COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, October 19, 2016 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. Provide an update from the perspective of the Director of the Department of Mental Health.
2. Review of MHSA budget Projections for FYs 2017-18, 2018-19, 2019-20.
3. Status report from CSS and PEI Workgroups.

MEETING NOTES

Department of Mental Health Update	**Dr. Robin Kay, Acting Director, County of Los Angeles, Department of Mental Health** • The new director for the department is Dr. Jonathan Sherin. He will take his position November 1st. He has worked for the Veteran's Administration and for Volunteers of America as their Chief Medical Officer and Executive Vice President, working with peers that could reach out and help Veterans to navigate the VA system. Dr. Kay will step back to role of Chief Deputy Director which she did for 8.5 years. It gives her a chance to dig deeper into the operations. **Discussion, Q&A** • Now that you have a year of experience how are you going to help us as a Chief Deputy Director? o Every time we push our self into doing something different there are insights and experiences from that. The role of Chief Deputy Director is internal and being the Acting Director takes you more to the outside like State issues. There is more chance to bridge the gap between internal and external. • We are moving more and more toward Health Agency. With the new Director will we be under it more? o The new Director is very open and thoughtful. When he comes in the family he will be impressed with the strength and wisdom that exists in this room and our system. We had meeting yesterday between the three departments to focus on using each department's strength to our advantage. Public Health wants to capitalize what we have done with Promotores. We are looking to see how we can work together to capitalize on our strengths rather than pushing any particular department to give up what they consider to be their core mission.

MHSA Budget Projection	**Kim Nall, Director of Finance, County of Los Angeles, Department of Mental Health** **Dennis Murata, M.S.W. Acting Chief Deputy Director, County of Los Angeles, Department of Mental Health** Schedule is 5 years from Fiscal Year (FY) 15-16 through FY 19-20. The numbers aren't final since the state allocation is a projection at this point. Part 1: Chart is information regarding Community and Service Support (CSS). First row indicates the amount allocated for MHSA CSS funds. • FY 15-16 o Budget is $385.4 million and Projected State Allocation-$307.8 million. In order to meet the amount in the budget we needed to use $77.6 million (unspent dollars). The unspent dollars are a pool of dollars that add up year after year based on the amount of MHSA expenses that we accrue in a given year. o Unspent is $302.4 million. This is what based our $84 million expansion, of which $58 million was ongoing and $25 million was one time. We decided $58 million over 5 years ($298 million) can be done because we had unspent $302.4 million. o MCE started in FY 15-16. A lot of our non-Medi-Cal clients are not eligible for Medi-Cal. We had allocated a lot of our MHSA none-Medi-Cal dollars for that purpose. Now that those clients are eligible for Medi-Cal and MCE resulted in a saving for us in MHSA funds. • FY 16-17 o Budget-is $421.2 million. The amount went up from FY 15-16 because of the 30-30-30 allocation. There was CSS expansion of $30 million for 3 years with it being one time funding of $90 million in FY 14-15 until the MHSA State amount would go up in order for us to be able to maintain that amount on an ongoing bases. Also, In FY 15-16 we did the $84 million expansion which was done to fund: Intensive Care Clinical Services Expansion for children, the forensic FSP expansion for adults, the homeless dollars that we have spent to CALHFA to expand housing). • The Projected State Allocation-is $384.6 million. It was expected to go up. We had allocated one time money to support it going up, however we didn't do a spending plan. • How we balance the use of the funds is basically the amount of the state allocation (can go up or down each fiscal year) and the amount that we spend in a given fiscal year. Combining those two we either use unspent $ or we put more money into the pot if it's not spent. • For future FY we don't know what our unspent dollar amount will be because we are not there yet. We have projected what those amounts would be. For State allocation amount we have used the figures from CBHDA. **Discussion, Q&A** • Does the unspent dollars include the prudent reserve or that outside of the prudent reserve that is required? What is the prudent reserve here? o It is outside. We have the prudent reserve plus the unspent dollars. The prudent reserve is $128 million of CSS. PEI has a reserve as well. • Given the unmet need in our County is there to much unspent dollars? Should we be spending more money?

