COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, January 18, 2017 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 and update on behalf of the County of Los Angeles Department of Mental Health.
2. Share information on State legislative and budget items.
3. MHSA 3 Year Plan Program and Expenditure Plan Review.

MEETING NOTES

Meeting Opening	**Review Meeting Agenda and Minutes.** Steve introduced the SAAC Reps. Cynthia- SAAC 1. SAAC 2- Patricia, SAAC 3, Greg 4. SAAC 5-Karen SAAC 6-Paco and Ms. Lamon. SAAC 7-Marcelo SAAC 8-Eugenie. Those in the audience should know who their SLT representatives are and use them as a voice.
Department of Mental Health Update	**Dr. Robin Kay, Chief Deputy Director, County of Los Angeles, Department of Mental Health** Couple of things from the Department and then I am open for questions. Dr. Sherin is at a Stepping Up conference-focusing on jail diversion--part of a team from Los Angeles County including the sheriff and district attorney. An LA County collaboration of law enforcement, mental health, and substance abuse are working together to address the needs of the people who are involved in the criminal jail system that really need to be in treatment. He sends his regrets that he is not here, but he is doing something really important for all of us. • Forming local study group/committee and principles of what will become of the ACA. Items we are working on include: o Whole Person Care – A component of the 1115 waiver, federally approved program for California. In LA County there are between 8-10 different programs under Whole Person Care. DMH is responsible as the lead for 2 of them, one having to do with assessing people who are in very high level residential treatments like IMDs determining if they need that level of care and devising alternatives for those stepping down from the IMD level care that is in a way that is more deliberate, thoughtful and more efficient than the system we have in place now. 2nd is a project similar to the adult hospital linkage program - ATCMS. We will be focusing on the needs of individuals, who are high utilizers of hospital services. The criteria is a little different this time we will be focusing on people who have been admitted 4 or more times in a 12 month period, also those with frequent emergency room visits. Our plan is to do the same thing, to work with hospitals, engage these clients when they cross the thresholds of the hospitals, to find them in the community to support them and prevent inappropriate hospitalization because no one would say, certainly not the department, that if a client needs to be in the hospital they should certainly

Department of Mental Health Update (Cont.)	be there, but in many cases people get accustomed to going to the hospital as way of coping and maybe there is a better way of coping, maybe there are some community based programs we can wrap around them that may help address their needs. Those are the two projects that will roll out in April. The IMD project, bridging project, and the ISR project. There are other whole person care projects that other county departments have the lead on. One is focused on jail diversion that DHS has the lead on, the other one is focused on people with behavioral health issues that aren't necessarily going into psychiatric facilities but may be seen in medical units because they have co-occurring medical issues, or physical health care issues and those are under the oversight of Department of Health services but we will be expected to develop programs to help meet the needs of the clients identified through DHS. Working on that intensively and for the providers in the room there will be some expectations on how all this will affect you, the dedication of FSP slots, people that need that level of care and we will talk more about that at the provider meeting on the 30th. • There is a lot of focus in the county on jail diversion. We are a very important part of that, there's the case findings that goes on in the jail through DHS and through the Office of Diversion and Re-entry, but the expectation is that the services that need to be provided will be provided by Substance Abuse Prevention and Control(SAPC) or by Mental Health. The County is applying for a couple grants right now focusing on the diversion populations. We will have some role ensuring those people identified will get the treatment that they need. • Continued focus on highly vulnerable populations—Commercially Sexually Exploited Youth (CSECY). The TAY Bureau is doing training on not only young women who are commercially sexually exploited, but young men who are often the victims of sexual exploitation. Their issues are often not identified. • Domestic violence initiative: Ensures that all providers including mental health providers, but not limited to our system are educated and trained about guidelines; for identifying victims of domestic violence, how to understand needs of women and men who have been victims of domestic violence, resources available in the county, etc. • Board meeting last week--Motion regarding the County support for immigrations, particularly unaccompanied minors. Proud to say, you all were on the forefront of authorizing the Department to spend initially $1.5 of MHSA funding to support the mental health needs of unaccompanied minors. We will continue to ensure the use of PEI funding for that population in the coming year. It was way out ahead of where the County was at the time and now we are walking in the same direction with and effort to support those vulnerable children and youth. • Motion last year on grief camps—DMH will work with the District Attorney's office to see if we can do some special programing for the needs of youngsters of parents who died of homicide. It is a small project but one that is important. **Discussion, Q&A** • Sandy: You said some of the FSP slots will be diverted? o No, not diverted, we are will be expected to use them for those populations. As part of the 3 year plan, as we are expanding the FSP slots we are taking that in account, that we would need more slots for these programs.

