**REASONS FOR MEETING**

1. Provide an update from the perspective of the Director of the Department of Mental Health.
2. Provide introduction into the Department’s MHSA 3 Year Program and Expenditure Plan.
3. Provide an update on the Health Agency.
4. Provide MHSA related updates.

**MEETING NOTES**

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| **Department of Mental Health Update****Department of Mental Health Update****(Cont.)****Department of Mental Health Update****(Cont.)****Department of Mental Health Update****(Cont.)** | **Dr. Robin Kay, Acting Director, County of Los Angeles, Department of Mental Health**Fiscal Year 15-16 closed with a slight surplus which is 3rd or 4th year of good economic health. **Jail Diversion**Biggest challenge is capacity issue in area of Enhanced Residential Programs and Full Service Partnership slots.**Tracking FSP slots**At this point Adult and Older Adult are at about 95% enrollment. Since any given point, at least 5% of the slots are dedicated to outreach and engagement, we are at full capacity. The only room we have is what comes at transitioning FSP clients into FCCS or Wellness Centers.**Residential Programs** We are at capacity. We are working with Office of Diversion and Re-Entry on the possibility of funding two (2) additional Enhanced Residential Programs. More info will come on this.**Mental Health Urgent Care Centers** We have four (4) new ones. The vendor that agreed to implement the Mental Health Urgent Care Center in Antelope Valley has backed away from their proposal. We identified another entity but it’s in process of being worked on. DMH is getting ready to go to the Board to get authorization to enter into contracts with the other three (3) selected providers. DMH is finalizing the sites except the one (1) in Harbor-UCLA which is final. DMH is hoping that for San Gabriel-Pomona site and Long Beach site we will have something by next month.**Crisis Residential Treatment Program** DMH is completing the scoring for the RFS. We could have up to 21 new Crisis Residential Treatment Programs, if the scoring comes out ok. They are complicated programs from perspective of contracting and going to Board because they involve two (2) components (Capital Facilities component and Service components). Over the last year we have implemented 24 new law enforcement teams with 24 different cities. We are working with the District Attorney and Office of Diversion and Re-entry.**Prop 47**While other County Departments have seen a decrease in work load or cost (as individuals who had their sentences converted, are back in main stream and new individuals aren’t convicted under Prop 47 for felony charges), DMH has had an increase in the number of clients we see under Prop 47. Hard to attached dollar figure because clients don’t identify as presenting for services due to Prop 47. When we do assessments, we recognize that we are seeing more people because they are justice involved. We are working with LA 211 and Public Defenders Office to see if they have information they can provide to us, which is limited because of confidentiality restrictions. We are trying to quantify the impact on Mental Health to report to the Board at the end of the month because initially the money freed up from the State Criminal Justice System was to be transferred to the counties for mental health, substance abuse and educational purposes, and we have yet to see the funding. **Child Welfare**We continue to roll out the Core Practice Model for Katie A, and Continuum of Care Reform (CCR). The legislature didn’t appropriate any funding for mental health beyond a tiny amount in this year’s budget as a placeholder. This will present a huge challenge for us as we move the existing group homes from their traditional model to becoming Short Term Residential and Therapeutic Programs beginning in January, as we contract with Foster Family Agencies to find foster families that can provide mental health services in their homes for foster care children who need mental health services. By January, counties need to make effort to show that they moving in this direction.**Certified Community Behavioral Health Centers (CCBHC)**Los Angeles County has submitted an application on behalf of one provider that meets all requirements. A second provider submitted their application directly to the State so we are not sure the application will be considered. If we don’t make it in we will use the experience as to get us ready for the future. We are learning what the future will look like both in terms of integrated service delivery and payment reform.**Homelessness**We continue to participate in all of the County initiatives. In the last year; we have opened new residential buildings, increased our federal vouchers through a collaborative grant that, Maria Funk and the Department, shared with DHS. We challenged county directly operated programs to increase the number of vouchers they obtained on the part of clients by 10%. We increased the number of vouchers we got by 58% last year. We just need to find housing to go with the vouchers in the upcoming year.**Discussion, Q&A*** We are averaging 57% success rate on FSP. What kind of quality assurance or improvements is being done to increase that success rate?
* Response from Debbie Innes-Gomberg – Data shows we are having more success. In last two (2) months we added two (2) more comparison columns based on local OMA data and analyses. We will review that report with the SLT as part of the 3 year plan process. In addition, the Mental Health Commission requested FSP data by service area twice a year. Those reports can be used at SAAC level for Quality Improvement.
* Response from Dr. Kay – We have number of new programs this year the MITS, Multi-Agency Homeless Teams, SB82 teams. We are trying to figure out how to convey data that is constantly moving. The new programs we have are successful but need to age before we can show complete data
* Can DMH get together and find out what’s going out with Prop 47 funding?
