COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, September 20, 2017 from 9:30 AM to 12:30 PM
Hollywood Hotel, Pickfair Grand Ballroom – Lower Level "R" 1160 North Vermont Avenue, Hollywood, CA 90029

REASONS FOR MEETING

1. Provide an update on behalf of the County of Los Angeles Department of Mental Health.
2. Begin discussion of reinvigorating the structure and function of the SLT.
3. Update the progress of the Innovation 3 (INN3) process.
4. Discuss a proposal to move fund to the IT plan.

MEETING NOTES

Department of Mental Health Update	***Jonathan Sherin, M.D., Ph.D., Director, County of Los Angeles, Department of Mental Health*** There are a million topics on the radar for everybody, but one of them being a great opportunity to revisit ways to activate communities, and leveraging the voice at the grass roots level of people who are struggling directly, indirectly, have input from the Department to help us direct the Department most effectively. The connection between individual people, coalitions, the SAACs, the SLT, and the commission are critical ways. Those are structures in place to help us do that. Put aside what we have done, there are a lot of great things we did and we will continue to do, however the way we've been operating, I ask you to put that all aside. Please think openly, broadly, together, collaboratively, cooperatively, and respectively, about ways forward to most to effectively distill and showcase the Department of what is going on at the grassroots level and how we can better meet the need. The needs of the people we serve have to drive this Department. That is what I hope to accomplish today, and I am not going to go on about updates, etc. I want to focus on making this meeting with you folks as effective as it can be. We have taken a deputy item and framed it differently than it has been in the past. Strategy doesn't just mean strategic planning it also means strategic communication, internal and external relations, which are critical for us to be cohesive and have a fabric that we all share and understand and care about to maintain and grow. We advertised this job a few months ago, and we had a number of fantastic people apply for it, and one of those people did this work for the State of Texas and has a great shared sensibility for the movement of this Department and the direction of this Department and her name is Mimi Martinez McKay. **Karen Macedonio** — Before you turn it over to Mimi, you said: "The needs of the people we serve have to drive this Department" and you got a reaction out of this room…. Who are the people we serve and how are we the role model for the world? **Jonathan Sherin** — You always ask me these really massive questions, and I appreciate it. This is a great question: "Who do we serve?" I can tell you that when I went through an interview process for this job after

	getting head-hunted when I was doing stuff for the VA. The Board of Supervisors who are the elected officials of this County and represent the population here of taxpayers made it mega clear to me that this County and this Department was to focus on caring for those who are most vulnerable and in the most need. That is who we are serving; those are our core customers. The people that are involved in the lives of those folks are our customers and at the end of the day that is the bullseye and we have to be thinking about that, In the most broad and informed way that we can. You heard me talk about the Sacred Interface and I am going to do it. We have the opportunity to change our customer service game. By that I mean providing better service for those that have needs, their families, their households, their communities, our providers, the people that are providing care directly to those that we are serving, either within the Department or through our massive legal entity network, we have to provide them customer service. I don't like hearing about our providers who don't have time to engage, who don't work in an unhealthy environment, that don't have technology that supports their work, that don't have the training that they need. How are we going to have the impact that we dream about if those folks aren't getting customer service? Customer service for me is a big thing and the sacred interface is all about customer service and the management moves and the structure of the Department is focused on that. That is the plan and the plan is a work in progress and focus on the Sacred interface as our primary goal to enrich it.
SLT Reinvigoration Discussion	***Mimi Martinez McKay, MA., M.L.I.S., Deputy Director, County of Los Angeles, Department of Mental Health, Strategic Planning & Communications*** Starting in March, I starting attending your meetings as a member of the public, I had just moved here from Texas. I did that to learn about LA County, which is my home. I came back here because I was excited about leaving the state of Texas. I spent the last 14 years as the Communication Director, Legislative Liaison for the State of Texas in both mental health and substance abuse. It was an amazing opportunity but five legislative sessions in, I felt that I have done a lot, and a lot of it I had done it in conjunction with stakeholders. It was getting to the point where I felt more could be done as an advocate from the outside. One of my degrees is that I am a librarian, I decided to spend my time advocating for librarians to be able to help people navigate the mental health and substance abuse system throughout the country. It is so complicated and convoluted that even those of us who work in the fields sometimes we don't feel that we are doing that with confidence. We sometimes send people off to a program and think: "Oh, gosh, I hope it works." I came out here in March and I spoke at the Western Recovery Conference. I knew Ruth and Jason from SAMHSA and I have been working with SAMSHA for years as a consultant, so I had some folks from California that I knew there. Ruth and I had a brief conversation, and mind you I was not looking for a job, I was really happy doing the consulting that I was doing, not working with a huge bureaucracy and being on the outside because it was very energizing. I came to the March meeting and this new director for LA County Mental Health was a man with vision. When I heard what he was saying, not only did he have vision, but a vision that I can support, he was looking for all the things that I have done in Texas. He was looking for help in communications, how to connect with the field, web services, and all the things that I am very familiar with because that is what I do. 3 months later here I am. This meeting and this group means a huge amount to me because this is how I learned about how things work here in LA County. I will say that I spend 14 years in Texas telling everyone everything in California worked really well. All the issues in Texas were just Texas issues, and of course I knew about the Mental Health Services Act. One of the interesting things is when I interviewed for this job, one of the things that I told the deputy was those from other states look at that and say what an amazing opportunity. Think

	about those dollars, and think about how those systems can be redone. I will say yes, I have seen some amazing things since I've been here, but I also seen a lot of things that need a lot more work than I originally thought, including connecting with the Stakeholders, including redoing the system with a vision and the reorganization that we are working on. I want to spend this morning focusing on a reinvigorating discussion. How are we going to look at this group and look at it fundamentally? We need the stakeholders voice, that is not only required by the MHSA but that is something that if we don't have it and it is not true and vital and bringing in new voices all the time, then we aren't going to succeed as a system. We need to hear from you, and we need to hear how you think we need to be looking at this. Some of the things we've talked about and conversations I've had is: "How can we get more voices from SAAC to the SLT table?" and one thought I had was that currently the representation is one representative from each SAAC, I think we need more voices from the SAAC. I think we need them fully engaged in this process because if that is not happening then we are not hearing from the field. If we aren't hearing from the field, then we aren't doing the work that we need to be doing. That is one thing to think about and I want to spend the morning having you have conversations about that and spend some time sharing with us what you believe should be happening. How would you like to see this group? Think about it from the ground up, in terms of the composition of the group, in terms of the meeting structures, everything is up for discussion. **Ruth Hollman** – I brought with me today a manual of what we did when we started planning for the MHSA. A binder where all the stakeholders met for weeks to come up with plans on what would be good for the Department, and after we finished this entire binder, it got shelved and we were told that we are going to do something else. **Mimi Martinez McKay** – So you would like us to revisit that? Is that what I am hearing? **Ruth Hollman**- That process really worked and engaged everybody but we have to listen. The things that are in the binder, 2005 we had a trauma committee, a flow committee, we had 26 different committees that did reports and it wasn't listened to. **Mimi Martinez McKay** – So if we wanted to learn from a summary of that, can you share that with us? **Ruth Hollman**- Yes, I brought it for you to see. **Mimi Martinez McKay**- I don't mean the whole binder, just a summary. **Ruth Hollman** – You have it, I am sure, at DMH on a shelf somewhere. **Mimi Martinez McKay** — ok, maybe there is a way we can work with you on a summary of some of that to help inform our process. **Ruth Hollman** – We as stakeholders are very interested in participating and I for one welcome the opportunity to have input and I am hearing that we are going to listen to that input. **Mimi Martinez McKay** — We are absolutely going to use the input and one thing that I want to mention is that while this is an important group for the MHSA, and that is the reason it was formed with the structure, the Department is using this input from this group well beyond that. How we are framing everything in the Department, this is a perfect venue for that, so think about that as you are discussing this, not just in terms of

MHSA, but also beyond that.