Department of Mental Health Update (Cont.)	• Eddie Lamon**:** a program that I used to work in, the Intensive Case Management - I was on advisory committee—it really worked when we lowered the case load people had. If they got down on skid row, they would go to skid row, get them, and keep them out of the hospitals. That was one of the best programs, the Department picked it up and watered it down; it is not nearly as good as that program. o We are making an effort to focus on combining the best aspects of earlier predecessors including FSP. One thing we have learned over the years regarding homeless clients is; if we assign an agency for primary responsibility and create the expectation that people will engage a group of clients, we hold ourselves accountable for that and can do remarkable things. We are taking the principles that worked in the past and applying them to the Whole Person Care program now. An example would be the Santa Monica Chronic Homeless program. • Jury: Would you kindly elaborate on the Commercially Sexually Exploited Youth program that you were referring to, in particularly you mentioned that it would be expanded to the young males, how would that be rolled out to the providers? o The County has had a focus on Commercially Sexually Exploited Children and Youth for the last 3-5 years. It began with a partnership between the District Attorney Office and law enforcement. DMH has built on our trauma-informed network of providers by offering specific CSEC training to providers. Those trainings in the past had focused on young women, but now we are focusing on young men – it is harder for them to come forward due to the stigma. The Department is recognizing that we can only intervene to a certain extent. We are involved in a pilot program now that uses a screening tool as part of our universal screening. Using this screening tool to help us identify children and youth that there is a high likelihood that they have been sexually exploited, but they haven't said anything. They are finding the high-risk indicators; the correlates are much more prevalent than with self-disclosure. That is another way of us trying to ensure that we identify youth that really need our help who may not be comfortable coming forward. • Ruth: You mentioned that there was a local workgroup for the ACA—who are the members of that and does that include providers, consumers, family members, or it is just a county group? o We haven't formed it yet, it is just getting formed. It will include providers, families, and consumers. The group is not complete yet, so if you are interested, come see me if you want to be part of it. • Ruth: 3 years ago the SLT approved a program for children who had been through major trauma including homicide of parents, death of parent, etc. It was a $150,000 program that never got implemented and instead the money was used for arts and crafts supplies. The program was called Rainbows, what was needed for it to be implemented throughout Los Angeles County was a paid coordinator and materials. We would have been 3 years ahead of the Supervisors on that one, as well if we had implemented our plan rather than use the money on arts and crafts supplies. o Let me be clear, the specific interest of the Fifth District was in grief camps, overnight camps. • Ruth: The thing is the overnight camp doesn't do it. You need something that is more long term, in fact they say grief is a year at the minimum and several years for the maximum and we aren't going to keep kids that long. o We will send out information to SLT and providers from the Child Traumatic Grief and Loss Conference; at the end of February—SLT and providers focus is on traumatic loss of a parent due to homicide. • Jim: In your discussion on the second part of Whole Person Care project, as you describe the qualifications of

Department of Mental Health Update (Cont.)	who could be served by that it seems there is a tremendous overlap with Assisted Outpatient Treatment, I am wondering if you thought through how those two programs will fit together. o The truth is there is overlap in almost all the Whole Person Care programs; it is one of the things we are trying to deal with, within the Department and with DHS. If you qualify to be a Whole Person Care client because you are a high utilizer, you may also be homeless and that is another portion of Whole Person Care. Or you may be homeless, a high utilizer and have been in and out of justice facilities, which is another project and you can only be counted once, so there is a great deal of attention being given now to how all of these intensive initiatives come together. • Patricia: With my son being in and out of hospitals and being a high utilizer, when he is not on conservatorship he will be discharged, without me knowing it and with no place to go. I tried to help others get their loved ones on conservatorship and it's very difficult. Some of these people that are high utilizers need to be on conservatorship, so that when they are hospitalized they can be there at least for enough time to be stable before being discharged. When someone is a conservator, they are turned down because they are worried they will be stuck with them. Issues worth looking into with are over- medicating, or not medicating and they go out and get high. o We had identified system issues and there were a number of issues related to IMDs and the kind of medication prescribing that went on. We used that program to identify system issues that we felt were important to tackle. Using Whole Person Care program is an opportunity to do the same thing again. I appreciate you highlighting some of these issues, and we look forward to the opportunity to do some of that system work rather than just individual work. • Cynthia: Regarding Whole Person Care implementation, can you tell me if consideration of resources and needs of each service area is being discussed; if so, is the Department planning on having programs in place for each service area, I am in Service Area 1 just to let you know. o Whole Person Care will roll out across the entire County; DHS is the lead on this. In the very beginning - there was an ambitious effort to roll out to all areas, and programs at once. What I am hearing, but hasn't been decided, is that it may become a rolling implementation; due to the enormity of the project. Is it for all areas? Your question is interesting, just yesterday the Executive Management Team had a conversation about looking; if we could, at the needs of the various service areas and disparities. We are moving so fast that we aren't going to really have the time to do an elegant job, like such as the group did with PEI. One of the things we can do is look at a higher level the different populations that we intend to serve and where they are represented relatively among the Service Areas. For example, the percentage of homeless individuals across each Service Areas. To the extent that we end up dedicating resources to the homeless program within Whole Person Care, we need to pay attention to those percentages understanding that every Service Area has a core amount of service to make this worthwhile. However, there are certain Service Areas like Service Area 4 that have 25% of the homeless population in Los Angeles County. Out of 8 Service Areas; that is grossly disproportionate, followed by Service Area 2 and 6. We have to take those things in account, also understanding that there are other Service Areas that may not have the same resources, and that would apply to Service Area 1. We are going to make our best effort and we asked for data also about the jail diversion population, where people are being arrested, where they are being returned to when they are released from jail. We will see how far we can

