Community Leadership Team (CLT) MHSA Meeting
March 5, 2021

[Please stand by for real-time captioning]

>> RIGO RODRIGUEZ: Getting ready to start now. Pinki, do you think we have enough folks to start? Looking at the list.

>> INTERPRETER: Hi, this is the Spanish interpreter. Apparently, all the interpreters were put in the same place. We're about to log into the correct line. Thank you for your patience.

>> RIGO RODRIGUEZ: No worries. Pinki, are you there?

>> PINKI MEHTA: Yeah, I see a handful of our CLT members and more trickling in. We have a handful of introductory items.

>> RIGO RODRIGUEZ: And in terms of accessing interpreters for different languages, do we need to announce that or fairly obvious when people jump into Teams?

>> PINKI MEHTA: You can add the Spanish and Korean is in the chat box.

>> RIGO RODRIGUEZ: Julio, why don't we start off by describing what people would do to obtain Spanish, Korean, or other translations.

>> JULIO MIRANDA: I'm typing in the phone number into the chat channel. Here is the Korean number with the phone conference ID. You dial in and enter the conference ID, and you will be able to get Korean translation that way. There is a separate line specifically for Spanish.

>> RIGO RODRIGUEZ: And they can find it in the chat box.

>> JULIO MIRANDA: In our chat box. They can click on the little chat bubble, and it will open a chat pane, and you can see the messages here, and this is the Spanish line I'm including now.

>> RIGO RODRIGUEZ: Perfect. Thank you, Julio, and we are taking this time on the front end to be sure everyone can hear in different languages and also with ASL interpretation.

>> INTERPRETER: Sorry, this is the Sign Language interpreter. Do we have a specific client in the meeting or is this just for general access?

>> RIGO RODRIGUEZ: Good question. Pinki?

>> PINKI MEHTA: General access.

>> INTERPRETER: Thank you.

>> RIGO RODRIGUEZ: All right. Always important to start meetings with clarity around how we're communicating … [audio distortion].

Thank you so much for joining us this morning. My name is Rigo Rodriguez, I will be your friendly facilitator for today. And welcome, welcome to [video recording starts here] the MHSA Three-Year Program and Expenditure Plan Session. It's a presentation to the Community Leadership Team. We are going to be together from 10:00 all the way to 2 o'clock today. Again, my name is Rigo Rodriguez, and I have had the pleasure of working with a number of you to design and plan today's session. I'm looking forward to engaging you all in this important, important discussion today.

I want to announce also that this session will be recorded. We're recording it because some people might not be able to attend today, and we want to make sure they have access to the recording. At this point, Julio is going to get the recording going. It says it has started. Am I correct, Julio?

>> JULIO MIRANDA: Yes, I got your opening. Thank you, sir.

>> RIGO RODRIGUEZ: Good. Also, when we break into the small groups, the small group breakout will also be recorded, just as an announcement for everyone.

I also want to thank the CLT community leadership team ad hoc group and the DMH team that helped with today's session: Andrew Preston, Jean Harris, Hector Ramirez, Pastor Nah, Sunnie Whipple, Wendy Cabil, and then Yolanda Becerra as well. The group met to really help me think about the kinds of outcomes, the purpose for today. Thank you so much for your participation.

We also had three really important folks who helped us out in all the background work, so Pinki Mehta, Darlesh Horn, and Cynthia Duong. Thank you so much.

There are other people from the DMH team that have, of course, contributed. They will be presenting later on, so I'll have a chance to present them. These individuals might not be presenting today, but they were really instrumental in organizing today.

More than anything, I want to thank the CLT and DMH leadership on both sides for spending the time together in trying to craft today's agenda so that it really tries to engage everyone meaningfully. Please note that if there are areas where we just didn't get it right, you can … [indiscernible, 00:02:39]. The intention here is really to create a context where we can align purpose and do collective collaborative work together, so thank you.

The purpose for today is to obtain the community leadership team's feedback. I'll start using the word CLT. It's to obtain the CLT's feedback on a draft MHSA Three-Year Plan – I'm sorry, on the draft MHSA Three-Year Program and Expenditure Plan for fiscal years 2021-'22 all the way to '23-'24. It's a three-year time horizon. From this point on, I'll use the word

MHSA 3-Year Plan for an abbreviation.

In case you're wondering what the CLT is, the CLT is an entity that is part of a broader partnership called Your DMH. It's part of this broader active partnership.

The CLT is part of Your DMH. Your DMH is that active partnership between DMH and diverse stakeholders who work collaboratively with consumers, family, and community members to generate meaningful input on mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations. So, this is a long-term commitment and institutional commitment on behalf of DMH to make sure that community stakeholders are actively engaged in the broader purpose of the Department of Mental Health.

Let me also say that I have had a chance to work with the CLT since August of this past year, and we are strengthening the ability of the CLT to provide this kind of input. This is the first time in working with the CLT that we're organizing a session like this to really focus on the 3-Year MHSA Plan.

The CLT members include the co-chairs from the SALTs. You can see the list there of the service area leadership teams. These are regional bodies that cover those different areas that altogether comprising Los Angeles County.

The CLT also includes co-chairs from the Underserved Cultural Communities. There are eight that have been in place for a while now. You can read them there [refer to slide] and two others that are being created around peers or folks with lived experience and youth.

So, the CLT is a coming together of the co-chairs who have responsibilities and are active leaders in those groups, and so represent the formal leadership of the community stakeholder body that works and collaborates with the department to reduce and eliminate mental health disparities but also, and more importantly, promote well-being, recovery, and resilience.

Because today's session is primarily focused on the CLT, I want to be clear about two levels of participation for today. For the primary audience, these are going to be the CLT members and DMH staff. They will be the ones who will be engaged in a verbal discussion throughout the session today and also in the breakout sessions. We will also provide CART services for this primary audience, but I just learned that CART services will be available to all who stay in this particular part.

The secondary audience are members of the public. You are welcome to be part of this. We are glad that you're joining us and, at the same time, we want to make sure to note that you are (today) observers only; we ask that you not use the chat box for today. It will be reserved for the CLT members during specific moments. However, the public hearing that will be held on April 22nd, that session, you will be full participants there. For today, again, we're

focusing primarily on the CLT members. Again, thank you for joining us.

Let me now go through the objectives for today. The first objective is to provide a big-picture view of DMH's approach to reducing mental health disparities in Los Angeles County through multiple strategies and resources. The CLT ad hoc team that met to provide input on today's agenda asked that we start off with this big-picture view so that everyone can have the kind of a broad understanding of how DMH is approaching these significant disparities, including but beyond MHSA dollars, so we will start off with that so everyone has a big-picture view of this approach.

Then we're going to move into Objective 2, which focuses more specifically on MHSA 3-Year Plan. We're going to describe the Community Planning Process and then will present the draft MHSA plan components, which you see listed there.

For this particular section, as you will see later on, it's really focused and contained on MHSA. There are certain things that MHSA can support, other things that MHSA can't fund, so a lot of the input that you have given through the Community Planning Process, some of that can be addressed through MHSA and some might not. So, in this section, you will be able to hear what and how the department is articulating the MHSA 3-Year Plan.

Then lastly, when we're done with these first two steps, we're going to then obtain more active and formal input – feedback, I should say – from the Community Leadership Team on this draft MHSA 3-Year Plan.

Here is a visual of our journey for today. Again, we will start off with the big picture. This will take us about 40 minutes, and we'll have some folks share with you the DMH approach, kind of a broad perspective on disparities. Then we will go over to presentations. This will take about an hour and 15 minutes, but we will build a break in between. It will be like 30 minutes or so and then a break in between so that we can give ourselves a body break, a mental health break as well.

We have reserved the biggest kind of segment of time for small group discussions. We will have small groups. We'll break into two groups, and I will describe in more detail what we will be doing in those groups. But the basic point here is that, in the small groups, in groups of anywhere from 12-15 folks, you will be able to engage DMH staff in a more intimate setting with regards to your questions, comments, et cetera.

Let me say a little bit about what the term feedback means in this case. It's a term of art that I use in the context of community planning. There is a difference between input and feedback. Input is what the SALTs and the UsCCs provided in October, November. That's where you get a chance to share information on needs; you contribute ideas on the kind of services that can address those needs. That is the input.

Feedback is a deeper level of engagement, and there, using your perspective as a SALT

co-chair for your region, as a UsCC co-chair for your community, using your perspective, you are able to then clarify certain items, identify strengths and limitations, and then give suggestions. So, feedback is more of an evaluative exercise on what you are seeing.

I'm going to give you a rough analogy here: It's like planning a wedding cake. First you give input to the baker, and you say, "I want this kind of cake." A month before the wedding, you meet to taste the cake. The cake has been baked, right? You get to taste and sample, and that's kind of what we're doing today. Then, eventually, at the wedding, you get the final cake.

Today, we're providing -- we're kind of tasting the first iteration of this cake, and we're going to kind of see if it's too sweet, not sweet enough, so on and so forth. But we do want to make sure that we get your input because there may be some strengths. There may be some gaps, still. But, in the end, we want you to give suggestions around what you think.

In order for us to give constructive feedback, we want to underscore certain commitments that we're going to ask of you and of all of us.

- One person at a time. Because we're in this virtual setting, it helps if you can raise your hand and to practice active listening because sometimes when you're the second or third person in line, maybe someone else already said what you had to say, so you could just ditto that by practicing active listening.
- Monitor our air time, and that means really striking a balance between taking space when we need to say something, but also giving space so that others can also participate. The CLT ad hoc team really underscored making sure that everybody has an opportunity to speak, so this really requires that we monitor our air time.
- Finally, offering respect is really important because we are trying to really role model and practice collaborative, non-violent communication. And so, that really means that we won't really accept any personal attacks or kind of aggressive actions or statements that undermine collaboration and non-violent communication. I have been working with the CLT members and also with DMH, and I know that all of us practice collaborative non-violent communication already. I just bring this up because sometimes when we are engaged in a dialogue -- it has happened to me before -- a certain word or things can get me frustrated and sometimes I can explode, and that can happen to any of us. If that were to happen, let's be patient with each other. But hopefully, we can really take a moment and really monitor and engage in self-care as well.

Those are the three things that will help us with making sure that we are engaged in constructive feedback.

Now, I'm winding down from the general statements. I'm going to start now getting

into the session itself.

I want to say a little bit about the chat box. We want to use the chat box strategically.

[audio feedback heard]

>> RIGO RODRIGUEZ: Oops. Can someone mute themselves? Okay.

For the CLT members, we are asking you to use the chat box, but we will use it very strategically for introductions or closing reflections, and questions at the end of specific segments, but not during presentations. That's to avoid distracting the speakers. We'll use it strategically. I'll prompt you when to use it.

For example, if we were in a face-to-face discussion today and I'm giving a presentation and then people are passing notes to each other, you know, those notes are very important, but it can distract the speaker – it would distract me – so we just ask that while the presentations are happening that we not use the chat box. But again, I will prompt you; there will be times when we use the chat box in a strategic way.

With that, let's use the chat box in a strategic way for members of the CLT and also for members of the DMH team that are part of the primary audience for today. I'm going to ask you to use the chat box and, in the chat box, if you could put your name, the entity or group that you're a part of (like SALT 1, SALT 2, or UsCC) and then just one word that represents how you're feeling at the start of this session.

