Sacramento County
Public Health Advisory Board

Meeting Minutes

June 1, 2016 (12:07pm-1:32pm)

Primary Care Center
4600 Broadway
Sacramento, CA 95820
Conference Room 2020

Moderator: Dr. Steven Orkand – Chair

Scribe: Cherisse Thomasson – Staff

Board Attendees: Dr. Steven Orkand, Dr. Sherri Z. Heller, Dr. Sandy Damiano, Dr. Olivia Kasirye, Dr. Adam Dougherty, Kimberly Sloan, Dr. LeOndra Clark-Harvey, Allie Shilin-Budenz, Paula Green, Sherry Patterson-Jarrett, Dr. William Douglas, Cathleen Ferraro

Board Members Excused: Kristen Connor, Dr. Jeffery Rabinovitz, Ben Avey

Board Members Absent: None

Guest Speakers: Richard Isaacs PIC, Kaiser Hospital-South

Guest: Dave Magnino, Steve Heath, Joanne Hamel,

Sacramento County
Public Health Advisory Board

Topic	Minutes
Meeting Opened	Meeting began at 12:06pm
Welcome and Introductions	• Each PHAB member introduced themselves and their current positions.
Minutes Review	• The minutes from the meetings of March, April, and May 2016 were accepted without correction or addition.
PHAB Vacancies/HIV Health Services Coordinating Council Appointment	• **Vacancies**: • PHAB currently has three vacancies: one Community Member, one Public Health Professional, and one Public Health Care. • One new member: Cathleen Ferraro • There are no applications pending approval. • Two candidates were submitted for appointment to the HIV Health Services Planning Council: Dr. Melody Law, to Seat Number 3: Local Public Health; and Brian Hancock, to Seat Number 34: Federal Title II. Their appointments were approved by PHAB. • A letter will be sent to Paula Gammell, chair of that Council. • During the discussion, Allie Budenz asked if Dr. Law's position with the County constituted a conflict. Dr. Kasirye stated that the position sought had always been filled by a County employee. Dr. Heller further explained that the county employee's role is to share their experience and expertise and to allow the Board or Council to work more effectively. They are not supposed to represent County policy and may recuse themselves from certain votes. • Dr. Orkand reminded the Board that there is no meeting scheduled for July 2016.
Public Health Division Update	• The Public Health Division has completed two needs assessments concerning the state of the public health in Sacramento County. One is an evaluation of the Public Health System, including non-governmental stakeholders and their work. The other is an evaluation of community needs. Dr. Kasirye would like time at the August meeting to present this information.

Research Topic: Emergency Services **Guest Speaker: Dr. Richard Isaacs, PIC, Kaiser Hospital, South**	• Dr. Isaacs is a head and neck oncologic surgeon who became Physician-in-Chief of the Kaiser Medical Center in South Sacramento in 2005. Around that time, Sacramento County government felt there should be a level 2 trauma center in the south county. Kaiser applied for permission to build such a center, and, in preparation, underwent a redesign of the Emergency Department, both physically and programmatically. Up to that time, the ED was not functioning well. It was busy, but waits were very long, and there was a relatively high walkout rate. Dr. Isaacs established an urgent care clinic near the ED, but there were inefficiencies. Patients would have a medical screening exam in the ED, then another in Urgent Care. He closed the Urgent Care center after just a few months. As part of the functional redesign, Dr. Isaacs moved ED physicians from treatment areas in "the back" to a treatment center in front, near registration Patients with low acuity illnesses (about 35%) were quickly handled in this setting, often discharged in 30 minutes. It made sense to deal with these patients before they reached the more capital-intensive, and time-consuming rooms in the back of the ED. Kaiser South's ED has been seeing tremendous growth, about 18-20% each year for the last 6 years. Last year there were 125,000 patient visits to the ED, and this year 150,000 are projected. Many of these patients are Kaiser members, but some are coming from other hospitals and health care systems. Many have recently gotten insurance through the Affordable Care Act. There are a fair number of patients coming with mental health problems. • Kaiser South ED has only 37 beds. It is an extremely efficient ED. Hospitalists and internists are now in the ED, seeing patients along with the emergency physicians. This disrupts the "normal" approach, but has introduced great efficiency. The surge period is from 3:30 PM to midnight, and staff is augmented to handle the surge. The treatment teams can see 4-5 patients per hour in the front area. They are generally seen immediately after registration. There is no delay in ambulance-patient drop off ("wall time"). For patients admitted to back rooms, ideally they spend no more than 2 hours until discharge, 4 hours until admission. It