Cynthia Jackson — I participated in those work groups in the beginning as well and we came up with big binders and worked through many of the steps and in fact the field capable services component came from a smaller work group in the Older Adult group and went system wide. I have a very different experience of those binders than Ruth. I use them and continue to use them every day.

Eddie Lamon — I am glad to be back, I have been gone 3 months, and I am glad I came. I don't have the same perception that I am hearing. When you are giving advice to people, that's just what it is, advice. People can take it and leave it. We are good that we have one from each SAAC, I was there from the beginning and I fought them for only having 2 people representing on the SLT for the SAACs. Every SAAC should have at least 1 person on SLT at least. I There was representative from SAACs and different entities and it was so big, the committee was so huge when it first started. They had to find a way to make is smaller, that's why they went down to 2 SAAC members. Over the years- people have a poor perception, if I am representing SAAC 6 I ask them what they think, then I go back to SLT. You should pose that question to them.

Sunnie Whipple — Since I am a USCC representative from American Indian/Alaskan Native group, coming to the table, nothing was passed on to me. I don't know how to best represent the Native American Community, is there literature, crash course?

> **Mimi Martinez McKay** — So an orientation did not occur, is that what you are saying?

Sunnie Whipple — The last SLT member never passed on any literature or information so I don't know what to do or go from.

> **Mimi Martinez McKay** — Ok, that is important feedback because if we are looking at new membership then we need to be providing that.

Karen Macedonio — My experience is totally different than everyone else in the room. When I came to SLT, we had an orientation that was excellent. I know where the PowerPoint is; I have them saved on my computer because that Orientation was so good. We need to bring that up to speed. Ruth, you are sitting in my SAAC and you've got a resource that I didn't have any idea that it existed. Now I'm saying I want to know about this 26-work group thing. With everything up for discussion, that is great, but I don't want to start from the beginning and reinvent the wheel. I would like to know what we have that is really working well and that we leverage our time and resources. At the same time, I think this group needs to look at this the same as we would for innovation planning. The way we have approached innovation planning is an outstanding format for what we are doing moving forward. What would we do innovatively to make this work?

Richard Van Horn — For the moment, three very brief points. One, for the statewide level, what are we responsible for? The MHSA is roughly ¼ of the system. The important this is that when we did that act, we set up a commission- Oversight and Accountability Commission, Mental Health Services Oversight and Accountability, not Mental Health Service Act Oversight and Accountability. It occurred to me being in the commission for over 8 years, and involved with it from the start, that not just the public system, but what is happening in the private system as well. Second thing, I

agree, the SAACs are critically important. However, SAACs have not been well staffed in terms of getting the level of involvement at the sub county level that we really need to have. Some attention needs to be paid to how we facilitate those SAACs. It used to be called the Citizen Liaison Committees; I got into this 41 years ago as a citizen advocate. At that point we sued the county and the state around least restrictive care and we lost because there is no guarantee in the system for least restrictive care so that's one that we've conquered that. The last thing is Quality Control; we do not have good quality control. FSP is widely variant across the County and across the state. It was based on a model, which I know extremely well, but people's feet have not been held to the fire in terms of quality or in fact doing all the things that was envisioned in the original legislation that set up the first integrated service program.

Carmen Diaz — I understand about the SAACs, I really do, I think they are great, I have been to them, but I also know that from the children sector, parents, many of them, not all of them, do not know what a SAAC is. They have never been to a SAAC meeting, their priority is schools where their children are, physical/medical doctors, faith based, so how is that going to be addressed? Many consumers do not go to a SAAC, I have gone to a few, and sometime I found them to be intimidating and not welcoming to new people. I am not saying all SAACs, just to the one I went to. A lot of the things they were talking about went over my head. If we are really going to go out there to get the community involved, I think something needs to be done to get that kind of input.

> **Mimi Martinez McKay** — Absolutely, and right now we a new structure at DMH that calls for Service area chiefs to be very engaged with all of the issues that you are talking about. Bringing in all the schools, the faith based partners, etc. Bringing them all to the table, having them understand and engage with those SAACs, change that dynamic so that everyone does feel welcomed, so those conversations are taking place and we're going to need your help in all that, obviously. Yes, I think what you are speaking to is exactly how we have to be redoing the whole conversation in the communities around all of the reasons why people do want to engage because you are right, right now, why would they? Correct?

Romalis Taylor — First of all, you touched on an issue or information that we need. We need to understand where the structure of this organization is, where is it going, what's the vision/mission of the Department? We, in SLT, have been an excellent partner with the Department and they have been a good partner with us, we want to know where you are going, what you really want to do so we can help you get there. The other thing is that we don't want to lose the fact that multiplicity of voices here. The problem gets to be that we don't want to lose the strength of our cultural support system. This Department really went after that and gave us voice, we don't want to lose that, and we want cultural competency to be real and not just a term. Really dig down deep for the communities and the clients that they serve so people stop treating it as a concept rather than a reality. It's not something you want to say that cultural competency is about speaking the language or understanding African Americans versus Latinos, no, it's about understanding the culture of those people, what they are struggling with, what they are dealing with, and what that reflective is. The other thing I want to hear is that you are going to hear many voices, so the quality of the kind of structure you want to create, to hear those voices, but we all understand that you can't do everything and you have to balance that out, but make sure that you are setting up a structure for engagement, I like that, but the engagement has to be structured in such a way that we can hear all voices but we have to find out how we integrate that into what we are trying to doing.

> **Mimi Martinez McKay** — I hope that I was clear in these initial comments, we are not as DMH saying this is what SLT is going to be. That is what this session is about today, which is what the conversations are going to

be about. We have some thoughts on that and when I mentioned the SAACs needing more representation that was one of those thoughts. In terms of cultural competency and all the voices in the room, absolutely, we want you guys to drive the composition of this group, to support the work that we are doing and what we need to do for LA County. Again, we don't have the answers.

Mariko Kahn — One of the lovely things about SLT, is that you give us an inch to talk and we are going to take the whole door down. I want to comment on a couple of items, in terms of service areas, I think one of the issues is that there are many non-legal entities, at least in my SAAC. I think there could be a mechanism by which they can be better represented at the SLT, because they bring a very different perspective. When I think of the SLT members, all of us were chosen, not because we represented one group. We were chosen because we represent multilayers. I am in 3 different service areas, I am a legal entity, but I also serve the Asian Pacific Islander community, and at one time I was a family member. All of these things were taking in consideration when we put the SLT together. There were these wonderful SLT trainings for the new people; I would love to see that started. In terms of parental participation, Carmen, Best Start and First 5 LA has done a lot of work on how to bring more grass roots participation from parents and I think we can look at that a model instead of reinventing that wheel. And the last thing I want to add is in terms of the different work groups, there are at leas one work group that is still active and that I am still a part of, it used to be called URep, but now its call UsCC, but don't forget we have the Cultural Competency and many good things came out of it, so some of the work groups are still active.

Patricia Russell — I was at the town hall for the agency and the Department and they are doing a whole thing on culture and how they are treating each other. I think that is what we need to do at DMH and how we treat the consumers and family members because at our service area meeting last month we had an outpouring of grieving and pain of family members of how they are simply trying to navigate to help their loved ones and how they were treated with disrespect. There is a judgmental way they treat people and family members are in the trenches with their loved ones and they need support. I recommended a long time ago to Debbie that we have a whole way of how we are treating the families and families' members and get more feedback.

Mimi Martinez McKay — Customer Service is the most important thing that we are looking at.

