APPROVED

COUNTY OF LOS ANGELES
PUBLIC HEALTH COMMISSION
FEBRUARY 14, 2013
MINUTES

COMMISSIONERS

Patrick Dowling, M.D., M.P.H., Chairperson*
Jean G. Champommier, Ph.D., Vice-Chair*
Waleed W. Shindy M.D., M.P.H.*
Michelle Anne Bholat, M.D., M.P.H. **

DEPARTMENT OF HEALTH SERVICES REPRESENTATIVE

Jonathan E. Fielding, Director of Public Health and Health Officer***

Angela Haley, Secretary*
Public Health Commission

PUBLIC HEALTH COMMISSION ADVISOR
Cynthia Harding, Acting Chief Deputy**
Public Health

PUBLIC HEALTH COMMISSION YOUTH ADVISOR
Vacant

***Present** ****Excused** *****Absent**

TOPIC	DISCUSSION/FINDINGS	RECOMMENDATION/ACTION/ FOLLOW-UP
I. CALL TO ORDER	*The meeting was called to order at approximately 10:13 a.m. by Chairperson Dowling at Public Health Administration.*	*Information only.*

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II. ANNOUNCEMENTS & INTRODUCTIONS	*Introductions of Commissioners and guests were conducted.*	*Information only.*
III. APPROVAL OF MINUTES	*The 1-10-13 & 1-24-13 minutes will be approved when Commissioner Bholat is present.*	

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TOPIC	DISCUSSION/FINDINGS	RECOMMENDATION/ACTION/ FOLLOW-UP
IV. PUBLIC HEALTH REPORT	*Carrie Brumfield provided the Commission with a Public Health Report and discussed public health activities since the last report on January 24, 2013.* ***Proposed Los Angeles (L.A.) City Ballot Initiative – "Public Health Protection Act"*** *Ms. Brumfield distributed and discussed a memo from Dr. Fielding to the Board of Supervisors informing them of the proposed ballot initiative for L.A. City to secede from L.A. County Department of Public Health. The proponents of the proposed ballot initiative, titled the "Public Health Protection Act," include Michael Weinstein, President of the AIDS Healthcare Foundation (AHF). The Department is currently reviewing the text of the proposed ballot initiative with County Counsel and the CEO in order to understand the impact such a measure would have upon the County of Los Angeles if voted in.* *In addition, on Sunday, January 27, 2013, an advertisement from AHF was placed in a number of local newspapers including the Daily News and the Pasadena Star News. AHF also issued a nation-wide press release.*	

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IV. PUBLIC HEALTH REPORT CONTINUED	*Ms. Brumfield indicated that the Department is in a holding pattern on this, and are investigating how much it would cost the city if they were to do this. The Department is keeping an eye on how the proposed initiative unfolds.* ***DPH and Health Care Reform*** *Ms. Brumfield distributed and discussed a memo from Dr. Fielding to DPH employees regarding DPH and Health Care Reform. The Affordable Care Act (ACA) provides DPH with a major opportunity to improve population health. The ACA established the National Prevention Strategy, which aims to increase the number of Americans who are healthy at every stage of life, and to move from a focus on sickness and disease to one based on prevention and wellness. One example of DPH's involvement in implementing the National Prevention Strategy is our $10 million Community Transformation Grant, which funds community-focused initiatives to prevent chronic disease and reduce disparities in L.A. County. DPH will also be relied upon for expertise in promoting quality assurance among providers in order to improve health outcomes.*	

TOPIC	DISCUSSION/FINDINGS	RECOMMENDATION/ACTION/ FOLLOW-UP
V. CHILD HEALTH & DISABILITY PREVENTION (CHDP) PROGRAM	*Dr. Joseph Duke, Director, Child Health & Disability Prevention (CHDP) Program provided the Commission with an overview of the activities within CHDP Program. Dr. Duke introduced Cheri Stabell, Program Director, CHDP, who explained the documents/forms in the CHDP packet.* ***CHDP Program Overview*** • *Provides free, comprehensive, well-child exams for low-income children* • *Develops, supports, and monitors a network of CHDP providers* • *Coordinates follow-up care for conditions found during well-child exams* • *Providers evaluation of health care status for children in foster care* ***History of CHDP Program*** • *1967: Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program was created by Congress.* • *1973: AB2068 created CHDP in California* • *1989: AB 75 (Prop 99 legislation) CHDP services became available to low-income non-Medi-Cal children*	

