Sacramento County
Public Health Advisory Board

Meeting Minutes
May 5th, 2021, 12:00 PM - 1:30 PM
Recording can be found here: https://www.youtube.com/watch?v=6jku5fCKET4

Meeting Location
Zoom Meeting (Open to the Public)

Moderator:	Dr. Farla Kaufman
Scribes:	Liz Gomez
Board Attendees:	Phil Summers, Farla Kaufman, Sonal Patel, Libby Abbott, Steve Heath, Barbie Law, Sandy Damiano (ex-officio) Dr. Kasirye, (ex-officio)
Guests:	Jim Hunt, Lori Miller, Andrew Mendosa, Lynnan Svennson, Jennifer Denno (Sutter Health)
Board Members Excused:	Tina Slee, Emmanuel Petrisor, Annie Tat, Larissa May
Meeting Opened:	12:08 PM
Welcome and Introductions:	Dr. Kaufman welcomed everyone to the meeting and outlined the goal of our time together.
Review of Minutes:	Approval of April 7th and 21st minutes will be at the next PHAB meeting on May 5th 2021

Sacramento County was awarded a $3 million dollar grant for children and youth.

Board Update – Farla Kaufman

We have 3 vacancies on the Board. They are actively searching for members so if you know someone who would like to serve and would be a good addition, I will pass it along to the Chiefs of Staff to the Board of Supervisors.

Public Health Update – Dr. Kasirye

Our numbers have gone down slightly. Our case rate was 7.5 per 100,000. We are still not making very good progress on getting to orange. Hopefully we will continue to trend downwards. We have hit over 1,000,000 doses of vaccine given. We are still struggling with vaccinations in the health equity quartile. This is our last week with Jim Hunt so wanted to publicly thank him of stepping in, in the midst of the pandemic and navigate through the last few months. Worked with him before and always appreciated working with him.

Jim Hunt: Thank you for your kind words, appreciate it.

Primary Health Update – Sandy Damiano

Echo everything Olivia said around Jim, someone who knew the subject matter, time went back quickly, we have appreciated your presence Jim.

EMERGENCY MEDICAL SERVICES

- I want to thank PHAB again for support of EMS and writing a letter of support for EMAG.

WIC

- WIC requested funds from the health plans due to funding gap for the lactation program. As you recall this was a planned First Five funding reduction. To date, will receive $55K which is 41% of the loss ($132K). Although this is a small amount it will help retain lactation consultant hours.

COVID-19 STATUS
CONFIRMED CASE DATA:
Snapshot in the jails Monday 5/3:

For Monday, 5/3	Inmates with confirmed cases in Custody	ADP snapshot
Main Jail	**0**	**1,809**
RCCC	**1**	**1,344**
	1	**3,153**

Data for last week:
Weekly COVID-19 Data as of April 28, 2021
Total number of COVID-19 tests since March 2020: 15,444 (Net increase = 380)

Total number of confirmed COVID-19 cases since March 2020: 1,788 (Net increase = 4)

VACCINATION DATA:
Vaccination Data – Inmates
As of 4/28/21, 1,294 inmates received at least one COVID-19 vaccine dose and 1,115 were fully vaccinated. Total doses given 1,624.
The Janssen pause impacted data and patients willingness.

Vaccination Data – Staff
As of 4/28/21, 432 staff received at least one COVID-19 vaccine dose and 408 were fully vaccinated. Data does not include: staff who received vaccines offsite or mental health staff who received vaccines through UC Davis.
Farla: I would also like to thank Jim Hunt too for his service.
Jim: Thank you and all of our PHAB members for the work you do it's very, very helpful.

Guest Speaker – Aimee Moulin, MD
Phil Summers can you introduce Aimee – I want to introduce one of my longtime mentors she is a professor of emergency medicine and psychiatry at UCD and co-Director of California Bridge Program. She is a really incredible advocate and wonderful mentor.

I am an Emergency Physician so what I am comfortable with is chaos and interruptions so please interrupt me to ask questions.

Attached please find Aimee's presentation that she walked us through. Some of the points she walked through are:

- Bridge Program: patient navigation and treatment for individuals who are unstably

housed and have substance use needs.