Carl McKnight — To reinvigorate means to return to an earlier state, I know because I looked that up because I was wondering what we are doing. The earlier state that I think we should return to focusing mainly on is that we are the only countywide stakeholder group really. There was a time when we had multiple stakeholder groups; a model was the PEI planning process that was a fabulous process. I felt that we reached out all over the county, got feedback and a lot of perspectives and I think that is the earlier state that we should strive to go back to. Return to a more formalized, a more better outreach and better scope of a stakeholder process and it seems somewhere along the lines we lost that so using PEI planning process as a model would be a great way to go back to an earlier state.

Dorothy Banks — I would like to say that maybe you can carve out some time to go out to each of the SAACs on a regular basis a sit in on some meetings so you get more of a feel of what is needed in that area. You can't get everything in that report that goes out, I would love to see that.

Mimi Martinez McKay — I agree, I think Dr Sherin already did all that. I think that is a great idea.

Groups broke up into 6 groups to discuss the idea, have one person record ideas and report back highlights.

Red Group Suggestions and Ideas

- Reinstate orientations
- Youth/Tay participation
- Countywide stakeholders truly represent county groups. (needs to have more people/broader representation, more inclusive)
- More small working groups.
- Stagnate as a group- refresh groups, expand-get input-hold accountable the representation of the SAAC needs restructuring
- Need more people at meetings, more parents, consumers, youth delegates-people need to have a voice
- Youth & TAY youth reps
- Whole Person- use the power of engagement
- Peers are rude, mean, and trigger as relates to DMH
- Don't empower me. Demoralized because they say I a New" but I am not heard because I haven't been around for a long time.
- Include people from schools, nursing homes, keep in mind of the most vulnerable people
- Countywide activity fund is misused
- Use creative thinking of engaging people in the streets & report to SAAC to get those resources immediately at the SAAC
- Have better communications
- 10 minute reports from each SAAC to have an understanding of what others are doing.
- More written communication
- Why is there a divergence in FSP, what helps, we need to have a say so
- Structure of SLT meeting with the SAAC report out. Each SAAC brings someone new to represent
- Solution section on the agenda
- Outreach culturally competent and include language-
- Outreach with interpreters at SLT/SAAC, different consumer family and TAY
- Have a more neutral process for facilitators
- SAAC centralized team
- Different age groups
- Don't throw the baby out with the bath water. Keep the gold nuggets, throw the rest away.
- New voices feel intimidated at the SLT
- Same face for years is not right-need new blood
- Same old, same old.
- Get info from the community
- Agenda's be more from ground up.
- SAAC priorities don't get tackled
- Bi-directional agenda setting
- USCC not integrated—Quarterly SAAC USCC meeting

- Hard to attend every month?
- Tackle REAL issues and not just be a rubber stamp
- Not System Listening Team but System Leadership Team
- Board of Supervisors priorities need to be priorities by they are elected officials
- Leadership for the SAAC need to come from community
- Committees to look at problems like IMD's
- Report the findings
- Build relationships
- Power of Outreach and Engagement.

Yellow Group Suggestions and Ideas

We had three major points - one of the reason why are are a viable advisory group is because we do have a broad knowledge and we are representative. We are hoping a strong commitment to hear our knowledge suggesting bringing questions to the SLT. We also talked within that frame of

1- Continuing to add age representation because of the specific clinical needs. More focus on integration of substance abuse that is a specific topic. Having clinical line staff be part of SLT. It is really important to get their perspective.
2- To make sure everyone in the room get their voice heard. The suggestion was that we used to go around the room and everyone who wanted to talk about a particular topic we just went around the room and that went well. Making sure the information we do get gets reported back to the SAAC and vice versa.
3- A separate recommendation, aside from the SLT, that there is an over arching employee and legal entity orientation to the entire system and all the different resources. For example, we were talking about the SMART team is not necessarily known to everyone and that is a great loss.

Green Group Suggestions and Ideas

Highlights from Green Group — Money is not an issue; we've already identified that. The question is how do we connect those with knowledge and awareness to those that are struggling? If we can take from SAAC a structure that develops where we are having community forums, it is not about bringing people to the SAAC meetings, it is about going into the community for some kind of forum. In those forums we can have workshops where we create the person-to-person contact.

We are wondering about the use of technology such as Telemedicine. We can use a central trainers and facilitators on the ground to provide education and a cycle of education and reeducation over a suggested period of 3 years.
Notes from Green Group —

- Who do we need at the tables? (family members, direct consumers, providers, etc)
- Who should be involved in the County wide dialogue?
- We don't even know that the SAAC even exists
- SA4 district Chief- how can we create a stakeholder friendly meeting lead by SAAC that would welcome the

	community to the table? - Presentations at SAACs to educate consumers and a cycle of re-education - SAAC involvement of MHS Commission - Budget for community outreach is not an issue - Some people that need to be involved are not going to come to a monthly SAAC meeting. - How do we align the system to the individual? - Newspaper funded by DMH (1981) "Connections" mailed **<u>Neon Orange Group Suggestions and Ideas</u>** - One of the ideas that our group discussed on a lengthy discussion was the idea getting more information onto the web. For those people that cannot attend, they can see the information, a place for people to go to find information online, or meetings to be broadcasted in a live way like the Board of Supervisors meetings. It will give the community a way to participate and gives them a voice. - Develop an election process so there can be an opportunity for others to be involved, other entities out there to make it more robust. - For the members of this committee to start inviting family members, friends, to participate in these meetings. It plays as a mentoring, shows people the clients and their family members how the committee functions, what the process and how decisions are made. - Having not only orientation but also some type of leadership academy. They're are so many individuals in this city that have no idea how to access the system, or know who their leader is, and how to get involved. Other than coming to a meeting a lot of individuals learn as they go, so maybe training or workshop would be helpful. - A big group that is missing here is Youth. Maybe we can make SLT at another time, or find a way to involve not only the youth and high schools, but maybe engage the college students. **<u>Yellow Group Suggestions and Ideas</u>** - A lot of the previous groups reported earlier are the same topics we also considered and discussed. There is a tension between the need and desire to have old participants heard and size and functionality of the SLT itself. Whether or not we have other avenues to address the needs of people to hear and be involved separate and apart from the SLT is something that perhaps needs to be considered. - The other issue is online access via a portal; which would help those that couldn't make it to the meeting. - The last thing is that there is a magnetism of attraction or need to talk about SAAC and SAAC itself, separate and apart from SLT but very much connected to it. How is structured, how is the feedback? It seemed in our group that people often give input but don't receive feedback, and/or see action or even feel heard. **<u>Blue Group Suggestions and Ideas</u>** We did it in two folds, we discussed what was currently working well in SLT and what could be improved or recommended

Currently working well:

- The fact that SLT brings stakeholders and representatives from all different parts of the system, from probation, DMH, to providers, we all wear many hats, SAAC members, committee members, and different ethnicities within the system of care.
- Legislative updates are excellent
- Time in workgroups is appreciated within the larger planning process
- People enjoyed the orientation for new members
- Everyone knows each other and there is a higher level of engagement

Improvements:

- Child care can be available to consumers so they can attend meetings
- The use of technology using Zoom or Skype for people to connect so it will create participation
- Polling consumer and client coalitions to have more representatives in the SLT
- Need a mechanism for all age groups to be represented equally
- Including a way for different county Departments to be involved without skewing votes
- Clearer definition of what a family is and established for SLT. There seems to be two different definitions of family. We have a family of older adults that can be included.
- We talked about recommitting membership, and that process should be formalized. We need to hold everyone to a 3-year term or discuss the length of service and attendance.
- We want to engage millennial in the SLT. Maybe we give TAY stipends? This is an aging profession, so we need to start pulling people along.
- Share information on how to become a member of the SLT.