* Response from Dr. Kay – CEO and the Auditor Controller are following to identify those funds. First step is to make sure the departments can quantify what the additional cost has been to the county. The estimate of initial saving at State level from State’s perspective has been overstated. We are working with LA 211 to get the information.
* Now that there is a Drug Medi-Cal waiver, how is the department working with SAPSI, to fund co-occurring disorders in one place?
* Response from Dr. Kay –DMH is working with SAPSI on 2 levels. Dr. Shaner is spearheading this effort. The Department is looking at the directly operated programs, at persuading Drug-Medi-Cal certification which would enable us to expand the services we are able to offer. We are looking at what our role might be with contract agencies that have not yet submitted applications for Drug-Medi-Cal certification. We are working on design of Enriched Residential Program to be funded under the Drug-Medi-Cal Waiver where Mental Health would be patched in (Programs primary on substance abuse side where mental health would be funded through a patch. Substance abuse providers aren’t limited by IMD exclusion that only applies to Mental Health).
* Cross training is huge.
* Response from Dr. Kay – We are working on a training that we will address next month.
* How can we help children get Mental Health services in the Child Welfare System?
* Response from Dr. Kay – As we move closer to CCR implementation, there is a tremendous amount of anxiety whether or not County Mental Health Departments have the capacity and readiness to do what we need to do. In Los Angeles, we have the capacity and expertise, the stress for us is going to be the contracting and relationships we need to establish with new providers. The information we are getting from the State, DHCS and California Department of Social Services (CDSS) regarding CCR requirements varies, depending who you ask.
* Will the State give us the money that we need to efficiently implement CCR?
* Response from Dr. Kay – There are two (2) pieces to CCR expansion. There is service delivery piece which is mostly going to be funded with EPSDT. To stress there is the local match portion of the EPSDT, which the State said they going to provide to us after we provide the service. On the administrative and training side, there is a timing and capacity issue which isn’t resolved. We are going to Sacramento constantly to work with CDSS, DHCS and the Department of Finance.
* How are we addressing the needs of children not in DCFS?
* Response from Dr. Kay:
1. We are there in terms of PEI. We should think about future presentation by Bryan Mershon (in terms of PEI) and Robert Byrd (in terms of school).
2. INN 2: is for kids/preschool programs and children of school ages.
* With DMH funding is there any money going to the temporary shelters?
* Response from Dr. Kay – We invest MHSA money in Shelter Beds for Adults and our Enhanced Sheltered Programs for TAY. Also, we are always looking for new shelter providers. The issue is in the area of Transitional Residential Programs where HUD’s emphasis on permanent supporting houses has come at expense of funding some of the transitional housing (We will address it next time).
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| **MHSA 3 Year Program and Expenditure Plan Process****MHSA 3 Year Program and Expenditure Plan Process** **(Cont.)** | **Debbie Innes-Gomberg Ph.D., Program Manager III, MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health*** MHSA 3 Year Program and Expenditure Plan-This is our 3rd Plan: 1st one was related to different components of MHSA, 2nd one was CSS expansion. (We did 30-30-30 and we are going to talk about status of those investments.)
* MHSA requires counties to do a 3 Year Program and Expenditure Plan and annual updates to those Plans. We are going to build on what we have learned in the last 10 years, as well look at future priorities and mandates. We going to review the key focal populations for clients served in CSS and PEI to determine whether there are focal populations that need to be added. We also will be identifying ethnic and cultural disparities in mental health care and strategies to address those disparities.
* This 3 Year Plan is going to be divided into several components:
* CSS Work Plan consolidation:
	+ Review outcomes across CSS programs and establish benchmarks as part of a quality improvement process.
* Review investments made in Workforce Education and Training (WET) as well as technological needs or the IT Plan to determine the need/value of continuing investment.
* PEI program modification. The initial plan approved in 2009 included 13 higher level programs, with Evidence-Based, Promising and Community Defined Practices associated with each program. We are going to take a look at consolidating those programs into seven (7) without eliminating any practices. It might broaden the services and make it easier for department to report progress of services to the State.
* Sign in sheets for Adult, Older Adult, TAY and Child CSS consolidation Work Groups are at the sign-in table. Issues to be addressed:
* Method for determining the percent or amount of Field Capable Clinical Services that will migrate to FSP.
* Identify an approach to establishing levels of care for each age group.
* Establish outcomes for the service continuum for each age group with the goal to have outcomes that transcend programs within age groups, so when a person moves along in the recovery you can measure that progress.
* Time Line:
* August: Review planning and overview as well as relevant program data.
* September: CSS Work Plan consolidation in detail. Each age group’s non- FSP plan is going to be different.
* October: We will report on CSS and PEI work group progress. Will look at unspent funds for CSS and PEI.
* November: We will bring the information together and put the reports together.
* December: Presentation of plan including service and outcome data for FY 15-16.
* January: Mental Health Commission will review the plan and then we will post it publicly.
* February: Public Hearing
* March: Mental Health Commission will deliberate.
* March-June: We will work on Board letter and contract amendments.