- We operate outside of many systems which leave us to utilize the 5150 which is not always the appropriate pathway
- Frequently we think people experiencing homelessness can't get connected to care but our numbers show that our system just isn't as accepting to people experiencing homelessness. But homelessness was positively associated with connection to treatment OR 1.78 (Odds Ratio).

Steve: Do people have to go through medical triage first before getting referred into the Bridge Clinic?

Aimee: We will self-refer people from ED to Bridge Clinic or people we've discharged from inpatient to Bridge Clinic and grow from there. Ideally we have walk-in capabilities in the future.

Aimee: Elephant in the room is stigma.

Farla: If you controlled everything what would you change?

Aimee: Everyone in my department would say we need more inpatient psychiatric beds

- An inpatient psychiatric bed is taking away people's rights so I am more interested in housing, I want to access full service partnerships, access to treatment. When they come to me in crisis I had access to that full spectrum of options – crisis residential, etc. I am just a conduit for the 5150 instead of taking an individual to assessing their needs and finding the best way to meet their needs.

Lori Miller: Have you had any conversations with Dr. Quist around linking people more quickly?

Aimee: You're right I am sure there is a better way to tap into some of the options out there. It's just the way the system is designed the ED isn't a part of case management and full service partnership.

Lori Miller: Sutter, Kaiser and other hospital systems also have some of these challenges as well. I will also bring this back to Ryan to let him know.

Farla: I will also bring this back to Ryan to talk about it. Would be great for interested parties to come together and talk about where we go from here. Perhaps this is low hanging fruit around accessing care for your patients.

Jim: Thank you for the presentation and I applaud you and we may be able to come up with some approaches to alleviate the problems you are seeing and to help these patients.

Jennifer: I want to put out the idea that the patients that are waiting to be evaluated often times you know our EDs are full and they are exposed to all of the sounds and chaos of an ER. This is not ideal. These people are here just waiting, and there's never been a really good plan to give those people a therapeutic environment.

Aimee: We say if you were not having a mental health crisis when you came in, try spending 50 hours in a hallway.

Farla: Do you see other potential solutions to that problem?

Aimee: It's waiting. We need to make sure that that time we have taken away from someone they deserve the maximum efforts we can provide to get them out of hospital jail. There could be more voluntary treatment options. Not everyone I see doesn't want to be there. There should be other ways to access acute psychiatric care than a 5150.

Phil: The data on our homeless patients getting plugged into care. That population is

stigmatized and subject to many determinants of health. It's very counterintuitive what is that the result of?

Aimee: This is true of UCD and the Bridge Program. We saw roughly the same odds ratio of persons experiencing homelessness more likely to access care when they were referred from the ED. We think this population is treatment resistant but when we make it really easy (pharmacy problem, transportation problems) they actually go at higher rates than people who are stably housed. I think it's because it's the only avenue.

Steve: Are there any racial disparities in the way people are treated for 5150s?

Aimee: I have looked at race and gender breakdowns as well as people we sent to our behavioral health area versus not. There was not a disparity, which I was surprised by.

Steve: Some of your patients are walk-ins, other are brought in by police and fire department. If you had your way with legislation and you were able to direct fire department and police, would you feel that they are safe enough to go to alternative places outside of medical emergency room outside of you?

Aimee: There have been pilots of EMS talking individuals to inpatient psychiatric facility instead of Emergency Department.

Steve: What about taking people to the urgent care?

Aimee: Someone who is low anxiety, we can refer people directly to the urgent care so I don't know that this is a huge volume. We do the SMART medical clearance with a lot of success and there is a population that does not need intensive medical interventions except for substance use. The triage that is happening is the functional wait times are trying to tease out who is intoxicated and will clear, who is acute psychosis will resolve or be mitigated once they clear from stimulants. It's not that there are a lot of people who have heart failure, COPD that need to be stabilized it's the co-occurring substance use.

Farla: obvious we should continue this conversation that includes all of the players involved and we will attempt to make sure that happens and I'm sure Lori and Andrew are also on that page. It would be wonderful to hear back and let's say a month or two that things are shifting and moving and these changes that could be incorporated will be making a difference.

Lori Miller: If we could have a standing item around substance use that would be great.

Farla: We would welcome a periodic update and we will follow-up on that.

We had two draft meeting minutes that were sent out from April: April 3rd and April 21st. Those minutes were circulated and I would like to call for a motion to accept. I am going to postpone the vote on these meeting minutes due to there being less members here.

