalfani directs the planning, implementation, and monitoring of all community health programs (Title X Family Planning Program, STD Prevention Center), training, state and national partnerships, and other strategic initiatives. Under her leadership, Essential Access Health's Learning Exchange has increased the overall number of training participants, training revenue, and training participants beyond California. She also launched Essential Access Health Solutions, which offers a broad range of consulting and product solutions. Before joining Essential Access Health, Ms. Khalfani held several leadership positions with St. John's Well Child and Family Center (SJWCFC), a network of federally qualified health centers. During her tenure, she was responsible for strategic planning, program development and oversight, and health care reform readiness and implementation. Ms. Khalfani currently serves as Board Chair at Community Asset Development Re-defining Education (CADRE) and Board Member for California Pan-Ethnic Health Network. She is also Co-Chair of the LA County Community Prevention and Population Health Task Force and the African American Infant and member of the Maternal Mortality Steering Committee. Ms. Khalfani holds a B.A. from the University of California, Santa Cruz, an M.A. from Phillips Graduate University, and a Ph.D. from Capella University, School of Public Service Leadership. She is a graduate of the Southern California Coro Women in Leadership (WIL) Program, the Blue Shield of California Foundation Clinic Leadership Institute (CLI) Emerging Leaders Program, and the California Women's Foundation Women's Policy Institute (WPI).

2021 Los Angeles City Health Commissioners



IRMA AVILA C.N.A.

Commissioner (Council District Nine)

Irma Avila serves as the Los Angeles City Health Commissioner for City District 9. She has lived in Los Angeles for 25 years and become a highly experienced leader in public health. Throughout her career, Irma has shown great passion and dedication to protecting the health of the people of Los Angeles as she served as a Certified Nurse Assistant (CNA) for 12 years from 1994-2004 at Wilshire Retirement Center in Los Angeles, California. In 2010, Irma set a bold course of action as a community health educator for the Coalition for Occupational Safety and Health (SoCalCOSH) planning and disseminating health and safety curricula. In 2011, she expanded her efforts in public health with Best Start Metro Los Angeles (BSMLA) by conducting outreach, leading health education initiatives, and serving as a liaison between parents and community stakeholders. Using her skills as a bilingual Spanish and English speaker, Irma played a key role with Choose Health LA Kids (CHLA Kids) and Champions for Change to spearhead community nutrition workshops, food demonstrations, and advocacy in healthy nutrition campaigns for children and families. Irma continues to aid community outreach events and health education projects by working in collaboration with First 5 LA to hold consulates, health fairs, and conferences in Los Angeles.

Irma Avila proudly serves various roles as member of the UCLA-LOSH Promotoras Committee (UCLA-Labor Occupational Safety & Health), a member of the Community Health Institute (CHI), member of the National Association of Community Health Centers (NACHC), secretary of EISNER Health Center, President of CD Tech – S.O.D.L.A. Group (Sociedad Organizada de Latinas Activas), President of All Peoples Community Center-Grupo M.E.J.O.R. (Mujeres En Justa Organización Reciproca), and commissioner of the Los Angeles City Health Commission.

Irma now lives with her husband Enrique Avila Martinez and her three children: Henry, Vincent, and Erick, and her granddaughters: Melanie and Melissa.

2021 Los Angeles City Health Commissioners



RON KATO M.B.A.

Commissioner (Council District 11)

Ron C. Kato is the Executive Director of the MOA Wellness Center, a non-profit integrative medical clinic in Del Rey Los Angeles promoting lifestyle changes introducing people to alternative methods other than just taking medications to deal with their health issues. Headquartered in Japan, MOA has clinics worldwide and Ron has worked for them in Japan, Brazil and England. Other than his native language English, he speaks Japanese, Portuguese and Spanish fluently.

Ron worked actively with the late Councilmember Bill Rosendahl of Council District 11 and his staff since 2013 as the Los Angeles City Planning Department was preparing the draft for ‘Plan for a Healthy Los Angeles’ promoting wellness fairs at the local farmers market. As a native Angeleno it continues to be Ron’s passion to see the ‘Plan for a Healthy LA’ implemented promoting health and wellness in body, mind and spirit for all Angelenos.

Since 2017, Ron has been volunteering as the deployment site coordinator in Del Rey for LAHSA’s annual homeless count. In December 2020, he was asked to become an advisor to the Friends of Venice Boardwalk, a grassroots group of dedicated community members concerned with helping the homeless, while working to keep the Ocean Front Walkway clean and safe for recreational activities. He continues to serve on LAPD’s Pacific Division Community Police Advisory Board and the Boosters. Appointed by Councilmember Mike Bonin, he has been serving on the Health Commission since July 2016.

