Quality and Productivity Commission

31st Annual Productivity and Quality Awards Program

“Celebrating Quality Service”

2017 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: NOVEL DELIVERY SYSTEM CLOSES HEALTHCARE GAPS

DATE OF IMPLEMENTATION/ADOPTION: **JUNE 29, 2016**
(Must have been implemented at least one year - on or before July 1, 2016)

PROJECT STATUS: x Ongoing _____ One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? _____ Yes x No

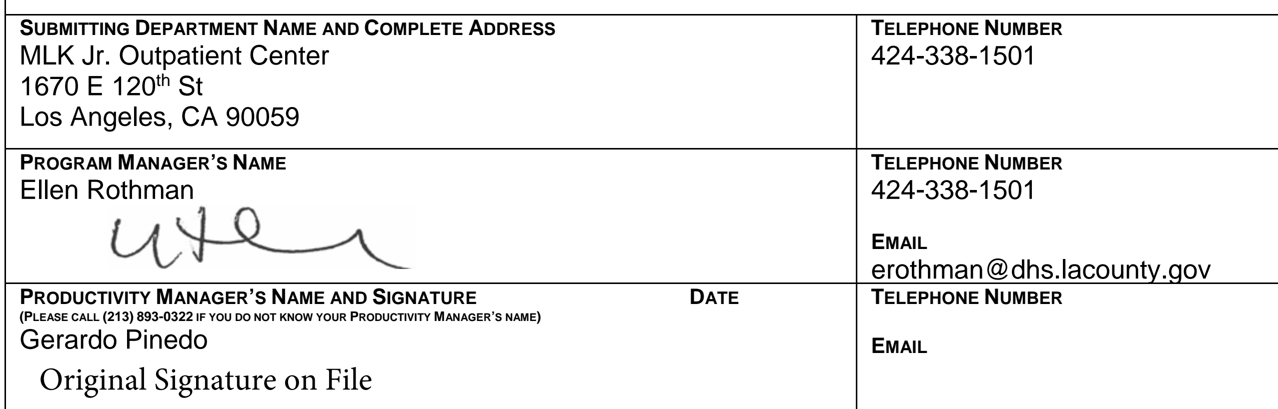
EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

1 At MLK JR Outpatient Center, we have created a novel approach to healthcare delivery
2 that offers comprehensive, patient-centered care to close gaps in access to quality
3 substance use disorder treatment and access to therapy for adults with the genetic
4 disorder Sickle Cell Disease. Our model combines primary care, specialty care, mental
5 health, peer navigation, and complementary health (acupuncture and yoga) in a single
6 location to meet the needs of complex patients rather than sending patients to multiple
7 clinics in various settings. Partnerships with DMH and non-profit organizations leverage
8 community resources to provide fiscally efficient, co-located services. Like the rest of
9 the nation, South LA has experienced epidemic increase in death and hospitalization
10 from opiate abuse, as well as methamphetamines and other recreational drugs. Our
11 clinic was the focus of attention for a recent visit from Senator Kamala Harris to promote
12 her War on Drug Addiction. The Sickle Cell program is the only local, public program to
13 meet the needs of adults who are missing access to basic medications and vaccines to
14 keep them healthy. Our Advanced Practice Medical Home fulfills the LA County
15 strategic goal to Make Investments that Transform Lives.

BENEFITS TO THE COUNTY

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED ANNUAL REVENUE	(1) + (2) + (3) = TOTAL **ANNUAL** ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$	$		$	X☐

ANNUAL = 12 MONTHS ONLY



SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS	**TELEPHONE NUMBER**
MLK Jr. Outpatient Center 1670 E 120th St Los Angeles, CA 90059	424-338-1501
PROGRAM MANAGER’S NAME Ellen Rothman	**TELEPHONE NUMBER** 424-338-1501 **EMAIL** erothman@dhs.lacounty.gov
PRODUCTIVITY MANAGER’S NAME AND SIGNATURE **DATE** (PLEASE CALL (213) 893-0322 IF YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER’S NAME) Gerardo Pinedo Original Signature on File	**TELEPHONE NUMBER** **EMAIL**

We Support Plain Language

Quality and Productivity Commission

31st Annual Productivity and Quality Awards Program

"Celebrating Quality Service"

2017 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: NOVEL DELIVERY SYSTEM CLOSES HEALTHCARE GAPS

DEPARTMENT HEAD'S NAME AND SIGNATURE MITCH ELL H. KATZ, MD Original Signature on File	DATE	TELEPHONE NUMBER

We Support Plain Language

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):
NAME OF PROJECT: NOVEL DELIVERY SYSTEM CLOSES HEALTHCARE GAPS

1st FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project. What quality and/or productivity-related outcome(s) has the project achieved? Provide measures of success. Use Arial 12 point font.