Now, you're not trying to make anyone feel good or bad. It's just kind of where you are at. It might not be where you end up today. It might be where you end up today. I don't know. But it's just a way of kind of registering where everybody is at, at the beginning for today. If you could do that, I'll start off as well putting my name and role modeling.

[typing]

>> RIGO RODRIGUEZ: Thank you, Marcus. Thank you, Erica. Motivated, optimistic, hopeful. I'm feeling good. Paul: hopeful. Debbie: energized, positive energy, motivated. Great. Thank you, everyone. I won't continue reading, but just look at the chat box. Cody feels motivated. Thank you, everyone. Someone is feeling kind of anticipating. Great.

All right. As you do that and as we get to see who is here, let's transition over to the first part of today. We're going to now transition over to the big-picture view, and why are we doing this?

Here's what I heard from some of your colleagues on the CLT ad hoc group, that these mental health disparities in and across Los Angeles County are significant and can make us feel overwhelmed. We kind of know that MHSA programs, services, and resources by themselves are likely not going to eliminate these mental health disparities, so some of your

colleagues on the CLT wanted to get a sense of the big picture, like how does DMH approach the reduction, elimination of mental health disparities through multiple strategies and resources? And how does it track impact, right?

To help us get kind of a perspective on this, Greg Polk, Chief Deputy Director, will start us off with kind of the big approach that DMH takes, the concerns that the department also has, some opportunities, and then we will proceed with Dr. Debbie Innes-Gomberg, Deputy Director, who is going to also share a perspective on mental health disparities.

Just in terms of format – because when we have large groups, we want to be sure we have clear time boundaries – the presentation from both of them will be about 15-20 minutes, and then we will have about 15-20 minutes for dialogue. When we get there, I will share with you how we will stage the dialogue. The end time, our target is about 11 o'clock so that we can stick with the agenda.

By the way, this is not designed as a deep dive because this can take a whole day. This is really just to give us a bird's-eye view of this topic. Let me take my slides down, and then as soon as we upload the other slides, Greg Polk will start us off.

>> GREG POLK: I'm here, getting a little feedback. First of all, I want to say good morning to everyone in attendance. Thank you for joining us for this presentation on the mental health plan. Again, thank Rigo for his uncanny ability to deal with these type of large groups. He does a great job. I want to thank him for being our emcee throughout this whole presentation.

A couple things I want to talk about to start. I kind of want to lay out the presentation layout.

Next slide, please.

There are three phases we will talk about today that just introduction and focus on disparities. Had a lot of conversation around our group and our department about disparities, how important disparities are. I think Rigo mentioned earlier one thing about disparities. I think we need to be clear about that the Mental Health Services Act (in and of itself) will not solve disparities in this county, in this country, and anywhere.

It's a collaborative effort, not only with the commission but the community, and not only local level but you have to get the state level and you've got to get the federal level involved when talking about a major shift and change around disparities. We can do what we can do with the funding that we have, but when you talk about $525 million that come in a year from MHSA with so many different priorities that are set by the board, no, it's not enough money to do away with disparity.

I always want to make that general statement that this is a process to deal with the

challenges of the disparities at all levels, whether you're talking about education, whether you're even talking about non-vaccine disparities. Everywhere we turn, there are disparities. I think it's important that we focus on knowing that it's going to have to be a collective effort at all levels.

In that section, the first breakout, we'll talk about mental health services purpose of the 3-Year Plan. I'm going to talk about some of the funding concerns that have in the department and the county. We'll talk about the direct services cost by ethnicity (in the plan). There are some EQRO performance measures that we'll talk about. The change in consumer services, I think that's a big area that we're going to discuss, and proposed actions to address racial, ethnic, and mental health disparities. We have that at every section that we talk about.

The second part of it around the community planning piece, the activities and the meeting dates, upcoming important dates, and stakeholder engagement. As always, we feel stakeholder engagement is vital. Not only is it vital; it's mandatory, right? We have to have positive stakeholder engagement, and we seek to listen and hope you guys help us inform what we're trying to achieve.

The third part is around existing MHSA programs and changes to those programs. When we get into the proposed changes, we will review existing programs and tell you where we are at, where we think we're going, and what we're trying to achieve in the 3-Year Plan, and where we see us moving into the future.

Then lastly, we will break up into smaller groups to answer three questions: What did you like? What questions do you have? And give some suggestions that you may have for us to improve this process.

Next slide, please.

To start off, the Department of Mental Health plan, obviously, in 2004, the voters supported Proposition 63, we kind of call it the millionaire tax, has imposed a one percent tax on personal income in excess of a million dollars. It provides the funding to expand and improve, transform public mental health systems. It's about improving quality of life for individuals with serious mental illness.

The WIC Code 5847 requires county mental health programs and plans to engage in the 3-Year Plan and Expenditure Plan.

[audio interference – background chatter]

>> GREG POLK: Welfare and Institution Code 5847 requires the mental health program to prepare and submit this 3-year plan—this is why we go through this—as well as important to have a stakeholder process here. The plan provides for an opportunity for counties to review their existing programs and determine if these programs are meaningful

and also effective. Also, the purpose is to propose and incorporate new programs through a robust stakeholder process. We continue to try to engage and just make sure that we hear the voices of the communities, take the importance of what the communities say, and try to incorporate them to the best of our ability based on the funding we have before us. It's through a Community Planning Process that this important feedback is gathered from the stakeholders.

Next slide, please.

This one talks about some funding concerns. With the COVID-19 impact on the counties, there are a lot of financial concerns, especially around sales tax. Realignment is what we call it. We call it sales tax for realignment. A huge dip in sales tax.

Obviously, sales tax are generated from businesses being open. Needless to say, our businesses in this county have been closed. Surrounding counties have had a little uptick in re-opening, but we have been kind of stagnant in our reopening. A huge impact on sales tax. Those taxes are basically funding streams for this department. It's one of the major funding streams of this department.

Also, the millionaire tax, a lot of millionaires are moving out of California for a variety of reasons, so we see a turn of that revenue starting to shift downward. Funding from NCC, which is a county general fund, net county costs, dwindling. Net county costs is heavily built on property tax and sales tax. As I said earlier, our sales tax are dwindling at our level. It's even more so at the high county level for other county departments – and property tax.

Property tax is the main focus of net county costs. When the county says you can hold off on paying the property taxes for a year, it impacts the influx of funding into the county. Just the economic impact of COVID-19 in and of itself is causing major concerns.

A lot of competing priorities when you talk about the ATI, which is alternatives to incarceration. You're talking about justice reform, the huge impact of homelessness and huge impact of affordable housing and just the whole healthcare integration that we're trying to do around making on campuses.

We always run into this issue of NIMBY (not in my back yard). When we try to go out and put up mental health facilities, a lot of people don't want those facilities, at least our population, in their communities. And so, it's a challenge for us.

There's a lot of potential funding opportunities out there. There's the Care Act dollars that hopefully the President at the federal level signs. The Cares Act maybe can have some of those dollars shift down to the local levels.

Again, the problem with Care Act money is it's one-time money. When you get one-time money, one of the major problems you can fall into is funding ongoing operations with

one-time money, which is a huge budget snafu to do. Once that one-time money goes where you have all these outstanding costs that you have to deal with, and you end up in a cost-cutting situation. If Care Act funding does come down, we'll look to use it in one-time operations.

There's money out there under Measure J. There's no Measure J money in this budget as of yet. I think the committee and the CEO is offering to provide (all county departments to provide) proposals. Right here, you see some of our proposals. We're heavily trying to find money for beds, for the subacute, and residential and congregate care. Mental health housing is huge for us. Our PMRT teams, therapeutic transportation, and the mental health conservatorship, crisis and intervention information exchange, outpatient and community services, peer workforce, all these are some of the proposals we put forward to try to get funding. We do not know when that funding is coming aboard, but hopefully we can get this funding. If we get this funding, I think Measure J is a funding stream that's pretty consistent. I think it's ongoing funding, so we're looking to fund ongoing programs with Measure J dollars, to the extent it's available.

Just some of the challenges, infrastructure needs to be rebuilt. [Indiscernible, 00:28:31] ... and I, we always talk about trying to change the organizational structure to reflect the present times. We're in the midst of trying to do that. A lot of implementation delays at the state level. A lot of people are not available to come into work because of COVID-19. A lot of things that's happening and just statutory and contractual limitations that we have.

A lot of guardrails around revenues that I don't think a lot of people are familiar with when you start talking about some of the things that you can and cannot do with certain funding. I don't think the general census around other general population -- I don't think they understand the guardrails around what we term categorical funding. There are only certain things you can do with certain dollars, and important to understand what those guardrails are.

The next slide.

I've been hearing big time about disparities. As a department, we have a huge focus around disparities and just the direct services cost by ethnicity in the plan. We wanted to lay out the direct services by ethnicity of the plan. When you look at the FSP – and I'm not going to read all of these, but it's pretty self-explanatory.

When you look at FSP, you have about 43.6 or 18% of FSP direct services are to the white race. Then when you look Asian Pacific Islander, you're only talking about 8.9% of FSP dollars or 4% spent there. You look at alternative to crisis services, ACS is what we refer to it as. You look at the African-American. There's about $17 million or 24% there. You look at

the Native American; you got 0.3, $300,000 spent there. When you talk about outpatient care services, you have about $76 million spent in the black and African-American area. In the Hispanic area, you have about $174 million, which is about 38%. Then when we talk about PEI dollars, you see a heavy spend over in the Hispanic area, about $24 million and about 43%.

Dr. Debbie Innes-Gomberg will talk a little more about this, but I just want the CLT to know that we're really concerned and focused around disparities. As I mentioned, this is a collaborative effort and we will continue to shift as much funding as we can to address these areas of inequities and continue to do the best that we can do to ensure that we can get some of these disparities in line with the community need.

Next slide.

[crosstalk]

>> DR. DEBBIE INNES-GOMBERG: Hi. Good morning.

>> RIGO RODRIGUEZ: Dr. Innes-Gomberg, before you begin, I don't know at what point folks have joined us, but I do see some chats in the chat box. Again, I'm going to ask if you could resist or desist from putting items in the chat box while the presenters are engaged. That way we avoid distraction. We will have time for your questions after the presenters are done. This is the same approach we will take with the next round of presentations. Again, thank you for helping us out in this way. Go ahead, Dr. Innes-Gomberg.

>> DR. DEBBIE INNES-GOMBERG: Thank you very much, Rigo. Good morning, everybody.

This first slide really helps to establish some context around disparities. What it represents, it's calendar year 2018. It comes from the EQRO (external quality review organization) and it comes from DHCS (Department of Healthcare Services Claims Data).

What you're going to see here is it compares the ethnic distribution of Los Angeles County Medi-Cal enrollees—which is the third column you will see there—with the percent of clients that were served in our mental health system. I'm going to highlight three particular rows here.

The first one is the second row and it's the Latino/Hispanic row. As you will see there in terms of percent of Medi-Cal enrollees, they represent 58.6% of Medi-Cal enrollees. We served—in terms of the composition of our system—51.4% of our clients identified as Latino or Hispanic.

The next one I'll highlight are the African-Americans at 9.9% of enrollees. In terms of our system in calendar year '18, we served 17.8%.

Finally, Asian Pacific Islanders, they represent 9.5% of the Medi-Cal enrollees in Los Angeles County, and we served 4.5% of them. This just gives you a little bit of a snapshot of

Medi-Cal enrollees and then how we served them and the percentages in which we served them.

