LOS ANGELES CITY

HEALTH COMMISSION

2022

2022 Health Commissioners

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Introduction to Annual Report 2022

The Los Angeles City Health Commission (Health Commission) is a government body established in 2014 by the Los Angeles City Council (Ordinance No. 183093), with the mission to improve the health and wellness of citizens residing in Los Angeles City. The Health Commission is composed of volunteer commissioners and staff that focuses on understanding the health needs of people in Los Angeles City, conducting public health research, and providing information and recommendations that help Angelenos lead healthy lives.

The Health Commission is requesting funding and resolution authority for three positions consisting of one Executive Director, one Legislative Analyst, and one Commission Executive Assistant to allow the Commission to fulfill its mission. The Executive Director position would require a Master's Degree in Public Health and some management experience. This position will be responsible for oversight of the Commission and serve as the liaison with the Los Angeles County Departments of Public Health, Mental Health, and Health Services, as well as with the various City Departments that provide health and safety services. This role is crucial to developing partnerships and assisting in the coordination of the provision of services to the City of Los Angeles, by identifying areas of need and recommended actions. This necessitates a high level of research, which would be the main role of the Legislative Analyst, a position that would require, at least, a Bachelor of Science degree in Public Health. This research is the basis for the development of this Annual Report, which articulates the areas of need and provides recommendations to address those needs.

The Office of the City Clerk has provided the needed assistance in the conduct of Health Commission meetings. However, a dedicated Commission Executive Assistant would also provide support to the Executive Director and the Legislative Analyst, as well as to the Commissioners. The Health Commission is also requesting funds to support research programs to benefit the City's communities. We are requesting funding to conduct four studies focusing on the following: 1) Improving access to healthcare for the homeless population; 2) Increases in infectious diseases, including respiratory illnesses and COVID-19, in Los Angeles schools; 3) Effectiveness of mobile healthcare units in meeting the needs of the homeless population and community outreach; and 4) Effectiveness of advance practice nurses working with the Los Angeles Police Department and Paramedics to address mental health issues with the homeless population.

The table below provides the requested positions and salary costs, based on the level of knowledge, experience, and expertise needed and consistent with City position classifications, and estimated office expenses and equipment costs.

Salaries	
Executive Director (9225)	$146,244
Legislative Analyst II (0192)	$115,237
Commission Executive Assistant I (9734-1)	$87,320
Total Salaries	$348,801
Expense	
Printing and Binding (Annual Report)	$1,000
Office and Administrative	$3,000
IT Services and Support	$65,000
Total Expense	$69,000
Equipment	
Furniture, Office, and Technical Equipment	$60,000
Total Equipment	$60,000
Research	
4 Studies @ $300,000 each	$1,200,000
Total Research	$1,200,000
Total Los Angeles City Health Commission Budget	$1,677,801

Section I: Homelessness

Introduction:

The 2022 Los Angeles Housing Services Authority (LAHSA) homeless count identified 41,980 total individuals experiencing homelessness within the City of Los Angeles (LAHSA, 2022). This number is a 1.7% increase from the results published by LAHSA in 2020, offering a stark contrast to the 16.1% increase from 2019 to 2020, as noted in the 2021 LACHC report. These results suggest that subsequent homelessness relief efforts as a result of the COVID-19 pandemic- such as one-time federal assistance, rental assistance, Project Roomkey, eviction moratoriums, and rent freezes- were effective in reducing the amount of people experiencing homelessness in the City of Los Angeles (LAHSA, 2022).

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.) that lead to homelessness. Individuals experiencing homelessness often suffer from severe health consequences. They often have higher risks of mortality with an average age of death of 51 for men and 48 for women in Los Angeles County (Kuhn et al., 2020). In 2019, Los Angeles County saw a death count of 1267 unhoused people, and in 2020, this number increased to 1737 deaths (LADPH, 2022) They also may have higher risks of contracting an infectious disease, chronic illness, subjection to violence, mental illness, and substance abuse (Kuhn et al., 2020). These risks are a public health issue not just for the homeless but also for other housed individuals in those communities: individuals experiencing homelessness use emergency departments at higher rates which creates a strain on the health care system via overcrowding. 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).

In order to understand the public health issue of homelessness, Nickasch and Marnocha (2009) highlight the four major causes of health disparities in the homeless population: lack of attainment of physical needs, lack of healthcare affordability, lack of health care provider compassion, and lack of available resources. To remedy the health disparities that come with being homeless and to rehouse individuals experiencing homelessness, these four deficiencies must be addressed through the city and county policy interventions, as suggested within our 2022 report.

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 or support to help reduce homelessness and improve the health of the City's homeless population.

Given the lack of implementation of our recommendations from the 2021 LACHC Annual Report, many of our recommendations remain the same.

Housing First Programs and Permanent Supportive Housing

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) Determine the impacts of Proposition HHH on the number of PSH units built and methods to improve Proposition HHH rollout speed and cost.
4) Utilize any vacant units in the City, prefabricated modular housing, and adaptive reuse for use in permanent supportive housing and Housing First programs.

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), 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 it has shown to have a long-term housing retention rate of up to 98% (Montogomery 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, school attendance, discontinued substance use, less time spent in the hospitals, and increased participation 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 hospital and jail emergency services in comparison to an unhoused individual. Compared to housed individuals, the average cost of hospitalizations for unhoused invidious is an additional $2,500, leading to poorer health outcomes and increased medical costs.

Los Angeles has already implemented a number of programs that follow the Housing First approach and permanent support 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 (LACDHS) 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 significant reduction in the usage of legal and health services: 1) participants exhibited 52% fewer ER visits; 2) inpatient hospitals stays were reduced by 44%; 3) mental health crisis service usage decreased by 47%; and 4) the average number of days spent in jail was reduced by 52%. (Palimaru et al., 2020). Since 2012, 14,000 individuals experiencing homelessness have been housed, and there has been 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).

In 2016, Proposition HHH overwhelmingly passed, providing a locally-generated, dedicated source of funding for streamlined development of PSH (LAHD, 2022). The project was spearheaded by the Los Angeles Housing Department (LAHD) with a goal of creating 10,000 PSH units by 2026. They have surpassed this goal as of November 2022: they have 3,420 PSH units that are completed, 5,446 PSH units under construction, and 4,113 PSH units currently being designed (LAHD, 2022). Throughout this project, the city has seen an increase in the annual production of supportive housing units by 600%, an increase from about 300 units per year to over 2,000 (LAHD, 2022). Although these PSH unit numbers as a result of Proposition HHH represent a dramatic increase from previous years, the rollout of Proposition HHH has been criticized for being slow and expensive. The office of the Los Angeles City Controller noted that these HHH project timelines do not meet the scale of the crisis, with many of the projects taking three to six years to complete. These projects also see soaring costs, because of the high cost of construction in Los Angeles, prevailing wage requirements, funding complexity, regulatory issues, and land use challenges. The average per-unit cost for PSH units under construction increased from $531,000 in 2020 to $596,846 in 2021 (LA Controller, 2021).

According to a report from the LADWP, the City of Los Angeles has 70,000 units in a state of non-market vacancy, which is equivalent to more than one for every unhoused person in the city (HCID, 2020; Ferrer et al., 2020). Los Angeles can also implement the adaptive reuse of older commercial buildings in downtown Los Angeles in order to obtain more housing units. Adaptive reuse of these buildings in terms of sustainability 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 typically about 95% complete. Upon their arrival, they only need to be fastened together by a crane, and this process takes workers a mere few days to do so (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).

Action Plan:

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

Interim Housing (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 through government-funded comparative research studies, in order to evaluate overall efficacy and need for improvement.
5) Implement the 5 LAC+USC Restorative Care Village strategies for helping homeless individuals use the appropriate services at other City and County medical sites.
6) Perform a cost-benefit analysis of Project Roomkey.
7) Seek reimbursement through federal grants for Project Roomkey expenditures, whenever possible.

Background:

The prolonged process of rehousing chronically homeless individuals and the increase in the number of homeless individuals stresses the need for interim housing, such as emergency shelters and transitional housing programs. People experiencing homelessness who need PSH may experience delays in housing attainment (Kuhn et. al, 2020). The Substance Abuse and Mental Health Services Administration (SAMHSA) (2021) 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 data collected during the analysis of the efficiency of Measure H: during the 2019-2020 fiscal year, Measure H-funded interim housing helped 14,804 people move off the streets. This number is a 24.8% decrease from the previous fiscal year, most likely due to the reduction in occupancies necessitated by COVID-19 social distancing protocols. Of those 14,804 people, 74% exited the program and retained permanent housing. However this percentage demonstrates a decrease from last fiscal year's proportion of 93% retaining permanent housing. Within 6 months of permanent placement, only 6.6% of participants returned to homelessness (LA County CEO, 2021)

The LAC+USC Restorative Care Village is a new transitional housing program implemented by Los Angeles County to offer 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 (LACHI, 2022). 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 (LACHI, 2022). The Recuperative Care Center also provides clinically enriched interim housing, on-site administrative support, health oversight, case management, and resources that lead to permanent supportive housing programs for those experiencing housing instability upon discharge (LACHI, 2022). The Residential Treatment Program has 64 total beds and provides a short-term alternative to hospitalization in order to address mental health needs. Phase 1 of the LAC+USC Restorative Care Village is complete as of July 2022, and the costs were estimated to be roughly $68 million. So far, the center is 55% complete and has exceeded the required 30% local and 10% targeted worker hire goals (LACHI, 2022). However, the LAC+USC Restorative Care Village as a whole, and, specifically, the 1200 State Street building, have been underutilized. The center must maximize its use of the property as each unit of new housing is quite costly. To ensure better health outcomes for unhoused patients, the center created proposed 5 strategies:

1. “No wrong door: A building with many doors and many reception areas allows patients to be welcomed no matter where they enter, with staff ready to direct them to the appropriate care team.

2. Removed from the ‘street’: The concept steps up from the street in levels. At the ground floor, individuals are welcomed and triaged. The rest of the services are located on the floors above; this incentivizes patients to recover by creating both physical and symbolic distance between themselves and the street.

3. Enabling choice: Research shows that health outcomes are better when patients make choices in their care. The facility is designed with this in mind, breaking up the building mass and offering a diverse array of spaces where patients can select their environment.

4. A life building: Gardens and landscape are an essential part of healing for the homeless population, and they are abundant throughout the building. Giving individuals the opportunity to begin caring for living things can support their ability to care for themselves.

5. Stealth outreach: Seeking treatment and staying in treatment is a huge obstacle. If this facility is to be successful, it can’t be intimidating. Creating gentle, gradual entrances with slow transitions from outdoor to indoor make the building approachable, and integrate it with the surrounding community” (LACHI, 2022).

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). The program allows for the County to perform vast street outreach and provide COVID-19 vaccinations. The office of the LA County CEO reported that this program housed 10,000 unhoused individuals and enabled 37 participating hotels and motels to stay in business despite the economic downturn (LA County CEO, 2021). As Project Roomkey sites close, participants are connected to permanent or other interim housing programs. Less than 4% of participants returned to living on the streets after exiting the program (LAHSA, 2021). Unfortunately, the majority of the program ended on September 30, 2022, and the hotels and motels contracted for Project Roomkey have been steadily closing, with many clients already back on the streets. The Los Angeles City Council voted to temporarily extend the program at three sites, the Highland Gardens, Airtel Plaza Hotel, and the LA Grand Hotel. They allocated $2.9 million to slowly wind the program to a full close on October 31 for the first two respective sites and at the end of January for the last respective site. They also allocated $2.5 million to provide housing navigation to the remaining program participants, which was a mere 725 people as of August, 2022. LAHSA also reported that LA City spent more than $220 million on the program, which the federal government has not reimbursed the city for (City News Service, 2022).

However, 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 (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 to them, such as making the shelter open 24/7, not requiring people line up for a bed each night or leave early in the morning, removing drug and alcohol testing, removing criminal background checks, removing income requirement, and allowing pets and other possessions.

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 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.

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Background:

Encampment sweeps are used by the City to increase street sanitation and the hygiene of individuals experiencing homelessness by cleaning up their trash. They typically involve law enforcement, public works staff, or a city-contracted cleanup crew posting an eviction notice next to an encampment in response to complaints or 9-1-1 calls (Goodling, 2020). Although encampment 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). According to outreach workers, the most frustrating and solvable source of delays regarding a transition to housing for individuals experiencing homelessness involve lost birth certificates, social security cards, and other identifying documentation, all of which may be lost and/or confiscated 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 more 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 (2022) has recommended that if individual housing options are not available, people experiencing homelessness 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 (2022) 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, 2022).

The Los Angeles City Echo Park Lake encampment sweep that occurred during the COVID-19 pandemic is a prime case-study of a poorly executed encampment sweep. A report by the UCLA Luskin Institute on Inequality and Democracy details this sweep: they note that due to comprehensive encampment sweeps in other districts, Echo Park Lake soon became a safe haven for unhoused residents compared to most places on the street, particularly for women fleeing domestic violence (Roy, 2022). In March 2021, approximately 200 unhoused residents of Echo Park Lake were evicted within 24 hours of notice. The Councilmember who enacted the sweep announced 209 people had been placed into transitional shelter. However, the report found this claim to be spurious, as only 17 of those 209 people have been placed into long-term housing. Many are still waiting in the system, have been forced back into homelessness, or have not been located. Seven former Echo Park Lake encampment residents had died by the time the UCLA report was published (Roy, 2022).

The City has conducted encampment sweeps without following CDC guidelines; however, the City has provided portable latrines and handwashing facilities to homeless encampments. 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). When the COVID-19 pandemic occurred, the City put out 363 handwashing stations and 182 portable toilets at encampments as a response. These toilets were said to be regularly broken, covered in graffiti, and used for drug deals and prostitution (LA Times, 2021). Handwashing stations were damaged, and soap and paper towels were stolen (LA Times, 2021). City officials said they replaced 175 toilets and 94 hand-washing stations (LA Times, 2021). As a result, the City is currently opting to add 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 or 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 throughout 2022 (LAHSA, 2020). These 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 and provide homeless individuals and communities supportive services and housing (LAHSA, 2020). Currently, an 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.

Substance Use Disorders (SUD), Sobering Centers, and Street Medicine

Recommendations:

1) Continue to implement and fund SUD treatment in PSH and interim housing programs.
2) Make the Sobering Centers more accessible by removing certain restrictions.
3) 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.
4) Invest $10 million into Healthcare in Action's street medicine model to provide mobile medical and social services to the unhoused.