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V. CHDP PROGRAM CONTINUED	• *2000: Health Care Program for Children in Foster Care (HCPFC) established under CHDP Program* • *2003: CHDP Gateway process implemented Providers began pre-enrolling children into temporary Medi-Cal* • *2003: Standardized provider enrollment process and performance measures implemented statewide* ***Eligible Population*** • *Medi-Cal eligible children and youth from birth to 21* • *Non-Medi-Cal children and youth from low income families from birth to age 19* • *Children in foster care* ***Funding*** • *Federal Medicaid funds for Medi-Cal eligible population* • *State general funds for uninsured low-income population*	

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V. CHDP PROGRAM CONTINUED	***Accessing CHDP Healthcare Services*** • *DPSS Referrals (PM 357)* • *Public Access through: website* • *Other Agencies* ***Client/Provider Relations (CPR) Unit*** • *Responsible for the federally mandated intensive informing of the Medi-Cal eligible population* • *Receives an average of 5,000-6,000 PM 357 referrals from DPSS every month* • *Provides CHDP information and provider referrals* • *Assists provider office staff and the general public* ***CPR Unit Activities FY 2011-2012*** *# of PM 357s Received* *73,462* *# of letters Sent* *73,462* *% of PM 357s Completed* *11%* ***Criteria For Becoming a CHDP Provider*** • *Physicians: Board Certified Pediatrics, Family Practice or Internal Medicine*	

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V. CHDP PROGRAM CONTINUED	• *Nurse Practitioners: Certified Family or Pediatric Nurse Practitioner* • *Physician Assistants: 600 hours of supervised pediatric clinical experience by a Board Certified Physician* • *Pass the CHDP credentialing and site approval process* ***CHDP Provider Responsibilities*** • *Enroll patients into CHDP Gateway* • *Perform well-child examinations* • *Arrange for follow-up care on any conditions found during examination* ***CHDP Gateway Process*** • *Implemented July 1, 2003* • *Process to use CHDP as a Gateway for families to gain entrance into Medi-Cal and Healthy Families insurance programs* • *Children may be pre-enrolled in temporary Medi-Cal for up to two months* • *If requested family will receive a Medi-Cal application in the mail* ***The CHDP Exam (PM 160)*** • *Head to Toe Unclothed Exam*	

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V.CHDP PROGRAM CONTINUED	• *Vision, Hearing and Dental Screening* • *Nutritional Assessment* • *Immunizations* • *Tests for Glucose Level, Anemia, Lead, etc.* • *Anticipatory Guidance* ***CHDP Exam Follow-Up*** • *Children with no insurance are referred to a County facility or a community partner contractor* • *Children in a Medi-Cal managed care plan must seek follow-up care through their plan* • *Children who have temporary Medi-Cal through the CHDP Gateway process can see any Medi-Cal doctor* ***CHDP Provider Site Approval*** • *Certify new applicants using a facility review and medical record audit tool* • *Conduct re-approval of provider sites on a recurring three year schedule* • *Provide focused in-services to assure program compliance*	

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V.CHDP PROGRAM CONTINUED	***Audiometric Screening Training FY 2011-2012*** • *Project assigned to Health Education began in April 2008 to help increase the quality of Audiometric screening among CHDP Providers* • *Partners LAUSD audiometrists & Head Start Staff: 26 Workshops, 434 Attendees, & 23% of sites* • *Re-certification training* ***CHDP Complaint Process*** • *External: Public can call (800) 993-CHDP to make a complaint* • *Internal: CHDP Program Staff conducts visit and evaluates complaint* • *Demonstration & Follow-up* ***Investigative Outcomes FY 2011-2012*** • *34 Sites Disenrolled* • *20 Voluntary Disenrollment* • *14 Programmatic* • *7 Program Non-Complance* • *4 Closed Office Without Notification* • *2 Medi-Cal inactivation* • *1 No (Vaccine for Children) VFC*	

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V.CHDP PROGRAM CONTINUED	***Public Health Nursing Care Coordination*** • *Public Health Nurses (PHNs) promote appropriate access to medical care and support services for CHDP patients by reviewing PM 160s* • *PHNs assist providers and families children with further diagnosis and treatment of problems found during a CHDP exam* • *PHNs ensure that families have and keep follow-up appointments* ***CHDP Program Successes*** • *AST re-certification initiated* • *Collaboration with L.A. County Tuberculosis Control Program* • *Renewal basic informing IAA* • *Expansion of physician staff training* • *Development of WHO Growth Chart training* • *Electronic transmission of provider updates* ***CHDP Program Challenges*** • *Timely coordination of care* • *Adequate referral resources* • *Reliance on paper copies of PM 160s* • *Expanding outreach to all families referred by DPSS* • *Maintaining oversight of provider network*	