Perhaps we can go onto the next slide.

This is a trend slide that might be helpful, as we begin this conversation. What it represents is ethnicities served over four fiscal years starting in fiscal year '14, '15, and going up to fiscal year '17, '18. What you're going to see here is year-to-year variations and some trends.

For example, the Latino population in fiscal year '14-'15, 51.8% of our clients were identified as Latino. The next year, it went up to almost 54%, the next year 57%, and then mysteriously dropped a little bit to 49% in '17-'18.

These will give you some trends here. African-Americans dipped and then came back up. Asian Pacific Islanders started off at 6% in '14-'15, dipped, and then '17-'18, came back up to 5.8%, while Native Americans stayed fairly consistent, actually with some increases over time. That gives you a little bit, and I will pause there for just a moment just so that people can take a look at that before we go to the next slide.

All right. Why don't we go to that next slide then?

This is a slide that we will probably embark on some discussion on. But the question becomes, how are we addressing disparities in the Department of Mental Health related to the Mental Health Services Act and other funding streams? One thing we wanted to be able to tell you about is that Solano County recently approached the LA County Department of Mental Health about participating in a multi-county learning collaborative consisting of receiving training from UC Davis (their Center of Reducing Disparities), which if you are aware of it, it's led by Sergio Aguilar-Gaxiola, who is definitely a leader in the field.

Basically, what we would be doing is participating with other counties and would receive training from UC Davis, and also learning how we apply the class standards. For those of you that aren't aware, the class standards is culturally and linguistically appropriate service standards, representing about 15 different standards for a mental health system. We would be participating in learning how to apply those to the populations that we specify and then how to use quality improvement principles to be able to decrease the ethnic disparities that we have identified. We really see this as potentially a vehicle for creating some very positive changes.

Then second—and you'll hear this throughout the presentation—are program-specific opportunities to be able to reduce disparities. I think, in particular, meaningfully (or maybe more meaningfully) leveraging the work of the ... [indiscernible, 00:36:34], the work of the community ambassadors, the CAM, the UsCC projects (which happen every year that are highlighted in our annual updates and 3-Year Plans), the integrated services management

model (ISM model, which was very effective as part of our first innovation project), and really being able to leverage all of those things, because they have helped to us create tools and approaches to reduce disparities. But one of the things we perhaps haven't done is brought those altogether.

The next slide.

I'm not sure if this was – Greg, are you presenting on this slide?

>> RIGO RODRIGUEZ: That's for the next section.

>> DR. DEBBIE INNES-GOMBERG: Oh, I apologize for that.

>> RIGO RODRIGUEZ: If you go back to the previous slide – okay, perfect. Folks, it is 10:45. Let's give ourselves 20 minutes for dialogue. Let me just reiterate a couple of key things, and then if you can raise your hand, that would be the function. We will start with you in a second. I do see that Carmen, Martel -- before we start, I see John Flynn raising his hand. John, is there a comment you want to make?

>> JOHN FLYNN: Sorry. No, Rigo.

>> RIGO RODRIGUEZ: Okay. In this order -- this is how I see it, real quick. Whoa.

Pinki, can you help me out real quick? I see Hector, Martel, Sarkis, Wendy, Andrew, and Carmen, so we've got six. What happens is that the hands move around real quick.

I would appreciate it if, when you're asking your question, if you can be as concise as possible, that really helps. Again, this is the first time we're holding this formal discussion on this broad picture. What I heard from Greg and Dr. Debbie Innes-Gomberg is an expression of concern around disparities, racial and ethnic disparities in particular, but also a concern with the limited amount of resources that are available, particularly through MHSA. But I also heard a commitment to raising additional and seeking additional resources and collaborations, as well as kind of a shifting of internal resources to better address the disparate access to resources that you just saw. I also heard from Debbie that there is a strong interest in engaging in deeper learning, focused learning, through that Solano project, as well as leveraging strategies but in a more integrated way. Those are the key points that I heard. Let's go over to Hector. Hector, your question.

>> HECTOR RAMIREZ: Yes. Hi. Good morning. Hector Ramirez ... [indiscernible, 00:39:37] UsCC co-chair. I appreciate the discussion, especially around disparities. The Latino community make up the largest number of residents in LA County, the largest number of people receiving services from the Department of Mental Health, and the largest number of people that receive MHSA-funded services through the MHSA Department of Mental Health.

I personally just want to point out the fact that Mr. Polk, we have been inviting him to

our UsCC to listen to our very important stakeholder group, and never once has he attended nor responded in the time that he has been here. For us, our biggest barrier for our community to access mental health services and have participation is actually Mr. Polk. I just want to point that out.

Secondly, I notice that the datasets you are using, all of our groups have discussed constantly how both the EQRO data collected by the cultural competence department, which is managed by Dr. Chang, is both inaccurate and definitely not reflective of the needs of our community, so I'm kind of concerned that you are utilizing those particular stats. We have brought up that issue with the Mental Health Commissioner, the Board of Supervisors, and definitely [indiscernible, 00:40:51] that the data that the department collected could very much heart our community since it doesn't really show the disparities.

I really want to highlight the fact that in the planning of these particular materials, the presentation, even the main person from the department, especially MHSA, really has failed to engage the largest number of people being documented as being both in need and disparities. In order for us to really have a conversation about disparities, there needs to be an actual intentional commitment from the Department of Mental Health to really engage the Latino communities. Specifically, that ... [indiscernible, 00:41:28] percent that is Spanish bilingual. Thank you.

>> RIGO RODRIGUEZ: Hector, there are a couple of things you mentioned. I think one is – this is bordering on – one thing is to – we're trying to stay away from personal attacks. When statements are made against an individual in this setting, it really is very close to a personal attack. Let's try to keep ourselves from going after individuals because I think that doesn't contribute to collaborative work.

But the second thing is, I think you're asking questions around engaging communities around data. And so, I'm wondering, from Debbie's perspective, Debbie, what are ways in which the department -- what are the kind of data sources that the department can draw from to kind of do the kind of analyses for different populations? That's what I'm hearing as an interest.

>> DR. DEBBIE INNES-GOMBERG: Yeah, and maybe I can start off by – the EQRO slide that I presented is from Medi-Cal claims data. Once I think the Affordable Care Act expanded who can get Medi-Cal, we have a much higher percentage of our clients receiving Medi-Cal, not necessarily because of their disability but because of their income limitations. That's something to point out that it's an important marker there, but that's claims data.

We're fairly confident that that's a good place to start. However, in the 3-Year Plan, the thing you will see is all claiming, all claiming to a direct mental health service, which also is an important component in terms of looking at diversity and disparities. When you look at

that, the trends are fairly consistent, I will say, in terms of where the disparities lie when you look at different data sources, but we're very open to looking at all data sources and using data to help drive our work in this area, which we know is expansive.

>> RIGO RODRIGUEZ: To follow up on that, today is kind of reviewing what are those data sources because that way we all know what they are and what they can help us with in terms of identifying, monitoring, and addressing disparities. I have Martel next.

>> MARTEL OKONJI: Thank you, Rigo, and thank you all for this information. I'm really excited about it, as we continue to move forward, really address some of these concerns, and have these conversations.

One question that I had was, so I love that we always kind of pinpoint and recognize (from a general lens) some of the disparities that are there, but I was curious to know, like, how are we also really having discussions on youth and the transitional age youth when talking about those disparities as well, too? I was really seeing what type of ideas or how are y'all been explicit, especially with concerns in the funding.

Two-part to that, I know we currently have some projects that are in place. With the concerns on funding, how would that also impact, say, the innovations projects that are currently taking place, and what does sustainability look like moving forward as well?

>> RIGO RODRIGUEZ: All right. I heard, again, concerns on funding ... [indiscernible, 00:45:12]. Who would like to address that?

>> GREG POLK: I can address that. When you talk about funding, you have to line up your priorities up right. I think our funding model shifts when your strategic direction shifts, and we're not in a place right now where we're trying to shift our strategic direction, which we have competing priorities. There's no doubt. There are a lot of priorities.

I'm sorry. My camera is not on.

There are a lot of priorities that the board has placed on this department that we have to really sit down and go through and determine which ones are the ones that we need to move forward on. TAY youth is always a priority of this department, but there are only so many dollars to go around.

You mentioned innovation projects. There are innovation projects that we have planned. Some are moving forward and some we need to sit down and reexamine whether or not those are the ones that we need to move forward on or should we be doing something differently. Something like TAY youth could be a part of something new when we sit down and talk about our innovation projects.

>> DR. DEBBIE INNES-GOMBERG: Rigo, just to add to what Greg just said, when we look at a five-year trend in terms of penetration rates for 0-5 population and the 6-17

year-old population, we're actually looking at increases in penetration rates going in calendar year 2015 from 3.16% up to 3.3% for the 0-5 population, which is significant. Then the 6-17 going from 7.6% to 8.57%, so we're making I think some progress in that area, and a lot of it I think because we're trying to focus as early on as possible.

>> GREG POLK: Just to add to that, another thing we need to remind ourselves of is our population of people is SMI (serious mental illness) and I think sometimes this department is unfortunately taking care of that population what we term mild to moderate, right? We're trying to find a way to partner with the health plans because this department isn't responsible for mild to moderate. They're responsible to SMI. The health plans are responsible for the mild to moderate. We have a huge conversation going on with the health plan that, hopefully, if we can get some funding from a health plan to take care of the mild to moderate and kind of take it out of our funding stream, for lack of a better term, we can have more dollars to focus elsewhere.

>> RIGO RODRIGUEZ: At this point, we're going to use the chat box in a strategic way. We have Sarkis, Andrew, Cody, Roque, Paul, Jean, and Carmen on the list – not in that order. I have a different order. If you could now add your questions in the chat box, that way we'll see your questions and I'll proceed with the same order that I have in the chat box. I will start off with Sarkis, followed by Wendy. But if the others can add their questions to the chat box, I'll be able to eyeball the questions and see if some are very similar. We could even combine those questions. If you can't, no problem. We'll still get to you. All right? Let's go over to Sarkis. Sarkis, your question?

>> SARKIS SIMONIAN: Good morning, everyone. I had just a quick comment. I was watching all the slides and the data. I noticed that there is no specific field for the Eastern European or Middle Eastern.

Sadly, we are classified as white, so that data, actually, is not useful to us whatsoever because it's so diluted. We don't know exactly what the outreach or the outcome is for Eastern European, Middle Eastern. I was wondering that maybe in the future that data can be divided to include at least—we have seven UsCCs—at least it should represent all the UsCCs because I could say the same about LGBTQ and Access for All UsCCs because that data doesn't represent them either. Maybe in the future we can divide that so we can have an actionable data we can use, actually. It's good for the department. It's good for us, so we can do the outreach. Thank you.

>> DR. DEBBIE INNES-GOMBERG: Yeah. Thank you, Sarkis. We'll take that one back.

>> RIGO RODRIGUEZ: Then I'll just note that, as part of a data agenda, it's being able to present data in ways that also account for the different UsCCs. That's what I

understood from Sarkis, even though he started off by referring to the Eastern European, Middle Eastern. We'll note that as part of a data agenda, as we make information more relevant to each population. Wendy, you're next.

>> WENDY CABIL: Hi. Thanks. [Indiscernible, 00:50:04] ...

This is a wonderful opportunity to collaborate and learn together. I'm thankful to be here at this moment with you all. Those of you who understand more, thank you for sharing your insight. I'm very green to this process.