MHSA Budget Projection (Cont.)	o Response from Dr. Kay - If you look over the FY 15-16 we are always walking between the fragile line of using one time dollars for ongoing services and being concerned if revenue doesn't continue to increase versus leaving dollars unspent when there is a public need. Had there not been for unforeseen increase in the last year we would be projected to spend all of that $300 million (exception of 4 million). We have a plan in place to spend all of that money. We have started spending it ($84 million Expenditure Plan hasn't been reflected) but takes time after making the plan to getting to the expenditures (example: Forensic FSP). We didn't expect the one time bump in the MHSA since it wasn't projected. It is added for FY 16-17 in addition to the 300 million. We talking in budget groups what we can spend the money on. o Response from Debbie Innes-Gomberg - Fiscal transparency is a huge issue across the State: the Oversight and Accountability Commission is addressing it, the Little Hoover Commission referenced it. The approach that you endorse to be able to balance the volatility of the Mental Health Services Act in the County can be extremely beneficial across the state. How it is that we address this and the manner we do it in can inform many other Counties' work in this area. • The OAC is saying Los Angeles County is doing all the right things to keep this under control. There is new Fiscal Responsibility tool that the OAC has developed that is looking across all Countries. We have a large unspent dollar amount. Last time we did that we lost $800 million to Arnold to fund other stuff. We let it happen so we can get off from cash accounting to accrual accounting. This is a critical issue for us to watch as the years advance. We need to have reasonable projection 2-3 years in advance. • Some of those unused dollars is there a plan to put some of it in reserves for the future? o Response from Dr. Kay - No not at this point. We have limitations of what we can put in the reserve. We have been deliberate about holding a pool of unspent money until it accumulates enough so we can make sure the programs can sustain once money is allocated to them. The amount of money that can go into the reserve is defined in the Act. We need to look back at the 30-30-30 and the $84 million plan and see which portions of it have either not implemented or fully implemented and if they are likely to be. At this point we may have the luxury to be little less conservative in investing those one time dollars. Only thing on the horizon that gives us pause is the No Place Like Home because we know that once the bonds are sold there will be decrease in our allocation. Funding will come out from top and we will have obligation to add support services for people in housing that have been built. In addition County has made commitment to the City that if the City initiative (HHH) is passed that we will provide the support services for the City bond measure. • Keep in mind the prudent reserve isn't something we can easily access. There has to be certain conditions based on allocation that allows us to access the prudent reserve. Also, keep in mind that we have other obligations that can impact the unspent. We are just finishing up with all the CHAFFA related type programs like the UCCs and Crises Residential. As this get implemented those dollars will get dropped. • As we go forward we need to look at the operational implementation of these programs because in some cases the services are there but the system and process isn't engaging because of hard demand needs. Example: PEI services. Money is there but there is disconnect between agencies like Probation and DCFS that are supposed to be using those services to help the community but aren't giving us the referrals to help the community. Also, we have to look at the past budget issues that when we were in crises the Board decided that we had to re shift money to MHSA to fun things when we're losing money to other places. When the State got rich they gave us

MHSA Budget Projection (Cont.)	the money back which created the shift. The bottom line is what we are seeing as high need services (FCP, FCCS) in these high need communities. We need to revisit that for funding adjustments that need to be made. • There are two areas of risk for all the unspent money. First is legislative proposals at the State level and they are going to have items that they want to use MHSA funding for. Second is within the County in itself. There is a lot of pressure to allocate some of this money to other projects that the Agency or the Board has some ideas to spend it. • There should be some form that includes onetime versus ongoing. It would be helpful to break down to show the unspent how much is allocated and into what it is allocated to. • The 3 Year MHSA budget planning is small in the idea of five year projection of budgetary. Some how can we see big picture what we doing in three year update in long run. o Response from Dr. Kay - We use state projections and have information up to FY 18-19. We are planning to get an update next month that might give us more years. Part 2: PEI • The project state amount is higher than the amount we have in the budget so we do not need to have some of the unspent dollars for the PEI to maintain the amount that we have allocated in the budget. Unspent PEI dollars are listed as well. Part 3: One time Allocation • In July the State identified that they have expedited funds. What they did is they allocated those funds to the County. We received $121.4 million onetime fund. Funding is split up between CSS(80% -$92.26 million) and PEI(20%-$23.07 million) and Innovation(5%-$6.07 million) • Response from Dennis Murata - Structure of our CSS and PEI plan and where you recommend we put additional investments into those structures in order to make them work or make them more comprehensive in terms of continuum of care. It may be we reduce disparities by implementing certain practice or outreaching and engaging certain way. Some of maybe just changing the practices that being engaged right now. Who are we not serving that we need to serve and how we need to do that. Also, the ongoing investments that we might want to make in Workforce Education and Training. • Response from Dr. Kay - Based on Priories that are coming out of the 3 Year Planning process and Counties priorities to address Homelessness, Jail Diversion, Child Welfare and Integration. It is time for us to talk about expansion to address high priority areas. • Response from Debbie Innes-Gomberg - Structure of our CSS and PEI plan and were you recommend we put additional investments into those structures in order to make them work or make them more comprehensive in terms of continuum of care. It maybe we reduce disparities by implementing certain practice or outreaching and engaging certain way. Some of maybe just changing the practices that being engaged right now. Who are we not serving that we need to serve and how we need to do that. Also, the ongoing investments that we might want to make in Workforce Education and Training.