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V.CHDP PROGRAM CONTINUED	***HCPCFC*** • *HCPCFC established in 2000 as part of the CHDP Program* • *Children in the L.A. County foster care system are Medi-Cal eligible* • *The PHN staff are housed in DCFS and Probation offices throughout L.A. County* • *PHNs collaborate with the child's social worker or probation officer to ensure that the child receives appropriate health care services* ***HCPCFC Program Challenges*** • *Extension of services to all foster care children to age 21* • *Integration of Pasadena and Long Beach Foster Care caseload* • *Request for increased documentation* ***Addressing Program Challenges*** • *Enhance referral process from CSWs* • *Ensure timely data entry in CWS/CMS* • *Redistribute staff to match caseload*	

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V. CHDP PROGRAM CONTINUED	*Vice-Chairperson Champommier asked Ms. Stabell how does CHDP relationship works with the medical hub in terms of follow-up. Ms. Stabell indicated that the PHN gets the information that they need to address regarding the child's health from medical personnel instead of having to wait on the social worker.* *Commissioner Shindy asked what's the average time that it takes for the unit operator to complete the referrals. Ms. Stabell indicated it takes an average of five minutes.* *Commissioner Shindy indicated he is surprised that vision and dental are the first and second most common reported conditions for CHDP patients. Especially, with the issue of obesity being a huge problem with kids. Ms. Stabell indicated that the nutritionist is specifically going out to conduct trainings for BMI and information is being reported accurately on the PM 160. Dr. Duke stated that in many offices, physicians and their staff, are not accurately reporting the BMI, and not using growth charts, and when we find these issues, we're looking at them systematically. Dr. Duke indicated that CHDP is in the process of implementing a new growth chart for the physicians to use as a guideline to report conditions, such as, obesity.*	*Chairperson Dowling asked is there a problem finding dentists for the CHDP Program. Ms. Stabell indicated yes, and also optometrists and ophthalmologists.* *The Commission thanked Dr. Duke and Ms. Stabell for their presentation.*

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VI. CALIFORNIA CHILDREN'S SERVICES (CCS)	*Dr. Edward Bloch, Medical Director, Children's Medical Services (CCS), provided the Commission with an update of activities within CCS.* ***CCs Administration and CCS Workload*** *After the drastic budget and staffing cuts of 2008-2009, L.A. County CCS has experienced a period of relative stability during the last four years. Although there have been a number of major changes in the State CCS Program, there have been very few changes in the CMS/CCS Executive Team, and there have been very few significant policy changes affecting CCS case management for its population of eligible infants, children, adolescents, and young adults with specifically defined special health care needs, as mandated by Title V of the (Federal) Social Security Act of 1935 and defined in California law (Robert W. Crown Act in the California Health and Safety Code and in the CCS Subdivision of the California Code of Regulations, Title 22). The CCS Program's active caseload has remained at approximately fifty thousand, while the State-defined workload has remained stable at around seventy-five thousand cases per year.*	

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VI.CCS CONTINUED	*CCS "Sub-Programs" such as the Medical Therapy Program (providing "hands-on" occupational and physical therapy and related services, in nearly thirty public school units in the county), the High Risk Infant Follow-Up Program (providing specific types of evaluations for at least two years following CCS authorized neonatal intensive care for certain premature or sick full time newborns), Orthodontic services for non-Medi-Cal beneficiaries with "handicapping malocclusion," the Newborn Hearing Screening Program, and the Metabolic Disorders Screening Program, to name a few important areas that go beyond the CCS "General Program." CCS also continues to serve as a regulatory agency to assure that its State-approved providers and facilities meet the highest standards (well above the quality threshold required by Medi-Cal or that of any managed care plan or other insurance entity).* *The apparent stability of the past few years is, however, virtually certain to give way to a sweeping transformation, largely as outlined in broad strokes, below. There is tremendous uncertainty in the details that will emerge during the next several months, which will be crucial to the CCS Program*	