That being said, a couple of things. I need more understanding about how data is collected. I would like to just have a better understanding, overview of how that works, and how that factors into the decision-making process. Then something that caught my attention....

[audio distortion]

>> RIGO RODRIGUEZ: Wendy, you are breaking up, but let's start off with your first question, which is, again, how are data collected and how does it enter into decision making? Part of that will be introduced into the Community Planning Process slide that Greg is going to walk through in a second. Just in a general sense, how would we characterize that?

>> DR. DEBBIE INNES-GOMBERG: Yes. When a client enters the mental health system, an intake is done, and the client is asked what their ethnic status is along with a number of other questions that kind of go into the demographic part of the intake. That then gets captured through direct mental health services. When the data goes to the state, the data travels up to the state as well. That is the basic way in which we capture that information.

In terms of how it's used, I think there's historically how we've used it and then the opportunity moving forward. I will tell you that I think Robin Ramirez does a wonderful job of putting together a lot of data for each of the SALTs (earlier this year) to really give them local information around this and how they can use it.

>> RIGO RODRIGUEZ: Andrew, you are next. Folks, thank you for putting your questions up in the chat box. Again, if we run out of time, the fact that you wrote your question in the chat box, we can register your question and Pinki, myself, and Darlesh can follow up and make sure you get a response to those questions – from a time management standpoint. Andrew, your question?

>> ANDREW PRESTON: Yes, so really focusing on disparities and also aligning with the criterion of DMH cultural competency plan, so training, having a diverse workforce, language, there are a lot of great ingredients there, but we know, especially in SALT 3, there has been exacerbation of disparities with COVID. Is the Solano collaboration really going to

focus on the change and shift to telehealth, tele-medicine, and how that's impacted disparities? Are there any strategic plans that you guys are already doing to address that?

>> DR. DEBBIE INNES-GOMBERG: That's a great question, and my hope would be that yes, it will because it really should address—

I'm sorry. There's some feedback on my end.

It really should address the way in which we're delivering mental health services now and in the future. I think the Solano collaboration, hopefully, in the next couple of months, we will get more clarity on what we will be doing, but I think it's a huge opportunity and an opportunity for us to come together as leaders of the disparities work along with the treatment system. Thank you, Andrew, for a question. I think it's a great one.

>> RIGO RODRIGUEZ: I have Carmen, followed by Cody.

>> CARMEN PEREZ: Yes. Hi. Thank you again for the presentation.

I just have a concern about the data because we received some data last year for Service Area 4 about the numbers of Latinos and whites. There was a large number of them not receiving services. Then, supposedly, the same data was used to present at the Latino UsCC, and the numbers were different for Service Area 4 about the numbers of Latinos not getting services.

My concern is about the data, like what data are you using for that and then the data that you are using for this presentation. Are you using the same data sets? Because it seems like the numbers of Latinos receiving services today seem pretty high compared to the numbers we got last year and to the Latino UsCC. That's my concern. Thank you.

>> DR. DEBBIE INNES-GOMBERG: Carmen, I think it's a very valid concern. One of the things we were just talking about in the meeting yesterday was having one place where data goes through to be able to be vetted and then how you use that data. I think the department could do a little bit of a better job in terms of articulating what this data is, where we pulled it, and how we will use it and how it can't be used. But I think we have some opportunities in that area.

>> RIGO RODRIGUEZ: Thank you. I have Cody followed by Roque. By the way, we will go until 11:10. I'm extending this time. We'll go to 11:10. Then, at 11:10, we'll pause at that point. Again, if you didn't get your question answered directly, we are registering your questions and will make sure to follow up. I have Cody followed by Roque.

>> CODY HANABLE: Good morning, thank you. Just to piggyback off of what Sarkis said, yes, I agree that we know that the data for those with physical disabilities and those who identify as ... [indiscernible, 00:55:48] deaf or ethnically deaf and communicate with Sign Language has been communicated in the previous data that was presented but has

never been incorporated into any strategic planning. This is an issue, and the lack of services in terms of ADA compliance with contracting agencies and within the Department of Mental Health itself is kind of a big problem. Thank you.

>> DR. DEBBIE INNES-GOMBERG: Thank you, Cody.

>> RIGO RODRIGUEZ: Duly noted, Cody. I think it speaks to what every prior ... [indiscernible, 00:56:28] around just a focus on a data agenda that disaggregates information by UsCC but also by SALT in a more granular way and that can also account for multiple forms of disparities and conditions such as COVID, for example, that was also mentioned by Andrew. We have Roque followed by Paul and Jean.

>> ROQUE BUCTON: Hello, everyone. This is Roque Alas Bucton, Access for All co-chair. In regard to the datasets, I haven't heard anything specifically regarding people with disabilities. Is this dataset just lumped into the general Medi-Cal, considering all of those folks on Medi-Cal as disabled? If that is the case, where is the funding for people with disabilities going to then?

The other issue that we have is that we have identified a discrepancy between the data that's being collected by MHSA and the data that is collected by the Department of Mental Health. DMH is collecting a much broader set of data with regards to people with disabilities. But MHSA is not collecting that data. There is a particular set of data which MHSA collects, but it is not reflective of what DMH is collecting and what, on the ground, the access center who has collected a great amount of data on DMH service requests by people with disabilities.

It's not being handled appropriately because, in fact, there was a lessening of the service for adults with hearing impairments and ASL services. The direct service to clients who are in need of ASL was not continued, meaning the contract was not offered to a single solitary provider of direct services for the deaf community. We would like to address these datasets. We have been actively working on compiling all these datasets and we are in need of the DMH dataset.

>> DR. DEBBIE INNES-GOMBERG: You raised a very valid point in that the Department of Mental Health, you are right, collects a lot of different sorts of data. The question we have is, what data do we display; what is helpful, not helpful; and how do we do it? I've heard several comments this morning about the need to display developmental disability data along with other cultural data. We will take those back. That is a combination of work between informatics, the chief information officer more broadly, and the outcomes unit, so thank you for that.

>> RIGO RODRIGUEZ: Dr. Debbie Innes-Gomberg, what I am also hearing is the request to integrate data collected by different parts of the department and from MHSA. Would that be part of what you are saying?

>> DR. DEBBIE INNES-GOMBERG: It would be, yes. With anything, our data systems collect so much, and the question is, what is most relevant and what are the questions being asked?

>> CODY HANABLE: Mm-hmm. Yes.

>> RIGO RODRIGUEZ: I have, I think, Paul followed by Jean. Then, after Jean, we'll pause there to see how we're doing on time. Then we will highlight next steps on how we make sure we follow up on this stuff. I have Paul followed by Jean.

>> PAUL STANSBURY: Thank you. To help address the disparities, there was a report by the California Healthcare Foundation talking about the prevalence of mental health needs relative to the access. To help understand by service area, the departments, they'd also be included.

>> DR. DEBBIE INNES-GOMBERG: Yes. Paul, I think you might be referring to the mental health disparities by race and ethnicity in MediCal November 2020. Is that right?

>> PAUL STANSBURY: Correct. Yes.

>> DR. DEBBIE INNES-GOMBERG: Yes. I've got it in front of me. It's statewide data at a very high level, and I think what they report, they break it out between county mental health and managed care data. The disparities are similar in terms of the trends that they're seeing versus what we're seeing. But Paul – and, by the way, it's good to hear your voice. A question. You're saying, how can we get this at the service area level? Was that the last part of that?

>> PAUL STANSBURY: Right --

>> DR. DEBBIE INNES-GOMBERG: Yes. That's something we can work on. I know that Robin, as part of the 3-Year Planning Process, gave data to all the SALTs. I know, historically, when I was involved with that, it was a lot of information for the SALTs to look at, but I think the feedback on what parts of that were useful and what going forward would be more useful, would be fantastic. We would be very interested in working with you on that.

>> PAUL STANSBURY: Thank you.

>> RIGO RODRIGUEZ: Thank you, Paul, for your question. Lastly, let's go with Jean.

>> JEAN HARRIS: Hello, good morning. Jean Harris. My question revolved around the Community Planning Process and how input is recorded and addressed. In order to develop a more robust Community Planning Process, our teams in the community need to do outreach and engage with our community members and have an understanding of how the process works. There is a question about the report, the proposed draft plan itself, but there's also questions about how is the input being addressed.

Greg Polk said in the February MHSA mental health commission executive committee in the October and November presentations there was a needs assessment and an online survey, but I don't know what that is or how that happened because I didn't experience that in our SALT meeting. Also, I want to address Wendy's issue with not being able to hear or speak relates to our ongoing issues with community engagement related to technology issues and the lack of ability to communicate in a virtual way for clients and our most important input in our communities.

>> RIGO RODRIGUEZ: Jean, I will jump in on that one just because we haven't yet covered the Community Planning Process. That's actually the next part of today's presentation. And, in the breakout sessions, anyone that has questions about the Community Planning Process and the CSS Plan, will have time to really go deeper into those questions.

On the issue of technology, I think we can also address it in the breakout session for that. But your point is well taken and it has been registered.

It's now 11:10, and I would like to start transitioning into the MHSA plan, starting with the Community Planning Process and the CSS plan. If you will indulge me for a second, I will say the questions that are in the chat box, we're saving those. I will follow up with Pinki and Darlesh to create a process to get responses to those questions. This is not a deep dive, as you could tell, into the data, but it is pointing out the need to have a clear data agenda that's shared by the department and by the CLT around the right set of data to be able to work together and address these disparities in a way that's more laser focused.

Greg, you are next in the next part, so if you want to add any reflections from this section to the next section, feel free to do that. Let me just set this up. For this next part, we're going to start off presenting an overview of the Community Planning Process and the components of the CSS plan. For this next part, we will take about 30-35 minutes in giving you an overview of the Community Planning Process and the CSS plan. Then we're going to take a ten-minute break. Then we'll come back, and we will focus on the other plans.

Earlier, I think last night or this morning, we also sent you a worksheet, and that worksheet, again, is for you to register your reflections and for us not to use the chat box during the presentations because it can get a little overwhelming for the presenters and also for me as a facilitator, being able to track the content and the chat box.

The worksheet, even if you didn't get the worksheet, don't worry about it. It's very simple. You're basically asked three questions that I'm going to post. Actually, I shouldn't even use the chat box right now.

I'm just asking you to think about what you like about what you heard; what questions do you have; and what suggestions do you have? What did you like? We do want to use a strength-based and constructive approach, so again, what did you like about what you heard?

Also, what questions do you have? Are there certain words? Like for example, Jean asked earlier, like, okay, how was the input gathered? That is a question of clarification. That's an example of the kinds of questions you might have that are also very useful. Then lastly, what kinds of suggestions do you have?

With that, let me transition over now back to Greg Polk who will get us started on the Community Planning Process and the Community Services and Support.

>> GREG POLK: Thank you, Rigo.

>> RIGO RODRIGUEZ: We can go to the next slide.

>> GREG POLK: Yes. I want to talk about the Community Planning Process. I think someone just mentioned the online survey. I just kind of want to go over some of the data and some of the activities that occurred during those dates.

October 21st, as you can see, DMH presented a timeline of the CPP efforts in CLT made up of the co-chairs and two stakeholders networks, the service area leadership SALT teams in underserved communities, the UsCCs. October through November, multiple meetings were held with the SALT and the UsCCs. They presented demographic and consumer needs specific to each service area and conducted a needs assessment.