Dr. Sherin — I heard a lot of great stuff. The idea here is to capitalize on a bunch of the great things that are happening and to think about other stuff we can bring to the table. The bilaterally of communications so that it's a real active process. The connection between the SAACs and grassroots is critical. We want to resource it more, but not to bias it to DMH. We need help from this group so we can activate the community. To have childcare, transportation, etc to allow community to come attend meetings and become involved.

Eddie Lamon — You are right, but when you say the Department wants this, you speak for yourself. I say that because I have been around a long time. There are a lot of people in the higher positions that won't want to hear from the rest of us. It is lovely that you believe they are you hope that you have a staff like that.

> **Dr. Sherin** —I think working in bureaucracy over time sometimes breeds certain cultures that become disconnected from their mission and become focused on maintaining themselves. That's not because of bad people; it's because of group process and organizational behavior. We have a great opportunity here to bathe the Department, the county, the communities; all of our stakeholders, in a culture that will help bring us all up. I was just up north last week at a meeting with high-level folks about workplace well being. I know we are here talking about stakeholders and I've talked about it before about customer service. We have to take care of each other at every level. That is part of the culture. In culture changes are the heaviest lifts, and I believe people over time can end up behaving in certain ways because of their culture, it's what they breathe, and if we can change

	that air and bathe them, they will behave in a different way, we have to give them an opportunity to recover and engage in a way that is much more constructive and healing across the board. There were so many great ideas that came up and we're collecting them all, it is all being recorded, and meticulous notes will be taken and they will be shared. I've said this before, I cannot promise anything except to fight like a dog. Everything that we can do that is feasible, we are going to do. Things that are maybe feasible, we will try to do. Things that aren't feasible, we will recognize their important but we cannot do them. We will try to do as much as we can to move the system. **Romalis Taylor** — I want to compliment you on what you are trying to do. I want to help everyone understand that the community's voice is that SLT deals only with MHSA funding, that is it. We don't deal with the other aspects of DMH 's operations that have nothing to do with MHSA funding. That is why whatever structure you are creating will cover the whole organization and not just MHSA. The community doesn't understand that, they have a voice and they say they aren't getting but they don't understand that your house is divided base on how it's funded. It has to have a structure that says how we get the voice to cover the whole thing and not just one aspect. I don't want the community to leave here today and think that what we did here today is going to cover the entire organization. **Dr. Sherin** — I am really in tune with comment and then the "but." For me this is not about MHSA. One of the first things I said to this team is I don't care if its MHSA thing, SB82 that, or MediCal whatever. What I care about is trying to address need. We need to design the Department, design our programs, resource it based on the needs. That is why it's so important to know what is going on in the trenches, us that information to make decisions about the deployment of resource. It would be a tremendous waste to do all this work and say it's only relevant for MHSA that makes no sense at all. I look forward to more of these dialogues. What just came out of these work groups to me was very encouraging. We have a long list of things that is recommended, we need to process them as a Department, and we need to analyze the data and come back and be responsive. That is the whole point, and that's true of the Department but that true to everybody. If we are going to come back to the SAAC or the SAACs to a group in the community, it has to be bilateral, active, and intentional and we have to all be working together and this is what it's all about. Setting up the systems, structures, and the processes so that we can do that in a unified way, which is very complicated. I have faith, I remain aspirational, I thank you so much for all the effort and I will always do my very best to be here every month and to stay as long as I can. I probably haven't done a great job but I am trying.
Public Comments	**Name not announced** — Really excited that I can come to these meetings because Dr. Sherin is hopeful. I am asking his staff to take some of the pressure off him and do what your boss is telling you to do. The foundation of stakeholders is very important, everyone's ideas have been wonderful, I love the Childcare idea, and we need that and transportation as well as the website, amazing ideas. However, the disconnect has been because there is no value in lived experience and constituents, peers, stakeholders. Some of you guys don't value us so I think that is why services have not been rendered properly because you felt that our lived experience and our trauma wasn't valuable enough to make it into policy and implement it into lifestyle and the way services are delivered. The System Leadership Team, I don't know nothing about how this works, no one told me anything about that. I did receive a SAAC manual, but I forgot that I have that from 1998. The power of engagement, going down to community, being creative in your skills of engagement, meeting the needs physically, mentally, emotionally, spiritually, financially,

socially, culturally, environmentally, that's what brings them in. You have to encourage and empower people to come out and be involved, they won't be involved if we feel that we are traumatized by any means if we feel that our hope, that you care nothing about us, if what I say doesn't mean anything to you because you are a retarded mentally ill person, you have been to prison… this is real! So, in saying that, we have to develop and maintain a culture of competency and respect for the clients that we are serving, once you do that, because if you want to invest in someone, invest in me, I give all day, everyday. I know the needs of this community, whole person care, and you have to respect your clients and listen.

Reba Stevens — I am an end user of health agency services. So, as I was engaged in our group, I discovered some things that I sort of knew of but wasn't quite certain of. For instance, they said we get $5k for each SAAC, and I am wondering why we don't get a treasurer report. Where is that money going? How long is that $5000 been on a monthly basis that money adds up. The other piece is how long has the current members of the SLT been seated at the table> The president of the United States only gets two 4 year terms. I am aware that are many at the table who have been there for decades. That is a concern, are members selected? Are they elected? That is a question that needs to be answered. In reference to the SAAC meetings, how are those seated, remain seated when we haven't had an election in our SAAC since 2013. These are answers that I feel are necessary, and in reference to the body of the SLT and its members, how is it balanced? I know there are providers do they get to get seated at the table. That is a concern. Are members elected, or selected. How is it balanced? I know there are providers and a lot of DMH staff that sit on the SLT, so the question is how do you lead the system when you are the system? Where are the voices of those of us who are utilizing the system? So that it will actually balance itself and you will learn and know more about what our needs are. I have yet to see anyone come out to our SAAC and do a presentation. I do know that our 2 SAAC co chairs that are part of SLT. When do we inform and educate the SAAC truly about what the SLT is, where do we fit in? How are voices heard? I had to pay $10 to come here to park. I didn't really appreciate that. The other thing is that I had to discover that the meeting location was changed through Mark. I am really grateful for the changes that are happening, the possibilities for new changes and new ideas and going in a new direction. I also want to know how I can create my own list to submit to what I would like to see change, so I can involve others who utilize the system so our voices are heard. Culture is the way and I certainly hope we all do the training on just culture.

Mark- One of the things we need to do is have jail integration into society. Basically, having relationships that facilitate communications. Mechanisms to inform participants of their rights and consumers to educate staff about jail and prison culture. Staff who work in the jails who are capable of acting as boundary spanners between criminal justice and mental health systems. The orientation needs to have human service and professional ethic responsibility, self help recovery skills, supervised internship in mental health, and ethics case management skills amongst consumers. HIV/aids counseling, cultural competency in the jail, conflict resolution, resume writing to get them ready for jobs.