Background:

The LAHSA 2020 homeless count reports that approximately 14,284 unhoused individuals (32%) in LA County have a substance use disorder (SUD). The availability of stable housing during treatment and recovery tends to produce better SUD outcomes among unhoused individuals, and many of LA's PSH and interim housing programs offer SUD treatment options (LADPH, 2022). For example, the Housing for Health program has nurses, social workers, and substance-use counselors to provide wrap-around services for individuals struggling with substance use disorders. They are instructed to act as non-judgmental agents and supporters of change; trauma-informed care; harm reduction; and pragmatic solidarity to enhance the client's dignity and purpose (LADHS, 2022). Project Roomkey serves as an example for SUD treatment in interim housing: Project Roomkey participants with SUDs are connected to SUD treatment services through the County's Client Engagement and Navigation Services counselors (LADPH, 2022). Approximately 50% of all Project Roomkey participants had a case manager to help with their SUD.

For unhoused individuals not in PSH or interim housing, 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 to increase the usage of the Sobering Center.

Healthcare in Action Medical Group, a non-profit organization, has proposed a strategy to increase medical care and social services for patients experiencing homelessness using a street medicine model. Using mobile vans, the Healthcare in Action street team is able to offer full scope primary care medical services, addiction treatment, psychiatric care, and case management for the unhoused population that might not have access to traditional medical facilities through programs and services, such as PSH, interim housing, or sobering centers. They also offer services to the unhoused population who are in shelters or in interim housing. To create 10 new, sustainable street-medicine teams which would each have one medical van, 2 full-time physician assistants, 1 full-time registered nurse, 1 full-time coordinator, 4 peer navigators with experiences regarding homelessness or substance abuse, and 0.4 FTE physician oversight, Healthcare in Action is requesting an investment of $10 million by the City of Los Angeles. The specific services provided by these mobile street medicine teams include:

- Full scope primary medical care;
- Addiction counseling and medication-assisted treatment;
- Psychiatric care, including medication management;
- Laboratory testing;
- Point-of-care ultrasonography;
- Medication dispensary/delivery of medications from pharmacies;
- Referrals and transportation to medical specialist appointments;
- Enrollment in the Coordinated Entry System;
- Other social services, including support with food stamps, disability and other social service program applications.
- Provision of mobile phones and GPS tracking devices to enhance communication between patients and the clinical team

Action Plan:

The Health Commission urges the adoption of the stated recommendations regarding sobering centers and the Healthcare in Action Medical Group 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 describes two major categories of food insecurity, defined as:

1. "Low food security: reports of reduced quality, variety, or desirability of diet. Little or not indication of reduced food intake
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. As a result, many unhoused individuals fall into the category of very low food security. Emergency shelters are often unavailable to the general homeless population not already interfacing with the city and county shelter systems. Thus, many are left to buy food from high-priced, unhealthy fast food establishments. To combat this issue, 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. Unhoused individuals have the same rights under the CalFresh program that all other people do, and the county welfare officer cannot make unhoused individuals give a mailing address if they do not have one. Shelter residents are also still eligible for CalFresh benefits even if they live in a shelter and get free meals there (CalFresh, 2022).

Using SNAP quality control data from 2016-2018, Caroline Danielson (2020) found that about 340,000 CalFresh beneficiaries (8.4%) were unhoused at some point during the year. Most unhoused CalFresh beneficiaries are eligible for the maximum CalFresh benefit, averaging about $175 per family member per month. Unfortunately, SNAP suffers from poor enrollment in the program from eligible individuals in California and Los Angeles County (TFT, 2020). The Food Trust released a report stating that 500,000 eligible individuals in LA County remain unenrolled (TFT, 2020). To aid in enrollment and SNAP use for the unhoused population, CalFresh should collaborate with LA County to utilize new technologies, such as a cell phone with the ability to store medical histories and personal photos, call doctors, clinics, City Services, 311, 911, and other social services, and use ApplePay or some similar service to pay for CalFresh. Through the use of this new technology, the government can load funds into CalFresh accounts monthly, and it is also likely that SNAP enrollment will increase.

Action Plan:

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

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Section II: Healthy Living

Introduction

The Los Angeles City Health Commission works to understand, prevent, and respond to emergency incidents as well as major disease outbreaks in Los Angeles County. The Plan for a Healthy Los Angeles, formally adopted in 2015, has laid the foundation to create healthier communities for all Angelenos addressing the root causes of health disparities and inequities throughout our City. A Health Atlas for the City was created in 2013 quantifying and communicating several different metrics of community vulnerability which was magnified by the latest COVID-19 pandemic. This section of the report focuses on the impacts of the COVID-19 pandemic on students and adults, environmental issues, and the variables that predicate a growing drug crisis and the rising cost of pharmaceuticals in California.

Promoting healthy living remains a top priority for the Los Angeles Health Commission in order to best enhance community health outcomes while focusing on major issues that were thoroughly discussed and evaluated in 2022. The COVID-19 pandemic brought upon major lifestyle changes that had significant impacts on both children and adults in Los Angeles City. The Healthy Living Section of the 2022 Report will outline once again the goals and objectives proposed in the Plan for a Healthy Los Angeles as it will also cover the implementation of remote working and shorter work weeks and explore the effects of virtual learning on student achievement levels.

With increased efforts to enforce sustainable practices within LA city, there is a pressing need to 1) address environmental equality for individuals who live in close proximity to oil and gas extraction sites and 2) evaluate the health consequences of gas appliances within homes. Given the rise in substance use disorders (SUD) in Los Angeles City and County, the Commission coupled with leading field experts to discuss the escalation of the drug crisis within Los Angeles and how legislators can best react to increased overdose and SUD rates. Lastly, this section of the report will further respond to the rising cost of insulin and the role that pharmaceutical benefit managers play within this crisis. In evaluating a wide array of issues alongside notable researchers, faculty members, and field leaders, the Commission is able to effectively advise stakeholders to allocate the necessary resources toward improving the health outcomes of vulnerable groups.

Plan for a Healthy Los Angeles

Recommendations:

1) Encourage the Los Angeles Mayor's Office to allocate funds to the Department of City Planning for staffing and resources to fully implement the Plan.
2) Request an update on the status of the 91 implementation programs listed in the Plan.
3) Request at least quarterly updates from the 20 city departments and three outside agencies responsible for the 91 implementation programs in the Plan.
4) Make available updates with program implementation and its impact with the City's Health Atlas.
5) Urge the Los Angeles City Council to create a Healthy Communities Task Force (Program 58) as soon as possible.

Background:

To increase understanding of health inequities, the City published a Health Atlas for the City of Los Angeles in June 2013 providing a rigorous analysis of health outcomes and underlying health inequities. Data from the Atlas with its 115 maps and 62 figures illustrating the geographic variation in socio-economic conditions, demographic characteristics, and health factors helped identify health disparities and the patterns of inequality underscoring a key issue: where Angelenos live often influences their health and well-being leading to the creation for the Plan for a Healthy Los Angeles.

On July 11, 2022, the Los Angeles City Health Commission heard a presentation from Ken Bernstein, Principal City Planner, Los Angeles City Planning Urban Design Studio and Office of Historic Resources and Marie Cobian, senior City Planner, Health and Environmental Justice Unit, Department of City Planning with updates on the Plan for a Healthy Los Angeles. This Plan receiving final City Council approval in 2015 has largely remained unknown to most Angelenos due to a lack of funding and initiative by the mayor's office to mandate and coordinate its implementation. The time frame for implementing the 91 programs listed in the Plan were categorized in Immediate (within one year of Plan adoption), Short (within 2 to 4 years), Mid (between 5 to 7 years) and Long (10+ years). Unfortunately, very little information has been made available on whether most or all of the immediate, short, and mid-term programs have been completed up until the date in which this report was published.

The Plan for a Healthy Los Angeles was formally adopted in 2015 as an Element of the City's General Plan, providing vision with measurable objectives and implementation programs to elevate health and environmental justice as a priority for the City's future growth and

development. Technical amendments were adopted in November 2021 to the Health Element[1] to be in compliance with SB1000 requiring local governments to identify "disadvantaged

communities" in their jurisdictions and address environmental justice in their general plans. In addition, City Planning completed the five-year update, identified as the Health Atlas for the City of Los Angeles, 2021. The Plan's Implementation Program, P59: Healthy City Data Tracking, directs the Department of City Planning to "prepare an updated Health Atlas Report in five and ten years from Plan adoption to evaluate community health and wellbeing."

The Plan is underpinned by seven goals and identifies new policies and possible programs that serve as an implementation blueprint for creating healthier neighborhoods. Each goal includes supporting objectives to track improvements to community health: 1) Los Angeles, a Leader in Health and Equity. 2) A City Built for Health. 3) Bountiful Parks and Open Spaces. 4) Food that Nourishes the Body, Soul, and Environment. 5) An Environment Where Life Thrives. 6) Lifelong Opportunities for Learning and Prosperity. 7) Safe and Just Neighborhoods.

In summary, the vision of a healthy Los Angeles incorporates: Complete neighborhoods that meet residents' basic needs, including: 1) Access to health-promoting goods and services, which include affordable grocery stores, comprehensive medical services for both physical and mental health, park space, and childcare, among others. 2) Community design that promotes healthy living for people of all ages, income levels, cultural backgrounds, and geographies. 3) Access for individuals with disabilities and across the age spectrum. 4) Use of community resources such as schools and underused assets to promote health and well-being. 5) Access to affordable and safe opportunities for physical activity, particularly for park poor communities. 6) Safe and just neighborhoods that are free of violence, where residents feel safe pursuing healthy activities, promote trust between law enforcement and local stakeholders, and where every resident has access to economic and educational opportunities that help support public safety in all neighborhoods. 7) A balanced, multimodal, and sustainable transportation system that offers safe and efficient options for all users. 8) Access to affordable, healthy, and safe housing for residents of all ages and income levels. 9) Access to healthy and sustainable environments with: clean air, soil, and water, tobacco- and smoke-free environments; ample green and open space, including a robust tree canopy in all neighborhoods and opportunities for urban agriculture; minimized toxins, greenhouse gas emissions, and waste; climate resilience that protects residents from the public health effects of climate change; opportunities for economic, educational and social development, including a thriving economy that provides all residents with the opportunity to access good jobs that offer the financial resources needed to lead healthy lives and educational resources and workforce development that prepares residents for the jobs of the future at every stage of their lives.

[1] See Los Angeles City Planning. (n.d.). General Plan Overview for more information on the Elements highlighted in The General Plan.

Nearly the same time the Plan for a Healthy Los Angeles was adopted in 2015, Los Angeles County's Department of Public Health presented their Community Health Improvement Plan (CHIP) 2015-2020 with similar priorities to: 1) Increase Prevention to Improve Health; 2) Create Healthy and Safe Communities; and 3) Achieve Equity and Community Stability. The goals for each of these three priority areas are similar to those outlined in the Plan for a Healthy Los Angeles.

Action Plan:

Both the City's Plan for a Healthy Los Angeles and the County's Community Health Improvement Plan (CHIP) were adopted five years before the COVID-19 pandemic. The negative consequences resulting from the pandemic could have drastically been reduced if the programs promoting health and preventative measures were implemented and started in the most economically and socially disadvantaged communities in Los Angeles. With the Los Angeles 2028 Summer Olympics, the Health Commission strongly urges the Mayor's Office and the City Council to create a Healthy Communities Task Force (Program 58) as soon as possible to begin taking accountability for results with the implementation of all 91 programs listed in the Plan.

Remote Working & Shorter Work Weeks

Recommendations:

1) Encourage business owners to evaluate workforce productivity and the needs of employees working 50+ hours per week and/or five days a week and reshift focus on employee/staff output instead of time spent working.
2) Ensure that reduced hours do not directly increase work intensity but rather increased productivity among employees.
3) Implement pilot trial programs to identify how shorter work weeks can affect productivity, engagement, empowerment, and health outcomes within the workplace.
4) Strongly urge business owners and firms to not sacrifice pay or benefits with the implementation of a shorter work week.
5) Urge business owners to evaluate the needs of all their employees and acknowledge that remote work and/or shorter work weeks are not necessarily feasible for all employees.
6) Create opportunities for in-person connection among employees who work remotely.
7) Encourage and reward companies who pilot 4-day work weeks and additionally incentivize companies that include at least 2 days of remote from home capability.

Background:

COVID-19 brought many changes into the lives of Americans, one of which included a transition to virtual working. In August 2020, the Los Angeles City Health Commission heard a presentation from Andrew Howard Barnes, founder of the Perpetual Guardian, New Zealand's largest corporate trustee company. Prior to the pandemic, Barnes tested the efficacy of a four-day work week in order to combat dwindling productivity in the workplace. The results, as discussed in the 2021 Annual LACHC Report, revealed promising results as employee engagement, empowerment, and enthusiasm soared while work-related stress decreased. With the rise of work from home, it is important to acknowledge the greater benefits workers would reap with hybrid work weeks and shorter work weeks.

Current research elucidates the beneficial health outcomes that arise with a reduction of working hours. A longitudinal study following the relationship between work-time reduction and general and physical symptoms revealed significantly decreased levels of stress in the experimental group subjected to reduced work hours (Voglino et al., 2022). Other studies found significant reductions in mental fatigue in groups with reduced working hours (Akerstedt, et al., 2001). Sleep quality was measured within the study and revealed significant improvements in sleep among the experimental group, revealing how long work hours can negatively influence sleep due to work demands and work-related stress (Akerstedt, et al., 2002).

A separate meta-analysis conducted by Kapo Wong and his team examined the effects of long working hours on health and occupational health, synthesizing data from studies conducted

from 1998 to 2018 to examine the relationship between the two. The study delved into the effects of long-working hours on cardiovascular and cerebrovascular disease, hypertension, diabetes mellitus, depression and anxiety, work stress, health behaviors, sleep and fatigue, and occupational injury. The most *relevant* findings within the study focused on various health outcomes within multiple categories, two of which include health measures and related health. Within health measures, five physiological illnesses were explored as sub-groups and included all-cause mortality, cardiovascular heart disease, metabolic syndrome, poor physical health, and type 2 diabetes. The related health category measured changes in fatigue, injury, poor sleep quality, short sleep duration, and sleep disturbance.