Someone mentioned earlier they had no knowledge of an online survey. This is when the online survey came aboard. If you need further information on that online survey, we can provide that, but there was an online survey done.

On February 11th, a summary of the plan was presented to the executive committee to the mental health commission for input and feedback. Then in March, today, where we are today here, a summary of the plan and stakeholder feedback and a focus on disparities.

I can't say enough about how important a Community Planning Process is. I want everyone to know that we take it very seriously here. Some of the comments that were made around not getting the information data, we take all of that into consideration.

When you speak to data, it's all about how it's framed. There's so much data in this department that we can decipher from. It's all about what perspective and how you frame that data and what you're trying to achieve with that data.

I'm not saying our data – we're far from being perfect in presenting data. I think Debbie does a great job of doing it, but it's a complex activity. I don't want people ... [indiscernible, 01:09:18] not knowing how complex dealing with data is. We make every effort to make it as smooth as possible.

Some upcoming important dates: March 19th, the full version of this draft – '21-'22 through '23-'24 – our 3-Year Plan will be posted on the website for a 30 day public comment period. Obviously, I encourage everyone to take a look at that and, if there are any

comments, please feel free to engage.

April 22nd, the draft plan is presented to the full commission at this public hearing day. Then May through June, the 3-Year Plan will be presented to the board of supervisors for approval.

The next slide.

I kind of want to talk about the stakeholder engagement a little bit here. Some of the questions when we talk about the survey, the questions were what are the unmet needs in your service area, how has COVID-19 (the pandemic) further impacted those unmet needs in your service area, and how do you propose DMH address those unmet needs? I think that's a key question there. What can DMH do to improve transitions between levels of care and ensure successful flow of clients through needed levels of care? – another important question. We consider that as this is kind of a four-pronged approach here. That's the needs assessment.

Then we got into the stakeholder input. There were eight major things that we talked about: additional mental health services across all ages—this is where the TAY youth come in at—geographic and culture [indiscernible, 01:10:53] with a specific focus on service in children and youth, and the API community. There's a focus on the levels of care, additional focus on supportive housing and beds, huge issue around beds, as I mentioned earlier. There is a focus on data. Data is not perfect, as we all know and have heard comments about. There's a focus on training as one of the major themes. Funding for non-direct services, and then COVID-19 safety measures, and a big one is social equity, which I think is huge.

Other pieces, the DMH strategic plan, we have the four domains, community in green, crisis system in yellow, orange is the institution, and the white being the infrastructure in and of itself. Then lastly, the evaluation of the resources of this 3-Year Plan.

We have to talk about available funding and capacity. We talk about funding all the time, but I think we don't talk about capacity to engage and implement. You can have a lot of money. But if you can't implement it, it does you no good. You have to have the resources available.

It's been tough times around hiring people during COVID-19. People weren't available. People had existing conditions that caused them not to be able to work. A lot of other issues around resources, so we can't forget. Just because we have funding, you have to build the infrastructure. You have to have the capacity to do some of this stuff.

Next slide.

I kind of wanted to go over the components of the MHSA. There are obviously five major components. Actually, four where the funding really sits. You've got the CSS, which is

Community and Support Services, which is the largest piece. I think there are about 76% of our funding there. Then you have prevention and early intervention, which we commonly refer to a PEI, of about 16% of our funding there. Then you have workforce education and training, which we refer to as WET, being of innovations. Then you have capital facilities and technology meetings.

Next slide, please.

The overview on the CSS, I mentioned earlier the largest component, about 70% total of the MHSA allocations. It's for clients diagnosed with SMI, as I mentioned earlier. Some of the major programs is FSP (full service partnership), operation care services, alternative services crisis (which we refer to as ACS), housing, linkage, and planning and outreach of engagement (commonly referred to as POE).

Just kind of talk about some of the unique clients served in fiscal year '19-'20. We had about 148,000 unique clients served. As you can see—I'm not going to go through all of these ethnicity breakdowns—the largest populations were 35% Hispanic, 20% African-American, and 17% white. The primary language was English at 79% and 14% Spanish.

New clients with no previous contact regarding MHSA, we had close to 51,000 new clients served with no previous MHSA service. Again, the ethnicity breakdown is laid out there of 38% for Hispanic, 15% African-American, 16% white, 3% API, and greater than 0.5% for Native American. Again, the primary language is pretty consistent: 78% English, 14% Spanish.

Just some interesting data round clients served by service area. Antelope Valley, the number of clients served was about 8,800. Almost half of those were new clients. San Fernando Valley, about 22,000. About half of that was new clients. San Gabriel Valley, about 19,000, about 11,000 new clients. We had the Metro Area with about 31,000. Half of those were new. We had the West, which is about 10,000; 5,000 new. In the South, we had about 28,500 clients served; about 15,000 new clients served. In the East, about 12,000 and thought that we have about 30,000 clients served.

The next slide, please.

An overview on the full service partnership. I'm going to turn it over to Dr. Lisa Wong, who is the program manager over full-service partnership.

>> DR. WONG: Hello, everyone. I'm so glad to be here with you today and get to talk a little bit more about our full service partnership. We have a lot of really exciting things coming up, but I thought I would start with a little bit of an overview for those who may not know much about full service partnership.

This is our highest acuity program in our outpatient service system. It provides 24/7

intensive outpatient services for high security clients who fall within the state defined focal population guidelines. Our intended outcomes are, we really want to see that people have a reduction in their serious mental symptoms and homelessness, incarceration, and hospitalization. We want to see an increase in independent living and people's ability to self-direct care.

You'll see here there's a chart on the FSP slots and clients served by age group, so in fiscal year '19-'20, for children, we had 3,584 slots and we served 3,944 clients. For TAY, 1,410 slots and we served 2,950 clients. Adults: 10,986 slots and we served 7,715 clients. For older adults: 885 slots and 1,897 clients. We have had a lot of activity in all of our FSP programs.

You will notice, for instance with the adults, we had a certain number of slots but only served a certain number of clients. A lot of those were not because there was not the need for these services. It was because some of our teams have undergone different fluctuations in ramping up or in staffing, so when there aren't staff available or hired or there are vacancies, then we don't ask those teams to take on more clients because we want to maintain a certain client to staff ratio so the clients get the care that they need at this high acuity level.

One of the big, exciting things coming up is our FSP transformation. FSP now is over a decade old, and we have seen some wonderful outcomes and we've also learned a lot of lessons. We have taken those lessons, and we've gotten stakeholder input, especially from clients and providers, to look at what could we do better or what do we want our FSP programs to be able to achieve.

We embarked on an FSP transformation process, I think about three years ago, actually, and I joined it about a year and a half in. We will be launching July 1st, and we decided to work only with existing FSP providers to begin with because we didn't want to push off this transformation any longer. If we brought in new providers, there would be a lot of lead time needed to bring everyone up to speed, so we figured we will start with existing FSP providers and treat it like a pilot project.

Over the next three years, we will gather data. We're going to gather input. We're going to have a real continuous improvement process. Then we will take our lessons learned from the pilot and it'll inform the rebid of FSP contracts in fiscal year '24-'25. At that time, we want to bring in new providers as well, so new legal entities as well as existing legal entities that have never provided FSP servers. We're especially excited about this because this gives us the opportunity to get more people involved in FSP who are the community-based organizations, because I think there is so much value in bringing in kind of a fresh perspective and people who have been in the community working with our clients, dealing with the families and all the issues that happen in our communities to bring all of that richness into our

FSP system.

One of the most common questions I get all the time is, how is FSP going to change in the transformation? These are some of the changes. It's not an exhaustive list but these are the major components of change.

One is that eligibility criteria is more focused on those most in need of FSP care. Rather than opening it up to all at risk, we're really trying to focus on the MHSA focal populations. Also, a multidisciplinary team and population approach rather than individual caseloads and slots, and what that really means is taking a look at a population of clients rather than one person, one case manager because, for any of you who have worked with clients or who have had lived experience, you know that when a recovery journey is started, the needs are very different than six months in, a year in.

Somebody who is starting an FSP might really need a clinician, a doctor, and a housing specialist to get housed. But six months in when there's more stability, that person might want to work with an employment specialist or might be ready to tackle substance use issues. There's a shift in needs that should be mirrored in a shift in people to access with a multidisciplinary team.

We want our providers to really look at an opportunity to get away from, okay, these 15 slots belong to this person despite whatever this person needs. But this whole population belongs to this whole multidisciplinary team, and whoever works with that client is going to change based on what that client needs. So, we're also integrating all specialty FSPs into one model. That's because a lot of our specialty FSPs were created because there were certain barriers or challenges met in regular FSP.

We created a workaround, and really what we should have done was just fix the issue in the system, so that's what we're doing with the transformation. Really, how many of our clients are just homeless or just having incarceration issues or just having hospitalization issues? Usually our clients experience multiple areas, so we feel that our FSP programs shouldn't be focused on one specialty but really need to meet the clients where they're at.

We're going to lower the client to staff ratio. When started, the FSP client to staff ratios were 15 to 1, which compared to outpatient services is really good, but we found that sometimes our clients have the kind of struggles that need much more individual attention. Through our specialty FSPs, we were able to learn that sometimes these lower client to staff ratios were very helpful, so the client to staff ratio is going to go from 15:1 to somewhere between 10-12:1.

Also, we are going to add additional staffing to enable our child FSPs to provide intensive care coordination and intensive home-based services just like they get in IFCCS for the child welfare population. We would like all of our kids to be able to access that high

intensity level of service, whether they're child welfare population or not.

Then also, we are going to have enhanced training and technical assistance to support FSP providers in achieving the wanted outcomes. It's a tough, tough job, and everybody losing when staff burns out or when staff don't have the right training to support them to do their best in working with clients. This is going to include a lot of training on culturally responsive, linguistically responsive services because we really need to take a look at the issues of diversity and equity, especially in our highest acuity programs.

Also, we will have enhanced services and supports to ensure successful transitions from levels of care. One of the things we've heard from stakeholders is that a big concern is what happens when somebody is in FSP in this 24/7 low caseload environment and they kind of graduate to outpatient services where the caseload maybe 150 to 1, or they might be seen just once a month for medication or maybe even once every three months. What we want to do is build a better bridge so that we don't lose everything that that person has gained on the recovery journey when they move to a lower level of care.

Also, we will have centralized authorization enrollment and dis-enrollment processes so that we can have a better idea of who is in our system, what the needs are, and how to best meet those needs. Then we have standardized rates to bring contracted provider staff salaries closer to parity with their counterparts in mental health. This came because we heard from a lot of our providers that they weren't able to get licensed clinicians or didn't have enough people who could be LPS designated to help, like in crisis when a 5150 eval is needed, because of the salary difference. What we wanted to do was bring that up to parity so that they wouldn't have as much of a challenge getting the licensed qualified clinical staffing to meet the needs of this population.

Also, we have changes to the FSP contract to add incentives to help clients achieve critical life outcomes. Then we're going to be really using data in a much smarter and useful way. Also, we're going to be bringing in a lot more consumer and provider feedback to drive continuous improvement.

Next slide, please.

I had mentioned a bit about disparities. Oh, wait. I think – go back, Julio, to the last slide. Great. Oh, wait. No, no, no. Sorry. Go back to disparities for FSP.