Katherine- I am a consumer. I have a few issues that I would like to address. We are talking about childcare for the consumers to get involved, what about my child who is 23? There is nothing for him to be involved in. Where do our children go, when at any moment their diagnosis might pop up? Where do the TAY children go? When we are sitting in these meetings, we are so tunnel vision on what the age bracket is, that we don't look innovatively on how we can actually look at others. Engage the end users and consumers and their families first. Look innovatively on the children of

	the consumers that you are treating. One of the things we talked about was how does the consumer voice travel up to the SLT if you don't have consumers sitting there co chairs and our voices are being heard. I believe we have top-heavy people making decisions about me and other consumers? What if you decide on stuff I am not even interested in? Where is the part of innovation that we as consumers get the say? Can we be a part of innovations on creating programs that we know and like to see within our communities and with our people? Where do Peers fit in in the system with our innovation and what we see work at the crisis? A lot of what we see is mental health popping up on off hours. My diagnosis does not fit in between 8am -5pm, it show's up at 5:01pm on a Friday or sometimes until Monday morning until 6:59am. Where do we fit in as the consumers on the SLT training, innovation, or vision? **Eddie Lamon** — I feel bad when people criticize things and I am a volunteer, I don't work for anybody. I thought years ago to have clients involved. SAACs could have any number on your committee, so I chose 5. 5 Clients, 5 family members, 5 community people (Police, fireman, etc), 5 directly operated, and 5 contractors, and that's the way the SAAC used to be. You don't know how hurt I was as a volunteer to hear people act like no body is trying to get the voice of the clients when I was the first one talking about. I had to beg, plead and go everywhere and try to get a client and family member to a meeting. You don't have to be a professional to be a member. We have quite a few people that are even running program that are clients. I feel like crying when people get up and say that we don't consider the clients, when that's all I have been doing all these years, since 1974. **Dr. Leticia Ximenez** — regarding the SLT Reinvigoration: Expand the SLT membership to include representation for more culturally diverse populations and advocates by using the CLAS definition of "Culture", which included the deaf or hard of hearing, blind and visually impaired. Expand the SLT membership to include community leaders such as MH Promoters from each service area and property and business owners from each service area. Great idea having the public comments in the middle of the meeting, rather than at the end. **Sandra Villano** — regarding the public comments, I would prefer to have the comments at the end. Agenda items are too important to be cut short, due to too may public comments. Or use a time with each speaker having 3 minutes each.
Innovation (INN) 3 Update	***Debbie Innes-Gomberg, Ph.D., Deputy Director, County of Los Angeles, Department of Mental Health, Adult System of Care*** For those that knew Catherine Bond, she impacted so many lives as a MFT, as consumer, a homeless rights activist and an employee at the Department of Mental Health at one point. I just want to acknowledge Catherine's life and her impact. I want to also acknowledge Ruth Hollman at SHARE! On Saturday morning, in the LA Times, the obituary of Catherine was in there and her picture was in full color. It was a wonderful telling of her life with quotes from Dr. Southard, Dave Pilon, and Ruth Hollman. I just wanted to acknowledge her passing. Another thing I wanted to acknowledge was that there are so many tragedies around natural disasters, most recently the earthquake in Mexico that had a death toll of over 200 at this point. Just wanted to say while we are thinking of things to really consider Mexico, 2 earthquakes in a little over 2 weeks and all the hurricanes that hit the East Coast, Puerto Rico, Caribbean, Virgin Islands, etc. The outpouring of support financially as well as man power from the Fire Department, Red Cross and other organizations, I wanted to acknowledge that. I want to ask Susan Rajlal to come up. Some of you know, many of you don't know Susan is going to be retiring from

our Department. Having worked with Susan for many years it has been an absolute pleasure, from my perspective, Susan has a legacy of at least 2 things. One of them is Peer Certification and Peer Support. Susan has done so much in the last legislative cycle as you know SB614 was a two-year bill. CBHDA, with co sponsor withdrew it for some pressures. Susan has continues to work on Peer Certification, in addition to that she is really the reason why the Governor will sign the Nazarian bill AB727. That has been amazing because that will allow us to fund rental subsidies outside of full service partnerships, which have been a barrier to a number of things including graduating people from FSP. Susan thank you for everything you have done, and thank you for your service to the Department on behalf of the Department.

Susan Rajlal — Thank you everyone, it has been a wonderful experience to work all of you, but I will truly miss you. I hope our paths cross again, even when I am in retirement because I can never stop working with the mental health community. It has given me so much joy and has taught me so much all these years. I also felt a little pain in my heart when someone says DMH staff doesn't care. I think a lot of us really do care and I have been working in this field since 1984. My experiences have been remarkable because of the people that we have served.
I want to talk a little about what we are doing with Peers now. We intend to go forward with the legislation for the peer training and certification. I spent the entire summer meeting with various groups through out the state trying to make sure we are on the same page. The reason why I never brought the group from SLT together was I wanted to get a basic outline of what can happen before we can meet as a group. We are going to co-sponsor the bill with CMHDA. One of the issues that I have had, related to the same issue with SB614. The reluctance on the part of the Department of Health Care Services to be the home for the certification. Their reluctance to include it in our waiver by adding it through a State plan amendment. So, what I've tried to do was find a home for it. Where people would really support this idea and nurture the training, the peers, and do a really good job on certification. After many meetings, we have fund a home, and it will be through the Community colleges in CA. They have an association that has agreed to be the home for this. I think it is super important to have a home where we are appreciated and supported from the get go. We should not have to beg to be included. DHCS has agreed to include us in the next waiver that they will do which is the 1920 waiver, which they will be working on shortly. It is important to be included because we want to be able to bill Medicaid as a peer service not as other because the whole idea is to help professionalize the peer position and have a funding source where we identify what we are doing and how much money it is bringing. Also, we need to be able to pay people a decent wage. This is really important and to that point I did go over the 17 recommendations from Working Well Together. I do not think we will have that all specified in the bill we intend to honor that. It will come in through regulations, and I know some of you were very involved with CAMHPRO and Working Well Together. Right now there is no one that I know of that does not support this so I hope that we will have an easy go of it this time. Thank you for all your support over the years.

Brief Update on Innovation
Innovation 2, which is the Community Capacity building, related to trauma, those are due back Oct 4th. We extended the deadline because we had some questions and it took some time to get the answers. We are really excited moving that forward. We had a very good bidder's conference.

Innovation 3; which is the Technology Suite. Dr. Sherin and I went to Sacramento to the Oversight and Accountability

	Commission and presented that as a conceptual proposal at the end of August. We received a fair amount of very positive feedback. In addition to us going up there, Mono County's Director, Ryan Roberts also came up as well as the Steinberg Institute, they also Public Commented in support of this. They are very excited about the idea of creating a Technology Suite. The next step in all of this is that we sent all our proposal to the Oversight and Accountability Commission and we are on the calendar for October 26 which is their next commission meeting for the full presentation and hopefully approval to move forward. The most recent development in this is that multiple counties have come forward and said that they wanted to join us in this. As a result of that, we know that Mono County is interested, Kern County, Monterey, Sonoma County. What we are not sure of it the staging of that in terms of their own stakeholder process, and posting of the plans. Nevertheless, there will be a set of counties that will implement the technology suite and work with Los Angeles with LA being the lead, so we are very excited about that and the opportunity that it brings. In the last month or so, one of the things that we gained feedback on was the idea of passive data collections- to create early detection strategies. We are thinking of broadening that to beyond what I already thought was a broad set of focal populations. To people early in the course of an illness, people that aren't symptomatic yet to people that are and need that extra support as well as coaching, information, and help. Also to thing about how we support families, and that has been a key theme today. How we help use technology in the set of technology that we are talking about to support foster parents or parents that are struggling in terms of their own stress levels, and their own ability to understand how their own emotions are affecting of their parenting or their stress levels. We are looking forward to, as we consider this technology the different population that can use it. In addition, the community colleges and the universities. The vendor that we go with, part of their job will be to go to the community college or university to engage people. Along with that being able to make sure people are aware of the application or the website itself. **Mariko Kahn** — This Innovation 3 proposal went through a different process, we talked about it after the last SLT meeting and I was very excited about the concept of using technology. I would like to know for other proposals that are technology oriented but are not covered under this, what is the process because I felt in the other two innovation plans there was a long planning process where the SLT had input This one I felt was more of an announcement and moving forward. I understand the need to move forward quickly but the same time I feel that there are other possibilities. I am very interested in technology but I am interested in technology from the workforce perspective of training and there are some exciting things going on that I am learning about. For example, my agency is applying for a grant with other API agencies to provide an app for human and sexual trafficking victims. There is a lot going on so we can have a forum to come up with Innovation 4 Project. **Debbie Innes-Gomberg** — Thank you that's helpful. The next thing that we are going to talk about is in October, the next SLT meeting, I want to have a fuller discussion about future innovation projects and a constellation of ideas that are coming up, we talked about Peer FSP, where we are in terms of innovation projects, what's in the queue and being maybe to add to those. I do want to say Innovation 3 was a very different process in part because of how innovative it is and the process that we got exposed to it, in other words, through the Oversight and Accountability Commission and Dr. Sherin. Thank you. **Cynthia Perez** — I wanted to talk about the Peer FSP. Are we moving forward? Where are we at in the process? I think the technological portion of will be great for my area, which is the Antelope Valley. I hope people will utilize mental

health services more through that.