Within the health measure category, the effects of long working hours were statistically significant and strongly associated with the subgroups 'cardiovascular heart disease' and 'metabolic syndrome', with a stronger association between long working hours and cardiovascular heart disease than with metabolic syndrome. Within the related health condition, the effects of long work hours were statistically significant in the subgroups of fatigue, injury, poor sleep quality, shorter sleep duration, and sleep disturbance. Of these sub-factors, it was revealed that short sleep duration was the most prevalent and significant issue that arose with long working hours. The studies evaluated in the paper demonstrated the higher risk of suffering from insufficient sleep in both male and female workers as a result of long working hours, with female workers experiencing more severe sleep deprivation when working 51-60 hours per week. This is important to note as short sleep duration has a myriad of deleterious health consequences, such as increasing the risk of cardiovascular disease, coronary heart disease, obesity, hypertension, and type 2 diabetes mellitus (Chandola et al., 2010; Cizza et al., 2005; Gangwisch et al., 2006; Heslop et al., 2002; Knutson, 2006). Shorter sleep duration also leads to fatigue and exhaustion, which may further contribute to negative performance within organizations (Wong et al., 2019).

In seeking a new model following pandemic induced changes to the work-life balance of workers, the findings mentioned above must be acknowledged. There are distinct links between manageable work hours and productivity and health. The working population, along with policymakers and business owners, are facing a changing working landscape marked by new hybrid habits. Moving forward, the two main areas of consideration for firms and employers include the benefits of shorter work weeks, as discussed above, and the flexibility of remote working.

Remote working is work that often happens remotely within a home office accompanied by the utilization of IT tools and devices. A few studies on remote working were conducted during the SARS-CoV-2 pandemic and revealed countless benefits (Wontorczyk and Roznowski, 2022). It was found that remote work allows the employment of individuals who otherwise could not sustain employment in the workplace due to professional duties such as raising children with disabilities and living far from an area of employment. As a result of working from home, workers can also spend more time with relatives allowing for a healthier work-life balance,

saving time and money that would be spent traveling to work, and greater environmental benefits (Liu et al., 2019). Remote working also provides great benefits to management, including greater employee engagement with work, greater efficiency and productivity, and higher employee loyalty to the employer (Canedo et al., 2017). It is important to note that the pandemic and forced remote work carry certain negative consequences for employees, such as difficulties in disconnecting from one's job and separating work and personal life, alongside certain psychosocial risks such as isolation (Chawla et al., 2020). Thus, it is important to leverage a remote working model that maximizes benefits while accounting for the negative effects that may arise.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve the health, productivity, and engagement of employees and employers within the workplace.

Impact of Virtual Learning on Students

Recommendations:

1) Consider the implementation of voluntary summer schools or increased hours spent in core subjects such as math and reading.
2) Urge stakeholders to research the risks and benefits of a lengthened school year.
3) Consider increasing federal aid packages or allocating increased percentages of COVID-relief money on academic recovery.
4) Urge educators to evaluate the status of student learning and identify learning gaps through regularly administered baseline assessments and/or formative assessment tools.
5) Identify and target students who suffered learning losses and provide specific learning support programs.
6) Implement corrective instruction through the use of personalized learning and 1:1 instruction.
7) Create a local or statewide intervention program to offer intensive tutoring services to students who are not meeting grade-level expectations.
8) Require school administrators and educators to attend seminars on how to accelerate learning during intensive tutoring sessions and/or through the classroom.

Background:

The SARS-CoV-2 pandemic forced millions of students around the world to acclimate to virtual learning without a full evaluation of its consequences, specifically declines in student achievement and widening of achievement gaps by race and socioeconomic status. In the past two years, there have been many discussions on the learning losses of K-12 students who underwent virtual learning during the pandemic, with a growing concern that students' academic performance and achievement have been hindered.

A recent research study by the Annenberg Institute at Brown University evaluated the test score patterns across the three COVID-19 impacted school years. Given disruptions to K-12 schooling, researchers utilized the test scores of 5.4 million U.S. students in grades 3-8 to track changes in math and reading achievements while considering achievement gaps between students in low and high-poverty elementary schools. They found that among students in grades 3-8, average fall 2021 reading and math test scores decreased by 0.09-0.18 and 0.2-0.27 standard deviations, respectively, relative to same-grade peers in the fall of 2019. Achievement gaps between students in low and high-poverty elementary schools grew by 0.10-0.20 standard deviations, particularly in the 2020-2021 school year. Prior to the pandemic, the achievement gap between low and high-poverty students was approximately 1 standard deviation. As expected, the pandemic widened these educational gaps as shown by a 20% widening gap in math and a 15% widening gap in reading relative to pre-pandemic scores. These income-based gaps can be attributed to a myriad of potential factors, such as greater economic, health, and socio-emotional

pandemic-induced impacts in high-poverty communities. These gaps may also be attributed to reduced support and resources for remote learning among lower socioeconomic (SES) students (Kuhfield, Soland, & Lewis, 2022). As many families experienced, the remote learning process was largely dependent on families, rather than teachers, and increasingly relied on the use of digital resources that may not have been accessible to low SES children and families. Research has shown that social class is associated with unequal access to digital tools, unequal familiarity with digital devices, and unequal use of technological devices for learning purposes (Harris et al., 2017; Goudeau et al., 2021). With unequal familiarity and access, many parents and children may experience decreased self-efficacy and engagement in learning activities which may lead to decreased support due to difficulties in adapting to distance learning (Prior et al., 2016). For more information on the effect of school time reductions and the effects of the digital divide, please reference the 2021 Los Angeles City Health Commission Report.

In October 2022, American College Testing (ACT) released data on the 2022 graduating high school class. The cohort endured three years of their education, through grades 10-12, affected by the global pandemic. As a result of the pandemic and an exacerbation of systemic failures within the U.S. Education System, the national average composite ACT score for the graduating 2022 cohort was 19.8, the lowest average score since 1991. Thirty-five percent of the cohort also took the ACT more than once, relative to 32% of the 2021 cohort. Furthermore, only 22 percent of students met the college readiness benchmark in all four categories which includes English, Math, Reading, and Science, relative to 27 percent of students in 2018. These statistics translate to an increasing number of students who leave high school without meeting college-readiness benchmarks and standards.

Another consequence of the pandemic was widening educational disparities between racial groups with greater losses seen in Black and Hispanic student performance. According to the Nation's Report Card, released by NEAC, Black students' math scores fell 13 points compared to a five point decrease among white students. A separate study conducted by the Center for Education Policy Research at Harvard University revealed that students at low-poverty schools that remained remote lost the equivalent of 13 weeks of in-person instruction, compared to a loss of 22 weeks at high-poverty schools that remained remote. Their evaluation of racial gaps also revealed that Black and Hispanic students in districts that stayed remote for most of the 2020-2021 lost four to five more weeks of instruction than white students had (Goldhaber et al., 2022).

While these findings are concerning, National Center for Education Statistics (NAEP) data reveals that California students held steady in reading scores relative to other states, and had slimmer gaps in math achievement relative to other students nationwide. The state of California invested nearly $23.8 billion to address these learning gaps and to further support students, especially those affected by the digital divide and at increased risk for learning loss. However, regardless of California's student performance relative to other states, students still require increased interventions to mediate learning losses.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to minimize learning disparities and losses and provide students and families adequate support towards recovering from the aforementioned consequences of remote learning.

Health and Climate Risks of Gas Stoves

Recommendations:

1) Refrain from utilizing unvented or poorly vented sources which may fill homes with hazardous levels of carbon monoxide and pollutants.
2) Refrain from using kerosene heaters and charcoal grills indoors.
3) Choose "direct vent" gas appliances which completely seal their exhaust vents from the indoors.
4) Routinely check combustion appliances for spillage through the use of spillage indicators on water heaters and gas furnaces.
5) Utilize oven hoods when cooking to reduce the risk of indoor combustion.
6) If living with young children or individuals with allergies and/or lung disease, consider the use of high-efficiency air cleaners in forced-air heating systems.
7) Consider implementing changes within homes to improve ventilation with the use of, for example, chimneys, windows, or ventilation holes.
8) Encourage local governments to subsidize the purchase of high-efficiency electric appliances or solar heating systems, which produce fewer combustion products when burnt.
9) Regulate policies with the intent to improve access to advanced cookstoves or fuels, with provided incentives towards healthier community development.

Background:

People use a wide array of heat sources to cook food, such as gas, wood, and electric stoves. Many of these cooking appliances, however, introduce indoor air pollutants that are inhaled and hazardous. An elucidating presentation by Dr. Rob Jackson, Professor at the Stanford School of Sustainability and Senior Fellow for the Stanford Woods Institute for the Environment and Precourt Institute for Energy, at the Los Angeles City Health Commission in May 2022 revealed a broader picture of how this occurs, why it occurs, and the consequences that may follow.

One of Dr. Jackson's earlier studies on natural gas water heaters, in 2020, measured 1) the amount of carbon dioxide emissions that occurred when gas was burning, and 2) the amount of leaking uncombusted or unburned methane from appliances. His team specifically examined water heaters from 64 northern California homes to reveal these emissions during steady state off and on conditions, with a large emphasis on methane emissions.

Methane, a potent greenhouse gas, is the primary component of natural gas (NG) which is often used in residential appliances due to its high energy density, low cost, and cleaner emissions than other fossil fuels (Merrin & Francisco, 2019). The issue with NG is that it contains unburned methane due to incomplete combustion. Once unburned methane reaches the

atmosphere, it is more than 80 times more potent than carbon dioxide in how it warms the climate (Environmental Defense Fund).

During a water-heater test, the steady state off emissions of water-heaters were measured and revealed small leaks occurring at all times, causing a slow bleed of methane into the air even when appliances are turned off. Eric Lebel, the lead author of the study and senior scientist at PSE Healthy Energy, demonstrated that the brand of the stove and date at which the stove was made do not significantly matter, as there will continue to be consistent leaks. These consistent leaks can be explained by the fact that natural gas or methane will not fully burn, and instead leak into the air, every time an appliance and flame are turned on. Furthermore, there are 'on and off pulses' every time an appliance is turned on. When using a gas stove, there is typically a short delay before the gas turns on with a flame. That short delay causes a peak of methane emissions, accompanied by another peak of emissions when an appliance is turned off.

It is important to note that different types of water heaters will vary in their gas emissions. The two most notably mentioned and discussed during Dr. Jackson's presentation were tankless and storage water heaters. Tankless water heaters, or on-demand water heaters, produce hot water only when needed. Storage water heaters have traditionally been more popular and familiar to homeowners and function by heating a full-capacity reservoir of water using a fuel source. When hot water is needed, the hot water is released from the top of the tank and cold water is filled from the bottom of the tank causing constant heating and standby heat loss (Energy Saver, YR). Tankless water heaters emit more overall methane than storage water heaters, primarily due to the on/off pulses that cause spikes in methane emissions as mentioned earlier. Storage water heaters, on the other hand, emit most of their methane while off, primarily due to the use of pilot lights that do not combust all the methane that keeps them lit on.

Thus, emissions from storage water heaters are primarily released during a steady state off phase, as the appliance is off for a majority of the time until hot water is needed. When factoring in both carbon dioxide and methane emissions, as seen in the chart below, it becomes evident that storage water heaters are worse for the environment than tankless water heaters due to inefficient gas usage as they are constantly heating a large reservoir of water, burning more NG than tankless water heaters. Although tankless water heaters cause worse gas leakage, they are still considered the 'safer' alternative since water is only being heated on demand.

Dr. Jackson's more recent work in 2022 measured methane and NOx emissions from natural gas stoves, cooktops, and ovens in 53 residential homes in California. The study found that over a course of a year, three quarters of methane emissions occur when stoves are turned off. A concentration profile of gas emissions from stoves allows the comparison of carbon dioxide (CO2), nitrogen oxides (NOx), and methane (CH4) emissions as a stove is used. When the appliance is turned off under steady-state off emissions, there are expectedly no carbon dioxide or NOx gas emissions, as CO2 and NOx are formed when a flame is on. Methane emissions, however, still increase when the appliance is off suggesting notable methane leakage.

When an appliance is turned on, a delay of flame lighting causes a pulse of methane emission into the air, followed by linearly increasing CO2 and NOx emissions. When the appliance turns back off, there is another burst of methane emissions but no CO2 and NOx gas emissions. The same trend follows for ovens, with a spike in methane emissions every time a new heating cycle begins.

While the implications of methane emissions have been covered, attention should also be paid to the quantity of NOx emissions within residential homes. The EPA recommends an outdoor standard of NO2 (100 parts per billion) exposure per 1-hour outdoors. Currently, the EPA has released no indoor standard and the fact remains that the outdoor standard of 100 ppb is regularly surpassed in homes within a few minutes of stove usage, especially in smaller kitchens. This should be of major concern to policymakers, especially in how it affects lower-income households who may own smaller kitchens with poorer ventilation, as it may introduce or further exacerbate health conditions. Many studies have evaluated the association between indoor combustion sources and respiratory symptoms, most notably the development or exacerbation of asthma. A 2009 study revealed that exposure from indoor combustion for heating was consistently more harmful in introducing risk than exposure from cooking. This difference could be due to higher exposure from heating devices that are used for longer periods of time in comparison to shorter duration of exposure when cooking (Belanger & Triche, 2009). Due to the number of confounding factors that arise when determining an association between indoor combustion and asthma incidence, many scientists struggle to find a definitive link between the two. While a number of studies report positive associations for asthma prevalence among children, other studies report negative associations (Bothwell et al., 2003; Diette et al., 2007). Despite these inconsistent findings, it is generally accepted that exposure to indoor combustion may increase one's risk of asthma and/or worsen the severity of asthma, particularly in children.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to reduce exposure to indoor pollutants and contribute to a healthier community environment.

Proximity to Extraction Sites

Recommendations:

1) Urge Governor Gavin Newsom to sign Senate Bill 1137.

Background:

As the seventh largest oil producing state in the United States, California has ceased to implement any regulations on the distance between oil wells and populated areas. In Los Angeles County, almost every resident is impacted by the 5000 active oil and gas wells. Currently, nearly 2 million people live within 2,500 feet of an operational oil and gas well and five million people live within 1 mile of an active oil well according to the nonprofit FracTracker Alliance. Furthermore, 70 percent of active wells in Los Angeles are located within a 1500 feet distance from sensitive land uses (California Air Resources Board, 2005). Certain neighborhoods such as South Los Angeles have active oil wells located close to sensitive land uses, such as residential neighborhoods, childcare centers, schools, senior centers, healthcare facilities, and urban parks. These communities often have lower median household incomes relative to other communities in Los Angeles City.

These numbers raise serious concerns, as proximity to oil and gas wells have been linked to numerous health consequences. Research on the health impacts of living in close proximity to oil and gas development sites reveals that those who live closer to active wells experience greater adverse impacts. Since oil and gas development can lead to poorer air quality and pollution, residential proximity is associated with dermal and respiratory conditions in residents near natural gas activities, with distances measured at less than one to two kilometers from well to residence (Rabinowitz et al., 2015). These effects exacerbate the effects of spatial and environmental inequality, disproportionately affecting poorer communities and communities of color who face greater pollution exposure and vulnerability and are more susceptible to experiencing symptoms such as nosebleeds, headaches, and worsened asthma (Witter et al., 2013).