MHSA Budget Projection (Cont.)	Discussion, Q&A
	• When will we have No Place Like Home projected? o Response from Dr. Kay - We have been working the numbers. We still are waiting on clarification whether or not the bonds that are issues for No Place Like Home will cover 100% of housing cost and operating subsidy or whether they will be leveraged. The projections on number of units that will be built vary. Right now we spend 30% of MHSA money on housing units and we leverage 70%. If leveraging ratios in the future are the same as now we can be looking at 5,000 units. If there is no leveraging that drops the number of units to about 1,700-1,800. We have looked at actual data. We normally use FSP money to support housing but the truth of the matter is that once the client is stable in a housing the actual cost of mental health service drops to about $8,000 year on average. We will be coming back with a projection of the cost of providing mental health services to people in MHSA funded units based on their actual cost of care supplemented by some housing case management dollars that DHS maybe providing to us. Based on the $8000 cost, we looking at about $8 million. It has to be supplemented by additional $5 million that would come from housing for health. • When we are doing housing were the child is the consumer and the client that it's very hard to get matching funds because it has to be an adult. What is being done with the younger ones and the children? o Response from Maria Funk – If the adult is not the head of the household some subsidy won't allow that. With our Caroline Severance Building that we did had many families in it. Five units were set aside for families where the child was the consumer of DMH (if we pay for the subsidy we will have an option of doing this with No Place Like Home). • You had mentioned it costs $8000 to give mental health service when someone is stable housing. How much it costs when someone is not in stable housing? o Response from Dr. Kay - Actually it's the full cost of the FSP program which for adults is about $16000. A lot of intensive service are proved up front • If they implement the No Place Like Home how much will it take from our money? o Response from Dr. Kay - At the point where the bonds are fully sold in 4 different stages. Initial roll out is about $5 million from top of our MHSA revenue. We don't get to the point where bonds are full sold till couple of years. At this point they are not even talking about releasing the beginning part until 2018 or after. It will take about $37.5 million from the top of MHSA. • A lot of the Counties don't use the money allocated for housing. Can we take their money and put it in a pot to pay for it down the road. o Response from Dr. Kay - That was true for the initial housing funding. It is written in the language that there can be reallocation of funding for any dollars that aren't used which would benefit us. The language in legislation says they will honor and fund only proposals from Counties that are ready to hit the ground running. The advantage we have here is the Housing Advisory Board.

Status report from CSS and PEI Workgroups	**A.** Children 1. CSS ➢ 20-24 people participated. Has met 2 out of 5 times. ➢ Discussed: ▪ 1st meeting: Service gaps at different levels. Looked at what are the needs on family and child level, community level as well at a provider level. Providers are seeing high risk families. There are a lot of crises basic needs like: housing, food, and clothing. Sometimes in FCCS they provide FSP like services because the family is attached to the teen and don't want to leave the teen, as well as there is linguistic need. ▪ 2nd meeting: Focuses on target populations. Looked at the State definitions of at risk child FSP and begun the process of figuring out who will be served at the intensive and none intensive plan. At none intensive plan they are looking at risk of or not at risk of. ▪ 3rd meeting will focus on target population and services. ▪ 4th meeting will focus on benchmarking and outcomes. ▪ 5th meeting will finish and tie it all together. 2. PEI ➢ 16 People participated on averages. Has met 4 times. ▪ 1st meeting: developed presentation for age 0-5.Age group leads were asked to develop a presentation on the current landscape impacting those 2 groups. They found that 0-2 population wasn't being served. They talked about how the impact of trauma and economic challenges that these families face impact these children. They brainstormed about where those families in need of services go to. They talked about health and where they got to. ▪ 2nd meeting: developed presentation for age 6-15. They did overview of evidence based practices and what has been used. They looked at Service Areas, ethnic data, as well as who was not accessing their services. ▪ 3rd group meeting -Looked at common themes. Broke out into 3 groups • Focusing on isolated families. • Focusing on the quiet child (possibly screening and working at after school programs. • The prenatal mothers 0-2. They worked on developing the program and identifying evidence based practices. • Hope for next 3 meeting is to develop these programs and have identified evidence based practices as well as what outcomes will be used. **Discussion, Q&A** • Will there be time to review the process and reports. Will we see draft of what they talked about? o Response from Debbie Innes-Gomberg - We want to spend November talking about what you have heard because this process will be done by then. We anticipate with some of the age groups it will go past November. We will make all the effort to do that.