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VI.CCS CONTINUED	*and its network of medical specialists and Special Care Centers, and more importantly, to the children and families served by the program. We have hope that the most important parts of the program (those that are unlikely to be carried forward by health care providers and managed care plans in the absence of CCS oversight) will be preserved.* ***New Issues and New Projects:*** *There are a number of quite recent laws and policies that are just now beginning to take effect, which are almost entirely overshadowed by the Affordable Care Act (ACA), along with its companion legislation in California, which must begin implementation during this year, but which has yet to be sufficiently interpreted (and comprehended, in my opinion) to allow for the kind of simplified and universal system intended by this law. It is becoming increasingly apparent that true simplification may not be possible, given the complexity of the existing healthcare delivery system and given the complex, intertwined and often "cross-purposed" pieces that must fit together in any new (ACA-driven) healthcare environment.*	

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VI. CCS CONTINUED	*There are a number of different workgroups, at local and State levels within the government (and many others in "the industry") that are madly racing to find answers to a myriad of different unanswered questions about the ACA. L.A. County CCS is represented on several such workgroups, with the L.A. County Department of Public Health (LAC DPH) and in collaboration with the State Department of Health Care Services (in which State CCS resides), in addition to regional and statewide groups of local CCS administrators and physicians (like those discussed above).* *While we do not yet have a good idea of the final shape of the new system, especially in relation to details that will dramatically affect CCS, its partners, and the children and families it serves, we continue to push for guarantees that current critical CCS responsibilities and functions do not fall through the cracks. These critical areas include CCS' regulatory function, which (as noted above) requires that CCS oversee the clinical activities of pediatric specialists, subspecialists, hospitals and Special Care Centers within pediatric tertiary care and teaching hospitals, to assure that the highest known quality standards in the entire system of care in California are available to the population*	

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VI.CCS CONTINUED	*of children with CCS eligible catastrophic illness, chronic disease and chronic physical disabilities (i.e., the medically most fragile children with the most severe and chronically debilitating conditions). We already know that a network like the CCS-approved Special Care Center (SCC) system cannot be sustained by private industry because of the additional expense (beyond the already high cost of basic medical services for these very sick children).* *In addition to the ACA's direct effects on the CCS Program, as yet to be fully understood, there are a number of concurrent (and related) changes in our State's healthcare delivery system, with the most important as follows:* • *The termination of the Healthy Families Program (California's State Children's Health Insurance Program or S-CHIP), with a transfer of health insurance coverage to an expanded Medi-Cal (California's Medicaid) Program;* • *The expansion of Medi-Cal, and the added complexity of several new categories (with new "codes") for strata of family income above poverty level, and the use of Healthy Families-like monthly premiums for some of these categories;*	

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VI.CCS CONTINUED	• *"Covered California"—our State's version of "health exchanges," which will be placed solely in the hands of commercial insurance plans that meet the necessary criteria. It remains unclear whether children in the exchanges will be offered anything like the CCS package of benefits if they have conditions that would have met CCS eligibility criteria (in my opinion, this is extremely unlikely). It is even less clear whether it may be possible for CCS responsibilities to be "carved out" from the exchanges' responsibilities, as they are currently in Medi-Cal Managed Care (and Healthy Families). Even murkier questions involve the potential healthcare status of a child whose parents elect to pay a fine rather than choose and exchange.* ***CMS (and CCS) and the Edelman Children's Court*** *A very important new responsibility for the L.A. County Program that does not quite fit into any of the other issues discussed above is the recent reassignment of the Children's Court Pediatrician (or Pediatric Liaison), a Senior Physician-level, board certified pediatrician, into CMS, under the direct supervision of the CMS Medical Director.*	

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VI.CCS CONTINUED	*The Children's Court Pediatric Liaison had formerly been part of the L.A. County Department of Mental Health, to help advise and inform the Court and its officers (and, when necessary, the mental health professionals overseeing psychotropic drug prescriptions and all other significant mental health considerations for Court-dependent children, such as those in foster care). Over the years, it became apparent that forty to fifty percent of the children with the clearest need for pediatric expertise at the Court were also "covered" by CCS. During the same period of time, the CMS Medical Director (already a member of related committee at the Court) became increasingly involved in dealing with foster care issues, and was contacted with increasing frequency by the Court Pediatric Liaison, essentially serving as an unofficial advisor and mediator. The former transfer of supervision to the CMS Medical Director finally was accomplished in November 2012. In spite of some unanticipated issues, it is already clear that this change is leading to much greater efficiency in dealing with the health of Court-dependent children.*	*The Commission thanked Dr. Bloch for a comprehensive presentation.* *The meeting adjourned at 11:30 a.m.*