Sacramento County
Public Health Advisory Board

Meeting Minutes

March 2, 2016 (12:02pm-1:33pm)

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

Moderator: Dr. Steven Orkand – Chair

Scribe: Cherisse Dossman – Staff

Board Attendees: Dr. Steven Orkand, Dr. Sherri Z. Heller, Dr. Sandy Damiano, Dr. Olivia Kasirye, Paula Green, Allie Shilin-Budenz, Ben Avey, Dr. William Douglas, Kristen Connor, Jack Reeves, Dr. Jeffery Rabinovitz, Kim Sloan

Board Members Excused: Sherry Patterson-Jarrett,

Board Members Absent: Dr. LeOndra Clark Harvey, Dr. Adam Dougherty

Guest Speakers: Dave Magnino, Brian Jensen

Guest:, Deborah Foster, Dr. Melody Law, Nissa Anderson-Lyman

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Topic	Minutes
Meeting Opened	Meeting began at 12:04pm
Welcome and Introductions	• Each Board member and guest introduced themselves.
Minutes Review	• Minutes from February 2016 PHAB meeting were approved.
PHAB Vacancies/HIV Health Services Coordinating Council Appointment	**Vacancies**: • PHAB has currently 3 vacancies: 1 Community Members, 1 Public Health Professional, and 1 Public Health Care. • There is 1 application pending approval. • No Appointments
Guest Presenter: Brian Jensen Hospital Council	• The Hospital Council is a collective voice for the hospital industry, including representatives from hospitals, health plans, and other stakeholders. They identify and focus on areas of common concern, occasionally advocating with decision makers. Emergency services has become a top area of concern. The local Hospital Council covers 50 counties from Oregon to Bakersfield. Discussion of emergency services often centers on issues of volume and the impact on specific services, especially on mental health. A UC Davis study from 2006 - 2011 found: • Volume of ED traffic up significantly in many counties, but especially in Sacramento County. Volume in Sac County was up 33%, while mental health visit volume rose 91%. • During the recession, the County cut beds in the Mental Health Treatment Center from 100 to 50. Introduction of the Affordable Care Act and expanded Medi-Cal also had tremendous impact. In California, ⅓ of all health care is provided by Medi-Cal. There are not enough primary care providers, and those who see Medi-Cal patients often don't provide timely care. As a result, Medi-Cal members often go to the ED for non-emergent care. • In response to this, the Hospital Council has formed working groups. One is the Emergency Services Task Force. Includes ED managers, law enforcement, first

responders, others. Meet every 2 months. Members share data. May discuss existing protocols. Big area has been non-diversion policy. Data is available through EM Resource dealing with factors that might feed into diversion decision. Diversions now very infrequent and those that trigger diversions have to explain why they took that step.

- **Question posed by PHAB**:
  We realize that Sacramento EDs are often very, very busy. Does the Hospital Council have data on the degree of over-crowding? How often is there a need to go on diversion or to close an ER? Does the Hospital Council have data on ambulance wall times in the past year? Do you have examples of adverse consequences that may have resulted from this? What processes are in place to monitor this problem?
  - Answer:
    The Hospital Council is "data-light." Individual hospitals track this. The ambulance agencies keep data on ambulance wall time. There are state recommendations on how to manage wall time, but the Hospital Council does not follow this in detail.

- **Question posed by PHAB**:
  Sacramento County ERs are obviously not immune from the problems that have plagued
  EDs throughout the country: overcrowding, long lengths-of-stay, boarding, staff recruitment and retention issues, workplace violence, increased mental health patients, lack of primary and specialty care providers, and many others. Is there data that shows how our eight Sacramento County EDs have been impacted by these issues? Are there plans to address these problems, and how is this being monitored by the Hospital Council

  - Answer:
    The Hospital Council does not track these issues.

Emergency Preparedness Coordinators do follow
- some of this data.

- **Question posed by PHAB**:
  We have heard repeatedly about the impact mental health patients have had on some of our EDs. There were budget increases last June to enhance mental health treatment in Sacramento County. Did the results of the approved budget meet your expected outcomes? Are there plans to further address ED utilization and the holding of mental health patients?

  - Answer: The Board of Supervisors authorized an additional $ 17 million in 2015. Some of this will go to crisis management facilities. Turning Point expanded from 12 to 15 beds. Sixty additional crisis residential beds will come on line. The roll out has been slow, and no benefits felt as yet. Sierra Vista Hospital is expanding by 51 beds. Signature is a company that is building a 120 bed psych facility. Heritage Oaks is adding 15 beds. They can receive Medicare reimbursement.
    There are other improvements coming on line, including new protocols on how to manage these patients. Some of the beds are filled with forensic patients, waiting to establish competency so they can stand trial. It is a questionable use of acute bed space and the County is addressing this.
    Psych patients are dropped off at the EDs to receive medical clearance. Psych hospitals don't want patients who have any question of medical need. Better approaches may be possible. The Medical Society has created a Smart Medical Clearance Form that will facilitate workup and transfer.

