

COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, August 16, 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. Update on Full Service Partnership
 2. Update on Implementation of PEI Projects in the 3-Year Plan
 3. Update on Innovation (INN) Projects
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MEETING NOTES

<p>Department of Mental Health Update</p>	<p><i>Dr. Robin Kay, Chief Deputy Director, County of Los Angeles, Department of Mental Health</i></p> <p>The big focus is regarding the Department reorganization. We are preceding; the Board has heard the request for the 5 new Discipline Chief items that Dr. Sherin talked about. We have gone ahead and posted it. In your packets there is a description for the Discipline Chief for Peer Services in the Department.</p> <p>There will be 5 Discipline Chiefs that will join our Executive Team:</p> <ul style="list-style-type: none">• Discipline Chief for Psychiatry,• Discipline Chief for Psychology,• Discipline Chief for Nursing,• Discipline Chief for Social Services, and• Discipline Chief for Peer Services. <p>That is the major new initiative and we are moving forward with that effective immediately. We are recruiting for those positions.</p> <p>In addition, and to be consistent with Dr. Sherin’s vision of how services should be delivered in the Department, we are moving forward with discussions, presentations on the other part of the re-org to align with his ideas about intentionally focusing on Outreach and Triage, Prevention, Treatment and Stabilization, Recovery and Rehabilitation in both directly operated and contracted programs as well as Intensive services like hospital services and case management services. The other entities and other divisions within the Department will support the delivery of those services. The work involved is tremendous and we are working on all of that and we will have more concrete details next month. We have had a series of retreats within the Department; we have another one on Friday to finalize positions and who is going to be doing what and how it will all work. We will have more to say about all of this at our next meeting. The focus on the re-org is all about ensuring that we can be intentional about pursuing both the programing and values that are intrinsic to the work that we are doing here in SLT.</p> <p style="text-align: center;"><u>Question and Answer:</u></p> <p><u>Marcelo Cavalheiro</u> — Is the Discipline Chief going to be a social worker, a psychiatrist?</p>
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Robin Kay – Off the top of my head, I can't remember what the qualifying criteria is on that. Certainly someone that has a degree in social services but it is more than social work incorporated in that position.

Marcelo Cavalheiro – the only reason I ask is that as an MFT...

Robin Kay —I believe MFTs are grouped with the social services position and if you go online you can find it. Yes, there is recognition being given to the fact that Social Services is more than just people with an MSW.

Lawrence Reyes- In regard to the MOU with the Board of Supervisors and the County: We are excited about the idea, but our concern is that we haven't met consistently for the Re-Org? Are we still going to meet to confer in regard to the issue of Re-Organization because we (SEIU) feel it is going to change working conditions, and the way services are being provided. The other question is about the Peer Discipline Chief, how the management structure will look. We understand the requirement of the Peer Discipline Chief is that they have lived experience, which I really appreciate. Our concern is that peers themselves cannot be in management position such as support staff.

Robin Kay — Two big questions, I know that our Admin Deputy has had conversations with all of the unions and she has offered to have additional meetings with her and Dr. Sherin on the Re-Org. There is a commitment to doing that. The intent is to minimize disruption and the impact on line staff to the greatest degree possible. I can't say there won't be any impact, there certainly will be, but less on the clinics where the services are being delivered and probably a little more so as you get higher into administration. Undoubtedly there will be some changes for line staff in terms of our focus but I know that the plan is for additional meetings to be had with the unions. The second question on the issue on the Peer Discipline Chief is a Master's degree or a closely related field and professional experience. It doesn't rule out having a peer in that position, in fact that is the desire to have someone with lived experience in that position but with the additional education requirement.

Lawrence Reyes —In regards to support staff, people who are under the Discipline Chief at the second level or third level, we feel that there should be peers that would be able to supervise peers because of that type of experience that they had.

Robin Kay — Thank you Lawrence, I will take that back as a comment and a question. I will say over in the Department, and again with Dr. Sherin's leadership, a strong emphasis on broadening opportunities for peers, both in terms of the number of peer positions in the directly operated programs and the contracted agencies and also the development of career ladders for peers. Whole Person Care is a really good example that we hired 12 peers for the first round of Whole Person Care 1 and we will add another 12 peers to the second part of Whole Person Care 1. Whole Person Care 2 we will bring in a cadre of 40 peers to work throughout the Department as supports to people who are transitioning through various places in the system.

Richard Van Horn — Is there a particular reason why the Chief of Peer Services reporting to Medical Director as opposed to some other person in Leadership? The Medical Director position is not exactly a recovery position, the recovery model would indicate that ought to be headed by a peer, but you may have ruled out the possibility by requiring a master degree or higher in social work, marriage family therapy or closely related field. This is begging the question of peer involvement, I would hope this is incomplete.

Robin Kay— Actually the position has been posted, so I don't know that it is incomplete. I think that the reason that this position is reporting to the Medical Director has to do with the fact that all of the Discipline Chiefs are reporting

to the Medical Director who is responsible in the Department for setting standards of care, and that was the intent. In truth the Re-Org is a work in progress, I think it is the relationships between the Discipline Chiefs and the Deputies and Managers that are responsible for delivery of care, including the contractors because the Discipline Chiefs are not just responsible for the directly operated programs but how we develop programs in the Department. Much attention needs to still be paid to those informal lines of communication, reporting and oversight, which is often where the work really does get done. We are talking actively about those relationships as well, so its not only the structural reporting relationships, it's the informal reporting relationships and working relationships that I think often can be the most impactful. I will take that back as a comment but I do think for right now, the vision is to have all the Discipline Chiefs together reporting through the Office of the Medical Director. Dr. Sherin is extremely invested in the peer specialist Discipline Chief. I am 250% confident that the formal reporting relationship will be augmented by the direct line of the Discipline Chief to the Director.

Richard Van Horn — The most involved peer we've had in this Department of 35 years was Bill Compton, who did have active schizophrenia, who was involved as a client as well as manager. His master's degree was in theater management not in a social service discipline, yet he was extremely bright, capable, and could have handled any of these things.

Robin Kay — I agree with you, I remember Bill. I appreciate the comment. Thank you.

Romalis Taylor — My perspective, we are supporting you, the Director and the Department management and the struggle to change in the new direction. I am having a hard time understanding where we are going, what it means, and what you are doing because you are still figuring it out. When can we have a presentation on the new philosophy that Dr. Sherin is bringing and how that affects what we are doing in MHSA and whether or not that he is restructuring it to be more of a medical approach rather than a social recovery approach? We need to understand where Dr. Sherin is going, what he intends and how he is going to do it so we can best support it but yet also offer suggestion to make it better or warn him if it is going off track. Hopefully he can share the plan with us.

Robin Kay — I appreciate that, and I will take that comment back. Recently we have done a couple PowerPoint presentations, and maybe next month we can bring some of those presentations as well as having Dr. Sherin here to talk about his plan.