A longitudinal study conducted from 1993 to 2012 revealed that decreases in ambient pollution levels are associated with statistically significant decreases in asthma-related symptoms among children (Berhane et al., 2016). California state and local officials are now looking to implement much needed public health protections governing oil and gas drilling through Senate Bill 1137. These protections would include a 3,200 feet buffer zone between new oil wells and residences, schools, and other sensitive areas where individuals face an increased risk upon exposure to oil and gas emissions. The bill would also strengthen protections for individuals already living in close proximity to existing extraction sites and ensure that oil and gas operators

develop a leak detection and response program plan to detect harmful emission releases before they can impact the surrounding communities.

Action Plan:

The Health Commission urges the adoption of Senate Bill 1137 to promote environmental justice for Los Angeles residents who are disproportionately affected by pollutants from oil and gas extraction sites.

Pharmaceutical Benefit Managers & Insulin

Recommendations:

1) Ensure that pharmaceutical benefit managers cannot collect rebates or kickbacks.
2) Provide waivers on deductibles and limit copays to no more than $35 a month.
3) Support patient access by ensuring prior authorization or other medical management requirements cannot be imposed to limit beneficiary use.

Background:

In 2019, the American Diabetes Association (ADA) reported that over 37.3 million Americans had diabetes, accounting for 11.3 percent of the population. Of this number, 29.2% of Americans ages 65 and older had diabetes. Furthermore, 1.9 million Americans in 2019 had type 1 diabetes. Of those 1.9 million Americans with type 1 diabetes, over 244,000 children and adolescents were diagnosed with type 1 diabetes. With type 1 diabetes, the beta-islet cells of the pancreas make little to no insulin. Insulin is a hormone produced and used by the body to allow for the uptake of glucose/sugar into cells to produce energy. When the cells of the pancreas are not able to produce insulin, glucose will accumulate in the bloodstream since it cannot properly be taken up into the cells of the body (Mayo Clinic). For these reasons, an individual with type 1 diabetes absolutely requires extraneous insulin to manage their blood sugar levels and to give their body's cells the energy they need to properly function.

Dr. Marion Mass, a pediatrician and co-founder and executive vice president of the Practicing Physicians of America presented on the issues predicating soaring insulin prices in America. Currently, there is a disproportionate amount of minorities who are affected by diabetes. According to the ADA, the rates of diagnosed diabetes in adults by race/ethnic background are: 14.5% of American Indians/Alaskan Natives, 12.1% of non-Hispanic blacks, 11.8% of Hispanics, 9.5% of Asian Americans, and 7.4% of non-Hispanic whites. In 2019, diabetes was the seventh leading cause of death in the United States. When assessing the monetary cost of diabetes, the total cost of diagnosed diabetes in the United States was approximately $327 billion in 2017. Of that, $237 billion was for direct medical costs.

On March 31, 2022, the Affordable Insulin Now Act was passed. Senate Bill 3700 (2022) "limits cost-sharing for insulin under private health insurance and the Medicare prescription drug benefit." Ultimately, the Affordable Insulin Now Act lowers the copay for Medicare and the commercially insured but makes no changes to the list price of insulin, meaning individuals who are uninsured with type I diabetes will have to cover the full, inflated cost of insulin. Evaluating the price of insulin from 2012-2019 demonstrates that the list price of insulin has risen 140% and is currently sitting at around $350-360. A vial of insulin costs approximately $10 to manufacture. The net price of insulin has decreased over the same time period, with the net price representing the monetary amount a pharmaceutical company collects. Currently, pharmaceutical companies

are collecting approximately 50 dollars, as the net price, for a vial of insulin that costs $10 to manufacture. The list price of insulin, which has significantly risen since 2012, includes what the pharmaceutical company collects plus additional rebates and fees. Rebates and fees, which comprise the majority of the list price, are collected from drug manufacturers by pharmacy benefit managers (PBMs). PBMs are third party companies functioning as intermediaries between insurance providers and pharmaceutical manufacturers. PBMs create formularies — a list of what is covered by insurance and third parties such as Medicaid/Medicare — and negotiate rebates with manufacturers (NAIC, 2022). As of November 2022, PBMs are allowed to legally collect kickbacks. These rebates are considered kickbacks since PBMs have an exemption from the Anti-Kickback Statute. This creates a conflict of interest when PBMs are financially incentivized to select more expensive drugs for the formulary. Three of the biggest PBMs, including Express Scripts, CVS Caremark, and OptumRx, control over 77 percent of prescriptions in America amounting to approximately 180 million prescription drug customers (Kane, 2018). Because a portion of PBM profits are based on the rebate, PBMs are further incentivized to choose drugs based on rebate amount rather than the lowest cost for the customer or drug efficacy. Furthermore, another notable issue is the lack of transparency regarding list prices, discounts, and PBM profits which remain hidden from the public, at the benefit of PBMs. Moving forward, Congress needs to ensure that PBM agreements are audited to improve transparency and ensure PBMs function to save patients money. As discussed heavily in Commission meetings, there also needs to be assurance that PBMs cannot collect rebates and further limit copays for customers.

Presentations by Dana Goldman, PhD and Dean of USC Sol Price School of Public Policy and Erin Trish, PhD and co-director of the USC Schaeffer Center and associate professor of pharmaceutical and health economics at the USC School of Pharmacy, further elucidated the necessary steps needed to be taken moving forward when discussing the future prices of medications such as insulin. Discussions with Dr. Goldman and Dr. Trish stressed the importance of designating the prices of drugs relative to their effectiveness. They articulated four health policy lessons important to remember when discussing drug prices and the linkage between innovation and market power. Their four health policy lessons include rethinking what is meant by the price of a drug, considering the long-term impact of pricing on innovation, linking drug prices to patient outcomes, and taking patient heterogeneity more seriously.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to ensure insulin and other pharmaceutical drugs are affordable to both the under and uninsured.

Responding to A Growing Drug Crisis

Recommendations:

1) Improve access to evidence-based treatment for opioid use disorders, such as methadone and buprenorphine.
2) Improve coordination between the Office of National Drug Control Policy and state and local government officials.
3) Integrate prescription drug monitoring programs with electronic health record systems within healthcare facilities.
4) Develop performance evaluation plans within the National Drug Control Agency to properly allocate funding and resources to districts who require more aid to combat rising substance use rates within the population.
5) Expand naloxone availability while funding pharmacotherapy, syringe exchanges, and psychosocial treatment.

Background:

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM), a substance use disorder (SUD) involves patterns of symptoms caused by using a substance that an individual continues to take despite its negative effects. According to the National Survey on Drug Use and Health, an estimated 740,000 Los Angeles County struggle with a substance use disorder (cite SAMHSA National Survey on Drug Use and Health). A data report released by the Department of Public Health's (DPH) Division of Substance Abuse Prevention and Control (DPH-SAPC) found a 48% increase in accidental drug overdoses during the first five months of the pandemic. More than three out of four (78%) of drug overdose deaths occurred among males, and "accidental drug overdose death rates per 100,000 population during the first five months of the pandemic increased by 196.1% among Asians, 55.6% among Blacks/African Americans, 48.1% among Latinx, and 41.7% among Whites" (DPH-SAPC, 2021). Furthermore, new data shows overdose deaths involving opioids increasing from an estimated 70,029 in 2020 to 80,816 in 2021. Overdose deaths from synthetic opioids, such as fentanyl, and psychostimulants such as methamphetamine and cocaine, also continued to increase in 2021 compared to 2020. It becomes evident that the pandemic further exacerbated an existing issue that continues to affect the livelihoods of hundreds of thousands of LA city residents.

Dr. Dan Morhaim, an emergency medicine physician, acclaimed author, and former member of the Maryland House of Delegates from the 11th district, presented to the Commission on the past policy failures that exacerbated drug use in America in November 2022. Despite the ongoing discussions on the consequences of the opioid crisis, there continues to be a lack of meaningful policy enforcement against health insurance companies who have been found to

repeatedly fail to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA is a federal law that prevents group health plans and health insurance issuers that provide mental health and substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical benefits (Centers for Medicare & Medicaid Services). The 2022 MHPAEA Report to Congress, generated by the departments of Labor, Treasury, and Health and Human Services, revealed that health plans and insurers are failing to deliver parity in mental health and substance use disorders. This is of extreme concern, as of the 40.3 million people aged 12 or older with a substance use disorder, 93.5% received no treatment. More than 27 million people aged 18 or older with a mental illness also received no treatment.

Dr. Morhaim acknowledged the historical context that led to these alarming statistics, starting with Reagan-era changes that increased FBI, Department of Defense, and DEA anti-drug spending while decreasing funding towards the National Institute of Drug Abuse and Department of Education. Furthermore, Clinton-era policies banned anyone with a drug conviction from public housing, decreased public spending by 61%, increased prison construction spending by 171%, and introduced the Anti-Drug Abuse Act which imposed mandated minimum 5-year sentences for simple drug possession. These policies created long-lasting impacts, especially in how they targeted poor communities and people of color and created the prison-industrial complex. In 2022, there were approximately 159,000 people in federal prison (Federal Bureau of Prisons). Of those, 45.1% are imprisoned for drug offenses and disproportionately consist of people of color, a product of decades of racially biased anti-drug policies.

A continued lack of support for individuals with mental health and substance use disorders accompanied by a legacy of racially charged policies that imprisoned rather than rehabilitated drug offenders has created a policy failure of massive proportions. It is crucial to recognize that within this issue exists one of the most pressing public health catastrophes — the opioid crisis. One of the major players fueling this crisis was Purdue Pharma which developed and marketed their opioid products, including OxyContin, to healthcare providers and policymakers while allowing the Drug Enforcement Agency (DEA) to believe that Purdue had an effective anti-diversion program. Furthermore, Purdue launched an aggressive marketing campaign to convince providers of OxyContin's increased efficacy in treating pain compared to older medications (Hirsch, 2017). Near the time of OxyContin's approval by the FDA, the American Pain Society introduced pain as the "fifth vital sign," highlighting a need for improved pain care (Scher et al., 2019). In 2001, the Joint Commission issued standards requiring the use of a pain scale while emphasizing the safety of opioids. Furthermore, it was revealed that the Joint Commission had partnered with Purdue Pharma to establish pain management standards that severely misrepresented the dangerous consequences of opioid use, further contributing to and encouraging inappropriate opioid prescriptions. It is also important to recognize the role of the Centers for Medicare and Medicaid Services (CMS) in the opioid crisis. In 2009, CMS implemented the value-based purchasing program which scores hospitals based on performance

measures that include processes of care, outcomes of care, efficiency, and the patient experience. The patient experience is based on scoring surveys that are disseminated to patients, including a patient scoring of their satisfaction with pain control which made up 30 percent of the overall score at the program's onset. The effects of this program led many physicians responsible for ensuring that their patients were satisfied, pressuring many to prescribe opioids to patients who requested them despite any reservations they held about the patient's need for opioid medications. It becomes evident, then, that the crisis was a result of a multi-system failure that needs to be addressed. In 2021, Purdue Pharma agreed to plead guilty to a "three-count felony information charging it with one count of dual-object conspiracy to defraud the United States and to violate the Food, Drug, and Cosmetic Act, and two counts of conspiracy to violate the Federal Anti-Kickback Statute" (United States Department of Justice, 2020). The resolution includes a criminal fine of $3.544 billion and an additional $2 billion in criminal forfeiture. Furthermore, in the past decade, there have been increased efforts to combat the opioid crisis and increase accountability. The American Medical Association's (AMA) 2022 Overdose Epidemic Report reveals that over the past decade, healthcare providers have decreased opioid prescribing by nearly 50% nationally, increased prescription drug monitoring programs (PDMPs) in every state, and increased the prescription of buprenorphine and naloxone for the treatment of opioid use and prevention of opioid overdose, respectively. Despite these efforts, however, drug-related overdoses and deaths have continued to increase. Currently, more than 1,500 people per week die from opioid-related deaths (Center of Foreign Relations, 2022). While the issue began with the overprescription of opioids, it has now intensified due to the massive influx of synthetic and cheap opioids such as fentanyl — costing the US tens of billions of dollars annually in the form of increased healthcare expenditures, societal costs, neighborhood disruptions, crime, etc. According to a 2021 CDC Report on the Cost of the Opioid Epidemic in 2017/2018, the economic cost of the US opioid epidemic was estimated at $1.02 trillion, including the cost of opioid use disorders estimated at $471 billion and the cost of fatal opioid overdoses estimated at $550 billion (Florence et al., 2021).

As discussed, there exist a multitude of factors that fuel the opioid epidemic and to continue addressing these concerns, policymakers must evaluate their root causes. Dr. Morhaim posed a few key questions centering around avoided discussions at the root of the issue: why are so many Americans regularly using drugs and what is causing this level of despair. American Psychologist, Dr. Bruce Alexander spearheaded revolutionary experiments in the 1970s that set out to identify the factors fueling addiction. One of his experiments, commonly referred to as the Rat Park experiment, studied the addictive behavior of rats in a community setting. Prior to his study, it had been established that rats preferred to engage in drug-using behavior when placed in cages alone, without a community of other rats, as they preferred to drink from drug-laced water bottles over drug-free water bottles until they overdosed and died. Dr. Alexander set out to identify whether social communities could influence rats' drug seeking behavior. Dr. Alexander created a similar experiment by placing a drug-laced and drug-free water bottle in the rat cage but also allowed the rats to live in parks where they were free to play, socialize, and fornicate.

When placed in the parks, no rats overdosed as they increasingly preferred to drink the plain water (Alexander et al., 1981). As Dr. Morhaim mentioned in his presentation, the opposite of addiction is not just sobriety; it is connection and community.

The Los Angeles City Health Commission endorses many of the past legislatures Dr. Morhaim introduced during his time in the Maryland State House, including a shift towards addiction treatment, a requirement that hospitals develop substance abuse treatment and direct referral programs, turning possession of small amounts of all drugs from a criminal penalty to a civil charge with referral to treatment, and the establishment of safe consumption facilities and overdose prevention sites, a bill which was vetoed by Governor Gavin Newsom in California. Existing research from cohort and modeling studies has demonstrated that safe injection sites (SISs) are associated with lower overdose mortality rates, 67% fewer ambulance calls for treating overdoses, and a decline in HIV infections (Ng et al., 2017). To fix the growing drug crisis in California and the greater nation, legislators need to consider the root cause of addiction and ameliorate the consequences of prejudicial legislation that predicates increased drug use in America. With the influence of for-profit companies, such as the several that have attempted to reach out and manipulate the Los Angeles City Health Commission, legislators need to remain vigilant. Future Commissions, the City Council, the City Attorney, and Mayor's Office should always be wary of lobbyists with corporate conflicts of interests that do not best serve the citizens of the City of Los Angeles.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to better support the care and rehabilitation of individuals with substance use disorders and/or opioid use disorders.