	is very efficient to have lab draws and imaging studies while the patient is in the ED. • The majority of patients seen are Kaiser members, but about 43% are not. The bulk of non-members are Medi-Cal and uninsured. Trauma constitutes only a small number, about 5%. • Dr. Isaacs feels that this model could be replicated in non-Kaiser EDs, but buy-in from physician leadership would be necessary. There could also be conflict with administrators who are interested in revenue generation, because "an empty bed is lost revenue. " In an accountable care organization such as Kaiser, "an empty bed is a healthy patient." Some of the efficiencies of an integrated system would be difficult to replicate. For example, at Kaiser doctors are connected by "smart phones." An ED physician who needs advise from a cardiologist simply picks up the phone to call one. EKGs can be transmitted by FaceTime and the cardiologist is free to give advice over the phone. In a fee-for-service practice, the cardiologist will want to visit so that there is financial compensation for this work. • Hospital length-of-stay, a determinant of how many beds are available for new admissions, depends to large degree on how much is accomplished in the treatment areas of the ED. Normal length-of-stay for patients with congestive heart failure might be 3 days, but if they are treating aggressively in the ED, this may be shaved to 12 hours. • Dr. Isaacs was asked how he was able to change the culture in the ED. He responded that physicians like to be "the best" at what they do, and when he proposed these changes, he framed it around the concept that Kaiser would be delivering the best, most efficient care anywhere. Physicians were resistant because they were out of their comfort zone, but it took only about 90 days for them to establish a new comfort zone. • Dr. Dougherty is in training in emergency medicine at UC Davis, and has spent

	time at South Sacramento. He echoed Dr. Isaacs comments about the positive features of having decision making and treatment up front. He said this is not the situation at UC Davis, where patient waits may be very long. One big problem is how to arrange follow-up care for uninsured patients. Dr. Isaacs agreed that finding resources in the community to provide follow-up care is difficult, and critical. • Dr. Isaacs was asked about the provision of mental health services. He has arranged for mental health professionals, inpatient psychiatrists, to help evaluate and stabilize mental health patients who come into the ED. The team has tried to create a calming environment, including activities, as part of their psychiatric care. • Dr. Douglas asked how quality is measured in the South Kaiser ED. Dr. Isaacs said there were several measures that he follows: (1) door to intervention time, (2) patient day rate, and (3) readmission rate. There has been no increase in readmissions despite more rapid turnover. • Paula Green wondered how the Kaiser ED functions when the 37 beds are full and true emergency cases come in. Dr. Isaacs spoke about efforts at efficiency, efforts to keep things moving. The goal is to optimize decision-making at the start. It can be very stressful.
Primary Health Services Update	**MEDI-CAL MANAGED CARE** • Provided and reviewed the following data reports: "Enrollment Data 2016" and "Net Enrollment & Net Increase 2011 – 2016." See ATTACHMENTS. • Also see webpage: http://www.dhhs.saccounty.net/PRI/Pages/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/BC-MCMC.aspx
Research Topic: Budget Discussion Guest Speaker: Dr. Sherri Heller, Ed.D Director, DHHS	• Dr. Heller spoke about the timing around the annual budget cycle. In February, the Departments submit their requests for program continuation and growth, and for new programs. The Department of Health and Human Services (DHHS) requested funding in about 30 new areas. At the beginning of April, the County projects how

	much money will be available from the current fiscal year. Around the same time, the Governor's budget becomes available, and the County does a reconciliation. This year the gap was $25 million between what was available and the amount needed to carry forth existing programs. If the gap had not been resolved, lay-offs might have been necessary. In 2009, this was very painful. In early June, the CEO recommends a balanced budget to the Board of Supervisors, and adjustments are made. At the end of June, the true amount available from the State is known, and final adjustments are made during July and August. In September, the Board of Supervisors passes the final budget. • There is a new CEO for the County, and he has allowed greater transparency in the budget process. Dr. Heller is able to report what her department has been granted, but also what she requested that was not funded. This gives the advisory boards more opportunity for input. • The CEO will recommend funding for certain programs: • There is currently funding for two mental health mobile crisis teams. It was recommended to increase this to four teams. Currently, ¾ of the calls they take do not result in a 5150 referral, greatly decreasing the numbers that have to go to the hospital. • Funding for electronic medical records expansion in behavioral health. • Additional support for IHSS (In-Home Support Services) • Two clerical staff in public health • Support for second opinions from child psychiatrists when psychotropic drugs are being prescribed for foster youth. • Support for intensive mental health services for children on Medi-Cal. This was the largest item. Funding was $1.2 million locally, matched by $1.2 million in federal money for 9 months. • Items that may be of interest to PHAB that didn't get funded include:

	• Request for an on-call pharmacist • Request for rapid HIV/STD testing available to the courts • Request for 5 additional investigators for adult protective services. Currently, the county is at 77% compliance when it comes to seeing people in a timely manner. • Money to expand early intervention family drug court. This is for situations where children might end up in foster care if there are delays in dealing with the parents' drug use. The request was for $700,000. • Request to start dealing with the waiting list of people who request drug and/or alcohol treatment programs. There is currently a 3-month wait list for people who want treatment. The request was for $500,000 in the first year. • Request for 8 additional public health nurses for the foster care program • Request to expand enrollment for the Healthy Partners Program for the undocumented. • Funding for an additional manager at the Chest Clinic (TB investigations) • Request for additional medical and mental health staff for California Children Services, which deals with young children with disabilities • Funding for an additional manager in the Public Health Lab • Dr. Heller was asked if the DHHS had priorities amongst the unfunded requests. She explained that she did have priorities, but that these may change over time, depending on other funding sources. High on her list were projects addressing drug and alcohol. She feels we should begin to address the waiting list, and that putting money into early interventions by family drug court is very effective. She also felt that having a pharmacist available to the mental health treatment center, while not very expensive, could facilitate admissions into the center. • PHAB members appreciate the transparency of the budgeting process and would encourage the opportunity to comment even earlier in the future. • Dr. Kasirye reminded the Board of the spike in Fentanyl-related deaths. It is imperative that those wanting treatment for their habits should have it available in a timely fashion.

	• **It was moved by Allie Budenz and seconded by Adam Dougherty that PHAB defer to the Executive Committee to direct a letter to the Board of Supervisors commending them for transparency in the budget process and stressing the need for drug and alcohol services.** The vote was unanimous.
Public Comments	There was none
Announcements	**1. Action Topic: Syringe Exchange Program** • During the last meeting, I announced that our Executive Committee had been invited to meet with Supervisor Patrick Kennedy to discuss how to move forward with our proposal for a syringe exchange clinic. That meeting was canceled. I spoke with Susan McKee, the supervisor's Chief-of-Staff. She made it clear that Supervisor Kennedy supports the proposal and would like to lead the effort. They are concerned, however, that the votes aren't there. • We agreed to two, parallel approaches. Since Supervisor MacGlashan is stepping down, the first approach would be to wait until after the elections, then speak with the new supervisor to help him or her understand the public health and public safety issues. He or she might support this issue. At the same time, we should investigate whether this issue could be included in the recommendations of the county's Opioid Task Force. It would help if syringe exchange and harm reduction could be understood as part of a broad, multi-pronged approach to address the issues of drug addiction. • I asked whether we should attempt to speak with the supervisors individually. Susan McKee didn't think this would be very fruitful. • I have not yet spoken with the other Boards and Councils that have expressed support for this proposal.

2. Research Topic: Emergency Services in Sacramento County

- I also wanted to bring you up-to-date on the work being done by the Emergency Services Task Force. At their last meeting they discussed a number of interesting topics:

- For some time, the hospitals have agreed on a no-diversion policy, which means they don't turn away ambulances unless they are experiencing an "internal disaster." However, hospitals interpret this in different ways, and it is not always clear what triggers a temporary shutdown. Ben Merin, who is the county's EMS Coordinator, announced that as of July 1, 2016, the county will be collecting data on this. Our EMS Agency is in a data-collection phase, which is the first step to sort this out.

- We've talked about ambulance-patient offload time, often called "wall time." There has been quite a bit of controversy about how this is defined, and especially about the roles and responsibilities of the EMTs, nurses, and others while patients have not yet been formally turned over to the ER staff. For example, EMTs are sometimes asked to transport patients for imaging studies. Dr. Hernando Garzon, who is the Medical Director for the county's EMS Agency, has written, and distributed rules governing this situation.

- The Sacramento County Mental Health Treatment Center is increasing the times it will accept admissions. Law enforcement can again drop off patients at this facility during the day, but hours are limited. In recent years, because of budget cuts, psychiatric patients in crisis have been taken to emergency rooms, which triggered the need for medical clearance and psych discharges. This caused a tremendous ripple effect, backing up emergency department throughput. Ben Merin, the EMS Coordinator, is seeking data from law enforcement about how they triage and where they take these patients. There are apparently reimbursement issues to consider if the fire department also becomes involved. Hopefully, he will find ways

	to bring some consistency to the system. • The Veteran's Administration is opening an emergency department on June 1. However, there were many, many questions at the Emergency Services Task Force about who they would see, whether they had transfer agreements in place, what subspecialists are available, whether they are certified to receive stroke patients, etc. A representative from that emergency department will be invited to the Emergency Services Task Force.
Adjourn	Meeting ended at 1:31pm