Karen Macedonio — We worked really hard to explore, talk about, learn about the recovery model. We have not finished all the learning and we are now in the position where there are a lot of forces that potentially look like they are trying to shove us away from that. I want to hear what the Department's commitment to the recovery model in every single conversation. I want to hear that recovery model comes first. This is what we are facing, how do we address it? I want it to be part of the conversations of the challenge but going towards the recovery model that creates cultural change.

Robin Kay- If I have given the impression that the Department is moving away from the recovery model then I am not doing a good job this morning. That is certainly not the case, I do know that when Dr. Sherin talks about vulnerable populations, and the continuum of services moving away from the definition of services as programs an focusing on prevention, outreach and engagement of vulnerable populations, treatment and stabilization, recovery and rehabilitation, that is a key driving factor in this reorganization is the ability and the intentional focus on recovery and resilience. In fact, if I suggested that we are moving away from that value, it is really just the opposite, if we look at the

traditional silos that we've had in the Department and instead look at the services that we are providing it is because the fact that we value the recovery movement, that is the point. The idea of bringing a greater peer workforce and looking for the opportunities to do that is recognition of the fact that we value that. We value people that are in recovery, people with lived experience, and people who can make a significant contribution. Hopefully we will have an enhanced opportunity to do that within the Department. There is nothing in the Re-Org that moves us in the other direction, the one thing that is a little confusing is the centralization of all the Discipline Chiefs under the Office of the Medical Director, but that is not an intent to make this a medical model. It is simply a reflection of the fact that in this Department, Quality Issues have been centralized in the Office of Medical Director and so that's where it nests in the Department and it could be somewhere else, but since that is where Quality Controls are located in DMH it makes sense to have Discipline Chiefs also nested in that part of the organization. There is no intent to move away from the recovery model; in fact it is just the opposite.

Ruth Hollman — How many staff does the other Discipline Chief have? This posting says up to 3 staff.

Robin Kay — Exactly the same number.

Ruth Hollman — Does everybody have the same duties to be responsible for reporting on the people within the Department who are working in the Department in that area?

Robin Kay — Yes, the duties are very similar, basically the major change from one to the other is the discipline that they are responsible for.

Ruth Hollman — How is this position going to interact with the Office of Consumer and Family Affairs, is that staying or changing?

Robin Kay — That office is absolutely staying, they will continue to do all of the same functions that they are currently doing.

Ruth Hollman — Is it going to stay both Consumer and Family together?

Robin Kay — We left off on that great debate 9 months when Dr. Sherin joined the Department and I am trying to recall the resolution, we will have to get back to you next time.

Ruth Hollman — This is basically to oversee people in the Department who are working as peers.

Robin Kay — It isn't just to oversee people in the Department that are peers, it is also to develop opportunities for peers to be in the Department, and that is true for all the Discipline Chiefs. It is more proactive than just looking retrospectively or what is in place, it's about looking for opportunities to enhance the capacity of all of us to employ peers in meaningful ways.

Ruth Hollman — Do you think these Discipline Chiefs are going to be part of the Executive Management team or not?

Robin Kay — The executive management team has been in a transition as well in terms of the way we have defined it and it continues to evolve so I do expect that they will be meeting with members what is now called the Directors' Management Team. We are trying to sort our way through whether that group that meets weekly will have all of those members meeting weekly or be some other arrangements to include them. I do expect them to be fully involved with the Directors' Management Team.

Ruth Hollman — Does peers in this case include parents and family members, the whole peers, peers, peers.

Robin Kay — Yes.

Marcelo Cavelheiro — Are all five Discipline Chiefs posted? Peer, Nursing, Psychology, etc?

Robin Kay — Yes, all five are posted: the Discipline Chiefs for Psychiatry, Psychology, Nursing, Social Services, and Peer Services.

Patricia Russell — With the reorganization of the Department, are they talking about co-occurring in terms of concurrent treatment within the providers being able to work with the new waiver and helping different providers trickle down to the consumers?

Robin Kay — With the issue of being competent in the treatment of co-occurring disorders has been a priority to the Department for the last decade. We continue to expand those opportunities both in terms of competency of our collective staffs and also in terms of the development of specialize treatment programs that can address those needs. With the Drug Medi-Cal waiver we have been working a lot with SAPC on the development of for example residential treatment programs that will be more accepting and inclusive and responsive to the needs of people with mental illness. Traditionally some of those residential treatment programs have had some trepidation working with people who have a serious mental illness. Many of them have been more a social model and has some concern about people with significant mental health histories. We are doing a lot of work with SAPC now on the design of new programs.

Patricia Russell — Is there any work being done with finding more residential programs that specialize in co-occurring disorders?

Robin Kay — Yes, that is what I meant, thank you for the question.

Hugo — What is the position on AB1250, are we fully aware of the impact if the bill passes, and is there more to be done?

Robin Kay — We have done an analysis of AB 1250. Legislation that will result in counties facing additional scrutiny in the area of contracting.

James Sokalski — It is more than scrutiny; it appears to be a prohibition.

Robin Kay — There was some question in the very beginning whether or not it was truly a prohibition or if the language allows for some contracting. I think it does, but in reality, in the implementation, it would make it almost impossible.

Richard Van Horn — It is almost like the old Prop A.

Robin Kay — We do Prop A analysis now and we have gone past Prop A analysis to contract out services and it has not been an impediment where we can meet the Prop A standards. This goes beyond Prop A significantly. I was asked early on by our legislative affairs folks, about the impact on the Department. It is important for people to understand that in the Department of Mental Health because as the local Mental Health plan, as any managed care entity must do, we have to demonstrate a geographic distribution of services in a network that has the capacity to provide services to any resident of Los Angeles County that need specialty Mental health services and we do that through our directly operated programs and a strong network of contracted providers. AB 1250 will really affect our ability to contract out and maintain that network. I have talked to Dr. Sherin and he feels confident that it won't pass, but I cannot speak for him. It would create significant problems for this Department in maintaining the network adequacy