Status report from CSS and PEI Workgroups (Cont.)	• I hope we talk about what's going on in the world regarding trauma informed care cross the board. The children 0-2 we need to somehow look at postpartum depression. We need to outreach to most needed community to inform and ensure that the family and parents and the family are getting the proper care to protect their children. We need to make sure that we have the opportunity to be informed to have chance to provide input. We need to make sure immigrant populations and children that are getting trafficked get help. • One of the issues I have concern with is with transition. Is part of this process looking at people who are not hooked up to the system or people are falling out of the system that need to get back in the system. Is part of this process looking at the navigation services we have in place and if it's good enough or we need to expand those. o Response from Debbie Innes-Gomberg - It speaks a lot about access and ability to get care when you need it. We are looking at NAMI as one way to think broadly in regards to navigation for families that need to understand symptoms and signs of mental illness and reduce stigma so people can seek care. o Response from Dr. Kay - It's one of the great frustrations. No matter how much money we spend and no matter what quality of services offered people still don't know how to get into them and people still fall out. The cross cutting issues we need to figure out how to address and that's on process side. On program side we spent a lot of time talking about access. There will be more done by those organizations and entities that are relying on us to solve their issues. Navigation in the future might be less internally driven and might be coming from outside in terms of referrals. Out Justice Partners, Child Welfare partners need to be engaged with us in different sort of way. The new Director has ideas regarding this issue. VA has dealt with access issues before. One of great strengths he will bring is starting in the trenches with starting programs to ensure navigation. • The 12 NAMI associates want to meet with DMH to say we would like to expand what the navigators are doing. They would like to use NAMI volunteered peers in order to provide information to take the stress off the departments. If they were given a road map this would be possible. o Response from Dr. Kay - In NAMI monthly meetings we had conversations. It's a natural partnership. The conversations have started. **B.** TAY 1. CSS ➢ 14 people participated. Has met 4 times. ➢ Primary focus has been on FSP and higher end FCCS consolidation. How are we going to determine what TAY meets the criteria for the FSP? Also, we talked about determinants of care and if we wanted to look systematic way of looking at it. One of the major things we discussed is Morse Level of Care Scale. We talked about how that would align with youth moving into adult system. We talked about CSEC youth and number of those youth is being serviced in FSP as well as FCCS programs but we don't have tracking mechanism which is a gap. ➢ Next focus is on Non-FSP bracket. What is the service continuum of care going to look like? 2. PEI ➢ 4 meetings

Status report from CSS and PEI Workgroups (Cont.)	➢ They have been able to determine areas where they are undeserved target groups, unmet needs, and service gaps (including CSEC, LGBT, Homeless, TAY and families). They have been able to come up with ideas for both prevention and intervention. They had focused on outreach and engagement. They are narrowing down to the recommended programs and looking at the overlap. They are looking at risk and protective factors. ➢ Next focus is rating the programs and finalizing the recommendations. **Discussion, Q&A** • How many parents you have on your teams? My concern is that a lot of the TAY populations live with their families. Last planning parents felt left out and they need to be involved in planning. o They haven't looked into to see if there are specific parents in participants. Discussion we had in group was about service delivery in group that was parallel with parents. • Is there SAAC involvement? o There is SAAC involvement. • One of my concerns with FSP programs is that we have very little quality control. We don't have comprehensive evaluation of differentials between agencies that are doing FSP. We have FSP that don't look like FSP. We need real evaluation across the programs. o Response from Debbie Innes-Gomberg - As we establish larger FSP programs like level 4 and level 3 FSP programs and establish Non FSP level of care for each age group we are going to be establishing the service expectations. We will identify outcome measures. The plan was to start thinking what we expect out of FSP program for adults they have been in a FSP program for certain amount of time. Do we focus on employment and housing? • We need to talk about the service: what worked, didn't work and how can it get better. The providers need to be thinking this way as well. Goal is improving and getting better. • For the API they have been meeting a lot about the TAY population. There are county wide TAY programs for TAY population, adult and children. They have identified the lack of county wide program for TAY. TAY is being kept in child FSP or being taken to Adult. The population needs a specialized FSP program. • A high at-risk population is boys of different color especially black young men. The suspension rate is high at traditional and none traditional schools. Somehow they don't get captured in the mental health world. The ones that do need to face specific criteria like ending up in jail. • Some of our TAY has pervasive disorders so when we talk about continuity of care when they are in TAY program they get what they need. However when their symptoms are reduced they might have relapse and when they get to the adult system there aren't enough slots so we lose them and need to start over again. **C.** Adult 1. CSS ➢ 25-30 people have participated. Has met 3 times. ➢ 1st meeting was people sharing their thoughts. They had to figure out how to migrate FCCS to FSP. They looked at Non FSP. Also, they looked at the concept of access. Having people from