Challenges:

The MLK Campus offers a wealth of resources to low-income residents of South Los Angeles. From robust mental health services, to inpatient care, to a wealth of primary and specialty care ambulatory services at the MLK Outpatient Center. Despite the wealth of services already available, we noted that there were two distinct gaps. Los Angeles County is home to approximately 1000 adults living with sickle cell disease, a rare heritable disorder that causes chronic pain and early death, with a concentration of adults residing in the area surrounding MLK Campus. Yet there was no public clinic in the area to meet the complex health needs of these adults. Additionally, the epidemic of opiate addiction and substance use has impacted the surrounding communities, but the campus lacked a robust substance use disorder treatment opportunity.

Solutions:

Our experience with prior co-location projects with Mental Health demonstrated the power of organizing services in the same location, affording ease of access for patients and ease of communication for health care providers. The patient-centered medical home model, implemented in 2011 in our primary care clinics, offered data-based evidence of the power of team-based, coordinated care to achieve improved health outcomes. We decided to expand the concept of the patient-centered medical home to combine primary and specialty care in the same physical setting. Partnership with campus and community-based partners allowed us to add mental health services, peer navigators, community health workers, and complementary health services like weekly yoga and acupuncture.

The clinics required expanding the skillset of our existing DHS clinical teams, and we spent the winter and spring of 2016 defining the needs, planning for staffing, and working with partners to develop co-locations. In June of 2016, we began a training series for our staff that culminated with a mock clinic. In June of 2016, we completed light renovations on a clinical space to house the two new clinics. In August, we were ready to open our doors.

Our initial experience with this unique and collaborative delivery model has been very exciting. Creative collaboration from partnering organizations offers a holistic approach to management of complex illness with reduced duplication of services and provide a "one-stop shop" experience for patients.

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: NOVEL DELIVERY SYSTEM CLOSES HEALTHCARE GAPS

2nd FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project. What quality and/or productivity-related outcome(s) has the project achieved? Provide measures of success. Use Arial 12 point font.

Benefits:

Clinic for Adults with Sickle Cell Disease:

The Sickle Cell clinic operates two days per week and includes a primary care nurse practitioner, a hematologist, a DMH social worker, acupuncture, community health worker. Partners include community-based organizations Sickle Cell Disease Foundation of Southern California and Center for Inherited Blood Disorders.

Adults with SCD have suffered from a lack of knowledgeable primary and specialty care providers in Southern California. As a result, the lifespan of adults in this community is lower than the national average. Our first cohort of patients is notable for health complications due to lack of coordinated, preventive services. One patient has undergone liver transplant from failure caused by iron overload from transfusions without chelation to remove the excess iron from the body, a preventable condition, and two more also had evidence of iron overload though not nearly as extreme. All patients were missing one or more immunization. Most patients were on a simplified pain control regimen limited to opiates only, without ibuprofen or complementary therapies. Several had not been prescribed hydroxyurea, the most effective therapy for sickle cell available.

Specifically, as of June 2017, we have seen 23 patients. One third of the patients had no care other than ED or inpatient care for the 12 months preceding their first visit to our clinic. 100% of the patients had not been immunized appropriately(hepatitis B, tetanus,pneumovax,meningitis,seasonal flu, HPV).Three patients are severely iron overloaded due to multiple transfusions as inpatients with no hematology follow-up to address chelation issues. One of those patients required a liver transplant due to iron overload. Forty percent of the patients (9 patients) seen were eligible for Hydroxyurea but were not on the drug. Four patients (17%) were on the drug but were non-compliant or poorly managed with episodes of neutropenia. Of those 13 patients, 11 are on HU with good compliance and excellent monitoring of labs since coming to clinic.