	<p>that we are responsible for ensuring.</p> <p>Hugo — I encourage us to talk to your representative and oppose this bill. It will be a catastrophe for all our clients not just the Department or the providers.</p> <p>Jim Preis — Recently the Board of Supervisors had approved a study of conservatorship and I am wondering what the Department has done since it involves stakeholders.</p> <p>Robin Kay — We are in process planning for the stakeholders group. It requires the Department to do a number of things, Stakeholders groups, looking at 3 different aspects of the Guardian program, probate conservatorship, the LPS conservatorship for adults and LPS for children. We are in the process of planning for those stakeholder groups. I understand that the Board offices may convene a preliminary group and we are waiting for them to decide on whether or not they are going to do that. If they do we will follow behind. We will divide and look at those 3 different issues because they carry with them separate questions. It also requires the Department to look at possible efficiencies and our procedures associated with the Public Guardian program, which we welcome. In addition we had a number of challenges over the last decade with recruitment and retention in the Office of the Public Guardian because the positions are extremely low-level positions. The level of responsibility of the public guardian is basically the same as a child social worker who's responsible for the lives of children that are detained by DCFS. It is a huge responsibility, very daunting and we need to look at the appropriate level of those positions and the appropriate compensation given the amount of responsibility that they take on. We will be working with the CEO classification compensation folks on that issues</p> <p>Jim Preis — It sounds like there will be an opportunity to talk about the job descriptions and the role of public guardian conservatorship, and really rethink how conservatorships should be carried out.</p> <p>Robin Kay — There are also some innovative ideas on the table. We have expanded that office in the last decade and given the aging of the population and our inability to use Mental Health dollars on the probate side, we are going to face challenges over the coming decades and we need to begin to look at innovative ways to enhance our capacity and understand that the Department won't be able to do it all. There are some terrific ideas on the table and I will wait until the stakeholders process to float them. We have to be so much more creative than we have and other efficiencies like technology and other things that we may do that will give us a broader more flexible approach to the services that we provide.</p> <p>Ruth Belonsky — I would like to speak to that particular point having worked in a hospital, where there had been people who have not had the mental capacity to take care of themselves, and often very difficult to get a hold the public guardian, who is really responsible for them, so I just want to reiterate how important it is to have more people.</p> <p>Robin Kay — One of the problems is that the caseload is too high. It is the same issue as DCFS faced with children social workers a number of years ago. Part of the reason the case loads are high are that given the level of the positions and the compensation, it is difficult to keep people that have a huge responsibility and they can go elsewhere. We are very motivated to fix this problem.</p>
<p>Update on Full Service Partnership (FSP)</p>	<p>Debbie Innes-Gomberg, Ph.D., Deputy Director, County of Los Angeles, Department of Mental Health</p> <p>FSP Provider Meeting — Providers were given opportunity to migrate field capable clinic service dollars from FCCS to FSP. This past May, the same providers looked at their clients who met criteria for the at risk category.</p>

- For children 1,077 more children FSP slots. FCCS clients that are now categorized as FSP. In addition to migrating slots, children met criteria but were being met in FCCS. The total number of child slots total 359.
- TAY 80 clients migrated over for a total 1395 clients.
- For Adults 505 clients migrated over for a total of 6,205 total.
- For Older adults we had 16 migrate over for a total of 885.
- Total of 12,082 clients in FSP.

Statement of Eligibility & Interest (SEI)/FSP Slot Expansion

SEI was issued for Full Service Partnerships in July. It is a rolling solicitation for clients 18 years and above and the focus is on a very specific focal populations. People coming out of jail, those that are part of the whole person care project or the forensic FSP initiative, people coming out of hospital-particularly the Intensive service recipient that is part of whole person care, residential and bridging, 2 housing populations-those that are homeless and those that are recently homeless. We went over the proposals that have come forward, and in a couple weeks we will start awarding new slots.

Ruth Hollman — On the homeless with care case management for Housing for Health, does it include all of the housing trust fund, essentially MHSA money gone to DHS, is part of the health agency. Is it that population or different population?

Debbie Innes-Gomberg — It is an ICMS approach, that is part of that initiative.

Ruth Hollman — Is everyone that was in the Housing Trust Fund units that have supportive services through Housing Trust Fund is that who is going to be eligible for these FSP slots or is that different?

Debbie Innes-Gomberg — We are going to have to get an answer for that.

Ruth Hollman — When money moved from the Department of Mental Health, to the Department of Health Services they required every provider to have medical supervision of all of their case management staff. Now we have to have a licensed person who is supervising all of our staff so it is now more money. Moving to a medical model rather than a recovery model and it wasn't broken, why are we using more money to do this?

Cynthia — I have a question for Ruth for clarification: Case management staff always had to have licensed supervision, are you saying it had to have licensed supervision by a MD, or just licensed supervision like always?

Ruth Hollman —The Housing Trust Fund was not case management that was Medi-Cal reimbursable. This is money for permanent housing providers to have support within their projects as well as scatter sites. We have peer bridgers providing the services and now they want them to look for a diagnosis of the person, which was not necessary on the old model. DMH needed to know the diagnosis, now we need to know who is diagnosed with what, they have to be monitoring all the mental health symptoms even though everyone in housing is tied to mental health services. Making recovery based stuff the same as medical model.

Debbie Innes-Gomberg — The way the Department is looking at it is that this is a way to leverage other resources, namely housing for health. It is different, and it is worth exploring particularly given the amount of increasing homelessness.

Mariko Kahn — In the SEI you mentioned specific FSP populations, but are they really any different than the FSP people we have been serving? You are categorizing them in specific parameters.

Debbie Innes-Gomberg — You are correct. The clients that have recently been homeless that are now housed and have case management, that you would consider them being at risk of being homeless again. It is the integrated treatment team that involves corners and the FSP team that is a little different than how we've been doing things.

Mariko Kahn — Also the AOT, at some point it would be nice to blend them all together.

Debbie Innes-Gomberg — I will talk about how we intend to move forward in that way. At the start of 2006, we were very general, pretty much every FSP provider served a multitude of populations and now we are getting more specific, in part because our concern of homelessness, Whole Person Care initiative and other things. We want to make sure we really focus on those key populations and we believe the FSP model is one that can do that.

Marcelo Cavalheiro — Just a caution if you plan AOT with FSP, in our experience for FSP client, AOT folks get seen 3 times a week, and 3 times more intense and 3 times as more expensive. Perhaps it wouldn't be a problem if you have different levels of service and runs like the pilot.

Debbie Innes-Gomberg — In addition to that we also added 300 Forensic FSP slots through a solicitation as well.

Patricia Russell — If someone is with Housing for Health and is housed with their project 180 case management can they also be getting service for FSP?

Debbie Innes-Gomberg — Yes, that is the intention. Full service partnership team would round out that team and provide all the other services That weren't Housing Case Management related.

Patricia Russell — Would they be talking to one another and working collaborating with each other?

Debbie Innes-Gomberg — Absolutely, we had a couple of ways to think about team approaches to care. In the assisted outpatient treatment the Outreach and Engagement, which is extensive, is done by the Department, the Emergency Outreach Bureau. We have learned how they have to communicate with the FSP team that accepts the client. Similarly in this new model we are going to learn the best ways in which the FSP team works as a team on site at the apartment complex.

Patricia Russell — If they can also include that the highest percentage is the co-occurring and have that kind of training.

Directly Operated Expansion

We are adding San Pedro mental health. In September I will give a count of the FSP capacity by age groups. It will increase between now and our meeting in September because of the solicitation of the SEI that we issued. We are adding some directly operated FSP capacity where we have some space in our programs. We are adding a new FSP program to San Pedro Mental Health, they have an increasing homeless problem.

FSP Approach to this Fiscal Year

Debbie Innes-Gomberg — Lillian, I just want to acknowledge all the work that you have done around Prevention and Early Intervention. One of the documents that Lillian forwarded to me was a document with attachments and it was very thick. It was the most comprehensive document on first break psychosis that I have ever seen; it included the evolution of the peer model from Portland to California. It talked about outcomes and practices, clearly Lillian and her staff has

done a tremendous amount of work in this area and we are going to lead this effort as we move into this fiscal year, so well done.