Department of Mental Health Update (Cont.)	drill down, but we understand that every Service Area has to have at least a core package of services to make this feasible. • Eddie Lamon: When you were talking about the kids who lost their parents, from homicide, hope you consider the children who lost their parents period. Kids, who lost their parents from cancer, can have the same stress. o There are two grief camps in Los Angeles County, and I am only speaking about the grief camps not the larger issue - they take children who have lost parents or loved ones for any reason, and we need to pay attention to specifically the issues raised by homicide. • Eddie Lamon: There other issue is jail diversion - instead of taking people with mental illness to jail, have a building to take them to, instead of jail. If I keep saying it enough then they will probably get one of those. o I think we heard you. Thank you, when we get the 4 new Urgent Care Centers up and running, they are intended to be sites where law enforcement can take people for evaluation in lieu of arrest and booking. We just completed a work group process with the District Attorney's office and local police departments that identified the kinds of infractions that would be eligible for that kind of pre-booking diversion. • Dorothy: My question was in regards to the youth that have been sexually exploited but don't tell anyone. Have they thought about using others that have had the experience to interact with them? People will talk to one another that have been through the same thing. This is a way to find out more and being able to help those that have not told someone else. This could be done through meetings, activities and conversations being brought up. o Thank you Dorothy, DCFS has started a program with peers they are doing exactly that. One of Dr. Sherin's big areas of interest is developing more of a peer entity within DMH, so more to come on that. • Carmen: Jail diversion - how is that affecting juvenile justice? Is it the same thing? Many of them are going to jail, and you can divert them younger rather than later. o We tend to talk about it as if it is an adult issue, and it is not. Our TAY division is looking at jail diversion. If we are going to change trajectory of somebody's life, it would be ideal to start younger. Better for us to get people before their first incarceration or even before that. Jail diversion discussion in Los Angeles to date has been largely focused on adults, partly because it came at the same time as the debate about building the new jail. So it's been focused on the adult twin towers incarcerated population, not so much the youth population, then we had AB109, and criminal justice realignment which was completely an adult focused conversation because people were coming from the state institution. I do think we are going to see a focus on diversion related to adolescents that go into the juvenile justice facilities. • Leticia: As the Co-Chair for our Cultural Competency Committee, it is wonderful to hear the hard work that you have been doing regarding Whole Person Care, and we really appreciate that. If there is anything the committee can do to support this effort, please let us know, we would be happy to do that. o That would be great, thank you.
Update State Legislative & Budget Items	**Susan Rajlal, Legislative Analyst, County of Los Angeles, Department of Mental Health** Governor's budget was released last week. This year is projected a $2 billion deficit but instead of cutting programs, the governor is proposing using the minimum level possible to contribute to Prop 98 fund to the schools. Rescinded some grants that were put out for bid last year that were never implemented, related to repairing roads, upgrading government

Update State Legislative & Budget Items (Cont.)	office in Sacramento. The children crisis grants will be taken back, but we continue to have the MHSA funds that would fund those grants. No budget cuts and in fact, he added some state general fund that helps with Medicaid expansion, and also the undocumented that are eligible to receive Medicaid. Through an agreement a work group, including CBHDA, CSAC and the Department of Finance, grow will be distributed through a rolling base for realignment 2011 has been set and we are in agreement with the way it was set. Consumers will get increase in SSI and FFP. The state supplement that California gives hasn't been increased in 7 years. Increased about 2% of budget increase. Roughly $20, not enough, but it is still something. When No Place like Home funds begin to be rolled out, they are expecting about $260 million to be made available for this next budget year for housing projects. **Concerns**: There is still insufficient funding for CCR, the children's foster care system revamp. Hoping due to the requirements for Mental Health that we will see more money for Mental Health. Concerned that the coordinated care initiative will be halted. In home supportive services workers were having everything paid through the state. With this being discontinued, it will now come back to the counties to pay 35% of it. The amount of funding that would be taken from the fund is greater than the amount that is in the fund. It will impact the ability to have growth funds. This is a fluid process and we are waiting to see; it looks as if the tax inflow was less than projected. **Affordable Care Act (ACA):** There is a possible repeal and we are all concerned about. If it changes, the repeal will impact the community. As of yesterday, 18 million people will lose their coverage in the first year if it was repealed and not replaced right away. In 1st year projections, the insurance rates will raise by 25%, and the 2nd year it would raise by 50%. Think about what we would like to see in the replacement and we need to make sure our voices are heard. There are many different ways to deliver health care. We need: • Effective coverage. • No burden in documentation. • Ability to cover as many people as we can. • No behavioral health care funds are cut. You are urged to be involved with this. Make sure the elected representatives are hearing from you. **Discussion, Q&A** • Ruth: I didn't understand the in-home supportive services and how that would impact Mental Health? o We all have our sub accounts. Behavioral health sub account is for behavioral health and substance abuse. Any growth over what was projected in the budget is allocated to the various funds. Historically the case- load driven programs, such as foster care or in home supportive services, they get growth before we do. We are not case-load driven, so we are not expecting growth and the problem would be in-home supportive services soaks up all that growth, we get less growth fund for next year. Does that make sense? • Ruth: So we aren't talking about MHSA money, we are talking realignment money? o Yes, Realignment money, not MHSA money.