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):
NAME OF PROJECT: NOVEL DELIVERY SYSTEM CLOSES HEALTHCARE GAPS

3rd FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project. What quality and/or productivity-related outcome(s) has the project achieved? Provide measures of success. Use Arial 12 point font.

1st FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project. What quality and/or productivity-related
Challenges:

Haven Clinic for Substance Use Disorder Treatment
Challenges for this clinic have mainly been in regards to recruitment and retention of patients. Opiates do not seem to be a problem in our community though are problematic in other areas of LA County. Unfortunately we have not been able to successfully recruit these patients. Our current services are targeted at treatment of those suffering from alcohol use disorder (AUD) and opioid use disorder (OUD). Other recreational drugs are being used in our community and we are not able to provide services for these and many patients who do qualify for services are not interested in sobriety. We also still struggle to identify a substance use counselor who can meet with patients during their visit and provide 1:1 counseling services.

Benefits:
Haven Clinic for Substance Use Disorder Treatment
This clinic also operates two days per week and includes a primary care nurse practitioner, a physician able to prescribe medication-assisted therapies, integrated behavioral health from DMH, acupuncture, yoga, and community health worker. We are hoping to add a co-located substance abuse counselor in July 2017 when the new Medicaid waiver for this service becomes active.
This clinic had an additional specific challenge because the DHS formulary did not include suboxone, a newer agent that is safer than methadone to manage opiate withdrawal, or naloxone, the opiate antidote. Work through various committees was required in the year leading up to the launch of this clinic to get access to suboxone and naloxone on formulary. They became available for prescribing in January 2017.
We began the clinic with two referrals, but in the month of May alone, we had 40 referrals for services. Participants have access to suboxone, naloxone, and vivitrol (an agent to support alcohol users). Providing AUD and OUD patients' easier access to medication assistance for their disorders. Though DHS still remains unable to carry Vivitrol we have been working with a local pharmacy which can fill the Vivitrol prescriptions and provide delivery of it to patients' homes. Our services have touched the lives of patients from various economic and educational backgrounds along with those of varying ages. Our youngest patient is age 20 while our oldest is in their sixties. Some of these patients have had formalized college education while others lack a GED. We are additionally able to serve patients suffering from these disorders that are receiving short term housing at out collated Recuperative care center. Some of these patients have been chronically homeless and have been without access to basic medical care and this is the first time their substance use has been addressed.

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: NOVEL DELIVERY SYSTEM CLOSES HEALTHCARE GAPS

Linkage to the County Strategic Plan – 1 page only. Which County Strategic Plan goal(s) does this project address? Explain how. Use Arial 12 point font.

GOAL I. Make investments that transform lives through Strategy I.2 Enhance Our Delivery of Comprehensive Interventions

This innovative service delivery model addresses the County Strategic Plan to Make Investments that Transform Lives. We identified a gap in services for two important patient populations, adults living with sickle cell disease and adults living with substance use disorder. We developed a fiscally sustainable, efficient, and patient-centered model to reorganize existing services into a single location of care based on experience with evidence-based programs including integrated behavioral health and the patient-centered medical home. We established partnerships with other County departments as well as community-based organizations to gain access to the skill and resources traditionally delivered outside of DHS. This innovative strategy offers patients a holistic, integrated experience, but it also builds stronger and more effective communication between our clinicians who deliver the health services.

31st Annual Productivity and Quality Awards Program

"Celebrating Quality Service"

2017 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: NOVEL DELIVERY SYSTEM CLOSES HEALTHCARE GAPS

COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFITS TO THE COUNTY): If you are claiming cost benefits, include a calculation on this page. Please indicate whether these benefits apply in total or on a per unit basis, e.g., per capita, per transaction, per case, etc. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12 point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes. Please indicate whether these are costs to the County or to other entities.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes. Please indicate whether these were expenditures by the County or by other entities.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED ANNUAL REVENUE	(1) + (2) + (3) TOTAL ANNUAL ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$	$		$	X☐

ANNUAL= 12 MONTHS ONLY

We Support Plain Language