Along those lines, a couple of other things in regards to first break psychosis. Steinberg Institute, The OAC and the Staglin Institute were all very interested in the Mullin bill that Lillian was referencing. One of the things that is likely to happen is that there will be public private funding that will be able to fund first break programs. In addition to that, I was invited by NIMH to a meeting that will focus on creating a unified a data set or a set of metrics for first break programs. In the coming year, there will be more of a focus on California on testing out different models of programs and collecting a unified set of data into a portal that the Staglin Institute is working on, so that is exciting work.

I also wanted to let you know that there is a greater emphasis on prevention over the last couple of years. Innovation 2 was a very intentional step towards preventing or intervening very early through capacity building related to trauma. That was one of the first things that we did. In addition to that, through the reorganization we will have a deputy over prevention services. Whether it is funded by MHSA or other funding; we will have a deputy over that. That deputy is Bryan Mershon and he will be working very intentionally on prevention services, particularly in the children area and particularly around trauma. I think that is a very positive step.

In your packet from DPH, it is information about how to obtain substance abuse services. One of the things we can do in the coming months is have Michelle or others come talk about the implementation of the Drug Medi-Cal waiver and how that is going.

Usually we start our planning for our Annual Update for our 3-year plan around September and we will start to do that work. It will be heavily informed and lead by our new Strategic Planning Deputy, Mimi McKay. I look forward to you all meeting her, if you haven't met her yet. This is really an opportunity to bring the Service Area Advisory Committee more into planning to use data in a way that we maybe haven't had an opportunity or expertise in doing in the past. I look forward to a robust planning effort that should include reducing disparities that many of you have talked about.

The Department has invested significant resources in Full Service Partnership Programs. After 11 years, we think it is about time that we look at the approach that we are taking in providing FSP services. We want to be able to do that in a way that looks at what are the best practices around all those things that comprise whatever it takes. We have a consultant, Sam Tsemberis. Sam is an expert in the housing first world, comes from New York and is doing some consulting work in California beyond this project. One of the things that he will be doing for us is gone out to 8 or 9 different programs so far, and will continue to go out to programs is that he is really taking a look at the way in which FSP programs, probably more in the adults arena than anything else. Looking at the types of services you provide, how you provide them, and make some recommendations to the Department around best practices in those areas. We will have an opportunity to take a look at team structure, the approach to housing, the approach to meaningful use of time and employment in FSP programs and this will all culminated, eventually, in a redrafting of our FSP guidelines, redrafting of our FSP service exhibits, and ultimately in a rebidding of the FSP contracts and the overall FSP programs based on those new parameters.

Evy Lowe —What about Children and TAY?

Debbie Innes-Gomberg — With Children and TAY we are going to be working with Bryan Mershon and Kalene Gilbert to take a look at those services . Sam may be able to help a little bit, but Sam's expertise is more in Adults so we don't have a complete answer at this point. It became clear in the last month that this really is focused on the 18 and above populations. Sam does have some knowledge of the Older Adult services but is not an expert in that area, so we need to take a look at that.

Evy Lowe — It doesn't quite translate, Children and TAY are different.

Marcelo Cavalheiro — I just want to say, speaking for myself, sometimes I may sound a little too critical of things. I do feel that we had traveled this journey that we had tremendous support from PEI demonstration, from Older Adults system of Care, Adult System of Care, I just feel that our role here, me representing Service Area 7 is to try to be as critical as we can. It's been a good journey and it's been a good partnership, I just wanted to say that, because I don't want to sound too critical. I also have had a few conversations with Sam, and the guy is amazing. I think he will take us to the next level in terms of recovery model.

Debbie Innes-Gomberg — I just want to say to your first point, I think each of you comes with perspectives and a different background and different way of providing or a recipient of services so I think the Department really appreciates the diversity that is around this table as well as at the round tables. One of the things that I prefaced in the Adult Provider meeting is that we have to acknowledge that we have done pretty well in our FSP programs but there is a lack of consistency when you look across programs, particularly in the Adult Providers and we can do better. We can always do better, and that is the perspective we are coming from. Its been 11 years and I talked about in the Provider meeting that many counties have lost the history of FSP because people have left the county, have gone to other jobs. We don't have that issue here, but what we do have is an ability to do things even better for our clients to get better outcomes.

Richard Van Horn —FSP is 27 years, not 11 years old. That is one of our problems: we have not learned from history, we have not learned from really understanding whatever it takes. I have seen a number of FSP programs, so called, that do not do whatever it takes, have limited amount of time for folks and are just frankly not transforming anything. I think Marcelo is on the same page as I am; there are problems that need to be looked at very closely. We used to do serious evaluations, we used to produce outcomes that was shared throughout programs back in the AB 34 days which are not done now. You don't have a way of really testing your model against some one else version of that model.

Debbie Innes-Gomberg — Your point is very well taken and I want to get us back to the point of time in 2006 or earlier. There was an incredible excitement across the state and certainly in Los Angeles about the opportunity that we have. We have all this new money to do some incredible things and I want to get back to that enthusiasm and think about what we have learned in the last 11 years. Richard is absolutely right.

The other entity or partner that we are bringing into this discussion is a group called Third Sector. Third Sector will help the Department and they are also working with the Department of Health Services as well. One of the things that they are going to do is help us be able to use data in a way that creates a feedback loop. Identifying the best practices, the most efficient way to deliver them for particular types of clients and then really looking at what those outcomes yield. Using the outcomes to then further inform practices. Creating the feedback loop that is outcome data focused. They will work with us on that. As we evolve this process we will do presentations and maybe we will bring Sam here as well as Third Sector so you can also hear from them directly. I am really excited about the opportunity to make our services better than they are right now. The outcomes are impressive but we have a little ways to go with housing and

employment and availability so we will be focusing on that.

Karen Macedonio — I just wanted bring up a conversation that we started having at our SAAC, and one that is really evolving. It started out as difficult. When we got outcomes and our outcomes aren't the best, that some of us may have been a little uncomfortable having the discussion in the group about that. Yet, what we are starting to realize is that as a community we need to have those discussions. It is not just about EBPs and its not just about best practices, although those are very crucial. It is about the discussions amongst us, What's missing? What it is that we are not seeing? What is the individual perspective? I think this is where we need to start talking and helping to raise the SAACs up in the level of engagement to know how we talk about community pressures to improve the outcomes.

Debbie Innes Gomberg — Thank you for saying that, I think that is another illustration of what Richard was saying about AB34 when counties were compared to one another. We were compared in a way that helped us up our game. Understanding what that data means and how it can be used and how you all can use it to improve the services in your area, I think it is an awesome idea and we will make that happen.