Update State Legislative & Budget Items (Cont.)	• Eugenia Lewis: I have an advocacy question. How does advocacy look with the support of the legislature and is there any overall strategy that we can unify around to advocate? To maintain the mandated benefits for behavioral health and have a more organized strategy. o We met with Chair of the Mental Health caucus and will continue to give her data, personal stories. Most of the CA Legislature is Democratic and we have Republican Kevin McCarthy in Kern County who is very involved. He is one that I would urge not to repeal and replace too quickly without a lot of public input. We are in the process of trying to develop our strategy with CBHDA and CSAC and we will be sharing that information as soon as next month. We are trying to develop principals and advocacy strategy. • Patricia: NAMI has been in favor of HR2646 helping families in mental health crisis and apparently it is passed. I hope DMH is in favor of that, do you want to talk about that since it is huge for people who have family members with mental illness? o It is a huge and lengthy bill - and it has taken a long time to get it passed. However at this time, until we see what happens with the ACA and the repeal and replace I don't think I will be willing to comment on that because there are so many pieces that could be changed, depending who is in charge. At this time I would not want to do a review on it. • Well, hopefully it will stay intact. o Please make sure to advocate for that, if you want it to stay intact. • Eddie Lamon: The Democrats are mostly for the Affordable Care Act, Obamacare, but the majority is Republicans, how do we get to them? o I mentioned Kevin McCarthy, he would be the one to get to first in California, or if you have any personal contacts, even if they are not in California, getting the information to them is key. You are right; we need to change the minds of the Republicans because the Democrats are already in favor of it.
Ground Rules for Effective Groups	**Dr. Steven Goodwin, Turning West** ***Ground Rules for Effective Groups*** One of the systems I use in facilitation is called The Skilled Facilitator (TSF by Roger Schwarz). **The 4 values that I'll be using to facilitate these meetings are:** - I will always be encouraging **Valid Information** to be shared; the more information we can get, the better we can deliberate and the more dialogue we can have with one another. - Encourage us to make **Free and Informed Choice**; we are making a choice to participate. - **Internal Commitment** - The more committed we are to each other and to the process; the better we are going to function together as a deliberative body. This will help as we try to understand this very complex system. - **Compassion** - When we think of the Mental Health system, it is very much like an intricately woven tapestry. When you tug on one thread, it affects threads throughout the whole system; it's a very complex system that we have. I hope we will continue to learn and encourage each other as we try to grasp the whole of this tapestry and how it impacts one another.

Ground Rules for Effective Group (Cont.)	**Group Ground Rules:** **#1: TEST ALL ASSUMPTIONS AND INFERENCES** Explicitly check to be sure that they mean what you think that they mean by their words, attitudes, and behavior. **#2: SHARE RELEVANT INFORMATION** Each group member shares all the information they possess including that which may not support their own position. Transparency is key; don't stuff any aces up your sleeve! **#3: USE SPECIFIC EXAMPLES AND AGREE ON WHAT IMPORTANT WORDS MEAN** Generate valid data by sharing specific stories including who, what, where, etc. Make sure that everyone understands how important words are being used. We used words differently from one another, even within our own culture. **#4: EXPLAIN YOUR REASONING AND INTENT** Your Reasoning is what led you to take action; your intent is your purpose for taking that action. **#5: FOCUS ON INTERESTS, NOT POSITIONS** Interests are the needs, desires, and concerns that members have regarding the situation. Positions are how the member wants to achieve his or her interests. **#6: COMBINE ADVOCACY AND INQUIRY** Explain your point of view, ask others about their point of view, and invite questions about your point of view. **#7: JOINTLY DESIGN NEXT STEPS AND WAYS TO TEST DISAGREEMENTS** The group decides together what, when, and how to discuss topics and determines the process for making a decision. **#8: DISCUSS UNDISCUSSABLE ISSUES** Raise issues left ignored or deemed too difficult to discuss. Do so with respect and gentleness and not attacking. **#9: USE A DECISION-MAKING RULE THAT GENERATES THE LEVEL OF COMMITMENT NEEDED** Use informed, free choice in order to increase internal commitment by determining how the group will make its decision. We are going to decide how to decide before we decide. What is our process going to be before we make a decision? What does the decision mean?
MHSA 3 Year Program and Expenditure Plan Review	***Debbie Innes-Gomberg, Ph.D., Deputy*** **Director, County of Los Angeles, Department of Mental Health** Dr. Innes-Gomberg acknowledged the amount of information presented last month and will review key elements with the SLT at this meeting. I presented an overview to the Mental Health Commission's Executive Committee and got some good feedback that I wanted to share with you. The Mental Health Commission's interest is in putting everything together, integrating the different components of MHSA with information that we know about this County. One of the things that we talked about was why does it appear that there are so many African Americans served in the Community