About addressing FSP disparities. We recognize this is an especially important issue given that this is our highest acuity really valuable services. We want to be sure we approach it in an equitable way and meeting the needs of all the communities.

One of the things we're doing, and we've already started to do, is we have increased the use of disparities data across the DMH system as well as at this local service area level to inform and shape FSP services for our diverse populations. This was a challenge because a lot

of our diversity data is at a department level. While that is important and that is useful, we really need to look at the local level because, for instance, the disparities in Service Area 1 are going to look very different from the disparities in Service Area 3. We need to tailor services, approaches to communities, specifically to the needs in that community so that is something we have begun.

Also, we have made additions to API FSP teams in service areas 3, 4, and 8. These we found looking at the disparities data that API were the most significantly underrepresented in FSP services. While we are giving attention to disparities across the board, this was something we were able to start right away without additional funding but kind of to shift some funding around.

Then what we're working on in the process of is trainings and support for working with diverse populations. This includes bringing in a lot of other experts, but our particular focus at this time is the API community for FSP just because we saw such a huge disparity for that community, but the work will be done across all ethnicities and races.

Then we are working specifically with UCLA and subject matter experts from the API and other communities to develop best practices. We are really lucky to have a UCLA affiliation agreement that we can draw on their expertise in developing these customized training to support FSP, but also thought it was so important to work with our subject matter experts in communities because they have the experiences. They have the knowledge. They know what works in their communities.

The next slide, please, Julio.

Onto outpatient care services. This is probably the largest number of clients that we have in our system. These are our basic outpatient services.

We provide community-based, clinic-based, and well-being services that include individual, group and family therapy, evidence-based treatments, peer support, medication, case management, crisis resolution, crisis intervention, linkage to primary care, assistance with benefits establishment, housing and other social determinants of health, and vocational and pre-vocational services. Really, what we're trying to do through outpatient care services is help people to achieve their recovery goals, have a safe place to live, use their time in a meaningful way, have healthy relationships, access public assistance when necessary, weather crises successfully, build that resilience, and have the best possible physical health as well because we know for our population, there are huge disparities in physical health outcomes. That's why we chose to focus a lot on that to help close that gap a bit.

Our clients served by age group for the fiscal year '19-'20 were 24,549 children, 17,971 TAY, 57,620 adults, and 14,934 older adults. As I said, this is a very large part of our system, and we reach a lot of people in the community through our outpatient care services.

Some of our coming enhancements, we have a lot of things coming up. These were just a couple that we're really excited about. One, we're going to have a modernized call center. This is already on the way, in process, to assist in access to services and helping people find the most appropriate level of care.

One of the things I hate to hear is a parent who needs services for their child. Sometimes it's their adult child. They're just randomly calling from clinic to clinic, program to program, just to find out "Oh, this isn't exactly what would be the best for your child," or "If your son or daughter has had three hospitalizations in just this last year, maybe they should consider an FSP program." Then it's another call. We wanted this to be a no wrong door approach, but to be able to have this modernized call center. Have people come in and not just get access to care but get access to the most appropriate level of care.

Also, we are going to be building up and supporting capacity to ensure successful transitions from higher levels of care. This is what I had just mentioned in the other slide with FSP. We don't want to set up people for failure when they kind of graduate. They have done the work. They have worked their recovery and now ready for a lower level of care. We don't want it to be dropping off a precipice. We want to support that continued recovery.

Next slide, Julio.

Of course, for outpatient care services, a lot of disparities as well to address. The same as with FSP, we've already increased our use of the disparity data across the DMH system, as well as at the local service area level. That's so that we can best inform and shape the kinds of services we offer, the kinds of approaches that we take.

Then we have training and support for working with diverse populations. Coming up soon with our move to our new building for our headquarters, we are going to have a new Korea Town clinic for the first time and developing telehealth network across the service areas to provide language capacity and cultural competency. This is has been one of the big pluses of telehealth. It's allowed us to be a lot more flexible and reach a lot more needs, in some ways, because then we have been able to have these hubs where we can concentrate certain areas of expertise, our language capacity. Like right now, we're beginning an API pilot where one of our API clinics in service area 8 is going to be reaching out to all the other service areas to provide assistance with API populations, especially the ones who have a particular language need. Why we're focusing first on an API pilot is because we have had the most difficulties in meeting language needs for that population.

I think that's it, Julio.

>> RIGO RODRIGUEZ: I just wanted to jump in with a time check. We have a few more minutes for this section, but just like with the last session where we took a little bit more time, let's extend this to give Dr. Funk and, also, Amanda enough time. Why don't we

say that we will end this segment by 12 o'clock, at the latest, and then we will take a break at that point. We've got ten minutes for each. Go ahead.

>> GREG POLK: Yeah. I was just going to say thank you, Lisa. I think it's important to note from the perspective of the department, how important FSP is to the department. I think we're really trying to reshape and reformat and repopulate how we do FSP in this department. A huge conversation with our LEs that are going to be responsible for helping us do this big focus of the department and a big spend, to be quite frank. It's one of the largest expenditures we have in this department, and we will continue to put funding available for FSP.

>> DR. WONG: It's such a great investment to keep our people in community. Thank you, Greg.

>> GREG POLK: Yes. Just now moving right along, I want to introduce Dr. Maria Funk. She's going to give us a housing overview.

>> DR. MARIA FUNK: Hi. Good morning, everyone.

You can move to the next slide, Julio.

I think it doesn't take any of us very long to understand that, in Los Angeles County, we have a very serious issue with homelessness. In the last homeless count in 2020, there was over 66,000 people who are homeless on any given day. The estimates of how many of those have a serious mental illness have really consistently been between 20% and 25%.

We know, in our department, that obviously we play a very big role with all of our partners in addressing homelessness in LA county. Our department has, over the years, really made very significant investments in this work to work with people who are homeless, including (in our homeless outreach teams) our home team, for instance, is on the streets providing outreach to people who are homeless. We've had an integrated mobile team FSP and homeless FSP, which, as Lisa just described, will integrate into a regular FSP. But they have targeting the homeless population and, of course, all of our FSPs serve people who are homeless.

It's important to know that people who are experiencing homelessness can access all of our services in our department, but we also have very specific programs and resources that target people who are homeless. One of the main things that we have heard from stakeholders for many years – I've been doing this work for the department for 20 years working with homeless programs in the department – we always hear that we need more resources for people who are homeless. We need more housing for people who are homeless. Our department, over the years, really has worked to increase the amount of resources that we have so we can help people who are homeless, not just by providing mental health services to them, but also by helping them move from living on the streets, living in

shelters, to moving into a permanent home.

We're very committed to that work. We have greatly increased our resources for interim housing. We have invested in capital housing to expand the permanent housing and affordable housing for people who are homeless and have a serious mental illness. We've also invested in local subsidies, rental subsidies, so people don't have to meet the requirements of HUD for homelessness, where we can help subsidize them living in different types of housing, including shared housing, including living in licensed residential facilities (also known as supported care homes), and we also have invested in helping people when they can't move into an apartment unless they have a security deposit. We don't want them living in an apartment that's empty, without furniture or other household goods like towels, sheets, et cetera. We have funding that we have invested in all those things to help our clients who are experiencing homeless to really, in their recovery journey, to get off the streets and move into a permanent home. All of our work, again, is to help our clients move into a permanent home, to help them stay in the home, providing services so they can retain their housing, and to, as I mentioned, increase our resources.

I am just going to just briefly talk about, highlight some data from last fiscal year to give you a sense of the work we're doing, the number of lives we're impacting in the department. We have the No Place Like Home funding. I think people are aware of that funding. It's statewide funding and, in LA County, it's estimated that we're going to receive about $700 million of $2 billion of No Place Like Home funding. So far, about $400 million has been allocated to the development of different housing development projects. Again, any funding that we invest is for a unit that targets someone with serious mental illness.

Also, we partner with LA County Development Authority. They're the ones that administer the funding for the county and for our department. They released a NOFA in December, and another $50 million will be awarded very soon of the No Place Like Home money.

We also have 18 contracts with the city and county housing authorities. That gives us tenant-based resources. I think people are most familiar with Section 8 or Shelter Plus Care. We have about 2,400 tenant-based resources allocated for our clients that they can use across the county to find housing that is affordable.

We invested (as a department) $10 million in what is called the Flexible Housing Subsidy Poo. This allows us to subsidize people's housing, all types of housing, including an apartment, shared housing, board and cares, and that we can use that funding to subsidize the housing. There's more flexibility with it because they don't have to meet the HUD standard of homelessness or chronic homelessness or the criminal background that people have to go through that sometimes prevents them from moving into housing.

We also, last year, spent about $2.4 million, again in assisting people with security deposits, helping them have furniture, et cetera, so they could move into a home. In our enriched residential care program, which is what we call our program that provides a subsidy for people living in licensed residential facilities, for clients that do not have an income, we're actually paying for the cost of board and care for them to live there. Then we've also expanded and created, actually, an enhanced rate program that allows us to pay above the board and care rate to pay the board and care operators to be able to provide more services to take our clients with more complex needs.

Then finally, we also have 504 interim housing beds that we purchased in shelters across the county. Those beds are dedicated to our clients and we are the ones that can gate-keep them, if you will, to make sure that our clients are the ones that are moving into them. Last year, we served 1,129 individuals and 153 families with short-term housing through our interim housing program.

In terms of multi-year investments, as I mentioned, we have the No Place Like Home money, but also had money we have been invested since 2008 in the development of permanent supportive housing. So far, we have invested $670 million—that includes the No Place Like Home money I referred to earlier—in 140 different permanent supportive housing development projects across the county. We have projects in every service area and projects that target every age group, including families with minor children, multi-bedroom apartments up to four bedrooms, including TAY projects and older adults, and then just general adults and also veterans.

So far, these 140 developments have 3,608 units for individuals, again, with serious mental illness. In those same projects, there are 13 of them where we are actually also paying for the operating subsidies for the people that are living there to make the units affordable. The rest of the units most likely have project-based vouchers from the housing authorities, and that is what makes the unit affordable to people that we work with.

We also have invested in what is called the housing full-service partnership program. This program is designed to provide services to people living in permanent supportive housing. So far, we are offering that service in 92 different housing sites.

I also wanted to mention that the money that we have invested, the $670 million in the capital development of housing, that doesn't pay for the whole cost of what it costs to build housing. As you can imagine, building housing is very expensive, and so that money leverages other local, state, and federal funding that allows the developer to actually build the projects.

You can go to the next slide.

In terms of our continued work over the next three years, we will continue to make investments with a No Place Like Home money, as was mentioned. We still have money left.

We have set aside $100 million of that to develop permanent support of housing at the Restorative Care Villages on the health campuses. I think, later in the presentation, you will hear more about the Restorative Care Villages.

Also, I mentioned the housing FSP that's providing services to people living in supportive housing. We are in the process of redesigning that program. After overseeing the program for a few years, we want to do some enhancements to the program. It will no longer be an FSP program. We're going to call it Housing Supportive Services Program, but it will continue to provide services to people to support them who are living in permanent housing.

We have also engaged, at the board's direction, in a lot of work to help strengthen and sustain the licensed residential care facility system. I think people know that they're really in crisis. They're extremely under-funded, so we're continuing our work in that area.

We are enhancing our budget by $6 million for our enriched residential care program. That will allow us to serve more clients by paying for their rent in a board and care or paying the enhanced rate. We got that funding from SAMSA, which is federal funding.