  - Medical groups are working on ways to efficiently handle patients who come into the ER but don't need emergency

	care. Community para-medicine is a new approach that should be expanded. There are state-sanctioned projects currently underway. It is hoped these will lead to new models of care that direct non-emergent patients away from the EDs. o Answering another question about data collection: Data is being collected by the hospitals and first responders, but not directly by the EMS Task Force. Regarding psych beds: there are different types: locked acute hospital beds in a large facility, locked acute hospital beds in a small facility, respite beds, crisis residential beds. If you add them all up, there are still fewer beds than there were prior to 2008. Some of these are public beds, some private, but in small enough facilities that they will receive public dollars. Mixed beds are supported by the psych community. Additional issue: there is a lack of psychiatrists. Another issue: Different counties have different systems of releasing 51/50 holds. This is particularly important in rural counties.
Guest Presenter: Dave Magnino, EMS Administrator	• EMS Agency deals primarily with pre-hospital care. Also deals with the scope of care in various facilities. They have a staff of seven. A handout was provided. • **Question posed by PHAB:** Does the EMS Agency have Monthly or quarterly data regarding response time for single-casualty incidents? For multi-casualty incidents? Have there been reports identifying opportunities for improvement and evidence of progress. From your perspective as EMS Administrator, what are the top needs in the County to manage incidents with multiple casualties? Answer: County does not keep this type of data. In the past,

	ambulance services would give this type of information to a contract vendor, but only the 9-1-1 providers participated in this data collection. By the end of 2016, all first-responders will be required to submit data about their calls. This should allow direct access by the EMS Agency. The State EMS Authority requires the collection of certain data, and this will become available to local the EMS Agency. By the end of this year, local data will also need to be entered into a national database. The new software will allow analysis of up to 400 data points. Multi-casualty incidents (MCIs) are currently reported by UC Davis to Mr. Magnino as they occur. Current software to track this, EM Resource, is being underutilized. County is trying to educate hospital ED staff in how to use this. New functional modules are being added to make it more usable. Right now, hospitals are periodically asked to report: total bed availability, subspecialty bed availability, numbers of negative pressure rooms, operating rooms, etc. This provides a snapshot in time, not continuous data. The EMS Agency recently did a review of a multi-casualty incident in Sacramento County that had some bad outcomes. Issues were discovered and discussed with the hospitals. Hospitals do conduct their own reviews, but the depth is not always clear. Top needs in the County: (1) develop MCI review process. Current MCI plan is from 1988 and involves 11 counties in this region. An MCI work group has been formed and hopefully a plan will be available at the end of this year.

	• **Questions posed by PHAB:** Does the EMS Agency have data on utilization of licensed emergency beds? We've all experienced or are aware of extended lengths of stay in EDs. Do you have data on (1) the number of boarded patients, (2) psych holds, (3) wall time in the ERs, (4) number of patients waiting to be "roomed" either in hallways or in the waiting rooms? o EMS Agency currently polls hospitals about bed availability. California Department of Public Health has detailed data about licensed beds. Hospitals activate a "surge plan" if they reach 110% capacity. Most hospitals today operate at 150%. Medical and psych holds in the EDs are causing a backlog. The hospitals count these every night at 11 PM. Medical holds are admitted, but waiting for an inpatient bed. Psych holds are medically cleared 5150 candidates who are waiting for transfer to psych facility. These numbers are reported to the County. Starting in Jan this data has been reported twice daily. Numbers vary from day to day, sometimes large. o On Jan 5, volumes were so high that an expanded emergency plan was activated, which meant that all ambulances were directed by the agency. The hospitals were all running at about 185% capacity. This worsened. Ambulances were down to 10% availability. 56 patients were distributed centrally to different hospitals based on bed availability. o Governor signed a bill that requires standardization of definition for ambulance patient off-load delays - wall time. This will allow measurement of this problem. A

workgroup to establish these regulations has already been set up by the State. In the meanwhile, the County will establish its own definition of wall time. Currently, there are reports of excessive wall time, but no data.

- **Question posed by PHAB:**
  We know many ERs gather data on specific quality measures. Does our EMS Agency
  measure patient care quality indicators with regard to (1) trauma, (2) STEMI, (3) stroke, (4) pediatrics, (5) people who leave AMA either on scene or upon arrival at the ER, or (6) mental health patients? Have there been efforts at quality improvement? Can you tell us how that is tracked?

  - Not yet tracked in a uniform way. All the providers will be getting on the same reporting system. Starting January 1, 2017, data on these calls will be collected. Also, special data on STEMI, stroke, pediatrics will be reported.

  - In June, approval was given for a quality improvement plan for emergency services. The technical advisory group has met once. It consists of multiple stakeholders. An new administrator has been hired by the County to handle quality assurance. State has asked counties to report on 24 different quality indicators.

  - The EMS Agency personnel are fairly new, and there has been a steep learning curve. Oversight and regulation are also new to providers in this county. The update of the 1998 MCI plan is being done at the county level. Eventually it may be extended to the entire Region 4. This would be at the discretion of the state EMS Authority.