MHSA 3 Year Program and Expenditure Plan Review (Cont.)	Services and Supports (CSS) plan relative to their numbers in the County and relative to Prevention and Early Intervention. I propose that we take the next several months to learn more about that. I would like to use the February, March and April SLT meetings to really understand our services, the ways in which we can improve our services, using data to inform all that. Population data, outcome data, encounter data, and maybe your own impressions, I want to have an informed discussion to find out where the gaps are and how we can address those. There is an interest in the interrelationship between outreach and services in the Community Services and Supports Plan and in the Prevention and Early Intervention Plan. Consolidation of CSS Work Plan - Purpose is to create a better service continuum and to sustain it. We had 24 or 25 CSS work plans. We took all the service plans and rolled them up into 6 plans. Expand FSP programs - expand the services to those at risk of becoming homeless, or institutions. We created a higher bar so we can balance those two efforts. In the process, we can use rental subsidies for more clients. **Discussion, Q&A** • Cynthia: I was asked by a member of SAAC who works with children in FCCS and is concerned and confused about what will happen now, where will they go? o Field based services - under FCCS will migrate to some degree to FSP programs and to another degree to Non-FSP - Community Integrated Recovery & Resiliency Services (CIRRS). FCCS as a work plan, as a separate stand-alone program, will migrate to two different services. We know there is cohort of clients that are being served in FCCS programs that are really requiring FSP level services. We know this because of their cost. We will give the opportunity for providers at each provider site to take a portion of those FCCS dollars and supplement their FSP programs for particular age groups. • Marcelo: In FSP and FCCS, the average cost is $15K, $16K. If you use $12K as the line - folks that cost more than $12K or less than $12K, you end up with folks that cost more. Let's say a program that has both - post consolidation you would have a FSP program that serves the folks that cost more, and then you have a wellness component that will serve the folks that cost and average of $6K, $7K. o The department met yesterday - we know that the average slot cost is too low. The result of that - FSP providers serves fewer clients to make up that gap. We recognize that it is an issue and one of the things that we are trying to do is look at the right slot cost for FSP at the highest level and the lower level. We used $12,500 as a proxy to develop a basic budget. The next step is to look at those specific clients at those provider sites. In order to make this work we have to have a cohort of FCCS clients that meet the operationalized at-risk criteria and a cohort of staff that will expand an FSP program. o The $12,500 was a budget proxy, we will then work with providers through the Service Area District Chiefs and the age group leads and go client by client to determine which clients will benefit most and which would meet criteria to FSP vs CIRRS (non FSP). Once we have a cohort of staff and clients then we will do contract amendments. We need this to be in place by the middle of March. • Dennis: State criteria are not as restrictive as our local criteria for FSP. As we move folks over, the issues that we will face how do we select these individuals who are moving up from FCCS to FSP, meeting the minimum criteria that state has for FSP and also manage and create more slots to those high end folks who are going to

MHSA 3 Year Program and Expenditure Plan Review (Cont.)	come through Whole Person Care and No Place Like Home, etc. • Cynthia: point of clarification - we did it with a pilot project- we moved people from FCCS to FSP we had a major discussion about when they came into FCCS, did they meet that criteria for the State? If you had someone in FCCS for 6 months, 8 months, they may not at that moment meet that criteria so we had to go back to the original AFA and the original presentation. Are you going to do it that way as other people move over? • Romalis: When we did our work group, the concept was to look at transition from high to low based on person's need rather than the systemic process. A client falls back into a higher level need you can have a transitional point that may not be at the highest level because it is not warranted, but it's not at the lowest level either, but they had to be a transitional point in which to create another level of service. Facilitate that concept in the design continuum of care. The idea was to come up with a second level of FSP that was not as intense, but was at least helpful, medium intensity. The idea was to give both provider and the client the ability to move up and down this chain as needed to improve well-being. Facilitating both sides, both the client and provider side to do that without having to come back to the system to tell them it's OK to do it. o If you have a high utilizer client, they come into service, and this is the opportunity to transition them within that same team to be able to receive eventually less intense services from that same team and still be part of FSP until they don't need that service anymore. We will talk about level of care later on. • Patricia: Page 25- Under FSP, can you expand on family support services and family crisis/respite care services? o Family support services are services for the parents or caregivers of children in FSP programs, so that is naturally a part of FSP. Family Crisis/Respite is only for children in FSP for the family. Expanding it to child FCCS. You will see it in non-FSP CIRRS area for children. • Patricia: Will it go to adults, eventually? o To those who would have the respite. • Richard: About 24 years ago we figured out that people recovered. Next year, in 1993 - these folks are recovering so we can lower the amount. Whatever it takes attitude has to be FSP. State came up with definitions, which made it very restrictive and put them in generic services or CSS. . We have to do something by March, but we really need have CBHDA and its friends sit down and draft regulations that make sense for the system then, we got to start doing that, and they are not recovery oriented regulations. Their regulations are controlled by a model that still depends on individual billing that draws these bright lines between things. We end up with things that are less than personalized and less recovery oriented. CBHDA, while it was still CMHDA, came up with a brilliant concept of various levels of care - all of which is basically FSP because they would be based on levels of need, acuity, and what the individual would need to move ahead. My hope is that we can get back to that and get serious about redoing these regulations so they actually make sense • Carmen: I keep hearing this new acronym and I don't know what it is… CIRRS is Non-FSP? o CIRRS. It is Community Integrated Recovery and Resiliency Services (Non-FSP). • Jim: One of the things we've always done is leverage MHSA dollars… for example the Whole Person Care has billions of dollars attached to it. Question is if we are talking about expanding FSP and for Whole Person Care that is a whole another pot of money that's not even in this plan, is that correct? o Robin: Whole Person Care will pay for certain non Medi-Cal reimbursable services. The focus of Whole Person Care is on Medi-Cal beneficiaries; it is an 1115 waiver Medi-Cal focused program. The dollars