Debbie Innes-Gomberg — Absolutely, I think that it is a very exciting opportunity. In terms of Peer FSP, the proposal should be completed by the end of this week and then we hope to be able to post it next week on our website and we will send it out to the SLT.

Cynthia Perez — So you are already accepting proposals?

Debbie Innes-Gomberg — No, when I say post, I mean for public comment.

Karen Macedonio — I am delighted to hear that Mono County and Kern County are interested because they are rural counties. I want to ask that as you work with this technology suite, Dr. Sherin at the beginning that the people that we are trying to serve are those in need. Even thought we are surrounded by urban places we have rural component of this county where there are no services. So, as you work with this, listen to rural counties. We have 2 federal installations that are not even speaking the same language, so when we get out there to the real people in need that are relocating because they can't afford to live here anymore, we have to look at the rural counties.

Debbie Innes-Gomberg — I really appreciate those comments. I think you are right, one of the things that we have talked about through this project and potentially through other projects that are related to the OAC, is the idea to learn across county. Rural vs. urban, there is a huge amount of potential for increase access to mental health services, prevention and early intervention.

Ruth Hollman — There are a lot of us that don't understand what you are talking about. Can you give us a general overview?

Debbie Innes-Gomberg- The technology suite is an idea and it posted on our website if you want to see the whole proposal. Basically, its an idea where through an application or a webpage, anyone can anonymously can link to peer chatting, family chatting to manualize interventions where the individuals that are providing these services are all trained and certified. These products and services come in many languages because some of these companies do this outside the US as well. It is the idea around that level of support and one of the things we talked about is this in particular aspect of it along with the second part of it, can be very helpful in engaging people that would normally not walk in our doors. The folks that use their phone more than they call people and talk to people. The people that are in the pre-contemplation stages of acknowledging an illness. The second part of this is the most innovative part of this and that is the use of passive date through the use of a cell phone. To engage users to be able to understand the changes in their behavior and what that may mean. For those of us who interact with people regularly when you don't hear from somebody in a day or two and you always hear from them daily, something might be up. That electronic way of identifying changes and intervening.

Jim Preis — What is the method of communication between someone who dials or connects? Is there a chat box on screen?

Debbie Innes-Gomberg — It could be an app or website that you go to. Ivy, can you talk about this more?

Ivy Levin — There is a lot of room for this to be shaped, and it may manifest differently. There are lots of different mechanisms where this chat and peer interaction can take place. It can be through use of downloading an app to have access to different exercises or different psychoeducation components. It also may be accessing

	peer chat through use of chat boxes that is linked through our website that anyone in county can access. They have real time access to chat with someone. Different language capabilities, people who want to have a brief conversation or ma ask a question. Even to foster online communities and meet ups. Have different initiatives or things they want to address in a more regular formal fashion but doing it with leveraging technology. I know a lot of it sounds vague and over time it will become clearer. Right now we are looking at all the possibilities and what's available and what makes sense for our system. There are a lot of different opportunities for us to continue work that is being done and also to start new initiatives that technology allows for that we would not be able to do in person. **Romalis Taylor** — I have a question, there are some other innovations going on with other groups and agencies. One of them is the Home visitations efforts with mothers that are having children and how that's going to help them in the home visitation concept, how is DMH connected to that innovative effort that is going on a countywide basis? **Debbie Innes-Gomberg** — Brian Mershon is in charge of that particular project that is being funded through Prevention and Early Intervention. I know early on we met with Christina Altmayer of First 5, and had a really productive talk and that was one of the projects that we talked about. In fact, in October it would be a good time to bring these projects back and tell you where we are in implementation of that project and other projects. **Jury Candelario** — More of a comment, I want to applaud the effort in terms of innovation and use of apps. I think this is going to go a long way in terms of tapping into youth and TAY that don't normally walk into a mental health treatment facility for instance. I also want to draw parallel to something that the HIV community has been doing; particularly from an HIV prevention and treatment perspective where having those apps will remind folks to take their HIV medications for instance. I applaud the innovation committee for doing this. **Debbie Innes-Gomberg** — Thank you very much. We have so much to learn through this and I think we have set up a mechanism, not only for cross county learning but learning within DMH and with specific populations. **Minsun Meeker** — Can you clarify what you mean by passive data? **Debbie Innes-Gomberg** — I can give you a couple of examples. Say I order something LL Bean and then on my Facebook feed it shows what I ordered. In your web search, content isn't looked at, but process is. For example, speed of texting, amount of texting, website, etc. Passive data is the use of the data that is out there that then prompts you as the used about things you may do to address in that behavior. I struggle with the language around this because it is all new to me too. **Marcelo Cavalheiro** — One caution is that passive data can become active data depending on circumstances. One thing that came in mind was and article in the newspaper about a guy killing his wife. In court the persecutor shows evidence of her fit bit activity after the supposed intruder broke in. The husband ended up going to prison for murdering his wife. It was based on inactive data that could be activated. There are a lot of issues in terms of civil rights and confidentially. Now there is facial recognition technology. Studies of people prior to going into a psychotic episode sometimes their voice changes. I work in Brazil with a lot of kids that will shave their heads before they have an episode. There are a lot of triggers people are not aware of, but at the same time, the information that you are giving to your device or fit bit, computer, Facebook, that is passive to a certain point. If you are going into litigation the passive

	data can become active data and can be used against you. **<u>Debbie Innes Gomberg</u>** — Thank you, elements around that have come up in every public comment we have been engage in, including the OAC. There really has to be an informed consent. I want to introduce Mirian Avalos who is our next presenter. I want to give you context for the presentation. When MHSA started there were two plans that have 10-year funding streams. One was Workforce and Education Training, and the other one was a combined Capital and Facilities technological needs. LA county submitted plans at different times, one for Capital Facilities, which funded our facilities. The second one was technological needs. Otherwise known as the Information Technology Plan, the IT Plan. Those plans and the money expires the end of this fiscal year, June 30th of 2018. The Department has recognized that there is a need to continue some of the IT funding to the amount of 15 million dollars. One of the things is that we have unspent CSS dollars and what we are going to do is present a plan to you about continuing with some specific investments that would help upgrade our IT system that would also benefit our entire Mental Health System that interfaces with IBHIS. One last thing the MHSA and the regulations allows for a County to take up to 20% of the average of the last 5 years of the community services support plan funding to be able to fund or add CAP facilities, IT, or add to put in reserve. The average for the last 5 years of CSS is 331 million dollars and 20% of that is about 66.2 million dollars, so I wanted give you that context prior to this presentation.
Community Services and Supports (CSS) Proposal re: IT Plan	***Mirian Avalos, Chief Information Officer, County of Los Angeles, Department of Mental Health, CIOB*** This is an inspiring morning, this is part of the continuing education that I've had in the last 4 months. I am new to Mental Health. I wanted to take a few minutes to introduce myself and give you a little background. I spent the last 5 ½ years with the District Attorney's Office in San Bernardino county as a Chief Technology Officer. I am resident of LA county and I commuted down to San Bernardino. It was a great experience working with the DA's office and law enforcement. Prior to that, I spend the last 10-15 years in IT. I have spent the majority of my career in the IT public sector. I always think of all the bosses that I had, the good ones and the bad ones and what a good CIO in public sector does. One of the good things that I aspire to be is to be a person that listens and understand the value of technology as strategic partner. One of the reasons why I am so excited to come to DMH is from the interview with Dr. Sherin. I learned that he is the type of person who understands technology as a driver to bring services not just to the community but as a driver to the clinics, a driver for everyone. He talked about the Sacred Interface, during my interview with him, and I really didn't understand that all to well. I have been thinking about that more and more and I began to think about what that means from a technology perspective. A lot of what I am going to talk to you about is an investment portfolio of projects, but more importantly, hopefully each one of them I can articulate why it is important to the many stakeholders within this room, why it is important to the directly operated clinics, why they matter, why they are important to the legal entities, and hopefully we can be more efficient in delivering the care that we are trying to provide. Your IT folks and the legal entities have a lot of interaction with my staff and some of the interactions is because the technology is not as sufficient as it we'd like them to be. **<u>Investment Portfolio of Projects: Breakdown of the investment portfolio</u>** 1) EHR Strategy: Continuous Process Improvement Programs $5,000,000 2) Consumer/Family Access to Computer Resources $1,500,000 3) Healthcare Enterprise Analytics Strategy $1,000,000