**Discussion, Q&A*** Expenditure Plan overview going from 13 to 7 means 8 programs will be impacted?
* Response from Debbie Innes-Gomberg – We are going to truncate the programs. It won’t affect the services. It will just make it easier to report to the State. Next month we will get into the programs. (Lillian Bando will get into it)
* We should start thinking about how to reduce cost and increase health outcomes.
* Are you considering workgroup for early prevention adjunct services?
* Response from Lillian Bando –right now we organizing groups by ages.
* Will work groups include people that do the work?
* Response from Debbie Innes-Gomberg – This work groups needs to be inclusive and should include people that do the work.
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| **Health Agency Update****Health Agency Update****(Cont.)****Health Agency Update****(Cont.)****Health Agency Update****(Cont.)** | **Mitchell Katz, M.D., Director, County of Los Angeles, Department of Health Services*** Looked over Focus Group minutes around integration. People understood the benefits but were unsure of the details but had openness.
* The agency has existed for 10 months, of which he has been agency director for 8 months.
* The agency is a way of working together in hopes of being more successful.
* An example of success we had is in program is in the jail, which include people that have misdemeanors but are incompetent to stand trial. Last year 180 people in this category have left jail for community restoration services.
* The results are amazing when the agency focus the efforts of three departments on same person.
* Responding East LA to Exide crisis: we sent a team that included Public Health, Health Services and Mental Health clinicians to take care of different issues people faced.
* We are working on a single consent, for patients to consent for services in three departments.
* Sees amazing services at 2 ends of "intensity spectrum". It means amazing outreach; wellness, recovery services as well as hospital and IMD based service on the far end. FSP is middle, close to outreach. Middle is addressed by small amount of residential/urgent care so we need to focus more on the middle.
* Urgent care helped. Before it all people having some form of crises had to go Psychiatric Emergency Department.
* Cruise Ship example: Utilizing the fact that many people pay to be isolated on a cruise ship due to the good food and to their benefits, could this same approach be applied to enhancing the experience of a residential care locked setting? If 30% of current people in IMD beds could make it in residential with an incredible set of services would it entice people into being there?
* We know that people with mental issues die earlier and they don’t die because of suicide. They die because of health issues. Everyone who touches DMH should get a doctor or practitioner that checks their health.
* Introduced Sandy Banks, former columnist for LA Times and current consultant for the Agency.