MHSA 3 Year Program and Expenditure Plan Review (Cont.)	that are being drawn down are specifically for non Medi-Cal reimbursable activities, not treatment services; it will pay for care coordination and integrated services that help people transition between levels of care that are Medi-Cal reimbursable. It cannot pay for FSP slots. • Jim: FSP has always had a significant portion of what they do, whatever it takes portion that's not Medi-Cal reimbursable as well, so it could possibly augment that, or could it not? o Robin: It's possible, but there were some restrictions that were built into the proposal. ISR project it will pay for largely supervised peer teams, who will help to identify clients, move them out of hospitals, ensure that people successfully transition into the community and are given the supports that help keep them there using evidence based practices. Transportation to and from, clinic appointments, making sure people have food after they come out of the hospital, peer services to reduce isolation and promote connections. All of those are not specifically Medi-Cal reimbursable but they are built into the Whole Person Care initiative. There is a second set of Whole Person Care funding that DHS is going to be receiving information shortly about the criteria for applying for it so we are hopeful that some of the other augmented/ancillary services could be paid for in that way. We initially hoped housing would be eligible expense but it is not. Housing cannot be paid for but the support services in housing may be. • Bruce: Is there budget somewhere that outlines Whole Person Care? Is it a billion, or 2 billion dollars? o Robin: No. What happens with Whole Person Care is that the County obligated to put up 50 cents on the dollar and then it gets matched with federal funds. It is done through intergovernmental transfer so that DHS compiles a pool of funding that is not currently matched to Medi-Cal that we are expending in Los Angeles County. We kind of pledge it in a form of an inter-government transfer and that enables the state to draw down an equivalent amount from the federal government. The whole pool is then returned to Los Angeles. A summary sheet will be sent out. • Romalis: I don't want to lose what Richard talked about when he made a statement of what we should be doing to look to the future. I would like to make a motion that we recommend to the Director that he create a work group to do exactly what Richard talked about, changing the legislation to make what we do more transitions from needing care to wellness, better and easier to work with. I recommend that we recommend creating a work group to the Director now so when the time comes we can affect the change we need to do. o Debbie: I will take what you said back to CBHDA, your comment and the endorsement that CBHDA needs to work with DHCS on modifying the community services and supports regulations. I can also work with the CBHDA and MHSA committee to be able to frontload some of that work, if CBHDA will take that on as a work priority. Susan has a role with this because of her legislative advocacy role. • Richard: This is regulatory advocacy, not legislative advocacy. This is all in the regulations, and this is not in the Act, it was never intended to be in the Act in that way. o Debbie: The whatever it takes philosophy doesn't stop at FSP, so one of the things we can think about as the age groups reconvene, that we think about or operationalize whatever it takes in CIRRS for each age group. Is that consistent with your thinking? • Richard: It will temporarily be consistent until we re-work the regulations. o Debbie: Richard, is there something specific in the regulations? • Richard: It's the regs that promulgated around FSP, which limited who meets criteria for an FSP. o Debbie: It will take all of us to figure out the balance between serving the very high service recipients or

MHSA 3 Year Program and Expenditure Plan Review (Cont.)	the people that aren't served by our system and those that are at risk and can benefit from a full service partnership program conceptually. • Leticia: I want to support what you said, to work while we get this figured out. There are a lot of things we can do to focus and strengthen that section of CIRRS. We can do more trainings on recovery, how do we work more towards doing everything that we can. A lot of times it's hard to have clinicians to move them out because in a way we are making them dependent on us. We need to teach them to do it for themselves. Help them become self-sufficient. A lot of people don't know about all the services out there, maybe we can link the clients and their families in community supports. Trainings on how to document and link the clients and their families. Link them while they are in the system so they can discharge in a comfortable way and they don't keep coming back. o Debbie- Thank you Leticia, you nicely articulated the feedback from the Mental Health Commission Executive committee. Mirtala and I were discussing about how to incorporate what we have learned to make our services better and to really create that continuum in CIRRS, the role of Outreach and Engagement in CIRRS and the role of linkage and housing. **Slide 25- CSS Work Plan Consolidation** - The jail linkage services staff now works for Health Services but they are funded through MHSA, they still have the same reporting requirements and duties as they did before they just report to a different department. • Ruth: When you did Planning, Outreach and Engagement, in the first column, I was assuming the service navigation was there so I am not understood what the planning is in the first column. o Debbie: Planning refers to the System Leadership Team and other related work. The CSS plan consists of FSP programs, System Development and planning outreach and engagement. Each year we can use 5% of our CSS dollars for planning efforts. • Patricia: My son is on FSP on and off and being in jail or hospital. There would be emergencies that he needed help with after hours, and they say they don't go out into the field after hours. Is there a way to help the family members before they get more decompensated? o Debbie- If you or anyone that you know are experiencing any lack of responsiveness from any program that we manage, please let me know. • Ruth: This is not an individual basis; I think it's happening all across the board. It's is an overall problem that we are not 24/7. o Debbie: its 2 levels, it's systemic and by provider. I am quite confident that not every provider is operating like this. If you come across this, you can let Wendy or I know. We will investigate that and we will make sure the providers are doing what they are supposed to do contractually. The second piece is that we will reinforce this at our provider meetings. • Robin: To answer Bruce's earlier question regarding the budget total. The total of the 4-year program is $180 million dollar a year. We pledge $90 million and we get back $90. The total gross program is $180 million a year over 4 years. • Eddie Lamon: Please say the whole words and then say acronyms so it is less confusing. Back to what Richard said about changing the regulations - are you still on oversight committee? Can you get them to do those regulations? This county correct what it should be and give it to those people to change it, they usually follow LA