Richard Van Horn — This is unrelated to the previous discussions here but it goes back to AB 1250. There is a phrase in there I do not like since I started working MSHA. One of the first things I heard from the Department was about contract agencies or contracts. I felt from the beginning- are we paving contractors or something else and since Mental Health Association (old name has been around here since 1924, Pacific Clinics have been around sine 1926, LA Child Guidance has been around since 1924, years decades before there was a Department of Mental Health -these community agencies were the back bone of community mental health in any way shape or form. The problem AB1250- ore anything like that is when you talk about contractors, yes SEIU has every reason to think "Why do you want to contract things?" but when you think of partnerships, that is a different ball game. I thought for a long time that most of the community agencies ought to be unionized but that wont happened. The problem is the language we use has to do with how we communicate ourselves. When Department talks about contractors, that is an unfriendly term, when you think about community partnerships I hope the County will finally learn to talk about community partnerships and treat community agencies like partners, that would go a long way towards helping us defeat AB1250.

Debbie Innes-Gomberg —When I use the word provider, I am thinking of providers, regardless of whether they are county operated or contracted, so your point is well taken, thank you.

Ruth Belonsky — I have a son who is 51 years old and has been missing the last 18 months. He has been ill for about 25 years. We tried everything to assist him and for many years I knew nothing of the county assistance and help that was available. I have been involved for many years and it took me a long time to figure out that there were services. All of the contractors that you talk about and the FSP, he fell through the cracks. There was nothing that we could do, and it's not as though we didn't try and not as though I wasn't informed. I certainly wasn't informed of what was out there. There is nothing there for someone who is non-compliant with medication. I have tried several places and they all said that if he is not compliant then there is nothing we can do. So he lived with us for many years and he's lived on his own for many years and then he got worse. Listening to all of this and thinking how wonderful it is that there are people who can get into this Full Service Partnership, but then there are some people like my son who falls through the cracks and there is no place for us to go.

Patricia Russell — FSP and the mental health was all for the most seriously mentally ill people and it doesn't seem to

me that there is a continuum of care. Sometimes they need an IMD and when you look at the IMD in the county it is abysmal. They are just warehousing people and they are not going to get better. I know Dr. Sherin is aware of this and he's talking about thinking without a box. Getting places out in the rural areas where there can be a family kind of atmosphere where they can be training both on the land, with the animals, crops and other occupational therapy opportunities where people can really feel good about themselves. We have to blow up the whole thing, my son has fallen through the cracks even with FSP. He hasn't seen a psychiatrist yet because was on a FSP in Service Area 2, but then he moved to Service Area 4 and he's had to have 3 meetings so far and has yet to be signed up because he needs a fourth meeting. In the meantime he has been hospitalized, I have no help to help prevent or any support. FSP need help now and whatever it takes now. People need help now not years from now.

Dorothy Banks — As I am looking at this handout, this Portland Identification Early Referral, is this referring to Portland Oregon?

Debbie Innes-Gomberg — I think it is Portland Maine.

Dorothy Banks — My question is, since I have been to both, have there been any questions about the services for African Americans in that area and what evidence is there?

Debbie Innes-Gomberg — The interesting thing about first break programs is that as the PIER modeled moved from Portland, Lillian's document outlines it quite nicely, but as they moved West, they became called different things such as PREP, etc. The service structures remain largely the same but the populations changed a little bit so I think as we start to implement services in California, particularly in urban areas that are ethnically diverse we really do want to pay attention to those differences. One of the things I have been very impressed with PIER and PREP is that there is a large outreach and engagement component and a lot of family psycho-education that happens. That goes to Marcelo's point in Outreach and Engagement being absolutely critical. Your program doesn't work unless you involve the family and educate the family on the symptoms and the illness itself. One of the things we can do is give information on that so you have the data to make the determination.

Dorothy Banks — Yes, I want to make sure the African American community is not lost in these programs that are provided, especially in Service Area 6.

Cynthia Perez — I live in the most rural area of LA County, the Antelope Valley. I agree that we have space available, however they just closed our only homeless shelter in the entire Antelope Valley. I want to ask from the Department and not just in the Antelope Valley, we need the full force of your backing up there. I don't know if any of you get a chance to look into Lancaster City Council meetings. Our Mayor up there just attacked Mental Health America during a council meeting. We are the only FSP program for adults up there and he shut down the only homeless shelter and attacked the only agency that is a provider up there. I agree, if I can get advocates from down here, to help us up there, that would be wonderful because we do have the space available to help a lot of people.

Debbie Innes-Gomberg — I will bring that back to Sharon, thank you.

Karen Macedonia — I just want to get one thing on the record Debbie. Ana talked earlier about the Promoters being about community change and then you talked about Lillian's document about the First Break, (I want to get a copy of that and read it) I am really looking at education for societal change, true prevention is the change that we are all looking for. The quality of health in our communities, the individual better quality of life. I don't want that to get lost when

	<p>we are talking about all the things we need to do. We need to address this end, but in the prevention part we address societal change, what it is that we can get people to relate to each other. Particularly in the Antelope Valley, I live in the Northern end and we have wonderful people out there that are dealing with problems with no resources because that is their coping skill, is to go out to the desert to live.</p> <p><u>Debbie Innes-Gomberg</u> — I couldn't agree with you more. We are going to be talking Innovation 2 in a moment and for me, Innovation 2 is opportunity to do exactly what you are talking about.</p>
<p>Implementation of PEI Projects in the 3 Year Plan</p>	<p><i>Lillian Bando, MHC Program Manager III, County of Los Angeles, Department of Mental Health, PEI Administration.</i></p> <p>Board of Supervisors adopted the Department of Mental Health's MHA Prevention and Early Intervention Plan on May 30, 2017.</p> <p style="text-align: center;"><u>PEI 3 Year Plan- FYs 2018-19 & 2019-20</u></p> <ul style="list-style-type: none"> • 7 PEI plan programs went down from the original 13 they had earlier. (Suicide prevention, Stigma Discrimination Reduction, Strengthening Family Functioning, Trauma Recovery Services, Individuals and Families under stress and At-Risk Youth and Vulnerable Communities) • Total of 79 LA DMH PEI Programs/Projects • 32 Prevention Programs • 38 Early Intervention Programs • 16 Evidence-Based Practices • 13 Promising Practices • 9 Community-Defined Evidence Practices. <p style="text-align: center;"><u>MHA PEI Spectrum of Services</u></p> <p>PEI covers 4 of the 5 pieces of the pie. Universal Prevention, Selective Prevention, Early Intervention, and a new thing we added for the Ongoing PEI Program is Relapse Prevention services. These are some of the programs we will be implementing for the Youth, TAY, Foster Youth and others once they stabilized with their services and we want to give them some supports to be successful.</p> <p style="text-align: center;"><u>Universal Prevention:</u></p> <p>We have 7 programs. The way we report to the state based on the PEI requirements we are really reporting on Suicide Prevention, Stigma Reduction, Prevention and Early Intervention. Universal Prevention targets the general public or a whole population group that has not been identified on the basis of individual risks.</p> <p style="text-align: center;"><u>Anti-Stigma and Discrimination:</u></p> <p>We have 6 programs, and most of these already existed.</p> <ul style="list-style-type: none"> • Children's Stigma and Discrimination Reduction Project • Family-Focused Strategies to Reduce Mental Health Stigma and Discrimination • Mental Health First Aid (MHFA) • Older Adults Mental Health Wellness Project • Profiles of Hope Project • Psychological First Aid

Suicide Prevention:

Straddles Universal and Selective Prevention, some suicide prevention programs are really targeting to specific groups. Most programs have existed before.