**Discussion, Q&A*** Would residential placement help not to take people with mental illness to jail?
* Yes, one of the purposes would be to have an alternative to jailing.
* A lot of our youth are falling through the cracks. Youth are being pushed out of schools and their needs aren’t being met.
* The wellness centers in schools have been successful. Dr. Katz has been trying to expand it so family members can go there. The kids with most needs are part of the foster care system. Schools need to be the center and have positive outcomes. When it comes to kids we need to focus on full potential.
* The example of cruise ship- we should look at substance abuse, high end rehab facilities and high end sober living. Their goal is to see how much money they can make because they are providing enticements. If you look at current science especially by Dr. Candace Pert and agriculture industry, about recipients of brain and molecules in intestinal track, there is strong correlation. If we look little bit outside the box we can get good idea to working general community.
* There are number of non- profit organizations serving people with mental illnesses and children with emotional issues. Many of them pre-date DMH. The level they can contribute you need to have better dialog with some of them.
* What do we do when we leave these groups? What we do when we go home and we alone? We need to engage them with activities. They can’t get help if they go one to two hours to the group and just go home with no activities.
* A third of individuals with developmental disabilities have a diagnosis of mental health problems. More go undiagnosed or untreated because mental health providers are concerned, confused, and not confident in providing therapy for this people. It would be good to pay attention to this population - the under-served category.
* He has a lot of experience in this area. Both his older brother and sister are developmentally disabled. They have spent time in positive residential programs and he has seen what they talk about in all levels. He has seen positive experience of mental health providers reaching out. It’s a great area for us to work on.
* Issue concerning co-occurring mental health and developmental disabilities (and the Regional Centers).
* We need to work on that.
* We need to make sure that these locked facilities are providing the correct services and are really helping and supporting and treating people, humanly and seeing the person as a whole. What happens when they leave to community? We need to follow Dr. Kay's idea of services without walls. We need to be able to provide services to our culturally diverse populations and our underserved populations that need culturally relevant services. We need to make sure we are working with none profit organizations, the faith organizations, the schools; places were our clients come from and go to. This makes sure there is no revolving door. We need to focus on providing services without walls.
* Want to commend you for looking at broader picture in our communities. There is the issue of how are we going to pay for that. How are we addressing the state, the Board and others to support that effort? How are we going to measure the quality of outcomes from those efforts? We have different immigrant populations with different needs and cultural needs.
* We are never going to have enough money to do what we want. The challenge is how you take the money we have and do a better job by combining resources.
* We need to bring together the efforts of all three departments into cultural sensitivity. Making sure they can communicate with those that have hearing disability, have TTY machines. We need to focus on language, culture, family and understand it all.
* Peer interaction is important. People that have been in a place for a while they can introduce new comers. Meaningful activities will help as well. If someone is in acute hospital and family member wants to talk to someone in the hospital and the patient is okay with it, they should encourage the psychologist to sit down with family members. Also, we need to make sure they don’t discharge people with bus tokens and nowhere to go.
* People dealing with mental illness need a purpose. People in nursing units rely on each other and there is low absentee issue, because they know their coworkers depend on them. We will work on the hospitals because there is plenty of room for improvement.
* We are noticing the flexibility of dollars for care coordination particular for kids is a struggle. Is there any thought how we can flex dollars to integrate health and electronic records.
* Integration helps because it calls into question the ridiculous rules. Example: FQHC generally provide primary care very close in community, a lot of times to ethnic populations, so we want them to provide mental health services. If they provide that service on a different date or place they can get paid otherwise they can’t get paid.