MHSA 3 Year Program and Expenditure Plan Review (Cont.)	County. Did you say that the money is on health services? o Debbie-Yes, for Whole Person Care, the Department of Health Services was the recipient of that money. **Slide 35- Determining the level of care:** - Introductory thinking of all the age groups. We will use a MORS score and certain # of determinants that if a client scores positively on will indicate a certain level of care. Our work would be to put that together. - Create/adapt a field in the current system to input the level of care. Level of care is really critical if you are creating a more fluid system of care. • Marcelo: Are you doing that through Avatar? o Yes, it will be through Avatar. We are also querying other counties that use Avatar and see what they've done and whether we can replicate it. **Slide 36** : - What was presented last month was very basic. The goal was to not lose anything that was already approved in the first CSS Plan. All those services map up to higher-level services. The next phase of this work is to fill that in. If there is a service gap, this is the opportunity to identify that and add it to CIRRS. What is the evidence- based practices that maximize recovery and helps move the client to community supports that promote recovery. • Romalis: What kind of data format are you capturing for that? o Levels of care would be one way, and a combination of symptom based outcomes measure for CIRRS by age group. Age group may recommend more functional outcomes. • Karen: If I am hearing correctly, slides 36, 37, 38 are now our framework to take back to SAACs to look carefully at gaps, to look for continuum, this is the place we need input. Can you please put the 3 slides in an email so it is easily forwarded? o Debbie: Yes, age group work groups are the place to start to insert this. The next step is modifying what we call a service exhibit, which is something attached to a contract which has all of the expectations. • Ruth: Why are we not using self-help support groups rather than staff-led groups? o Debbie: What would MHSA fund in a self-help support group? • Ruth: They need to fund support for getting the referrals done, for providing space for the programs to meet, developing formats for the groups so the group has a written format. This isn't just about throwing people into a room together, it's a highly structured meeting format that is written and different people participate in, it can be done in pictures for people that are not very literate, it can be done in writing for people who are literate. Getting all those formats put together and making sure that is all coordinated and the outreach is being done to get the people into these meetings. o Steve: Ruth, can you put together a small bibliography for us, to review some of that? Highlight a couple references that you really like. • Ruth: I have given it to the SLT several times. The American Psychological Association has put out a bibliography on self-help groups, urging all public health and mental health to include them in stuff. • Helena: Debbie, I think that is a targeted case management issue. There are so many peers out there that do not know that there are self-help groups available to them. Our clinicians really need help or guidance or

MHSA 3 Year Program and Expenditure Plan Review (Cont.)	instruction on actually getting that information to the consumer. • Ruth: There is a best practice for doing a referral for self-help support group, which is telling the person that this would be helpful for them. Calling someone that goes to that support group and handing the phone over to them, buddy system. 100% of the people that did it that way people showed up within two weeks rather than just given a referral only and 0% showed up. • Leticia: That is really good information and that could be a training. Helping people move through the continuum of care, and that could be one of the trainings that will explain those things. • Romalis: We should add a tab to the chart- so the information will be in there and understood. Expectations that we will provide that kind of services to the community so that we would not lose our focus. • Eddie - Ruth- don't you run those programs? o Ruth: Yes we do. You need to have all the above, the social support is 40% of mental health and the cheapest intervention that we can do. In August 2016, every county received a one-time allocation of MHSA. LA received $121.6 million and we have 3 years to use it, per regulations. We decided it to spend it mostly on FSP slots. To be able to provide the service capacities for those initiative that we've been talking about (housing initiatives, Whole Person Care). • There is a little bit of money for CIRRS (Non-FSP) • For next 3 fiscal years, $25.3 roughly will go to FSP, and $5.5 will go to CIRRS (non-FSP) for a total of $30.8 in CSS. I say roughly because we under-funded cost per FSP slot, so we have to look at the number of clients and cost per slot. • Budget - CSS Programs - Slide- 56- took our budget and broke it down in different elements of CSS per work plan consolidation. This does not include the $121.6 million; it only includes the annual allocations for the next 3 fiscal years. In 2019 and 2020, there will be a certain amount taken off the top for No Place like Home. The allocations will reduce a little bit. There are a lot of budget uncertainties right now and what we are trying to do is present you with what we know. As we know more we will come back to you. • Bruce: CIRRS or CIRS –who are we excluding? o Debbie: we will make the change- CIRRS **FSP Slot Increase** (Estimated) • Slide 57- it's a proxy. We won't know until we do the work in the next month or so. We think it could create 2,837 but contingent upon what the cost per slot becomes. • FSP conversion slots - Majority of slots are in Child and TAY. Majority of FSP expansion slots will go to adult due to the associated initiatives address individuals ages 18 and above. Whole Person Care is 18 and above. • Of note- billing plans for FSP and CIRRS will no longer be associated with a particular age group. This should not impact actual services delivered to the age groups. For reporting purposes. DMH will be reporting services based on the age of client and by the program they are receiving services from. • Michi: I have a question on the Whole Person Care, is that going to be an allocation in our funding for FSP? o Debbie - That is correct. Though a solicitation to issue additional FSP capacity. • Michi: Reimbursements for non Medi-Cal with cultural competency, we had to utilize persons that can speak the