- 24/7 Crisis Hotline
- Applied Suicide Intervention Skills Training (ASIST)
- Assessing and Managing Suicidal Risk (AMSR) Training
- Latina Youth Program
- Partners in Suicide (PSP) Team
- Partners in Suicide (PSP) Team
- Recognizing and Responding to Suicide Risk (RRSR) Training

Selective Prevention:

Targets individuals or a subgroup whose risk of developing mental illness is significantly higher than average.

- Largest increase of new prevention programs
- 15 COS expansion programs that contract agencies may now provide
- Parenting Programs
- School-Based Programs; School Failure Reduction Programs
- Veterans Programs
- Housing Supportive Services for adult housing.
- Community Mental Health Promoters Programs
- 43 Selective Prevention Programs

Underserved Communities:

Subcontracts with local community organizations and/or outreach by providers for Mental Health Promoters Program

- American Indian/Native American
- Armenian
- Ethiopian, Somali, and other African Communities
- Filipino
- Japanese
- South Asian
- Thai (pending)

Early Intervention:

Early Intervention is directed toward individuals and families for whom a short duration (usually less than 18 months), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.

- 40 Evidence-Based Practices, Promising Practices, and Community-Defined Evidence Practices
- 3 Practices for Anxiety

- 8 Practices for Trauma
- 2 Practices for First Break/Early Psychosis
- 9 Practices for Depression
- 1 Practice for Emotional Dysregulation Difficulties
- 4 Practices for Disruptive Behavior Disorders
- 9 Practices for Parenting and Family Difficulties
- 4 Practices for Severe Behaviors/Conduct Disorders

A new program that we have addresses the issue of Maternal Depression, post partum depression.

Maternal Mental Health:

- Renewal of Nurse Family Partnership with Department of Public Health Services
- Planning of in-home visitation programs
- Ongoing Individual CBT Trainings Countywide through Adult System of Care
- Interpersonal Psychotherapy Therapy for Maternal Depression-Trainings projected to occur in Fall/Winter 2017
- Exploring possible collaboration with community providers (Maternal Mental Health, Welcome Baby, etc.)

**Early Psychosis Intervention (EPI) Program:
Portland Identification and Early Referral (PIER) Model**

- As part of the PEI 3 Year Planning Process, research into FEP/EPI programs to include in the new PEI Plan began in September 2016
- Extensive discussions with developers, other agencies, and counties about their first break programs.
- The Portland Identification and Early Referral (PIER) Model program selected.
- The PIER Model has both outreach and mental health components and was included in the 3-Year PEI Plan. Other supportive components, such as supportive employment, peer support groups, family support, are an inherent part of the program for LA County.

We will build upon and expand the PIER model and we will develop and brand it as our own PEI program. A number of counties have used the PIER model, added different components to it and then renamed it. The core of it is the PIER model, and that is what we are intending to do. The model is in line with legislation, AB1315 which was passed June 2017, regarding private public partnership bringing in some other private funding, other public resources, so that we have a more robust, wide spread effort at addressing early psychosis. There are a number of counties that have the PIER Model, and we have been in touch with them. We are excited to get this off the ground and really strengthening it, the key part is that it takes 2 years of dedicated Outreach, community education, working with schools, teachers, and hospitals to get it off the ground.

Relapse Prevention:

In the course of illness, relapse is a return of symptoms after a period of time when no symptoms are present. Any strategies or treatments applied in advance to prevent future symptoms are known as relapse prevention.

- Peer support group training — A number of different ethnic groups, minority groups, specialized populations.
- Peer support groups
- Supportive employment services — For youth coming out of the foster care system, for a number of them they

will need help not only getting a job but maintaining a job, which is often the hard part. Help them in their jobs and help them be successful.

- TAY housing supports- TAY who are going in for housing. We want to set it up, up front rather than after words so they have success in their housing.

Examples of Implementation Strategies for New and Expanded PEI Programs- (This is not exhaustive list)

Providers:

- Current Legal Entities/Contract Agencies
- New Community-Based Organizations
- DMH Directly Operated Programs
- LA County Departments
- Philanthropic Organizations
- Community/Collaborative Partners
- Media

Strategies:

- Expanded COS and Prevention Programs
- Pilots for Prevention Programs
- Subcontracting
- Solicitations/Bidding Process
- Sole Source Contracting
- Expanded Training
- Media Campaigns (Internet, Social Media, etc)

Marcelo Cavalheiro — We provide Older Adults and TAY, we were one of the folks that had to drop out of CAPPs. Some recommendations and lessons learned. 1- I am glad that you are doing the PIER Model and making it your own so it will be more sustainable. One issue we had was that Capps use to be in UCLA when they started, and then moved to Yale, it was very hard to get them to Yale to train. That brings the main issue of sustainability is the issue of training in which we got early on in the prevention. We had to arrange the trainings ourselves, which involved too much time coordinating. The second this is that the provider is able to have a spectrum of services. What we found out about our TAY is that sometimes they arrive too late and it was no longer prevention. They need more intense services and we did not have TAY more intense services. The systems in prevention, in crisis or outpatients are all linked. Another thing that did not happen was that there was no money for outreach and what made us shut down our TAY program. Especially for minorities, it takes a lot of time to outreach and penetrate. Lastly, pair Early Intervention folks with Prevention folks. There are all these folks doing prevention and we are doing early interventions and we don't know who is who. It was difficult to set up a system ourselves and provide the services. We would expect DMH to be the one to set up the system and we provide the services.

Lawrence Lue — This is an impressive list, and I am still trying to wrap my head around the number of programs here. I am trying to keep myself grounded in a basic concern that the Commission has had is the distribution of these

programs, the penetration and not just for API but for underserved populations and regionally. We have programs scattered across the counties, do they know whom they are linked with? Are we forming continuity both regionally or within specific targeted populations? I can report this to what LA County is doing but I am not sure how well we are penetrating and how we are thinking through that in terms of really targeting the strategies.

Ruth Hollman — I have 4 things, One, I am interested in the warm line expansion because as I have told everyone before, we are paying NAMI in Orange County to do a peer warm line, rather than using that money for our own consumers to have jobs here. We need to bring the warm line home.

Two is the concept that Promoters doesn't work in other cultures. What I have seen on the research is that is a very good way to work around the world. I have a report that I can give you on that if you would like. I am wondering who is saying that or do we think that peers can't do anything, is this because "we know better" than the research is showing? Thirdly, I was approached by an agency, a 0-5 agency that has been successful in providing services and is getting referred by all of the other agencies with PEI money. They send the people to them to get services yet they do not have a contract so apparently there hasn't been an open solicitation for 0-5 in a long time. Contractors who don't have a legal entity contract with the Department are not able to get the services and this agency is providing the public mental health system with free services when other agencies are getting money to do it. Lastly, how is training? People talked about difficulty with training and are we going to be doing training? Is the Department going to be doing any training on EBPs, and if they are can we check to make sure that what we are paying for is not already in the public domain? You'll remember I showed you the data that I brought back from the American Psychological Association Conference that analyzed the LA Evidence-Based practices and we were paying large amounts of money for practices that were in the public domain. Rather than working with the developer that wants to make money, we could have gotten a trainer to train on the reports from the National Institutes of Mental Health, substance abuse, etc.