4) Virtual Care Strategy: Telepsychiatry Expansion $ 1,000,000
5) LAC-DMH Resource Search/Performance Dashboards $ 3,000,000
6) Digital Workplace Strategy: Wireless LAN Infrastructure $2,500,000
7) Hybrid Integration Platform: Migration from Bimodal to Adaptive Integration $ 500,000
8) IT Asset Management Modernization Program $500,000

1) EHR Strategy: Continuous Process Improvement Programs

In 2011, the Department of Mental health took on a significant technological innovation project. They migrated over to the EHR system. The timeframe of the implementation of the project and where we are now. We are in the midpoint of 2017; we have several more years to go on with our current EHR contract.

Right now we are going to take a look at some of the projects we want to fund, a lot of them is ongoing maintenance of the system. One of the important things we need to take a look at is that any EHR system is not one and done. It is a continuous improvement project in which we are constantly taking a look at the user interface. There are a lot of pain points with the current user interface in our clinics. It takes a long time and many clicks, while we are never going to get to a perfect point where it will be seamless, there are improvements that we are going to try to do. Basically the end result and benefits is the improvement of client care. Allowing the clinicians to go through the application and enter the data that is important. Another thing that we wanted to make sure was our continuous improvement process. We have current needs identified as far as making sure we have a portal for claims to be submitted so that is improvement to care. Be in a position where we can respond to any future needs. There is legislation in the federal and state level that we can adapt to and making sure we set aside funds to adapt to that. It is a continuous process of improvement so we have those designated for the next 3 ½ to 5 years.

2) Consumer/Family Access to Computer Resources

The Department of Mental Health has a significant investment in providing hardware to the library system. We want to make sure that we can refresh that lifestyle and expand that to many other sites.

- Collaborative project with LAC Library
- Have set up labs in 27 DMH sites so far
- Uses same computer images as in Libraries

Benefits:

- Consumers gain basic PC skills, research wellness, enhance their lives
- Library image on PC empowers consumers to use PCs at County Libraries.

3) Healthcare Enterprise Analytics Strategy

One of things that I have heard initially from both the directly operated clinics and from the legal entities is that you guys ask to collect a lot of data and we return a lot of data. Our ability to make sure we have an analytic portal and be able to provide a framework in which we can provide analytics to both our legal entities and to our directly operated clinics is what we are looking at. We broke down some of the requirements and requests. One of the things is improve the data delivery.

	Project: craft analytic technology framework (healthcare analytics architecture Benefits: delivers value based on triple aims of healthcare: Outcome, Cost and Experience. **4) Virtual Care Strategy=Telepsychiatry Expansion** We currently have a Telepsychiatry program. It increases the cultural competency. Sometimes we have some locations that need to provide service in another language to another location and its not feasible to have the client commute. We have a current infrastructure that needs to be refreshed. We intend to do that with the funds. We also intend to expand that to leverage the new technology in order to deliver those services. Initial project: - Set up central TeleHub for Drs. - Placed video conferencing (VC) equipment at clinics for Adult Programs - Expanded to take mobile VC equipment to Older Adults' homes Benefits: Address service disparities among remote and underserved populations Provide direct Tee psychiatry treatment to mobility challenged older adults. **5)LAC-DMH Resource Search /Performance Dashboards** We are currently under a Board mandate to take a look at the Performance Dashboard and a research search. We are taking a look at creating dashboards not only for Executive Management but also for the directly operated clinics and the legal entities. This is a complete infrastructure project and it is something that we are renewing in our system. Project: - Provide easy to use DMH mental health services locater - Develop performance monitoring dashboards to: o Depict current conditions, do root-cause analysis, use historical data for trending and planning, provide actionable insight and predictions to prevent future issues. Benefits: - Improve access to services - Improve client outcome effectiveness **6) Digital Workplace Strategy: Wireless LAN Infrastructure** This is something I presented to the Directly operated directors last week and they are very excited about it. It means that we will enable wireless infrastructure in 10 of our clinics. That means folks can begin to work in collaboration and take their laptops to access our wireless infrastructure. We will do 5 clinics this year and 5 next year. Project: - Implement wireless access (Wi-Fi) at DMH clinics to provide ease of system access for DMH staff and other Department providers. Benefits: - Work can happen anywhere - Improves care

- Improves care coordination

7) Hybrid Integration Platform

Right now we have a bottleneck when it comes to processing claims from our legal entities. Switching from a Bimodal infrastructure to an Adaptive Integration. We can accommodate the needs of all our legal entities to be able to absorb data. You do a lot of transfer of data or double data entry; we are trying to figure out a way to submit a lot of the data through the back end.

Project:
- Modernize LAC-DMH integration strategy and infrastructure to enable a unified approach by adopting a comprehensive integration as a platform service (IPaaS)
- Serves as a conduit for contract providers to submit claims and share data

Benefits:
Improves coordination of care

8) IT Asset Management Modernization Project

Making sure that we can track all our assets and making sure we do life cycles. A lot of our directly operated clinics have a lot of technology that is fairly old. We want to make sure that we can refresh it and in order to do that we need to track it.

Project:
- Implement wireless access (Wi-Fi) at ten DMH clinics to provide ease of system access for DMH staff and other Department providers.
- Identify and manage technology assets by business priorities and outcomes

Benefits:
- Reduce costs
- Reduce risks
- Improve availability of technologies used by workers to help in the delivery of care.

Marcelo Cavalheiro — There were a couple suggestions from a couple of tables regarding DMH website, links for SLT, website be portals so contractors can go in and look at policies, the public can look at SAAC information, etc.

> **Mimi Martinez McKay** — It will take awhile since the website has not been touched in anyway in the last 15 years.

Marcelo Cavalheiro — In old days we can go in and find the service areas, but there are no maps anymore. It's hard to find. One last thing is for the people saying to have a voice. Perhaps the portal can have a chat box or a place where consumer's family or providers can write a comment or suggestion.

> **Mimi Martinez McKay** — Now you are talking where Marian and I overlap. Technology is going to allow us to let us do that and is critical.

Marcelo Cavalheiro- where is the money going to come from? Is it part of the 8 programs that Marian discussed?

> **Mimi Martinez McKay** — no it is not part of the 8, it is part of a mandate in my position.

Cynthia Jackson — In regards to the collaboration contract with the Libraries. You said you are at 27 currently, countywide; do you at lease have one in every service area? And can we make sure we have one in every service area?