Also, we have a request for funding proposals right now that is to seed a membership association for the board and care system. That is out right now. It'll close in about a week, and we hope to have identified an entity that will be a membership association that the board and care operators can join.

We're also administering a capital improvements grant program. Many of the board and cares have deferred maintenance. When we went through a stakeholder process, what we definitely heard loud and clear is that we need to make investments to help them make improvements in their board and cares, which will also improve the quality of life for those living in those facilities.

Then finally, we're working with our CIO, a bed tracking system. It's actually a larger system, but we're going to be using it that will allow board and care operators to indicate when they have empty beds and allow the case managers working with the clients to find an empty bed more easily when they are assisting clients in finding board and care housing.

We are also partnering with that Department of Mental Health Services and California Policy Lab. This is funded under the homeless initiative, Measure H funding. We're implementing a new homeless prevention unit, and this unit will actually use predictive analytics to try to identify people that are at risk of being homeless and to then provide outreach to them and retention services to prevent their homelessness.

Then finally, with prison reform and more people getting released from prison, the Hilton Foundation identified a need and are partnering with us to provide $500,000 to pay for the short-term housing needs for those that are leaving prison, that are getting connected and linked to DMH services because they have a serious mental illness. That allows us, again,

to have more resources for housing.

Next slide.

In terms of looking at housing disparities, we are participating in system-wide work to research and address racial disparities as it relates to homeless services and housing. We're collaborating with the California Policy Lab to evaluate differences in service histories for different racial and ethnic groups.

DMH is just a small part of what is being done. Really, they're looking at the whole system, all of Los Angeles Homeless Services Authority, and the Department of Health Services. All the work we're doing collectively in working to house people, we are looking at what is being done with a lens, looking at racial disparities. Part of this came out of recommendations that came from the ad hoc committee on black people experiencing homelessness. Before that, there was an ad hoc committee on women experiencing homelessness. Out of those two groups came many recommendations that we need to make sure that the tools we're using, services we're providing, that they are provided in a cultural way and that they're not biased. And so, we're actually looking at biases as it relates to the coordinated entry system and the tools that are used there, looking at really changing some of the tools that are being used.

I included a chart here to show. This is just looking at data in more traditional permanent supportive housing, people living in an apartment—

[Loss of audio at 01:49:13]

>> RIGO RODRIGUEZ: Maria, I think you cut off.

>> GREG POLK: I can finish this part. What she was trying to show here obviously speaks for itself. It gives a race breakdown in the permanent supportive housing percent and also the homeless count percentage of each race. When you look here, you see the Hispanic and Latino race, it's about 36.1% on the homeless count and about 10.5% of the permanent supportive housing, and about 48% of LA County. This is what this chart was trying to display here.

>> RIGO RODRIGUEZ: Thank you.

>> GREG POLK: Just moving into the next area, we're going to talk about alternative crisis services. You'll get an over of that. But just to kind of prompt that, I think it's important. This is an important piece. This is where we talk about funding for beds, the whole board conversation around care first model, more care in the community. It's important that we find funding to fund beds in the community, which is a huge struggle for us because either not beds out there or the types of beds are not sufficient for the population that we're talking about. You are talking about clients coming out now with felonies and

misdemeanors, high level felonies that some of these community-based organizations just are not ready and staffed to handle. And so, this is a huge piece that, as an organization and a department, we're trying to deal with. Dr. Ruiz will give you an overview of what we're doing.

>> AMANDA RUIZ: Thank you so much, Mr. Polk.

Next slide, please.

Alternative crisis services, I wanted to give you a brief definition of what that is. It provides a comprehensive range of services and supports to severely mentally ill individuals that are designed as alternatives to emergency room care or inpatient hospitalization. Really, the reason for that is because emergency room care or inpatient hospitalization or institutional care can really be traumatic for some people. We want to reduce that, if we can, and get the person to the lowest level of care that is appropriate for them. We want to reduce homelessness, and we want to prevent incarceration.

I'm going to go through the different levels of care that make up alternative crisis services. The first is the residential and bridging care program. It's one of the components of ACS, and the goal of this is to bring DMH psychiatric social workers and peer advocates to assist in the coordination of psychiatric services and supports for persons with complicated psychiatric and medical needs so that they can be discharged to our different levels of care. We have a whole range of levels of care within our network, so this includes county psychiatric emergency services and inpatient hospitalization, county contracted acute inpatient beds for uninsured patients, DMH urgent psychiatric care (what we call subacute institutions for mental disease, so they're locked beds, which Mr. Polk was just referring to), crisis residential treatment programs, and what was previously called IMD step-downs, which we now call enriched residential services.

The next one is psychiatric urgent care centers. These are Medi-Cal certified, LPS designated, crisis stabilization units that provide rapid access to mental health evaluation and support. Basically, they're crisis receiving centers, and the patient is taken there or can go on a walk-in basis when they're in an emergency, and they can be stabilized there for up to 24 hours. Then they are linked to services. Depending on the nature of the crisis, they can be referred to an inpatient unit or they can be sent to another level of care depending on the situation. If they need to go to a board and care program, similar to what Dr. Funk was referring to, they could be referred to a board and care or they could be referred to a crisis residential treatment program.

Enriched residential services is similar to what Dr. Funk was referring to a board and care program, but an enriched residential services program provides limited mental health treatment off-site to the client. In some instances, they also provide assisted living or congregate housing to the individual.

Crisis residential treatment programs are programs that are short-term, intensive, residential programs that are recovery-oriented and provide intensive supportive services to persons that are 18 or older. They are designed to be safe and therapeutic and in a home-like setting. They provide treatment 24 hours a day, 7 days a week. Typical capacity is 16, so these are not designed to be large programs.

I wanted to give you some statistics from '19-'20. For our enriched residential services programs, we had 988 admissions. For our urgent care centers, we have eight urgent care centers. They include service areas 2, 3, 4, 5, 6, and 8. We have new urgent cares that are coming on board in service areas 1, and the Restorative Care Village. We have approximately 126 beds and have served almost 50,000 clients.

With our CRTPs, we have 7 centers and almost 100 beds. We have an additional 280 beds planned. The majority of those will be in the Restorative Care Villages.

With our law enforcement teams, they're made up of a clinician that is paired with a law enforcement officer that responds to 911 calls that involve mental health crises. There are currently mental health clinicians that have been assigned to work with 39 of the 46 police departments in Los Angeles County. That has involved 31% homeless individuals, 3% resulted in arrests, and approximately 61% required hospitalization.

Next slide.

In terms of proposed changes, we are always looking to add additional beds and expand what we can do in order to provide services to the county. This, of course, is pending funding commitments. In October of 2019, there was a report that was issued that indicated that we needed approximately 1,500 beds due to the current capacity limitations that we have in the county. We were asked to do a 2-year pilot program to add 500 additional beds.

COVID-19 resulted in a greater need for beds to focus on prevention. This included open residential treatment and crisis residential treatment beds, which I was just discussing with you and telling a little bit about. We were also asked to decompress county hospital beds, and the purpose of this was to move patients from the county hospital so that we made room for patients with more severe medical conditions related to COVID.

In order to strategize and pay for these beds, we need funding, right? And potential sources of funding for these beds would include net county cost funding, Measure J, Cares Act, MHSA, and SAMSA funding.

In terms of the '20-'21 budget, we have acute psychiatric hospitals. We budgeted $209 million. So far, we have added—of the 500 beds that we have been asked to add and pilot—we have added 172. That includes beds for patients that are on involuntary holds and are COVID positive, so that has been a great success for the county.

Subacute beds—including IMD beds, medial SNF beds (which is a first for us), state hospital beds, and alternatives to the state hospital—this includes beds for patients that have complex legal histories which are very difficult to place. We have budgeted $194 million. Open residential beds, which includes the ERS beds, the crisis residential beds, the ERC beds, which are the board and care beds that Dr. Funk was talking about, and the congregate care beds, $38 million. The urgent care centers beds or chairs at $49 million. For a total of $490 million, and this is typically not paid for by MHSA funding but by 2011 realignment or these other sources I just mentioned here, whether that's Measure J or Cares Act or SAMSA or a combination of all of the above. That covers it.

>> GREG POLK: Thank you, Amanda. I think, Rigo, we can kind of go back to you now. I know it's hour slide time. I think we're talking about a break or something now. Go ahead.

>> RIGO RODRIGUEZ: Yes. Thank you so much. And thank you for the presentation. It's 12:08. Let's go ahead and take a break. Let's reconvene at 12:20—that would be 12 minutes from now—to give you time to take a break.

I also wanted to indicate that for CLT members, Pinki sent you the slides that you're now seeing. For presenters that are coming up, in light of time constraints, if you could just do your best to stick within your timeframe because the more we go over our timeframe, the less time we will have for dialogue.

Let's reconvene at 12:20. Take a break, stretch, and we will come back.

>> GREG POLK: Just to add to that, what you said, Rigo, I was going to say the same thing. Maybe we could focus on more of the big key points moving forward, so we could kind of move through it a lot quicker.

>> RIGO RODRIGUEZ: Yes. That would help, the highlights, and then folks already have the slides, so they can eyeball the slides as well. Thank you so much.

>> GREG POLK: Yep.

>> RIGO RODRIGUEZ: We'll reconvene.

[Break at 02:02:41 to 02:12:31]

>> RIGO RODRIGUEZ: Hi, everyone. It's 12:19. We're going to start in about a minute. As we prepare to start in about a minute, go ahead and put the slides back on. I don't know if Julio can put the slides back on.

>> JULIO MIRANDA: I will check it.

>> RIGO RODRIGUEZ: Okay.

[Indistinct chatter]

>> RIGO RODRIGUEZ: Hi, Andrew. We love your couch, too [chuckling]. All

right. Thank you so much. Julio, if you could move it to one slide further.

So, it's 12:20. Let me give some time markers and then hand it back to Greg Polk. It's 12:20. I'm hoping we can do our best to close this section by 12:45, like in about 25 minutes, with highlights, knowing that the folks at home have the slides you are reading. This will allow us to use time from 12:45 all the way to 1:55 to have more small group dialogue. With that, let me hand it back to Greg. When we're at 12:40, I will give everyone a 5-minute track. Greg.

>> GREG POLK: Thank you, Rigo. This one here, I'm moving to the second component, which is PEI (prevention and early intervention), which is the second largest component. Darlesh Horn is going to give us an overview of this piece.

>> DARLESH HORN: Yes. Thanks, Greg. As Greg mentioned, PEI is the second largest MHSA component covering about 19% of the total MHSA funding allocation for the department. PEI programs focus on a range of strategies, ranging from prevention, early intervention, suicide prevention and stigma and discrimination reduction.

In fiscal year '19-'20, there were a number of clients served; 47,600 unique clients that received a direct service. I want to point out that this is our early intervention strategies data. Clients that are referenced here in terms of unique clients and new clients for '19-'20 were those who received services through our traditional clinics through an evidence-based practice. You can see the ethnic breakout for those unique clients and new clients that received these services in their primary language.

I do also want to point out the unique clients served by service area. One of the things that I do want to note is that clients can be unique across a service area because, of course, clients have the option of receiving their services at any clinic in this area they choose, so a client may be unique in Service Area 1 in the Antelope Valley, and then receive evidence-based practice in Service Area 5 and that client would be considered unique (in this data) to both of those service areas.

Next slide.