Status report from CSS and PEI Workgroups (Cont.)	community helps know the need of the community. There were different ideas regarding outcomes. We are focusing on the gaps. ➢ They are going to focus on service expectations and benchmarks for both FSP and Non FSP side. 2. PEI ➢ 30 people have participated. Has met 3 times. ➢ They are on step 2 of the 5 step plan. They have 15 potential recommendations. Common theme was identifying better approach to server ethnic, cultural and LGBT communities. ➢ People are going to fine tuning the recommendations. **Discussion, Q&A** • How are you insuring that you're actually hearing from the populations? o We have good representatives from populations and different stakeholders come from different ethnic communities. **D.** Older Adult 1. CSS ➢ 15-25 people have participated. ➢ Older Adults has been part of the pilot program in terms of consolidating FCCS and FSP. They are building on the learning. They are looking into: how to differentiate FSP and Non FSP services, the frequency and intensity of the service, the amount of field base services, cost of per client per service. They have need of expansion of FSP services. They have site visits where they have rubric they go and talk to providers about their FSP programs and look at certain elements. They have monitoring and oversight. They have been talking about level of service needed for the client. They have been comparing state and county definitions. 2. PEI ➢ 15-25 people have participated. ➢ There is a tool that helps them guide their meetings. First area they are looking at is suicide prevention. Second area they are talking about it around reducing emotion and physical pain. The third area involves looking at the issue of social isolation for older adults and their care givers. The fourth area is increasing the awareness around older adults with depression. They are discussing and researching different evidence based practices such as CBT, Healthy Ideas. They are looking for some that haven't been implemented by the department and focusing on service gaps. How do you access isolated seniors to provide the service that is needed? There are some programs that have access to isolated seniors like Home Meal Delivery program, Adult Protective Service involved older adults.

Status report from CSS and PEI Workgroups (Cont.)	**Discussion, Q&A** • Does your group talk about trauma and stigma discrimination? It's hard for a Native Americans because they don't trust government. Do you cover historical trauma? o Historical trauma is part of the one of the areas we have been covering. We work with communities to reduce stigma. We try to reduce the stigma by providing information in the community. We have something called Wellness Series were we engage the community and talk about issues that are not stigmatizing. o Response from Debbie Innes-Gomberg - Our Innovation 2 project has a strategy around Inter-generational Trauma and Historic trauma is a component of that. • We need to look how we integrate mental health in settings where people are going for primary care. A lot of times this can be used as entry points. o That's important for older adults. They let their primary doctor's information regarding their mental health. We are discussing this in the work group. • Innovation 1 showed that integrated care approach was very effective for Older Adults. Also, none traditional practices are very appealing to the older adults. o Response from Debbie Innes-Gomberg - We have access patting to look across groups at key places where people might enter the mental health system. • I would like to see all the age groups add the recovery and re-entry component. • The world for children isn't recovery its resistance. System Navigator only does FSP? o Response from Debbie Innes-Gomberg - We were thinking of navigation as a vehicle into a system. What happened over time is their work has become very specialized. • Housing Work group is meeting November 1st 1:30-3:30 at Star Apartments, 240 E 6th Street, Los Angeles 2nd floor. **E.** Countywide PEI, ➢ 10-12 people have participated. Has met 3 times. ➢ They looked as service gaps and needs for specific target populations. They are proposing specifics programs. Also, they are discussing access concerns. Their focus is on co-occurring intellectual disabilities. They going to focus on the violence that happens in the community and want to increase the services of the STARK program. They want to focus on refuge population. **Discussion, Q&A** • Look into the silos. Look what others are doing and think about how we can add and improve their effectiveness. • There are other family groups besides NAMI out there. Some of them help parents get ready.

Public Comment and Announcements	Public comment • New York has program called Hands Across Long Island. They are working on getting people out jails. They are outreaching.