* Finding culturally sensitive bilingual stuff is a challenge. There is a huge work force shortage. What is the Health Agency going to do to address the work force shortage? How are you going to cut down on the bureaucracy and paperwork?
* We still need expansion in the middle. Dr. Kay will follow up on your ideas of trainings.
* Response from Dr. Kay – One of the best things about the agency is the ability to share between departments what has been most successful. We have had great fortune to have WET dollars to engage people in the workforce. We have recruited thousands into the workforce through these funds. The issue we facing is what happens when the WET money goes away. There is work force development which is recruiting people into the field and making sure we are engaging people at the top of their field of expertise, not the bottom. We need to create positions for people who may be able to extend the services that some of the traditional clinicians in our program are providing. DHS is taking the lead on the Whole Person Care Initiative. There are going to be more opportunities for people that have expertise but not formal training. Looking into expanding our training academy to support providers. Also, we have thePromotores Program which this coming year will expand, so it’s not only for Spanish speaking clients.
* Multitasking isn’t doing four things at once but doing one thing that accomplishes four goals. If we get university professors to send their students to do sampling and testing, we would lower cost and have better data. Peer services are nowhere they need to be. SHARE just got grant from OSHPD, grant which is state training and development, to train Peer Workers in advanced training across the State (LA County gets 100 of those slots). Peers would get more jobs done that staff managers don’t like doing. We need more Peer Services. We need to focus on getting people to come and not put punishments for coming. We need to take the control out of the system.
* There are eight (8) Interdepartmental Work Groups but we don’t know where they are in terms of developing Work Plans. We need better way to track what is happening in Health Agency.
* We have eight (8) Work Groups. They are working on a metric so we know what we are trying to achieve. We want to increase the number of people with mental health issues that are getting great medical care. The agency is trying to enhance services by improving the coordination. He likes working with smart people like those in SLT. He is good at taking ideas and making them happen in county bureaucracy.
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| **MHSA Data Trends****MHSA Data Trends****(Cont.)****MHSA Data Trends****(Cont.)****MHSA Data Trends****(Cont.)** | **Debbie Innes-Gomberg Ph.D., Program Manager III, MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health**CSS shows steady increase of clients we have served, even in years when funding decreased or increased (FY11-12 to FY15-16).PEI shows a decrease in PEI clients from 73,000 clients to 45,000 clients. (FY 12-13 to FY 15-16). Lillian Bando will help address best use of funding and if the services the right services, if we are reaching out to the right population.CSS for Service Area 8 went from 17,496 clients (FY11-12) served to 21,043 clients (FY15-16).PEI for Service Area 8 went from 12,833 clients (FY12-13) served to 7,519 clients (FY15-16).Percentage of CSS clients served by ethnicity (119,277): Hispanics are the largest group at 41.81%, followed by African Americans at 25.32%, White at 19.75%, Asian/ Pacific Islanders (API) at 5.38%, and Native Americans at 0.65%.Percentage of PEI clients served by ethnicity (45,288): Hispanics are the largest group at 65.18%, followed by African Americans at 14.59%, White at 9.7%, Asian/ Pacific Islanders (API) at 2.64%, and Native Americans at 0.31%.There were slides that included the percentage break down of CSS and PEI.**Los Angeles County Demographics** * Analyzing this data helps develop strategies to decrease ethnic and cultural disparities.
* Data is for Year 2014 and Naga Kasarabada is working on updated data that will be reading in 1-2 month.
* Data shows that Latinos are the largest group at 48.2%, followed by Whites at 28.4%, Asian/Pacific Islanders (API) at 14.6%, African Americans at 8.6%, and Native Americans at 0.2%.
* Data shows the highest percentage of African Americans was in SA 6 (27.8%) compared to SA 7 (3.1%) with the lowest percentage. The highest percentage of Asian/Pacific Islanders was in SA 3 (28.7%) compared to SA 6 (1.9%) with the lowest percentage. The highest percentage of Latinos was in SA 7 (73.3%) compared to SA 5 (16.0%) with the lowest percentage. The highest percentage of Native Americans was in SA 1 (0.42%) compared to SA 5 and SA 6 (0.15%) with the lowest percentage.