Lillian Bando — With regard to the warm line, I would have to defer to the Older Adults who are working with Didi Hirsch on that. With Promoters, the reason we couldn't take, at this time, the model that is being used in Latino is when you are working with a number of the API communities, or some other communities, what is brought out is that often, because of cultures and how you interact with people, having someone peer or go and talk to your peer is not seen as someone that can help them. I know that there are other ways that it is being done, but we are trying to get this off the ground and we working with community groups.

Ruth Hollman — I can tell you in my 3 years living in a village in Thailand doing my PhD dissertation the promoters in Thailand were incredibly accepting, people loved to have them core, the women sat around and talked to them about nutrition, vaccinations, getting their cattle vaccinated, etc. This concept that some how Asians are different just because is not a good concept and the same goes for India and Pakistan. They have also had good results in this, so I think we need to look at where this information is coming from, is this part of the stereotypical prejudice that people hold or is this really evidence because we are supposed to be working off of evidence not off of what should work.

Lillian Bando — This is from people in the community themselves and let me tell you that may be working great in Thailand, or India, but we are not there. If you have an API community, we are scattered throughout LA County. I cannot go to my neighbor in many ways, the person that I may be relating to is in another city. With regards to 0-5 agency we haven't had contracting. It is difficult to become a legal entity, however with Dr. Sherin, they will look at contracting process and a lot of their services before that were just renewed year after year are not going to be bid out.

With bids out and some performance based criteria on that so that is already being worked on. With regard to trainings, we have increased significantly the amount of training. For the EBPs, we have about 15 different trainings coming up. It is very intensive and what we have also done a few years ago, we were able to pay stipend for the staff attend the trainings and we are able to offer that again. Some people say you can go on the internet, just download the information. LA County said that is not sufficient, you cannot just listen to a DVD, you need interaction with someone that can provide scenarios and how you can use that.

Mariko Kahn — Since I am on the board of the Asian Pacific Policy Council and our Mental Health Committee is very active with the API community, I do want to speak to that issue, and that is whether or not API's can or cannot work with the Promoters model. The real issue for us is that each individual Asian community has different needs, but overall what we are hearing is that the model is set up, as presented, doesn't work as well, that doesn't mean it cant work without some adjustments but we feel that unless the model is more flexible it will not work. We had a lot of pushback from our Korean community for example. We will work together, but we just don't think every shoe fits every foot.

Jim Preis — Listed under relapse prevention is TAY housing support and my question is that if housing supports is good for relapse prevention for 24year olds I assume it is good for relapse prevention in 34 year olds. Is it a monetary decision that we are only going to focus on TAYS in terms of housing support?

Lillian Bando —We are running that as a pilot program. We want to start out small, strengthen it, make sure we are doing it the right way, and that it works, then we will expand it. That's why we are doing a lot of these programs as pilots.

Jim Preis — I am just focus on that because there is a whole pot of money out there with Measure H and that could be used and a way to leverage additional dollars.

Romalis Taylor — I just want to ditto the comment made by Mariko Kahn. For the African communities, there is a lot of them and they are very different and require different engagement approach. You cannot do the same thing for each of the different communities. They are vastly different, their cultural amenities on how you approach them, and what you approach them with, how you speak and who you speak to just to have a conversation, it is different, so even though the core can be there, its this unique approach to engagement like Mariko stated.

Ana Suarez — Having run the Latino Promoters program for a while now I feel like I need to respond. What we are looking at is that we have some basic foundational structure. Getting a group of lay people and educating them on mental health concepts at a level that they are enable to educate their community. The other piece is how to exactly do it, how to tweak it, how to outreach to that community, how do you make it culturally sensitive acceptable and approachable. That is the reason why we would want an ethnic community to do it, they know how to reach their community. That is the beauty of Promoters is that every ethnic culture would bring their knowledge of the culture and be able to utilize that have great access to a culture that generally does not have access to the mental health system because it is a foreign concept to those people in that culture. Especially if they are immigrants. The idea of tweaking it to make sure it is culturally appropriate for a particular community is absolutely right on and I think that we should do that, the idea of maintaining some of the core concepts, and foundations, like teach lay people about what is depression at a simple level so they can share it with their community. We've done surveys and it has shown that the people who

	<p>have taken the trainings feel much more confident afterwards that they can help their family members, that they can help their neighbors and their child because they can now understand the concept better and they feel empowered to help. That is so important, Promoters is not just about another form of treatment, Promoters is about community change. The idea of community change is that people can help each other and you don't have to go to a formal system of care to receive some assistance and help. The idea is community change and community change is done by educating peers, family members, community members that can then outreach into their own community and help their neighbors.</p> <p>Sunnie Whipple — For the Underserved Communities in the first bullet point, is that supposed to be American Indian/ Alaskan Native? With Promoters as far as Native Americans I do not have a positive or negative because it was introduced to us, we had a meeting about it, but it didn't go forward. We are so spread out throughout the county that we are going to have problems reaching all the different communities and there is such a big disconnect within the different communities because of different cultures and the way they view the world.</p> <p>Mariko Kahn — I just want to make it clear that the API is not against the Promoters model, or the practices. What we are saying again and again is that it needs to be adjusted and we don't feel it necessarily the only model that we can use. We think there are some other models that might work more effectively, so please we are not against the Promoters model we supported it, and it working well for Latino community. We looked at it but we are also looking at other things.</p>
<p>Update on Innovation (INN) Projects</p>	<p>Debbie Innes-Gomberg, Ph.D., Deputy Director, County of Los Angeles, Department of Mental Health</p> <p>INN 2- Community Capacity Building to trauma Some of you guys were involved in the planning for this. If you haven't been, the proposal is on our website. I wanted to let you know the Bidders conference is tomorrow. Innovation is specifically challenging because it is supposed to be out of the box. Richard's commission doesn't approve it if it is not outside of the box. Consequently, the County has then be able to understand that and accordingly act out of the box. It has taken awhile but the bidders conference is tomorrow. We really hope that agencies who don't currently have contracts with us would be on the bidders list and will be attending, and I believe that is the case. This is the opportunity to inspire the community, to educate the community, to have the community be the first responder in a certain sense as opposed to the Mental Health Community of providers. I am really looking forward to this opportunity, the proposal are due back by Sept 19th. We will then score those proposals, there are 7 strategies associated with INN 2- span age groups including intergenerational trauma strategy and the contract would be for a with lead agency that would come in with community partners that would be closely aligned with each of the SAACs and would pick one or more of those strategies to implement. All together we would be funding 10 lead agencies, 2 in each supervisorial districts and it's the lead agency collaboration within their community that would define geographically what that community is.</p> <p>Jim Preis — Can you find the RFP on the website? Debbie Innes-Gomberg — Yes, if not, we can send it to you.</p> <p>Ana Suarez — I know in my area we had some school districts that were interested in doing this but we are in summer break. Have you thought of how this may affect possible school districts that may want to bid? Debbie Innes-Gomberg — I know I talked with the Monrovia school district, or which one that one was but yea, I</p>

don't know how they operate outside of school year, I mean someone has to be getting the mail right?