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Section III: Medical Services

Introduction

The Los Angeles City Health Commission works to understand, prevent, and respond to emergency incidents as well as major disease outbreaks in Los Angeles County. To address the growing number of medical emergencies, the Emergency Medical Services (EMS) Bureau was created as a service provided by the Los Angeles Fire Department (LAFD). Since the EMS system is housed in the LAFD, former Medical Director, Dr. Stephen Sanko M.D., FACEP, FAEMS stated "LAFD is a medical organization" (Sanko, 2022). Less than 1% of LAFD incidents involve fire suppression, while approximately 85% of incidents are medical-related emergencies (Sanko, 2022). Therefore, the Los Angeles City Health Commission believes the LAFD and EMS bureau warrant proper attention, funding, and support. The Emergency Medical Service Agency of the Los Angeles County Department of Health Service oversees the 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, running the LAFD Tiered Dispatch System (TDS), and establishing policies, guidelines, and procedures for EMS services. More information on their services, challenges, and accomplishments will be described in this section.

This section also covers the latest updates on major communicative diseases in Los Angeles City including Typhus, Hepatitis, and STIs. The majority of information on communicative diseases is provided by the Los Angeles County Department of Public Health (LACDPH). However, there is a lack of city-specific data that is needed to understand and control the spread of disease in Los Angeles City. The Health Commission urges increased partnerships and exchange of data with the LACDPH to address health risks in Los Angeles City.

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 transports 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) Increase the number of psychiatric beds in public hospitals.
7) Encourage the use of the Los Angeles Network for Enhanced Services (LANES) to allow healthcare providers safe access to patient information.
8) Continue the LA City's Innovation Fund to financially support LAFD projects that can improve the efficiency and effectiveness of their services.
9) 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.
10) Lobby the State to allow EMS teams to determine when a 5150 call would be appropriate.
11) 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.
12) Develop an opt-in location tracking system that enables EMS users to share the location of their mobile devices.
13) Increase compensation for clinicians working at the LAFD to increase retention.
14) Encourage all LAFD to be vaccinated against COVID 19 and Influenza.

Background:

The LAFD-EMS responds to over 400,000 emergency medical incidents per year. Although the number of incidents waned before and at the start of the COVID-19 pandemic, the current number of incidents has dramatically increased (Table 1).

As the primary provider of emergency care for the City of Los Angeles, the LAFD was responsible for responding to the following cases in 2021: over 50,000 incidents of traumatic injury, approximately 25,000 patient encounters with mental health or behavioral crises, over 9,000 encounters with seizures, over 6,000 encounters out of hospital cardiac arrests, over 1,200

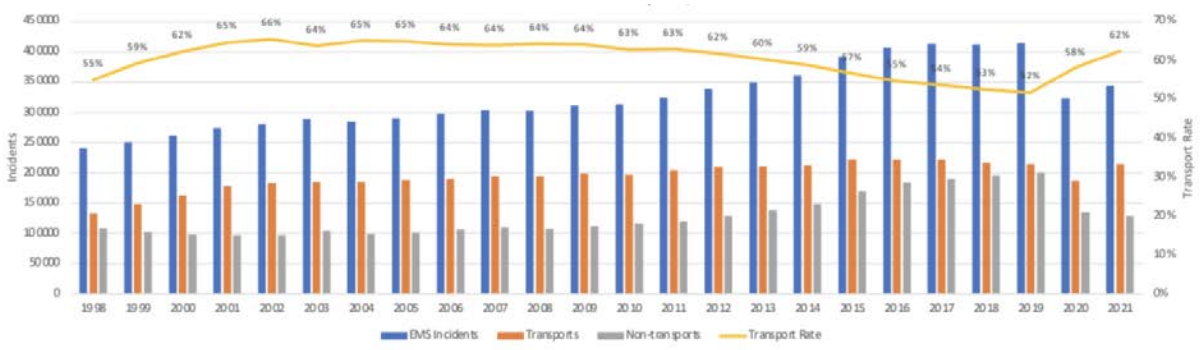


Table 1: Number of LAFD EMS Incidents and Transports, 1998-2021 (Sanko, 2022)

opioid reversal cases, and 139 childbirths (Sanko, 2022). During incidents, LAFD personnel conduct a wide range of services. Common on-site medical activities include determining who requires transportation to the hospital, deciding if and how patients need resuscitation, administering vasoactive medication or controlled medication such as narcotics for pain control, selecting which facility or destination is appropriate for patients, deciding potential causes of altered mentation, collecting data on polypharmacy, identifying subtle, potentially dangerous clinical exam findings, and caring for fragile, elderly patients (Sanko, 2022). The enormity of calls overwhelms the EMS system, causing EMS personnel to look for more efficient ways to respond to medical emergencies.

To address these issues, the Los Angeles Fire Department Tiered Dispatch system (LA-TDS) was created in 2015 (Sanko et al., 2020). LA-TDS enables dispatchers to identify and assess EMS calls with streamlined protocols, reducing processing times from 9-1-1 calls to dispatching resources. In 2016, the Advanced Provider Response Units (APRUs) were established as teams consisting of a firefighter, paramedic, and a nurse practitioner or physician assistant. APRUs provide pre-hospital care, connections to social workers, and clearance to alternate destinations such as acute hospital care, urgent care, mental health urgent care, sobering centers, primary care, pharmacies, or social workers. In 2019, the Alternative Destination Response Units (ADRUs) were created to allow LAFD paramedics with additional training to conduct Medical Clearance Checklists to appropriate patients for direct transport to Mental Health Urgent Care and Sobering Centers (Sanko, 2022).

The EMS system is advancing not just in on-site care and delivery, but also in telemedicine. In March 2020, the Dispatch-Initiated Telemedicine program was launched (Sanko & Eckstein, 2021). 911 Dispatch Centers are triaged and selected to Advanced Provider, which is a part of the Dispatch Center for video evaluation and disposition. The 911 Advanced Provider can perform an assessment on video. In November 2020, on-site EMTs and paramedics were enabled to assist the 911 Dispatch Advanced Provider through video evaluation and disposition

(Sanko & Eckstein, 2021). The Health Commission believes the LAFD-EMS demonstrates commendable development, innovation, and adoption of new technologies and supports its programs and initiatives.

Action Plan:

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

Emergency Medical Services Leadership

Recommendations:

1) Develop an attractive recruitment opportunity to attract an outstanding Chief Physician for the EMS Bureau. The successful candidate should be board-certified in Emergency Medicine and have the necessary experience and management skills along with an outstanding reputation as a leader in the field.

Background:

The Los Angeles County EMS Agency, which under state law is charged with oversight of all EMS agencies in the County, requires EMS provider agencies such as LAFD to have a Medical Director. This position oversees several critical roles and responsibilities including coordinating the medical aspects of field care, oversight of medications including controlled substances, and overseeing the quality improvement process. The Los Angeles City Health Commission is concerned to learn that, as of recently, the LAFD EMS Bureau no longer has a full-time Chief Medical Officer and that the department is recruiting a Chief Physician. Since LAFD EMS is the largest provider of health care under city auspices, the Health Commissioners have a continuing interest in the success of the service while fully cognizant that operational responsibility for the LAFD rests with the Fire Commission.

The job announcement for the LAFD Chief Physician has a proposed salary range of $168,606.00 - $253,272.40 (LAFD, 2023). While this would be an attractive salary for many, it is too low to attract a top candidate with the necessary qualifications to the Los Angeles area. The requirements for the candidate are; medical licensure, appropriate board- certification, and eight years of management experience, including three years in a supervisory role. By way of comparison, the publicly posted base salary for the Medical Director of the Los Angeles County Fire Department who has qualifications like those is $364,579 with total compensation of $416,181 (Transparent California, 2023). It is our understanding that the proposed salary is constrained by various City regulations. Since the LAFD is one of the largest EMS agencies in the country, it is very important that the Chief Physician for the agency be an experienced leader in the field of emergency medicine.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to create attractive opportunities to hire a qualified Chief Medical Officer.

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. Saint Vincent Medical Center, a general acute care hospital which had 381 beds, over 480 attending physicians, and 22,991 annual ER visits, is one of the hospitals included under Verity's bankruptcy petition.

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. 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:

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 into a mental and behavioral health care facility by 2026 (UCLA Health, 2022).

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.

Communicable Disease Response

Recommendations:

1) Enhance outreach at airports on communicable diseases.
2) 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 itineraries or tickets (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 Health Commission supports the Los Angeles County Department of Public Health Communicable Disease Control and Prevention Division's 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." Collaborative city-wide efforts are needed to support infectious disease prevention, education, surveillance, containment, and treatment. Best practices from past outbreaks should be used to improve current communicable disease programs and reduce risks and disease burden in Los Angeles.

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.
    - Increasing 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 Instagram, 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.
    - Including public-private partnerships in order to disseminate information.

Background:

Meningococcal disease (meningitis) is caused by a type of bacteria known as Neisseria meningitis. The disease 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 (LACDPH, 2022). It is a severe infection that can cause brain infection and/or bacteremia (blood infection), leading to death. According to a survey in 2006-2015, the average annual incidence in the United States is 0.26 cases per 100000 people; 14.9% of these cases were fatal (MacNeil et al., 2018). 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. Another outbreak in 2016 resulted in 27 cases and 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 ten cases in 2017 and eight cases in 2018 as of June 29, 2018 (LACDPH, 2018). In 2019-2020, there was an increase in penicillin- and ciprofloxacin-resistant meningococci in the United States. The CDC reported 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. One of the isolates was detected

in California. To monitor the resistance of meningococcal disease to antimicrobials, the CDC recommends antimicrobial susceptibility testing (AST) of meningococcal isolates (Los Angeles County Health Alert Network, 2020).

Although there has been no local outbreaks in Los Angeles recently, the Commission would like to alert the public about the recent increase in the number of meningococcal disease cases in Florida. If traveling to Florida, the California Department of Public Health encourages gay, bisexual, and other men who have sex with men (MSM) to talk with their healthcare provider about getting the meningococcal conjugate vaccine (MenACWY) (Aragón, 2022).

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 orientiabacteria. This disease is transmitted by fleas, mites, lice, or their feces and causes various degrees of symptoms, including fevers, chills, headaches, coughing, muscle aches, and rashes. Fleas often take refuge in animals such as stray cats, dogs, and pets which can lead to human exposure and transmission of Typhus (CDC, 2020). The average number of cases in Los Angeles County annually between 2017-2021 was 100 cases. In 2021, there was a record-high number of 144 cases. Outbreaks were identified in the Westlake neighborhood of LA City and in the unincorporated community of Willowbrook. Most cases were related to exposures to dogs and/or cats, rodents, and opossums (Los Angeles County Health Alert Network, 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/or have poorer hygiene and toiletry habits. 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 (LACDPH, 2020).

Hepatitis A (HAV) is highly contagious and is 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, vaccines and supportive treatment of symptoms are recommended (LACDPH, 2020).

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 person experiencing homelessness, 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 intravenous (IV) needle sharing. HBV symptoms often last for several weeks, but some cases become persistent and are labeled chronic HBV. Vaccines are available and recommended for Hepatitis B (LACDPH, 2020).

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 (Khullar & Firpi, 2015). Similar to HBV, HCV is spread through the transfer of blood or bodily fluids. People with HIV infection, organ transplants 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, 2022).

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.

Lastly, the Health Commission would like to highlight one alert in May 2022. The CDC Health Alert Network sent an alert about the rise in pediatric cases of acute hepatitis of unknown etiology in the United States. "As of May 5, 2022, CDC and state partners are investigating 109 children with hepatitis of unknown origin across 25 states and territories, more than half of whom have tested positive for adenovirus with more than 90% hospitalized, 14% with liver transplants, and five deaths under investigation" (CDC Health Alert Network, 2022). The possible association between pediatric hepatitis and adenovirus infection is unclear, and the rise in pediatric hepatitis or adenovirus may be due to increased healthcare-seeking behavior during 2020-2021 (Kambhampati et al., 2022). Studies continue to evaluate this cluster of reported cases of pediatric hepatitis of unknown etiology.

Action Plan:

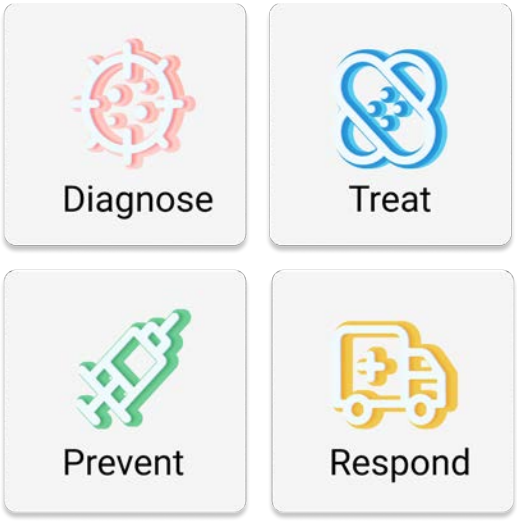
The Health Commission urges the adoption of the stated recommendations to improve public health control over Hepatitis transmission.

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 at 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:



There are approximately 58,000 people living with HIV (PLWH) in Los Angeles in 2021. About 1,700 new infections occur each year. 90% of cases are male, 9% female, and approximately 1% transgender (LACDPH, 2021). 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. 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;
4) **Respond** quickly to HIV outbreaks and deliver prevention and treatment services to people who need them"(LACDPH, 2021).

In 2021, the LA County Department of Public Health released the Ending the HIV Epidemic Plan for Los Angeles County. This detailed plan explains the research, discussions, and decisions taken to move LA County towards the EHE goals. A summary of the strategies and activities from the EHE Plan for LA County is detailed below.

The "Diagnose" goals of the EHE plan are to
"1. Increase the percentage of PLWH who are aware of their HIV status to 95%.
2. Reduce the number of undiagnosed persons living with HIV" (LACDPH, 2021).

The LADPH is working toward these goals by expanding or implementing routine opt-out HIV screening in high prevalence communities, creating specific HIV testing programs to reach Los Angeles residents in non-healthcare settings such as at home and self-testing, and improving the communication with as well as the identification and rescreening of people with an elevated risk of HIV (LACDPH, 2021).