	○ During the question and answer period, it was pointed out that a significant number of Sacramento County hospital and psych hospital beds are taken up by non-County patients. They are often brought to Sacramento by law enforcement from other counties, especially Yolo County.
Public Health Division Update	• Zika: Per CDPH, there are total of 6 CDC confirmed cases in the state of California. They are all travel-associated cases, none locally acquired. No cases in Sacramento County. CDPH and CDC have a dedicated Zika page with information from travel advisory to information on laboratory testing and QandA for healthcare providers. As of February 24, 2016, CDC reports 107 cases, all travel-associated in US states, none locally acquired vector-borne cases reported. However in US Territories, there is one case of travel-associated disease and 39 locally acquired cases. US territories include Puerto Rico, US Virgin Islands, and American Samoa. • Testing is recommended for: ° Pregnant women who develop clinically compatible symptoms within two weeks after travel to an affected area ° Infants or children age <18 who develop compatible symptoms within two weeks after travel to an affected area ° Asymptomatic pregnant women 2-12 weeks after travel to an affected area. • If it has been longer than 12 weeks since travel, serologic testing is not recommended. • CDC travel alert remains in effect for countries in Central America, South America, the Caribbean and Mexico.

	• Varicella: Varicella outbreak in Community Outreach Academy in McClellan. Reports of cases to public health department began on February 15. As of 3.2.2016, there are 11 cases, one case serologically confirmed by PCR, others clinically diagnosed by Primary care provider or District school nurse. This is an elementary school with a total of 1230 with 65% of the students either unvaccinated or partially vaccinated. This school is traditionally known to have parent population who are resistant to vaccinating and this will be a good opportunity for education. • SB 277: California Senate Bill 277 (SB277) is a California law which removes exemptions to vaccination requirements for entry to private or public elementary or secondary schools in California, as well as child day care centers. It was passed in the California State Senate in June 2015 and signed into law by Governor Jerry Brown on June 30, 2015. • Opioid taskforce: A kick off meeting which was organized by Behavioral Health with participation from Public Health was held on February 29, 2016. Over 100 people attended and invitation is extended to you all for future meetings since opioid epidemic is affecting all ages including youth. In middle of 2015, OxyContin use was approved by FDA for children as young as age 11 to 16. Since history of opioid use put a person 40 times at risk for heroin addiction, our efforts shall also include children.
Action Topic: Needle Exchange Update Report from Human Services Coordinating Council Next Steps	• Dr. Orkand met with the Human Services Coordinating Council on September 11. This group consists of representatives from a number of other County Boards and Committees. Unlike the Alcohol and Drug Advisory Board, this group has representatives with very diverse interests. Dr. Orkand was surprised, however, at the level of sophistication regarding IV drug abuse, addiction, and related issues.

	• Dr. Orkand presented our preliminary recommendations in the context of harm reduction. The concept is that we recognize the intrinsic risks of injectable drug use, and we don't condone that behavior. However, we don't want people to die or to have unnecessary morbidity. That is why we want drug users to exchange dirty needles for clean ones. We also want to get dirty syringes off the streets, out of the parks and school yards. We see this as a public safety issue. • Given that philosophy, a couple of people wondered if we would consider sponsoring safe locales where people could inject drugs and be under observation for possible OD. This is apparently the model in Amsterdam, where there is a park that serves that purpose. It was pointed out, however, that drug injectors spend quite a bit of time in these places, and that was unlikely to be acceptable to any of our neighborhoods. • Another Council member pointed out that many municipalities are starting to control the number of medical marijuana dispensaries, and wondered if a needle exchange site would somehow be a conflict. Dr. Orkand was unaware of any conflicts. • Someone wondered what we would do if a 14 year-old showed up to exchange needles at our clinic. Dr. Orkand since found that these clinics are legally restricted to age 18 and older. Someone who works in a harm reduction clinic, however, admitted that they sometimes have "trouble" recognizing the age of their clients. Their goal is harm reduction, and that would apply at any age. • Finally, it was suggested that future presentations contain more hard data. It was also suggested that I take this presentation to community groups for their assessment. • After discussion, the HSCC approved our recommendations unanimously.

	Next Steps • We need to consider next steps in our investigation. Dr. Heller has been trying to make contact within the Sheriff's Dept, and I appreciate that. I am told that the Sheriff's Dept also has an advisory board, and that this may be a logical next step.
Report from Opioid Task Force	• The Opioid Task Force was convened on February 29 by Sacramento County Behavioral Health Services, Alcohol and Drug Services, and Public Health. The group is very large, consisting of local substance abuse and mental health treatment providers, members of the health community, people in recovery, and family members of those struggling with addiction. • Dr. Kasirye provided background information about the scope of the problem, how the opioid task force as developed, prevention strategies, a description of local treatment resources and collaborations, a description of current challenges, and finally a call to action. • Those present broke up into smaller groups for more detailed discussion of our concerns. There were initial efforts to form working sub-committees. • The follow-up meeting will be on March 21, 2016.
Public Comments	No comments
Adjourn	Meeting ended at 1:33pm