Recap of April 21st Special Meeting – Farla

There was a decision to setup a working committee because PHAB has an interest in this area around correctional health. A number of public comments were offered and we had a special meeting where we heard from correctional health, sheriff's department and community groups. This is such a complex issue that we as a full board cannot focus on it. A smaller group can be more nimble. They can have more latitude to speak to a number of individuals and entities. PHAB has the capability to form a working committee, 9 members at maximum. We have 12 members on the Board. So we could have 5 Board members and 4 community members from the public. The purview for this committee would be set by this committee. Correctional Health, we would ask that they be present. Sandy Damiano, I am sure would provide a wealth of

information and has a tremendous perspective on this. Sandy, I am hoping you would be willing to participate.

Libby, Phil, I know you expressed interest. I will also put it out to the larger board. When we have all of our members back I am sure you will get more participation.

Sandy: Right now, part of our workload is so heightened it's almost unbearable because we are doing all of this work with the experts and plaintiffs council. I don't know that we can duplicate all of the work we are doing in these other spaces. Just from a bandwidth standpoint.

Farla: Perhaps the committee could ask you to send materials that they could review to get a background on the issue. Perhaps they could then come back with questions that you could answer and then you wouldn't have to participate all the time. Last time Sandy you recommended starting with the consent decree and the remedial plan?

Sandy: Last time we were just presenting on the COVID. I think people do need some framework on what's involved with the remedial plan, otherwise, it's very difficult.

Farla: Phil and Libby, would you like to setup some kind of time table for meeting? Would you be comfortable getting the ball rolling?

Phil: Yes Libby and I can coordinate and meet separately and send a note out to the group.

Libby: We would work with you Liz to get information out to the community about this opportunity?

Farla: Liz can play that role.

Update from Subcommittee on Mental Health – Sonal

Farla, Phil and I met with Ryan in March to understand what Sacramento County is doing within Behavioral Health and what else PHAB can do to support the department's effort.

The State's infrastructure proposal, Ryan said that it was good to see the State's proposal.

One of the things the State is planning on doing is an IMD waiver to CMS which would allow billing or more than 16 beds because a lot of the facilities have way more than 16 beds.

We also discussed assisted outpatient treatment for individuals with serious mental illness. AOT has strict legal criteria – must have a history of medication noncompliance. This program has not been implemented in Sacramento County. It's called Laura's Law and it's been an opt in program from County and became an opt out. So Counties are going through the process of publicly deliberating and determining whether they will opt out. He said there's a lot of trauma and conversation and the idea of involuntary commitment can be traumatizing for many communities. He takes both sides concerns very seriously. He is interested in seeing how this conversation moves forward at the County level. We talked about the CalAIM proposal of which he is very excited about and it will streamline the department's efforts to get paid. A couple of the components such as enhanced care management which would allow Sac County to bill for services they had already been doing but can start to bill Medi-Cal. Broadly we discussed behavioral health funding and the impact of COVID-19. While there are fewer concerns now than at the beginning of the pandemic because we were concerned about a recession. However, in the out years Sacramento County is spending more than we are receiving so there are concerns about future fiscal status. What are things PHAB can do to support behavioral health? He would like to see urgent care become a 24/7 option which it hasn't been because of a lack of funding. He would like to see around the clock model. He also was really interested, given his work with the California Behavioral Health Directors Association, in reopening the

conversation around realignment and reopening this conversation with the State. The funding model is based on population from several years ago and that methodology doesn't align with what our population looks like now. Last thing was funding alternatives to 911.

Liz: Dr. Kasirye, Lynnan and Liz have also been connecting with partners around CalAIM and how that may intersect with Public Health.

Lori Miller: On the substance use side we are looking to increase access to care and decreasing barriers to getting into care. How individuals get care on demand moving forward is what we hope to see.

Farla: Would you come next week and help us understand some of the pieces?

Lori Miller: Yes, we would be happy to, and we would like Andrew to attend regularly.

Barbie Law: This is a large scope problem that will take a multidisciplinary approach to resolve.

Farla: I will follow-up with a few people to see what would be necessary to setup a committee.

Public Comment

Farla: Do we have any public comments? No.

Adjournment The meeting was adjourned at 1:30PM

Submitted by Liz Gomez, scribe