INN 3

At the last SLT meeting I spent some time talking about the technology suite. It is posted it July 21st for public comment. Go on website, on the lefts column, MHSA, under announcements and you will find the 3 year plan as well. It is increasing access to Mental Health services and supports, utilizing a suite of technology based mental health solutions. You will see that the goal of this project is increasing purpose, belonging, and connectedness for users regardless of age, increasing access to care. Access to care for anybody for a broad array of individuals, people that may be experiencing risk factors, may be experiencing early signs of a mental illness, social isolation, or may have a full blown mental illness. It is really an opportunity through the different components of this approach to engage people. There is a peer chatting function as we articulated as peer chatting and peer led interventions through this application as well as family support as well as family chatting for parents with children in the system as well as parents with adults in the system. The next steps related to this is that Dr. Sherin and I will go up to Sacramento to the Oversight and Accountability Commission and present the concept because this came out of the Oversight and Accountability Commissions interest in creating an innovation summit. We will present the concept and support he innovations summit, which is likely to happen in October. We will present a formal proposal to the Commission and go from there. This is new work for us and, again, we are working on County Council on these issues and looking at the types of tech companies that can actually do this work.

Ruth Hollman — I am lost on this a little bit, I am not against the technological things but who came up with that and why is it a done deal and why hasn't the SLT discussed it to come up with is as the example we want. This is one of the problems we have seen over the years with the SLT is that we are presented with this is what we are doing and we may have a few comment on it but we aren't given an opportunity to be part of the actual planning of it.

Debbie Innes-Gomberg — We actually had an extensive discussion around this about 2 months, which I don't believe you were here for. The evolution to the project is two pieces to it. The Oversight and Accountability Commission has really been wanting Counties to think very broadly and very strategically and out of the box as it relates to Innovation.

Richard Van Horn — We have been talking about this at a couple of these meetings of this innovation sub committee for the OAC. The upshot of this is that you are recognizing that we're spending in this state a \$100million dollars a year on innovation and guess what? There is probably not \$100 million dollars worth a year of out of the box things so that is a portion of what goes. The apex of the triangle is the crazy and wild ideas that nobody thought of yet and did not come out of a group process or a series of meetings, it came out of some fertile brain. I think that is where Innovation 3 is starting out. Below that level of strange and weird and genius ideas there is going to be a range of other things, which, radically improves something we had done or apply something in the behavioral health world for the first time. We have to look at this in striations so that we really spend this money wisely. A hundred million a year means on these 5 year programs means there's 5 million dollars in circulation at any time for innovation.

Debbie Innes-Gomberg — As a result of that we got invited to a meeting with Google Verily. Many of us walked away really excited about the potential to do something pretty significant. John has been very involved with this innovation sub committee as is several other health directors. There will be a summit in a month or tow that will be open to counties and stakeholder. It will be an opportunity to partner together. Santa Clara, Mono County, and Monterey

	<p>County are interested, we are looking forward to this and that is the evolution of the project.</p> <p>Last month I also talked about a Peer-run FSP program as an innovation project, that is in development, we hope to be able to post that in a couple of weeks. That will be a good opportunity. It will be a 30 day public posting, then it will get on OAC calendar for that.</p> <p>There is another Innovation project that we want to bring to you. We will probably be able to do that next month. Innovation has historically been for us linear, so you will see multiple projects coming so it will be more exciting and more going on with innovation.</p> <p><u>Mariko Kahn</u> — I am going to ask a question of clarification, because I was at the meeting where we discussed the technology part of it. I didn't realize that these projects would just go forward without the process that we normally go through, which is rather painful and long. Is this a shift in the way the Department is going to handle innovation? Before it used to be the Innovation Plan1 then Innovation Plan 2, I have noticed it has changed to projects, so I just need a clarification on that and the speed. much debate.</p> <p><u>Debbie Innes-Gomberg</u> — Yes, thank you. I think there is a little bit of a shift. Part of it is when we came with the first innovation project and the second one it took us a long time to get to a place where we had something that was innovative. The Department does not have that kind of time because we have accumulated some money. I have asked several years ago: "Where do we see ourselves as a County of Behavioral Department five years from now?" and "What is the role of innovation in getting us there?" Whatever we come up with has to meet the criteria and the primary purpose for innovation according to the regulations and sometimes that is a struggle. When we have done it openly we get great ideas, but they have already been done. That is the struggle the Department is going through right now. We wouldn't move anything forward that if there were considerations or public comments that was problematic. The way we envision the SLT is that through your perspectives and your lenses you are helping to shape an idea that is likely come from the Department. You may also have ideas that you bring to us and we help shape it.</p> <p><u>Karen Macedonio</u> — I want to put the Einstein quote on the table here: "The mind that got us here is not the mind that can find the solution" I am hearing the shift and you are expressing it very well but in that shift whether it is coming from the Department to the SLT or from the SLT to the Department we have something priceless and treasured in our discussions about innovations because it is not just the outcomes that we come up with in innovation, it is the discussion that brings all of us into it and raises our awareness. Some how we need to find the time to have the discussion because that is where we make community change.</p> <p><u>Debbie Innes-Gomberg</u> — That is really helpful, I am going to think about the best way to raise that consciousness and have that rich dialogue that will help us create a better project, program, product in what ever it may be. Lets think about how to do that.</p>
<p>Public Comment and Announcements</p>	<p><u>Penny</u> — This last round of innovations was somewhat confusing because by the time it got to bid as a contractor, it was pretty well defined what you were going to do. There wasn't much room there for any innovation by the person that took on the project.</p> <p><u>Debbie Innes-Gomberg</u> — Thank you. I want to say something to that. The Department struggles with this because there is a fine line that we go through to write the RFS and then to create a set of expectations but not to</p>

be so prescriptive that what we get back is what is what you regurgitating what was written on the Statement of Work. We struggle with that, and I think that is the only thing I can say is that we struggle with how prescriptive to be vs how creative we can allow you to be. Thank you.

Mark— This weekend conference is at Boston. Project Return is sending 25 people, which I think is great. My job with them is to bring programs, and some of us is not able to go. It is for us to get look at Webinars, and doors for well being webinars. To bring that stuff back to Los Angeles County. The idea that I have is to do something with Satellite broadcast. With webinars we can do that and I would like to do something like that. The Phoenix conference is also next month. It is vital that the alternatives conference takes place because it is in danger of being taken away. We need to fight to keep these conferences going and to keep the spreading. We need to find ways in getting these people to these conferences and get them back and use webinars.

Adjourned: 12:01pm