The "Treat" goals of the EHE plan are to
"1. Increase the proportion of people diagnosed with HIV who are linked to HIV care within one month of diagnosis to 95%.
2. Increase the proportion of diagnosed PLWH who are virally suppressed to 95%" (LACDPH, 2021).
To meet these aims, seven strategies were identified including rapid linkage to HIV care and antiretroviral therapy (ART) initiation, support for re-engagement and retention in HIV care and treatment adherence, promotion of Ryan White Program services (programs that provide HIV/AIDS treatment), development of an emergency financial assistance program for financial constrained PLWH, improvement of the delivery HIV services and client satisfaction, provision of rental subsidies to prevent homelessness among PLWH, and studies on financial incentives to increase treatment adherence (LACDPH, 2021).

The "Prevent" goals of the EHE plan are to
"1. Increase the proportion of persons prescribed PrEP with an indication for PrEP to at least 50% from a 2017 baseline of 21.5%.
2. Increase the number of syringe service programs by 50%" (LACDPH, 2021).
The LADPH is utilizing new strategies from the LAC-funded PrEP Centers of Excellence to increase PrEP use and is expanding comprehensive syringe services programs (SSPs) to promote safe injection drug use (LACDPH, 2021).

The "Respond" goals of the EHE plan are to
"1. Develop and maintain capacity for cluster and outbreak detection and response.
2. Increase the proportion of people newly diagnosed with HIV that are interviewed for Partner Services within 7 days of diagnosis to at least 85%" (LACDPH, 2021).
Key steps to meet these targets include enhancing systems that enable cluster detection, time-space analysis, and response as well as refining current processing to expand Partner Services (LACDPH, 2021).

More detailed activities to achieve the EHE Plan for LA County can be found in the 2021 Report.

Action Plan:

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

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Section IV: Infectious Disease Surveillance and Control

Introduction

Since the start of the pandemic in late 2019, Los Angeles County and City health departments have readily reported public health information and developed strategies related to prevention strategies for COVID-19 and other infectious diseases. As COVID-19 incidence rates are beginning to diminish, the residents of Los Angeles are transitioning back to a pre-pandemic state.

Lessons from the progression of COVID-19 over the last two years have played a fundamental role in the analysis of the emergency response programs needed for future improvements. This analysis is especially important in preparing for the unexpected fluctuations of COVID-19 cases this winter, given the spike of infection occurring last winter with the Omicron variant (Powell, 2022). Additionally, lessons from COVID-19 responses can protect us against re-emerging diseases such as monkeypox.

Our disease control recommendations are based on an analysis of trends, essential health services, and public health guidelines supplemented with research, government-reported data, and presentations delivered to the Commission. The Health Commission believes city-wide policies and interventions are required to control and prevent the further spread of diseases, especially among at-risk populations.

Encouraging local communities to follow guidelines and prevention strategies is a critical goal of the Commission. In examining the impact of COVID-19, the Commission also recognizes that disease control 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, specifically on the COVID-19 cases, deaths, and vaccinations in Los Angeles, capture the 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. It also aims to expand past the scope of the health effects of the pandemic to recognize economic and social divisions that may have been exacerbated over the last couple of years.

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.
4) Communicate and collaborate with "ethnic and diverse media outlets" to extend data and COVID-19 information outreach (Los Angeles County Department of Public Health, Chief Science Office, 2020).

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 from the entirety of the pandemic.

Race/Ethnicity	Number of Cases
American Indian/Alaska Native	6236
Asian	236,482
Black	169,724
Hispanic/Latino	1,426,329
Native Hawaiian/Pacific Islander	16,732
White	448,873
Other	373,555
Under investigation	615,501

Table 1: Confirmed Positive COVID-19 Cases Disaggregated by Race/Ethnicity in Los Angeles County (Los Angeles County Department of Public Health, 2022).

Table 1 displays confirmed COVID-19 cases in 2022 by race/ethnicity groups within Los Angeles County. Throughout the course of the pandemic, cumulative data reveals that causes among the Los Angeles County Hispanic population outnumber those of any other race/ethnicity group, as similarly reported in the Health Commission's 2021 Annual Report.

Demographic of Deaths by Race/Ethnicity in Los Angeles County

	Race Ethnicity	Total	Total percent	Population Percent	Crude Rate	Age-Adjusted rate	Population
1	American Indian or Alaska Native	75	0.2	0.2	341	309	22005
2	Asian	4096	12.7	14.5	293	210	1395605
3	Black or African American	3011	9.3	8.2	382	331	789202
4	Latino / Hispanic	16164	50.2	49.3	340	471	4758809
5	Native Hawaiian or Other Pacific Islander	112	0.3	0.2	585	636	19152
6	White	8303	25.8	27.6	311	194	2666559
7	Other	364	1.1	NA	NA	NA	NA
8	Under Investigation	79	0.2	NA	NA	NA	NA

Table 2: Demographic of Deaths by Race/Ethnicity in Los Angeles County from March 2020 to October 2022 (Los Angeles County Department of Public Health, 2022).

Table 2, a measure of deaths disaggregated by race/ethnicity in Los Angeles County, contains supporting data to Table 1, illustrating confirmed COVID-19 cases. Compared to other race/ethnicity groups, the LatinX population contained over half of total confirmed COVID-19 deaths throughout the pandemic. This discrepancy provides important insight into the continued need to increase access to COVID-19 educational resources (including signs/symptoms, prevention techniques, quarantine guidance, vaccine benefits, etc.), transportation and proximity to testing sights, and addressing other social determinants of health that have led to disproportionately high cases within LatinX communities. Although cases have lessened from 2021 to 2022, the burden on LatinX populations within Los Angeles County is undoubtedly high, signaling a potential failure of healthcare services to address the needs of underrepresented populations.

Area Poverty	Percent of Total Cases
<10% area poverty	24.1%
10% to <20% area poverty	34.1%
20% to <30% area poverty	23.4%
30% to 100% area poverty	15.7%
Under Investigation	2.7%

Table 3: Percentage of Confirmed COVID-19 Cases Disaggregated by Area Poverty from March 2020 Onward (Los Angeles County Department of Public Health, 2022).

Table 3 displays COVID-19 cases displayed by areas 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). While confirmed cases of COVID-19 followed a pattern of equal distribution, the number of deaths from these cases are reflective of resource supply, as seen in Table 4.

Demographic of Deaths by Percent Area Poverty in Los Angeles County

	Percent Area Poverty	Total	Total Percent	Population Percent	Crude rate	Age-adjusted Rate	Population
1	<10% area poverty	7215	22.4	29.8	252	185	2865529
2	10% to <20% area poverty	11722	36.4	35	347	320	3373746
3	20% to <30% area poverty	7716	24	21.6	372	412	2075710
4	30% to 100% area poverty	5403	16.8	13.7	410	549	1316399
5	Under Investigation	148	0.5	NA	NA	NA	NA

Table 4: Demographic of Deaths by Percent Area Poverty in Los Angeles County from March 2020 Onward.

The CDC defines crude rate of mortality as the "total number of deaths during a given time interval," usually in a population of 1,000 or 100,000 individuals (Centers for Disease Control and Prevention, 2012). When observing the crude rate of confirmed COVID-19 deaths since the beginning of the pandemic, there is significantly greater burden on regional areas with 30% to 100% area poverty. Increased population vulnerability in these areas 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.

Age Group	Percentage of Total Cases	Percentage of Confirmed Deaths
0 to 17	18.0	0.1
18 to 49	54.6	8.0
50 to 64	17.3	20.5
65+	10.0	71.4
Missing	0.1	0

Table 5: Percentage of Confirmed COVID-19 Cases by Age Group and Percentage of Total Deaths by Age Group in Los Angeles County From November 9, 2022 (California State Government, 2022).

Table 5 presents the distribution of confirmed COVID-19 cases and deaths across age groups in California and Los Angeles County, consequently revealing many disparities. While people ages 18-49 represent a disproportionate number of cases (over 50%), nearly 75% of total deaths have occurred within senior populations ages 65 and older. Although deaths in older adults could be partially attributed to underlying medical conditions, it is important to increase

accessible information about COVID-19 boosters as well as other preventative measures for COVID-19, such as mask-use and hand hygiene in order to reduce deaths.

Additionally, an increasing number of sources since the beginning of the pandemic have also shown a strong association between extended length of hospitalizations and ventilation use and 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 (Centers for Disease Control and Prevention, 2022). Additionally, obesity has had significant correlation with ventilation use, as lung capacity is reduced with increasing BMI. These effects may result in even worse outcomes for children diagnosed with obesity and COVID-19 infection. In research conducted by the CDC in patients 18 years and younger, having obesity led to an approximate 3.07 times higher risk of hospitalization and a 1.42 times higher risk of severe infection (requiring ICU admission, invasive mechanical ventilation, and even resulting in death) during hospitalization. The Health Commission will continue to monitor trends relating to the correlation between BMI and COVID-19 infection.

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.

COVID-19 Progression

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) Consider the possibility of mandatory vaccinations and boosters (Rutherford, 2022).
3) Promote increased vaccination levels among those who are still unvaccinated to prevent cases of severe infections.
4) Educate the greater community on safety measures and the importance of COVID-19 vaccines.
5) Reallocate resources to increase equitable testing and vaccination distribution in high-poverty communities and vulnerable populations including nursing homes.
6) Continue research on early treatments to COVID-19 such as the Paxlovid pill and long haul symptoms, especially those of the Omicron variant (Chin-Hong, 2022).
7) Follow current guidance for COVID-19 prevention and self-isolation in the case of infection or exposure.
8) 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 and 2021 Annual Health Report, the Commission recommended Los Angeles residents to follow relevant guidance of LADPH, including face mask requirements, quarantine, and workplace conditions. The Commission continues to encourage 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. However, as cases decrease across Los Angeles County, attention should be focused on assessing needs of highly-impacted populations.

One effective and well-proven method for reducing infection and mortality within all populations is receiving any one of the FDA-approved COVID-19 vaccinations. As in 2020 and 2021, the CDC defines "fully vaccinated" as someone who has received the second dose in a two-dose COVID-19 vaccine primary series or one dose of a single-dose COVID-19 vaccine primary series, respectively (Centers for Disease Control and Prevention, 2022).

Since the beginning of 2021, nearly 7.5 million Los Angeles residents have been vaccinated, representing approximately 73% of the full regional population. Of this approximate 73% of fully vaccinated individuals, the Los Angeles Department of Public Health has disseminated the number of vaccinated residents by race/ethnicity and age.

Race/Ethnicity	6 mos - 4 yrs	5-11	12-17	18-29	30-49	50-64	65
American Indian/Alaska Native	5.2	49.1	88.5	88.3	87.8	64.8	66.7
Asian	9.3	61.7	>= 95	90.8	82.6	82.4	86.6
Black/African American	1.8	21.9	53.3	48.0	60.1	66.7	74.1
Latinx	1.3	22.2	65.1	58.4	62.3	73.9	83.0
White	8.6	42.1	79.5	76.9	77.1	71.5	86.4

Table 6: Percentage of Population of Los Angeles Residents Fully Vaccinated, Disaggregated by Race/Ethnicity and Age, as of November 2022 (Los Angeles County Department of Public Health, 2022).

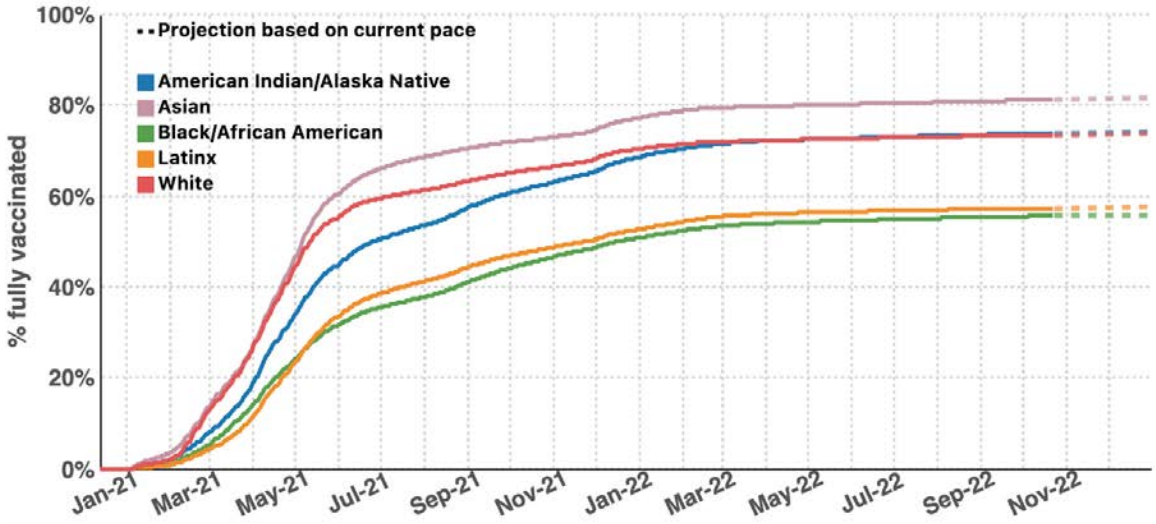

Table 7: Percentage of Race/Ethnicity Groups of Los Angeles County that are Fully Vaccinated From January 2021 to September 2022 (Los Angeles County Department of Public Health, 2022).

Table 6 displays the division of COVID-19 vaccinations among Los Angeles County residents of various ages and races/ethnicities. In aggregating this data with that of Table 7, a graphical measure of the percentage of fully vaccinated individuals from each race/ethnicity group, it is evident that middle-aged Asian American residents generally represent the highest vaccination group among any other age and race/ethnicity group, respectively. While middle-aged residents display consistently higher vaccinations in comparison to other age groups, Table 7 illustrates clear discrepancies in percent of race/ethnicity groups fully vaccinated with African American and Latinx communities plotted significantly lower than others.

Dr. Jodian Pinkney, Research Fellow in Medicine at Massachusetts General Hospital, and Dr. Emily Hyle, Associate Professor of Medicine at Massachusetts General Hospital, claim that this vaccination gap can be attributed to widespread vaccine hesitancy and medical mistrust. In presenting their commentary, they define vaccine hesitancy as a "delay in acceptance or refusal of vaccines despite availability of vaccine services" (Pinkney & Hyle, 2022). In general, vaccine

hesitancy is derived from multiple contextual influences, individual and group preferences, and vaccine-specific issues, as displayed in the Vaccine Hesitancy Matrix.