MHSA 3 Year Program and Expenditure Plan Review (Cont.)	languages of the people that we serve and we haven't been able to bill for that. o We are expanding FSP in response to Whole Person Care and the impact that many of the plans will be referring for intensive services. We have been calling it Whole Person Care FSP but it has nothing to do with Whole Person Care, it is our response to the Whole Person Care and how it will impact our System. We are trying to be proactive so that we will be able to create the capacity for the demand that we are going to have. Two separate things, it will be a hand off and connection from the Whole Person Care teams but we will then lending support though our DMH funded Medi-Cal reimbursable services. • Romalis: She made a great point about finding people that can speak the language in order to facilitate this expansion. In our budget on the next page it shows eliminating in the WET program and the ability to go out to recruit and support young people that speak these other languages. We don't have the budget to continue these efforts, we are losing sight and we need to rethink that plan of not funding something to recruit these people for the expansion of what we are going to do and also with what we are trying to do now. o Debbie: The EMT's intention is to look further at our investments in WET and after the initial allocations go away at the end of 2017/2018. Also making sure it is in alignment with what you are talking about. Specifically addressing disparities to work further on before we brought you a proposal. • Ruth: How does that compare to the number of slots we have in FSP currently? o Debbie: This is in addition to the slots we already have. • Ruth: Adults 26-59, which is a much bigger category than TAY yet, they are getting fewer slots. o Debbie - It is a rough estimate. There is a portion of TAY that are EPSDT Medi-Cal versus non EPSDT Medi-Cal, it just results in a tremendous amount more of slots. It happens that the 12,000 clients for FCCS they happened to be TAY under the age of 21. **INN** is $23 million/year. I will come back in a month or two with some potential new Innovation projects. If Department recommends and you endorse funding for WET beyond 2017/2018 then the dollars do have to come out of CSS money. • PEI annual budget- they consolidated the 13 project/programs into the components of PEI per the PEI regulations. This is a basic budget of suicide prevention, stigma and discrimination reduction, prevention, early intervention and administration of PEI. **2017 Action Steps:** • Determine the clients that migrate over to FSP. Working with Providers and District Chiefs. • Change the financial summary to reflect the 6 CSS work plans. • Reconvene CSS work groups to o Review and finalize the CIRRS service continuum o Articulate the methodology for level of care assignments. o Agree, across the system on the frequency of data collections both of the level of care as well as outcome measurements. o Identify Outcome measure (instrument) for CIRRS and frequency of collection o Identify outcome benchmarks for FSP-domains and benchmarks. • DMH to modify IBHIS and work with providers to modify their EHRs to accommodate level of care field • DMH to build out OMA (web based application) for CIRRS data collection and reporting

MHSA 3 Year Program and Expenditure Plan Review (Cont.)	• DMH to draft Service Exhibits for FSP and CIRRS • Determinants of Care and MORS trainings being scheduled for providers. • Romalis: Are all of these systems in place and working? What is automated or what is paper? Make sure we get the date by paying for the time and energy that it takes to put it in. The expectations to the providers of both county and contract are going to be putting this data in so we can ascertain the effectiveness of the service outcomes. o Debbie: The systems we talked about are mostly automated. In terms of outcomes we have identified a procedure code for certain elements of outcome data collection reporting. QI bulletin will go out sometime in January. • Cynthia: I have a statement- I work for Mental Health America. Determinants are paper based as far as I know; Utilizing both of these may take a case manager 5-10 minutes. On the MORS and Determinants you can also, depending on you electronic health records, we just built them into the electronic health records with the alerts. It would be nice to electronically get them to you guys other than running reports and send them to you. o Debbie: Work with us on that. Do that on your end, and we will work with you on it. • Cynthia: One thing we added was non-travel minutes of service. What does this client need? Non-travel minutes of service. o Debbie: The non-travel minutes of service is a metric that determines level of need. • Richard: I have an extended suggestion regarding what others have endorsed by nods, what happens next? o Action: Motion made and majority seconded and in favor of looking at regulations and how they can be changed. o Debbie: Dennis and I will take that back to EMT next week • Patricia: How co-occurring disorders are going to get some kind of recognition? There are discussions going on but I would like some concrete steps that will be happening. o Debbie: this goes along with what Ruth was talking about earlier. This is an opportunity whether it is in FSP or CIRRS to think about what are the best practices for this care? SLT will come together to make recommendations in this area. It is pretty fluid right now with the drug Medi-Cal waiver being close to initial implementation. • Ruth: We didn't get an update on the Drug Medi-Cal outcome. What is the State doing? o Debbie: There is no change in the trajectory. The new presidential administration has not impacted either DHCS' movement toward implementing the 1115 waiver. • Ruth: We are still set for treatment for all for those that cannot afford it? o Debbie: will get back to you on that. • Thank you for packet, it's nice to be able to read it. • Karen: I just want you to repeat what you said in the Mental Health Commission co-chairs—you stated how our input to our legislator is tracked, whether it is hand written, emailed, etc. Can you please expand on that? • Steven Goodwin: Legislators track the amount of comments that they receive. A written letter is more valuable to them because it takes more time to do, then comes a phone call, then an email. • Cynthia: If anyone is interested go online to the Indivisible Guide.

Public Comment and Announcements	• Mark: in Sacramento- wellness educations training—want people to be a part of it. Concern is language- they will try to reintroduce it, minus the money for it. It will be next month or two; the summit will be on March 9th. Cal Mental Health peer run organization. Conference we want people there. Deadline is Jan. 31st. **Reminder: The Orientation Session for the SLT is on Feb. 7th at 9am.** **Adjourn**