2021 Los Angeles City Health Commissioners



STEPHANIE LEMUS

Commissioner (Council District 13)

Stephanie Lemus grew up in the Pico-Union area of Los Angeles with her Salvadoran immigrant mother and her two siblings. She attended California State University, Northridge (CSUN) where she double-majored in Anthropology and Central American Studies with a minor in Pan-African Studies. After she graduated from CSUN, she then went on to earn a Master's Degree in Latin American Studies from California State University, Los Angeles (CSULA) where her primary research focused on the community of the Salvadoran Diaspora in Los Angeles. Stephanie is currently a Doctoral Student at the University of Southern California (USC) Rossier School of Education. She has worked with various non-profit organizations and groups for the past 10 years in community organizing, education, workforce and advocacy. She has been teaching in the Central American and Transborder Studies Department since August 2016, and is currently Director of the Central American Research Policy Institute (CARPI). Also, Stephanie works at Clinica Monseñor Oscar A. Romero, a Federally Qualified Health Center that was founded by Salvadoran refugees in 1983. Stephanie has been at Clinica Romero for the past three years as the health center's Director of Community Affairs and Advocacy where she oversees the Outreach and Eligibility departments which focus on patient and community health education, advocacy, outreach and enrollment.

2021 Los Angeles City Health Commissioners



SUSIE SHANNON

Commissioner (Council District 14)

Susie Shannon has represented the 14th Council District on the Los Angeles City Health Commission since 2014, where she also served as president for two years.

Shannon has worked with homeless and low-income communities since 2005 and currently serves as the Executive Director of the non-profit Poverty Matters, working for systems change and public policy to support solutions to homelessness and poverty. In 2015, Shannon spearheaded legislation to place California on a Housing First model, helping our chronic homeless community with underlying medical conditions achieve better health outcomes through housing. The legislation passed the California legislature and was signed by the Governor in September 2016. Shannon has also served as an expert witness to Congress on matters of homelessness and housing. Shannon serves on the boards of Safe Parking Los Angeles, the Democratic National Committee, the California Democratic Party and the Los Angeles County Democratic Party.

2021 Los Angeles City Research Associates



LAUREN YEN

Research Associate

Lauren Yen is a Master's student at the USC Keck School of Medicine. She has served the Commission since 2019 and was the primary researcher and author of the 2020 Los Angeles Health Commission Report. She is the CEO of Frontida Records, a digital health technology company, and the co-founder of Torch, a non-profit focused on providing low-cost, low-tech solutions to increase comfort in tents and makeshift structures for the homeless in Los Angeles.

She also conducted medical and public health research at the Schaeffer Center for Health Policy and Economics, USC Keck School of Medicine, and Children's Hospital Los Angeles.

2021 Los Angeles City Research Associates



SARA KHOSHNIYATI

Research Associate

Sara Khoshniyati graduated from the University of Southern California with a B.S. in Human Biology and a minor in Health Care Studies, as a Warren Bennis scholar. She has served the Commission since 2020, and was the first-author of the 2021 Los Angeles City Health Commission Report.

She served as the Founder and President of Holistic Healthcare Advocates, an organization that provides direct services to individuals experiencing homelessness, and the co-founder of Safe at Home Delivery, a non-profit that provides complimentary grocery service delivery services to high-risk individuals. Her goals in working with the City focus on building an effective and sustainable homeless coordinated effort that addresses the immediate needs of the population, and ensures that the City's core values are reflected in the way it protects under-served citizens.

2021 Los Angeles City Research Associates



MARVIN CHOWDHURY

Research Associate

Marvin Chowdhury is a Master's student at the Brown University School of Public Health. He is an elected official on the Los Angeles Neighborhood Council where he represents Reseda's population of 80,000. His advocacy for his constituents includes fighting for better community health care and housing. He also helped to sequence COVID-19 as an RNA Extraction Technician at the California Department of Public Health.

Marvin currently is helping two Brand New Congress endorsed individuals run for Congress by advising them in marketing and policy. He hopes to pursue a career in public policy and government.

Appendix A

The following approved meeting agendas and presentations for the Los Angeles City Health Commission were discussed between January 2020 to October 2021. The Health Commission expresses our deepest gratitude to the presenters - government officials, healthcare providers, professors, researchers, advocates, and leaders in the community - who contributed their time and expertise to the LACHC Meetings. We believe the City Council should collaborate with community stakeholders and work together to confront challenges in the City of Los Angeles.

Click on this link: [Appendix A](#)