In a research study on vaccine decision-making that evaluated thirteen focus groups with seventy participants (21% LatinX and 24% African American) in Los Angeles, several of these themes were identified under this Vaccine Hesitancy Matrix. Specific to contextual influences, participants claimed to mistrust vaccines due to a lack of clear and reliable information as well as previous references to mistrust displayed in "historical and modern unethical research studies" (Carson et al., 2021). In terms of individual factors, participants claimed to experience vaccine hesitancy due to a lack of individuals who could provide trustworthy medical information. Similarly, vaccine specific concerns were centered around underrepresentation in vaccine trials and misconceptions around vaccine development. Considering the weight of these factors within the Vaccine Hesitancy Matrix, various strategies were divided in an effort to improve percentages of vaccine uptake. Among these strategies, the most effective was the addition of mobile clinics occurring after work hours and on weekends, boasting a 131% increase (Pinkney & Hyle, 2022). Additionally, widespread media campaigns and primary care physician sessions proved to be almost equally as successful.

Within late 2021 and throughout 2022, similar data has been collected on the percentage of individuals receiving an additional 1+ dose of their chosen vaccines series. Receiving this additional shot became particularly important amongst the spread of COVID-19 variants, such as the Omicron variant, that appeared in Los Angeles in early 2022. Dr. George W. Rutherford, Professor of Epidemiology and Biostatistics at the University of California San Francisco, reported on the condition of California and Los Angeles County residents during the spread of this variant in January 2022. In his presentation to the Health Commission, he stated around a 23.0% test positivity, despite nearly 70% of Los Angeles County being fully vaccinated (Rutherford, 2022). Although cases of infection were initially daunting, Los Angeles County reported lower than expected oxygen utilization and mortality, in addition to a shorter incubation period of the virus. While the variant spread rampantly among both vaccinated and unvaccinated populations, the protective effect of the COVID-19 vaccine against severe illness and hospitalization increased general vaccination and booster uptake for those already fully vaccinated.

Over the course of the pandemic, vaccine effectiveness has proven to be dependent on several factors. 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. In 2021, 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). However, both Dr. Gandhi and Dr. Hellerstein emphasized a need for greater research in order to fully understand the durability of vaccine-generated antibodies, T-cells, and memory B-cells against COVID-19 and its mutants.

In his examination of ongoing vaccine trials in 2022, Dr. Harlan Robins, chief scientific officer and co-founder of Adaptive Biotechnologies, presented data of the long-term persistence of T-cells and the impact of vaccines on spike-associated T-cells to the Los Angeles City Health Commission. From a study of 72 people with prior infection, where around 43 of which were vaccinated for 15-17 months, vaccination led to an increase in spike signal, proving that mRNA vaccines effectively promote spike-focused T-cell responses (Robins, 2022). This data supports a new conclusion within COVID-19 research: vaccination after natural infection significantly improves both neutralization and cross-variant neutralization. Dr. Fikadu Tafesse, a professor on Molecular Microbiology and Immunology at the Oregon Health and Science University, provided further supporting evidence on antibody responses after COVID-19 vaccinations. One main conclusion stated that getting vaccinated leads to far more neutralizing antibodies than does natural infection. This finding holds true especially for third-dose vaccinations, which evidently improved Omicron neutralization and improved "antibody potency" (Tafesse, 2022). These responses are even greater for individuals who become vaccinated after a case of natural infection, although natural infection itself is highly variable.

While vaccine distribution remains a top priority of the Commission, there are also new ways in which COVID-19 infections are being addressed in treatment. Dr. Peter Chin-Hong, Professor of Medicine and Infectious Diseases at the University of San Francisco, described the benefits of the new Paxlovid pill designed by Pfizer specifically for COVID-19 treatment. This oral treatment is meant "for the treatment of mild-to-moderate coronavirus disease in adults and pediatric patients with positive results of direct SARS-CoV-2 testing, and who are at high risk for progression to severe COVID-19" (Chin-Hong, 2022). Currently, an individual is eligible to enroll for Paxlovid if they have at least one prominent risk factor for disease. The medication is administered as three tablets taken together orally twice daily over a period of five days, amounting to a total of 30 tablets. Regardless of its success thus far, the FDA states that "Paxlovid should not be a substitute for vaccination in individuals for whom COVID-19 vaccination and a booster dose are recommended" (FDA Office of Media Affairs, 2021) Paxlovid consists of nirmatrelvir, an inhibitor which prevents a SARS-CoV-2 protein to stop the virus from replicating and ritonavir, which slows down the breakdown of nirmatrelvir in the body. While these two protease inhibitors help to reduce severity of COVID-19 infection, they do not have the protective and preventive power of mRNA vaccines that have consistently reduced infection, hospitalization, and deaths in Los Angeles County. Thus, mRNA vaccines continue to be the best source of protection against COVID-19 infection and severe illness.

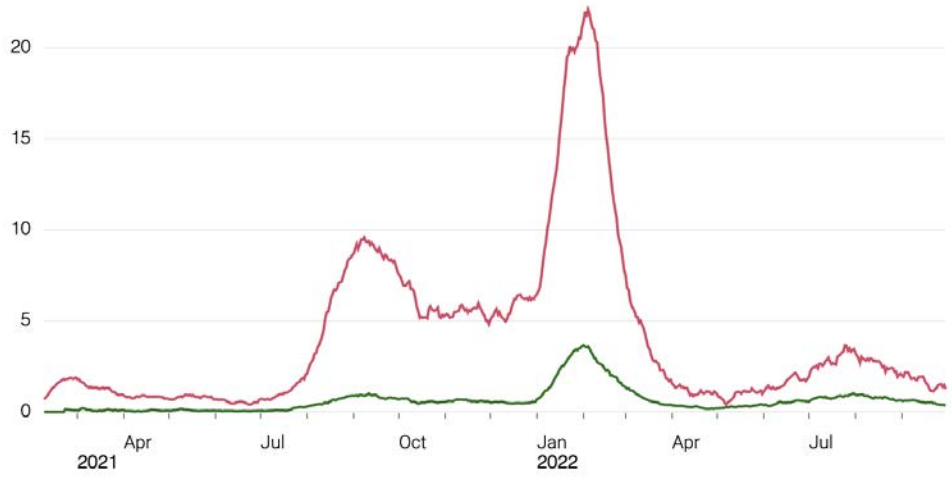

Table 8: Deaths per Million in Los Angeles County in Unvaccinated (Red) Individuals Versus Vaccinated (Green) Individuals From the Onset of the Pandemic to September 2022 (California State Government, 2022).

Table 8 illustrates deaths per million in Los Angeles County disaggregated by unvaccinated and vaccinated individuals from the beginning of the pandemic until September of 2022. In collecting this data, a vaccinated death is one that occurs in a person who received all doses of a primary series vaccine, whereas an unvaccinated death is one that occurs in a person who has not received a COVID-19 vaccine. During September 2022, "unvaccinated people were 3.1 times more likely to die from COVID-19 than people who were vaccinated with at least a primary series" (California State Government, 2022). Similar trends can be seen in case counts and hospitalizations within Los Angeles County, presenting a clear need to encourage vaccinations.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to mandate all residents to follow the guidelines set by the CDC, specifically for vaccinations and boosters, as well as funding further research on new treatments for COVID-19.

Infectious Disease Control

Recommendations:

1) Encourage mask use in crowded, shared areas to limit the spread of the COVID-19 virus: communal areas in health care facilities, public transportation vehicles (cars, taxis, buses, airplanes, etc.), and nursing homes.
2) Continued use of medical resources (such as surgical masks, gloves, and face shields) that can help prevent the early transmission of COVID-19, such as surgical masks (N95 masks) to high risk areas i.e. nursing homes, assisted living and some departments in both acute care and rehabilitation hospitals.
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) Provide hand washing and sanitizing stations for all staff and students.
6) Address the critical nursing shortage through the expansion of accessible higher education programs.
7) Reduce vaccine hesitancy by making trustworthy medical information publicly accessible.
8) Continue to provide Monkeypox vaccinations as needed for vulnerable populations in Los Angeles County.
9) Acknowledge and provide greater resources for students who suffered from the digital divide and losses in educational achievement.

Background:

Infection prevention and control (IPC) remains a priority in policymaking combatting the COVID-19 pandemic. However, a lack of personal protective equipment (PPE) makes this goal more difficult to achieve as health care workers and vulnerable populations are put at a disproportionate risk (i.e. minority groups, areas with 30% to 100% poverty, or people with immune deficiency diseases) (WHO, 2021). Additionally, Dr. Marina Zhavoronkova, Senior Fellow for Workforce Development at the Center for American Progress, explains the damaging effects of the nursing shortage. While nurses are one of the most critical pieces within the United States' health care infrastructure , whether that be in emergency care, vaccine distribution, or school health, nursing employment is undergoing its largest decline in the last 20 years. At the peak of the COVID-19 pandemic, many states suffered such significant effects that nearly "1 in 6 hospitals formally declared a critical nursing shortage" (Zhavoronkova, 2022). During these shortages, emerging supply-side and demand-side issues arose. The Center for American Progress states that the limited capacity of nursing students at higher education institutions have led to many aspiring nursing students to be turned away from the profession. This lack of available nurses has resulted in longer hours and lower morale for working nurses, leading to a cyclical relationship of burden.

However, increased accessibility to vaccines has made infection prevention and control more attainable for eligible individuals and eased the burden on healthcare workers. An improvement from coverage of 2020-2021, a recorded 67% of the Los Angeles County population was reported to be fully vaccinated at the beginning of 2022. Since then, individuals fully vaccinated within the county have raised nearly 6 percent, with around 42% also having received an additional dose. However, when disaggregating vaccination data by race/ethnicity, clear discrepancies in the percentage of the individual population were found. While all other race/ethnicity groups claim over 70% of their population to be vaccinated, LatinX and African American populations fall more than 10% below this general benchmark (Los Angeles County Department of Public Health, 2022).

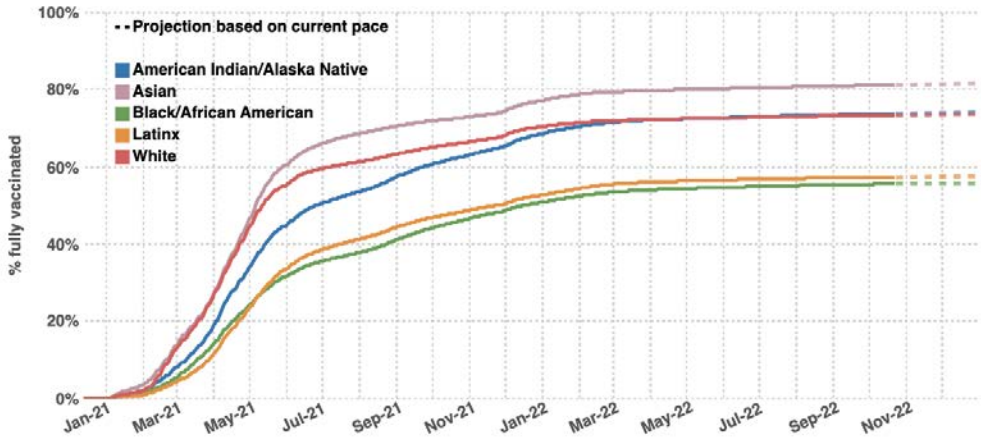

Table 9: Percent of Race/Ethnicity Group that is Fully Vaccinated (2+ Doses) in Los Angeles County from January 2021 to September 2022 (Los Angeles County Department of Public Health, 2022).

With lower incidence rates and greater resource distribution, determining vaccine and booster shot allocation is no longer a critical issue. A greater emphasis should be placed on debunking vaccine hesitancy and general medical mistrust that may be playing a role in vaccination gaps between these populations (Pinkney & Hyle, 2022). This mistrust is of particular concern within vulnerable populations, specifically reproductive-aged women; Black, LatinX, and Indigenous communities; immigrant populations; people aged 65+. A research study conducted on vaccine decision-making factors in minority communities in Los Angeles identified several themes using the "Vaccine Hesitancy Matrix" (Carson et al., 2021). These themes included contextual, individual, and vaccine-specific patterns sourced from unreliable information, inadequate exposure to reliable information and vaccine development misconception.

In a trial comparing the effect of various strategies on vaccine uptake, some of the most successful approaches included an expansion of mass media campaigns, which increased vaccine uptake by 30-500%, as well as the opening of mobile vaccination clinics, resulting in a 131% percent increase. These methods worked to increase vaccine uptake by placing a focus on trusted voices (such as well-known figures, vaccine ambassadors, or highly trained physicians) and reduced the burden of transportation to vaccine sites (Pinkey & Hyle, 2022).

As a result of increased vaccinations and reduced infection, widespread school reopenings and a full return to in-person education occurred in fall and winter of 2021. Since then, LAUSD schools have reduced restrictive measures for both students and faculty members,

while still remaining precautious. New measures for the 2022-2023 school year indicate that LAUSD will implement a new "response testing protocol, in which students and faculty are required to test only on the occasion of an exposure to an individual testing positive (Los Angeles Unified School District, 2022). This adjusted protocol is a major transition from their previous system in place during the 2021-2022 school year, in which every student and employee would test weekly with a PCR test. Additionally, while "indoor masking is strongly recommended," it is not required for all people present on LAUSD campuses, with some exceptions (Los Angeles Unified School District, 2022).

Return to in-person education has provided many benefits for children's emotional and social wellbeing, as shown in comparative studies from the 2021 Annual Report. The "indirect costs of COVID-19 on children seen within previous years 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" (JAMA Pediatrics, 2020). Furthermore, distance learning limited children's academic development. In urban districts, elementary school students have reportedly lost 30% of their reading skills. These consequences were especially harmful to low-income students, who may not have had access to an internet connection, tutors, or other technology to complete their mandatory school work. Consequently, there was a "widening gap between the 'haves' and 'have-nots' resulting in inequities" (JAMA Pediatrics, 2020). Without greater infection control and prevention methods in place, there is hope that these inequities will continue to diminish.

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 who presented to the Commission in 2021, 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 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.

While efforts have been focused on the COVID-19 pandemic, re-emerging diseases such as Monkeypox have diverted attention towards early prevention. Although the first human case of Monkeypox was identified in 1970, the CDC released an advisory about Monkeypox in the United States in late May of 2022. Soon after, on June 2nd, LA County confirmed its first presumptive case of Monkeypox. LA county then began providing commercial testing in local areas. In light of rising cases, both California and Los Angeles declared Monkeypox a state of emergency in early August. One determinant of infection with non-endemic regions, such as Los Angeles County, has proven to be age and sex. While there was a fairly equal split of cases between males and females in endemic regions, there was a disproportionately high percentage of males aged 30-39 who were affected by Monkeypox (World Health Organization, 2022). For

this reason, the vaccine was made available first to these vulnerable populations as well members of the LatinX community, accounting for nearly 46% of total cases.