**Percentage of Populations by Ethnicity***(Data Source :US Census Bureau, 2012.Prevelance estimates by ethnicity for 200% FPL population taken from 2011 California Health Inventory Survey(CHIS) database)** *African Americans:* they were **9%** of total population (out of 10,068,036- people in Los Angeles County), **4%** of population was below 200% FPL (Number of *African Americans* below 200% out of total population in Los Angeles County) and **8.69%** of estimated population below the 200% FPL, was in need of services (out of 336,168-people below 200% FPL that need services).
* *Asian/Pacific Islanders:* they were **15%** of total population (out of 10,068,036-people in Los Angeles County), **4%** of population was below 200% FPL (Number of *Asian/Pacific Islanders* below 200% out of total population in Los Angeles County) and **8.69%** of estimated population, was below the 200% FPL, was in need of services (out of 336,168-people below 200% FPL that need services).
* *Hispanics:* they were **48%** of total population(out of 10,068,036-people in Los Angeles County), **26%** of population was below 200% FPL (Number of *Hispanics* below 200% out of total population in Los Angeles County) and **67.89%** of estimated population below the 200% FPL, was in need of services(out of 336,168-people below 200% FPL that need services.
* *Native Americans:* they were **0.2%** of total population (out of 10,068,036-people in Los Angeles County), **0%** of populations is below 200% FPL (Number of *Native Americans* below 200% out of total population in Los Angeles County) and **0.46%** of estimated population below the 200% FPL, was in need of services (out of 336,168-people below 200% FPL that need services.
* *Whites:* they were **28%** of total population (out of 10,068,036-people in Los Angeles County), **6%** of population was below 200% FPL (Number of *Whites* below 200% out of total population in Los Angeles County) and **14.26%** of estimated population below the 200% FPL, was in need of services (out of 336,168-people below 200% FPL that need services).