> **Marian Avalos**— Yes, we can make sure we have at least one in every service area.
>
> **Dennis Murata** — Can I comment on the library? We will make sure and I believe we do have one in every service area. Keep in mind that Marian is talking about the technology associated with what we are doing with the Libraries but we also have been training librarians and librarian staff on mental health first aid and other types of things as well.

Helena Ditko — Marian, thank you so much for a comprehensive presentation, I really appreciate it. The health portal for consumers was part of this correct?

> **Marian Avalos** — Yes it was part of this.

Helena Ditko — Thank you for that, I know the health portal has taken awhile. I can access my medical information but I would like to get mental health information as a consumer, so I appreciate that.

> **Mirian Avalos—** It is part of the EHR system. It is been working, it just hasn't been socialized. A lot of the large health care providers have that, its one of those things that it just needs to be socialized.

Helena Ditko — I think we have a good training protocol out there already.

> **Mirian Avalos** — I will work with you Mimi on the communication part to make sure we communicate that.

Helena Ditko — My real question was cognitive remediation, it that anywhere on the radar for the future? Cognitive remediation is the use of computers as a treatment protocol for major mental health diagnosis.

> **Mirian Avalos** — no, it is not.

Cynthia Jackson — First, to follow up on the health portal for patients, that is part of the requirement for the incentive payment for CMS. We are working on that on our own EHR so it is an essential I would presume for the Department. Then next, I am really excited about what you guys are doing too. I am a little confused why you haven't had Wi-Fi in the clinics. A couple things: when you were talking about the dashboards, we use dashboards, the thing about that and what is essential with those is not that the administrative types see them but the line staff can see them client by client. Then the staff entering the data can see a rationale of entering the data into the EHR. If there is something they get back that can inform treatment or inform work. Also would be helpful to add that to the patient portal as well. A couple of other things, the stuff about Older Adults, one of the barriers for the library is that it won't really work for them. If CSS funds can be used to have them have equipment that is inexpensive and practical. I think it would be very helpful, occasionally we have done that. In terms of the Telepsychiatry and expanding on that, doing Telepsychotherapy as well, the other mental health codes I think can be helpful at times or having that quickly available. It makes the technology not about apps and the self-help; it gives the people quick ability to have face-to-face contact. Also I noticed that you guys cannot use Skype for business?

> **Mirian Avalos** — We can do Skype for business, it is fully employed. It is not fully socialized. We have it and it is available and we have tested it with several of our town hall presentations. We are just beginning to be

	intentional in our delivery making sure the folks understand the training part is essential; we are working on a comprehensive training package. **Ruth Hollman** — When you say it is the same as library, how are you mitigating porn, violence, hostile work environments, etc? **Mirian Avalos** — We have filtering systems in order for us to lock down those devices. We also have technology that we open up certain sites, and restrict certain sites. It will be filtered and it won't be open access. Make sure we can titrate that if need be, sometimes inadvertently we block out sites that are needed. **Ruth Hollman** — My other question is we are a COS provider only and every time these things come up, they all say we can do COS and at the moment we have to have the employees input the COS on the form. Making us to fill out 4 forms per day, fill out online, and then they get printed, and then entered back into system. We are on Legacy system, not on IVIS. We cannot get reports now, because they shut us out of all reports. We found a work around to get a report. **Mirian Avalos** — The good thing is that I understand what COS is and we spent a lot of time looking at. We need to take a look at that and what does mean for the COS. Right now we do not have an elegant solution it will still be clumsy. We are trying to figure out what the proper road map is for that. **Ruth Hollman** — I think what we need to do is have a COS committee that looks at all of the different issues with it, where we all come together and figure out what needs to be done to make it so that we are not taking a super antiquated concept of Community Outreach Services for wellness centers when they aren't community outreach, they are actual peer services being delivered elsewhere. **Debbie Innes-Gomberg** — Mirian and I can speak from the program and the IT side of it. The Department will come up with a solution, and you are right, we used, like a lot of other things, a work around for far too long. You have our commitment that we are going to figure this out. **Ruth Hollman** — Stop having people having to stop work to fill out four forms. And if they speak another language, then it will be 8 forms per day. **Jim Preis** — I have two questions. I am having a hard time figuring out how this technology suite and the innovation discussion fits in with the consumer portal and the stuff that you are doing? Is it the same effort or is there two parts or different groups doing parts of it? Mirian- They are different and separate. Eventually the data will live in the data warehouse that we are redesigning but to the extent that a lot of that is separate. Depending on whom we end up getting after the bids and how the data is going to be hosted. We will eventually have that data in order to be doing the analytics correctly. **Debbie Innes-Gomberg** — The peer chatting and family chatting is anonymous. Mirian has been very involved in this on the tech side. There is a big difference in what we envision in the technology suite and the components of this proposal primarily because the users of the technology suite will not necessarily be clients of our system. **Mirian Avalos** — At the point when they become clients of our system that is when they go into our enterprise

and the portfolio of applications that we have.

Jim Preis — The second question is a year ago when we moved to a health agency, there was discussion of integration of a medical database that included behavioral and physical health- how does that fit into your presentation?

Mirian Avalos — The rest of county is with a different system with a different vendor. We are working closely with CIO so on back end we can deliver the information after County Council and privacy and everyone else have vetted it. The experience is seamless between DMH and DHS. If we have shared clients they can be both seen both in DMH or DHS. Our clinicians can see the health information and DHS can also see the mental health information of our clients.

Jim Preis — Part of moving this forward is to make that happen?

Mirian Avalos —There are about 10 initiatives in order to do the migration of data from both our system to DHS system on the back end. When a DHS clinician opens their application they can see data from DHS and a tab for DMH information to see data for mental health. It is seamless and both integrated in our program and on their system. We are making sure there are connections on the back end. We are going through the process now, legal counsel, privacy, covered entities, there are a lot hurdles and process to go through. Technology wise it has been done among many other systems.

Marcelo Cavalheiro — Folks at DHS can see DMH information.

Marian Avalos — it's the sharing of the data and not the applications.

Ana Suarez — I want to support Marcelo on the portal being much more friendly. We have to carve out some dollars to be able to do that because it is not in the budget, but it is really important. People cannot find what they need on the DMH website. I am in support of that. This is an innovation for the Department; I have a friend that works for the city of Los Angeles. They take their used computers that they are replacing and they upgrade them and give them away to youth who are low income. Could we take that idea and do that at DMH? Is there something we can put in place where we can recycle our computers?

Mirian Avalos — Yes, we can take a look at it. Obviously, the bureaucracy we will have to deal with that. We will reach out, and we can talk to them about it. Also with the legal entities.

Romalis Taylor — I heard DHS and DMH but I did not hear anything about Public Health around depression and other issues in a sense that we are also serving their clients.

Mirian Avalos — I haven't taken a look at that. But it is something that I will take a look at. To the extent that we are all under the agency we are all working on collaborative projects.

Romalis Taylor — I talked about home visitation. I learned late in life about post partum depression and all those other things, so that is there and there is overlap. That is just one example of where there is an overlap of public health and mental health.

Mirian Avalos — This is part of my ongoing education, which I am beginning to take a look at all those areas of leveraging the technology.

	Romalis Taylor — I didn't want that to be the all inclusive, there are others and I don't know them all, but I think there needs to be a dialogue with that part of the agency. **Dorothy Banks** — I have a comment on the computers, I think it is a great program. I am volunteer and volunteer coordinator at West Central. We are using volunteers to co-facilitate the computer lab. We only have staff 2 days a week. The Computer lab is only open those two days; if you are going to have that program, have a paid staff for the lab to be open every day. We have some faithful clients that come every week because that is their only way to use a computer. So many have connected with their families that they haven't seen in years through Facebook because they came to the lab to learn how to use the computer. I would love to see a paid staff be assigned to the lab so it can be open everyday. When clients come for their groups, or doctor appointments, they can go in and use the computers.
	Adjourned: 12:29pm