Symptoms of Monkeypox infection have been identified as a rash occurring on areas such as hands, feet, chest, genitals, face, or mouth. The rash undergoes several stages before fully healing, including itchy and painful scabbing. Other traditional flu-like symptoms of illness can also occur, such as fever, chills, swollen lymph nodes, fatigue, headache, and respiratory symptoms (Rimoin, 2022). The Monkeypox virus is spread through direct skin-skin contact with these rash lesions. It is possible to transmit the virus through shared clothing, sheets, or towels as well as extended face-to-face interactions. In the case of contact, the California Department of Public Health has provided many ways in which individuals can prevent further spread of the virus. This includes awareness of sexual partner(s), monitoring of any unexplained sores or rashes, avoiding close contact with symptomatic individuals and their materials, washing hands with soap and water or an alcohol-based hand sanitizer, and using appropriate personal protective equipment when caring for infected individuals (California Department of Public Health, 2022). Los Angeles County also recommends vaccination, either a single dose or double dose series, for those currently eligible.

Action Plan:

The Commission encourages community education programs on vaccinations for COVID-19 and Monkeypox viruses in order to decrease vaccine hesitancy. Additionally, as recommended in the 2021 Annual Report, the Commission continues to support extensive research on emerging COVID-19 “long haul” symptoms.

COVID-19 Response

Recommendations:

1) Urge and consider mandating individuals above the age of 5 to receive a COVID-19 vaccination unless they have a medical exemption.
2) 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.
3) Support research that studies the longevity of T-cell and B-cell immunity against COVID-19
4) Begin drafting infectious disease control measures while promoting the Plan for a Healthy LA to be put in place for the 2028 Los Angeles Olympic Games.

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, 2021b).
- December 22, 2021: FDA authorizes emergency use for Pfizer's Paxlovid, the first oral antiviral for treatment of COVID-19 (FDA Office of Media Affairs, 2022).
- January 3, 2022: FDA expands use of Pfizer COVID-18 vaccine, updating the booster interval to five months for people 12 years of age and older as well as issuing a third primary series dose for immunocompromised children ages 5 through 11 (FDA Office of Media Affairs, 2022).
- January 7, 2022: FDA shortens interval for booster dose of Moderna COVID-19 vaccine to five months (FDA Office of Media Affairs, 2022).
- February 11, 2022: FDA authorizes new monoclonal antibody, named Bebtelovimab, for treatment of COVID-19 that retains activity against the Omicron variant (FDA Office of Media Affairs, 2022).

- March 29, 2022: FDA authorizes second booster dose for Pfizer and Moderna COVID-19 vaccines for older and immunocompromised individuals (FDA Office of Media Affairs, 2022).
- April 14, 2022: FDA approves first COVID-19 diagnostic test using breath samples, providing test results in less than three minutes (FDA Office of Media Affairs, 2022).
- April 25, 2022: FDA authorizes first COVID-19 treatment (Veklury) for young children 28 days of age and older weighing at least 7 pounds with a positive COVID-19 test (FDA Office of Media Affairs, 2022).
- May 17, 2022: FDA claims eligibility of Pfizer COVID-19 booster for children 5 through 11 years (FDA Office of Media Affairs, 2022).
- June 17, 2022: FDA authorizes Moderna and Pfizer COVID-19 vaccines for children down to 6 months of age (FDA Office of Media Affairs, 2022).
- July 6, 2022: FDA authorizes pharmacists to prescribe Paxlovid with certain limitations (FDA Office of Media Affairs, 2022).
    - Must be issued within five days after symptoms begin.
- July 13, 2022: FDA authorizes emergency use of Novavax COVID-19 vaccine for individuals 18 years of age and older (FDA Office of Media Affairs, 2022).
- August 31, 2022: FDA authorizes Moderna, Pfizer Bivalent COVID-19 vaccines for use as a booster dose (FDA Office of Media Affairs, 2022).
    - Bivalent vaccines contain two messenger RNA components of SARS-CoV-2 virus, one of the original strains and one common in the omicron variant.

Despite efforts to prevent the spread of COVID-19 infections over the past two years, a meta-analysis study conducted by Johns Hopkins University reported that "lockdowns have had little to no public health effects," as lockdowns in both Europe and the United States were only able to reduce COVID-19 mortality by approximately 0.2% (Herby et al., 2022). However, these lockdowns have had vast economic and social costs for individuals abiding by these policies. In order to reduce these costs, the study suggests looking to successful international COVID-19 plans, such as that of the Swedish government. Rather than the restrictive measures put in place by the United States, Swedish adults and children encountered much more relaxed guidance that allowed them to continue on with their daily lives. Surprisingly, this strategy resulted in the deaths of fewer citizens than in most American states and other European countries. Countries with similar guidance also avoided the immense burden associated with lockdowns such as decline of local businesses, lack of workers, stunted education, and delayed medical treatments (Tierney, 2022a). While the system of lockdowns itself may be at fault, Dr. Anthony Fauci, chief medical adviser to the president, claims that there should have been "much, much more stringent restrictions" during the early stages of the pandemic (Tierney, 2022b). For this reason, the World Health Organization is adjusting its official guidance to create stricter lockdown measures in the case of future pandemics, yet plans continue to evolve with greater experience.

Action Plan:

The Health Commission urges analysis of past recommendations of the city of Los Angeles to improve responses to future COVID-19 and pandemic-related events.

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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 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 Health Commission also recommends that the City Council and Mayor implement the programs that are stipulated in the Plan for a Healthy Los Angeles. 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. A 2023-24 budget allocation of $1,677,801 would provide adequate funding for full-time staff and directed research, which the Health Commission believes is necessary to accomplish its goals and objectives.

2022 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 40 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 The 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 Physician's 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 then Senator 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 "Leaders of Influence: Top Los Angeles Doctors" by the Los Angeles Business Journal and previously one of the Top Three Gynecologists in Los Angeles by Threebest related.com.

Currently Dr. Mandel is a member on the Board of Directors of the National Board of Physicians & Surgeons, 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 as a Chair Emeritus on the Johns Hopkins University Krieger School of Arts and Sciences Dean's Advisory Board and on 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 Angles 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 Doctor's Hospital. He was the Chairman of Surgery as well as Chief of Gynecology at Century City Doctor's Hospital and served twice in that role at Century City Hospital. He represented Century City Doctor's 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 35 and Mallory 33.

2022 Los Angeles City Health Commissioners

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.

2022 Los Angeles City Health Commissioners

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.

2022 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.

2022 Los Angeles City Health Commissioners

JOHN HISSERICH M.P.H., PhD.
Commissioner (Council District Two)

John Hisserich began his career at the Charles Drew Postgraduate School after serving three years of active duty in the U.S. Army, obtaining his BA in political science from Cal State LA and completing his Master's and Doctoral degrees in Public Health at UCLA. At the Drew School he was administrator of the first MEDEX Physician Assistant training program in California. He went from Drew to USC to serve as Director of the Cancer Surveillance Program, Deputy Director of the Norris Cancer Center and, after 34 years, retired as Associate Vice President for Health Affairs and Clinical Associate Professor of Community Medicine. Pursuing his interest in the interface between public policy and health care, Dr. Hisserich joined the staff of Assembly member Paul Krekorian who subsequently became a Los Angeles City Council member. Hisserich's role on the staff in both offices was focused on public safety and emergency medical services. Over the years he has had the opportunity to serve on several boards and commissions including, among others, the California Coastal Commission. The Committee of Bar Examiners of the California State Bar, the State Board of Food and Agriculture, the Court Reporters Board, the National Cancer Institute Cancer Control Peer Review Committee, the Los Angeles County Emergency Medical Services Commission, and the Board of Directors of the San Fernando Valley Community Mental Health Center. In addition, Hisserich served 43 years as a Reserve Deputy with the Los Angeles County Sheriff's Department assisting with the investigation of child abuse cases and also serving as an instructor for inmates participating in the Education Based Incarceration Program.

2022 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.

2022 Los Angeles City Health Commissioners

TRAVIS CHAPA, Ph.D.
Commissioner (Council District Six)

Travis Chapa, Ph.D. currently works at Atara Biotherapeutics as a Program Lead for two promising immunotherapies to treat virus related cancers. Over the past 19 years, Travis has been a research scientist working on infectious diseases: starting his career studying Bacillus Anthracis (the bacteria associated with anthrax) during the early 2000s scare; moving to studying viruses including Zika during the WHO declaration of public health emergency; and recently turning his focus to immunotherapies for virus related cancers. During his career, Travis has published 10 manuscripts on his research, presented his findings at 13 conferences, and received seven honors & awards for his work as a scientist.

Travis has been increasing his role in public leadership, including serving on a committee for the American Public Health Association, serving as a founding member of the Associate Board for Shelter Partnership, and participating as an instructor for the NAACP STEM Fellows Program to expose underrepresented youths to STEM careers. Travis enjoys taking opportunities to educate on the topic of infectious disease and microbiology. Whether the opportunities are informal—like discussing the science of film for the Writers Guild of America—or an official teaching position as a part-time instructor at Pierce College, Travis has been effective in his approach to simplify complicated concepts and make science accessible. Travis believes that maintaining the scientific progress of the future requires engaging and growing all of our young scientists today.

As a member of the Los Angeles City Health Commission, Travis hopes to review, discuss, and advise on items that protect health, prevent disease, and promote the health and well-being of all persons in our city.

2022 Los Angeles City Health Commissioners

NOMSA KHALFANI M.A., Ph.D.
Commissioner (Council District Eight)

Nomsa Khalfani, Ph.D., is the Co-CEO/Chief of Strategy + Equity Officer at Essential Access Health. As Chief Strategy + Equity Officer, Dr. Khalfani provides strategic leadership, management, and guidance to develop and implement strategic programs and initiatives. Khalfani drives efforts to ensure that the organization's programmatic and administrative activities and policies reflect a commitment to diversity and inclusion and advance health equity for all. Before joining Essential Access, Nomsa held several leadership roles at St. John's Community Health, a network of federally qualified health centers.

Dr. Khalfani is a graduate of the Southern California Coro Women in Leadership Program, the Blue Shield of California Foundation Clinic Leadership Institute Emerging Leaders Program, and the California Women's Foundation Women's Policy Institute. Nomsa currently serves on the LA County Community Prevention and Population Health Taskforce and the LA County Anti-Racism, Diversity, Inclusion Initiative Community Input Advisory Board, and on the Board of Directors of Community Asset Development Re-defining Education (CADRE) and the National Family Planning & Reproductive Health Association (NFPRHA). In 2020, Dr. Khalfani was recognized as one of Southern California's Top 50 Diverse Leaders.

Khalfani holds a Bachelor of Arts from the University of California, Santa Cruz, a Master of Arts from Phillips Graduate Institute, and a Doctor of Philosophy from Capella University, School of Public Service Leadership.

2022 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 curriculums. In 2011, she expanded her efforts in public health with Best Start Metro Los Ángeles (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.

2022 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.

Ron has been serving on the Health Commission since July 2016 appointed by Councilmember Mike Bonin. He is active in the Westside community as co-chair of the Del Rey Neighborhood Council's Health and Wellness Committee as well as a member serving on LAPD's Pacific Division's Community Police Advisory Board and Boosters.

2022 Los Angeles City Health Commissioners

STEPHANIE LEMUS
Commissioner (Council District 13)

Stephanie Lemus grew up in the Pico-Union/Westlake 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 graduating from CSUN, she earned 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. In 2021, Stephanie earned her Doctorate in Education from the University of Southern California (USC) Rossier School of Education. She has worked with various non-profit organizations and groups for the past 12 years in community outreach, education, advocacy, healthcare, and public health.

Currently, Stephanie is an adjunct professor at CSUN's Central American Studies Department. She is also a strategy consultant at Uproot Talent, a search and talent advisory firm dedicated to attracting, hiring, and keeping executive leadership, and co-creating anti-oppressive cultures. She serves as Board President of El Rescate, an immigration legal services non-profit, board member of the Central American Policy Research Institute (CARPI), and committee member of the Cedars-Sinai Cancer Diversity & Inclusion (D&I) Steering Committee.

2022 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.

2022 Los Angeles City Research Associates

LAUREN YEN
Research Associate

Lauren Yen completed her Masters of Science in Global Medicine 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, the USC Keck School of Medicine, and Children's Hospital Los Angeles. She is currently an incoming medical student at Loma Linda Medical School.

2022 Los Angeles City Research Associates

SARA KHOSHNIYATI
Research Associate

Sara Khoshniyati is a graduate from the University of Southern California and an incoming medical student in 2023. Sara has served on the Commission since 2020 and co-authored and researched the 2021 and 2022 Los Angeles City Health Commission Reports.

In working for the city, Sara hopes to improve community health outcomes and mitigate disparities in health through innovative solutions. In the past, she has founded and led a homeless service organization and Safe At Home Delivery, a non-profit providing free grocery delivery services during COVID-19.

Sara also works as a medical researcher at UC Irvine and directly serves individuals experiencing homelessness at Homeless Health Care Los Angeles, a center for harm-reduction on Skid Row.

2022 Los Angeles City Research Associates

MARVIN CHOWDHURY
Research Associate

Marvin Chowdhury is a Master's student at the Brown University School of Public Health. As a Rhode Island State Assembly Legislative Aide, Marvin worked on Medicaid expansion to vulnerable Rhode Island residents. He personally wrote the Cover All Seniors bill that would expand Medicaid coverage to non-resident Rhode Island seniors. He also worked and testified on the Cover All Kids bill, which was written into law and provided non-resident Rhode Island kids with Medicaid coverage. He has also written legislation on other topics, such as housing, labor and wages, and technology.

He was previously an elected official on the Los Angeles Neighborhood Council where he represented Reseda's population of 80,000 and advocated for better community health care options and housing. He also helped to sequence COVID-19 as an RNA Extraction Technician at the California Department of Public Health.

2022 Los Angeles City Research Associates

CLARE WILLIAMS
Research Associate

Clare Williams is a current undergraduate student at Duke University, where she plans to pursue a B.S. in Biology and a B.A. in Global Health with a minor in Chemistry.

Clare has served on the Commission since 2021 and was a co-author of the 2021 Annual Health Commission Report. In this report, she primarily focused on the research of world renown presenters at the Commission during the COVID-19 pandemic.

At Duke University, she works on the Student Collaborative on Health Policy in digital marketing and outreach for Curamericas Global, a non-profit organization that works with local partners in South America to reduce preventable child and maternal deaths.

Appendix A

The following approved meeting agendas and presentations for the Los Angeles City Health Commission were discussed between January 2022 to December 2022. 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.