**CCS Program*** Appear to be serving a higher percentage of African American in need of services (103%) followed by Native Americans and Whites at 50% and 49%.
* The numbers suggest that Asians/Pacific Islanders and Hispanics may be ethnic populations with unmet needs (22% each).

**PEI Program*** Appear to serve African Americans in need of services at a slightly higher rate (23%) than Whites and Native Americans (9% each) and Hispanics (13%).
* The numbers suggest that Asians/Pacific Islanders may be the ethnic group most in need of services (4%).

MHSA Continuum Care is broken down into six (6) categories:* Transition from Institution
* Hospital/Institutional Diversion
* Intensive Community Services & Support
* Liaison to Community
* Prevention &Early Intervention
* Wellness/Self Help/Peer

**Discussion, Q&A*** Why is the Hispanic level so low for poverty level needing services?
* Response from Naga Kasarabada – we have applied CHIS data from UCLA.
* Have you broken down the White group into different ethnic groups?
* Response from Naga Kasarabada – we have that data and have provide before to the Easter European/Middle Easter at the request. We can break it down when needed.
* Having the actual numbers instead of percentage would be easier to read.
* Is there any change in the data based on newer census data? Data changes fast. Example: when Older Adults was doing it was 6% initially by the time MHSA got implemented it was 16%, now its 24%. Is the undocumented Latino populations counted in this? We are now moving to the IBHIS so would be important for us to setup platform so we can collect data that will be meaningful at the other end of the outcome. Seems like in this data individual has one choice and we should talk to IBHIS vendors to have possibility of multiple choices for ethnicity.
* Response from Debbie Innes-Gomberg – the information came from Cultural Competency report. In next meeting we will try to have Naga Kasarabada and her staff to address this.
* Response from Naga Kasarabada – for the county we use Census data. The method is consistent across all years. For consumers served as of last year some of the directly operated programs changed to IBHIS so we had some data from IBHIS and some data from IS. We can send you the link to the data.
* Just want to suggest the intergeneration work group be included as well.
* Response from Lillian Bando – we do plan to have intergenerational cross cutting age group
* For PEI – it is dropping. Is the population going to keep dropping or is prevention is really working?
* There is a clinical disconnect between the PEI department and the reality of PEI services. Example: If someone had major depressive episode in their 30s and now is having a reoccurring depressive episode mild/moderate in their 70s. That should be PEI client but to the department they question this. Some of the PEI thought process need to be revisited.
* How do we use our current PEI funds? Example, if we are matching Medi-Cal they need to meet Medi-Cal necessity criteria. For programs that have CalWORKs, GROW you don’t have to meet Medi-Cal necessity yet we are not billing them.
* Was wondering how PEI correlates with staff trained in EBPs? So when you see a decline, is it because there aren’t any preventive youth, family, adults out there? Do we have staff trained in PEI? Did it decline because we had training in EBP and then they moved on?
* We should look at “P” as prevention and “E I” as early intervention rather than combining them together because a lot of people out there are invisible. People living with incredible pain that fall through.
* In the data the white category was so high because it includes many different cultural groups. It will be even higher because there is a lot stigma in those groups to seek help. We need more outreach for those ethnic populations that fall under white.

**Data Correction (***Please see attached slides 26-28 for the correction*)*In section “ Percentage of Populations by Ethnicity”:** *African Americans* compose 9% of the total population(10,0069,036) and 9.5% of population at or below 200% FPL(4,097,055)
* *Asian/Pacific Islanders* compose 15% of the total population(10,0069,036) and 10.3% of population at or below 200% FPL(4,097,055)
* *Hispanics* compose 48% of the total population(10,069,036) and 64.8% of population at or below 200% FPL(4,097,055)
* *Native Americans* compose 0.2% of the total population(10,0069,036) and 0.2% of population at or below 200% FPL(4,097,055)
* *Whites* compose 28% of the total population(10,0069,036) and 15.2% of population at or below 200% FPL(4,097,055)

*In section “CCS Programs”:** Appear to be serving a higher percentage of African American in need of services (55%) followed by Native Americans at 50% and Whites and Asian/Pacific Islanders at 29%.
* The numbers suggest that Latinos may be an ethnic population with unmet needs (18%).

*In section “PEI Programs”:** Appear to serve African Americans in need of services at a slightly higher rate (12%) than Native Americans (9%) and Latinos (10%).
* The numbers suggest that Asians/Pacific Islanders and Whites may be the ethnic groups most in need of services (5%).
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| **Public Comment and Announcements****3Public Comment and Announcements****(Cont.)** | Public comment1. In Montana they have Peer Recovery and Outreach Coaches.
2. Hospitals state that there is huge increase of people coming and seeking care. One issue is some FSP providers aren’t responding to the hospital when there have a patient that needs to be reintegrated into the community. Same times there are hospitals needing spaces to place patients meeting in patient criteria. How is DMH going to implement the recent notice that DHS sent out to counties advising them that they can use MHSA funds for involuntary holds.
* Response from Debbie Innes-Gomberg – That relates to Urgent Care-Crisis Stabilization Centers. That info notice clarified that county can use MHSA funds for voluntary and involuntary clients in Mental Health Urgent Care Centers.
1. County might want to expand the number of Urgent Care Centers.
* Response from Dr. Kay – We have existing five (5) and we are going to add four (4) more. Also, we are looking at a number model but we are not there yet. We are looking to expand them.
1. When we cross over to case management it messes up what peer and parent peers can do.
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