Just given that much of the PEI strategy early on focused on early intervention strategies by EDP, more recently we've been focusing on building out our prevention … [indiscernible, 02:16:24]. Prevention services are more or less those that have been within communities where people live, work, and worship and gather. We seek to promote positive social and emotional development through various community-based strategies and community-based organizations, grassroots organizations that will serve their communities and provide supports for individuals to avoid adverse system involvement.

Some of the continued work that we have done in terms of community work through prevention efforts include our school-based community access platforms. Those are services that we provide in our early intervention centers through our LA USD partners and also our

middle and high schools through our LACO partners. We provide supports through schools to families and their students, and also training and education to teachers and administrators. We also have a wide range of youth diversion and development programs. These programs are seeking to avoid youth from entering into the juvenile justice system by providing programming and supports also through community-based organizations.

Then finally, Greg mentioned building out capacity a little bit earlier. We have what is known as Transforming LA. Transforming LA is a strategy that is also funded by prevention that provides supports to grass-roots organizations to train their workers in terms of providing supports within their communities and bringing them on eventually to train them to, at some point, become part of the DMH network of providers.

Next slide.

Some of the prevention and early intervention efforts that we have been recently involved in to address disparities, what we have noticed is that there are a number of communities that were disproportionately negatively impacted by the COVID-19 pandemic. One of the strategies that we have engaged in is working with UCLA and partners with them to develop heat maps. Essentially, those maps identify the top 30 communities that were negatively impacted by COVID-19 due to the economic downturn and already being disproportionately disparity impacted, so we have created these heat maps to identify these communities and to identify specific plans to address resources and other things that those communities need to recover from the pandemic.

Another effort that we are currently engaging in is our community ambassador network, known as CAN. That network provides community-based organizations and neighborhoods with a career path. Again, there are a number of communities, our BIPOC (black, indigenous, and people of color) communities that were disproportionately impacted by the economic downturn from the pandemic. Our CAN effort seeks to provide a career path for employment to support those areas that are in need.

With that, that is basically what we're doing in the PEI realm. I am going to turn it back over to Greg.

>> RIGO RODRIGUEZ: Greg, are you muted?

>> GREG POLK: I was muted. Thank you, Darlesh. I'm going to give the overview on innovation.

Next slide, please.

This is about 5% of our MHSA allocation. The innovation projects range from Innovation 2, 3, 4, 5, 7, 8, and 9, and the TRIESTE project. Some of the priority projects for us right now is Innovation 7, which is therapeutic transportation where we engage in putting a

van out to go out and working with law enforcement as well as with the fire department to go out in the field and seek clients to serve in the field, kind of taking it away from the fire department and making it more mental health focused. There's Intervention 8, which is early psychosis learning network that we engaged in.

A big one is the TRIESTE project that we talked about that we had engaged a lot of funding in. We kind of titrated down a little bit because of COVID. There's a partnership with the First Presbyterian Church in Hollywood. I'm going to have Maria talk about that a little bit after I get done with this other stuff here. We're just reevaluating the remaining Innovation projects to make sure that they aligned with the strategic plan, as I mentioned earlier. Some of the proposed changes to the 3-Year Plan, a lot of extensions on the Innovation, 2, 3, 4, 5, and 7. We may be looking at timeline adjustments.

Now I can go back and have Maria talk about what we're doing with the Hollywood pilots.

>> MARIA FUNK: Sure. Sorry that I dropped off last time I was talking. Hopefully, that won't happen.

This pilot is still going to be in Hollywood. It's still targeting people that are homeless and have a serious mental illness. We are working with the First Presbyterian Church in Hollywood. The department has a long history of working with them and collaborating together.

This is still in the development stages, so it's evolving, but what's being envisioned right now is that the church (for many years) has had a winter shelter. They call it a winter refuge. It is very small. It targets people with very significant barriers to getting into other interim housing and shelters.

There is a very large encampment on Gower and Franklin right under the 101 Hollywood Freeway. They typically target people that are there. That's very close to the church.

One component of this is expanding the three-year winter refuge to being year-round. It would be a collaboration with our HOME team. Again, HOME is our homeless outreach team. They would work together and the year-round refuge would serve the HOME clients.

Then there would also be a pop-up village component. Again, we want this to be very innovative. The church has a parking lot that we're talking about creating a village that would have many different opportunities for people to move from where they are in the streets to this village that we're creating. It could have a section where people, if they wanted to come in, and we have a membrane, like a tent membrane, that they could come inside to.

It could be that we have pilot shelters or have shipping containers, so we want it to be

innovative. We want to address some of the concerns that stakeholders have brought up over the years about it takes too long, housing takes too long and is too expensive. We are trying to work to make sure that this happens faster than the normal trajectory. Again, we are going to be working on creating a community for the people that live there and focusing on the well-being and creating a community where there are all kinds of services there and that it would include an employment component.

I will stop there, so more to come on that as it continues to evolve and develop. We will keep the stakeholders informed.

>> GREG POLK: Thank you, Maria. The next piece that we're going to talk about, we will get an overview of our WET program from Debbie.

>> DR. DEBBIE INNES-GOMBERG: Hi. Thanks, and good afternoon. If we could maybe advance the slide, that would be great.

The workforce education and training component of the Mental Health Services Act really focuses on building a pipeline for the public mental health workforce. This pipeline really strives to create a workforce that reflects the diversity of clients served in our system. It provides opportunities and incentives to sustain the public mental health workforce, improve the skills of the work force (and that is usually through training and technical assistance).

On the left-hand part of your screen, you see the different components of WET, and I want to highlight three of them. The first one is the DMH UCLA public partnership for well-being. This has been referenced one or two times throughout the presentation, but it is really focused trained provided by UCLA and their partners for FSP programs and for the HOME team. They have done a couple of other things as well, and so there is that component of it.

Then the second one is the expanded employment and professional advancement opportunities for parent advocates, child advocates, and caregivers in the public mental health system. This one is, I think, really the opportunity and the vehicle to provide training when we know more about what the training should consist of for certification. That and there's one other one and that's the recovery, the intensive mental health recovery specialist training program. Again, those broaden the workforce and they increase the skills of the workforce.

The other thing we wanted to highlight, and this is on the right side of the screen, and that is we have invested in the MHSA WET regional partnership program. The great thing about Los Angeles is it's its own region, so we don't have to share the money with anybody else but ourselves. The money will go to basically what is called a loan repayment program, which basically repays student loans to help grow and diversify our workforce and sustain the public mental health workforce, so it is really for people that are already in our system to help them to continue providing mental health services in our system and focuses on the hard to

reach populations and areas of our county.

Then finally, due to the pandemic, we suspended (this fiscal year) the stipend program for MSWs and FTUs and nurse practitioners. That's just because we were unable to hire in the directly operated system and our contractors were being impacted as well by COVID, so it wouldn't make sense to be able to target people graduating from graduate school, give them a stipend, and then them not be able to find work in our mental health system, which is the goal for that.

That is, in a nutshell, our WET program.

>> GREG POLK: Thank you, Debbie. The next overview will be our capital facility. This is where we have been talking a lot about Restorative Care Villages. I think Jo Ann is going to be presenting. They've done a phenomenal job working on these sites and getting us this Restorative Care Village that is going to be very beneficial to our clients, so Jo Ann.

>> JO ANN YANAGIMOTO-PINEDO: Thank you, Gregg. Good afternoon, everybody.

You have heard a lot about the Restorative Care Village, so I will start with just a background and the board priority around this, talk about the different county healthcare campuses that these Restorative Care Villages are going to be sited on, and then give you an overview of the different types of beds and centers that are going to be built. The Restorative Care Village was actually a board priority that started back on October 31st of 2017. The board decided that they wanted to really look at providing integrated care on health care campuses and it really allowed for DMH to start thinking about building a continuum of care.

The first photo you see on your slide is LAC-USC. That is the flagship of the county healthcare campuses. We will be building 64 crisis residential treatment program beds: 16 in each of 4 buildings there.

Next slide, please.

The next rendering is of the Mark Ridley-Thomas Behavioral Health Center. We are going to have 16 crisis residential treatment program beds there, and 80 subacute beds, 32 of which are dedicated to our alternatives to incarceration. This is a major undertaking. It was a remodel of the former King Drew Hospital, and it should be done, I think, I want to say, the summer of this year, so we are looking forward to that opening. The LAC-USC crisis residential treatment program beds should be open and operational by the end of the year, and these are the same ones that Dr. Ruiz was mentioning in her presentation as well.

Olive View, we have seven buildings going up there. We have five crisis residential treatment program beds, each with 16 beds, for a total of 80, and we also have an outpatient center and a new urgent care center that will be relocated from its current location. The

current location is about two and a half city blocks away from the actual hospital. By having the outpatient center, the crisis residential treatment program and the urgent care center, located in close proximity to the hospital, you can have a continuum going whether a patient needs more care or less care, and, you know, the goal of reintegrating them back to the community.

The next one is Rancho Los Amigos in Downey. It's known as a rehabilitation center, but we had learned from Rancho medical staff that while they do an amazing job at treating people from physical trauma due to spinal cord injuries from car accidents, et cetera, that they were really kind of weak on the mental health side. Our crisis residential treatment program will have 80 beds there, 16 in each of 5 buildings, and will help support folks who are recovering from their physical trauma at Rancho.

The last picture is of the High Desert Restorative Care Village. We just completed construction on an urgent care center on that campus. It is co-located next to the High Desert Regional Health Center, which is a DHS facility. There is quite a bit of land in the Antelope Valley, and there is some landed adjacent to the UCC site. We hope that, in the near future, we can get some feasibility studies done to add a crisis residential treatment program there.

I just want to make one quick note that all of the buildings that you see really have its own theme. We wanted to make it less institutional and more of a residential feel that, you know, people would feel comfortable living in. If we didn't feel comfortable about designing this space in a way that was respectful and meaningful to healing and promoting good therapeutic services, then it really wasn't worth it. And so, my team and I have done our best in trying to design space that will make this a more homey feel and help the healing process.

>> GREG POLK: Thank you, Jo Ann.

>> JO ANN YANAGIMOTO-PINEDO: You're very welcome.

>> GREG POLK: Next, we are going to talk lastly about our technology meetings, an overview from our CIO Miriam, and Jenn helping out. Go ahead, Miriam.

>> MIRIAM AVALOS: Sure. Thank you, Greg. Thank you, Rigo, for helping us.

Good afternoon, everyone. I am here to briefly talk about a couple of points in our technology needs overview. You'll have specific MHSA funded IT projects. However, we're continuing to forge ahead and build. We heard loudly and clearly the need for transparency in our data, and we've already committed. Dr. Debbie Innes-Gomberg and I have already committed internally with the team to begin to work on some ways in which we can deliver the data.

One of the things that I do want to highlight is the work that we have done in order to work on the virtual mental health delivery system. We have deployed a virtual mental health

system which expanded our network through the jails, camps, and shelters, and also allowed us to continue to not only respond to the COVID crisis, but also increase the clients that we serve. Lisa Wong talked about the importance of the virtual mental health system in addressing disparities, language disparities, and making sure that we are able to connect with folks with different needs.

In addition, I believe Dr. Fong talked about the MHRLN system, which is the tracking system that is providing case management overviews. That is something we are also working on.

We have done a couple of things regarding our interoperability with the federal requirements that are geared specifically to have the mental health data be accessible by clients. That is a big effort via the federal government in order to have the mobility of data. Those are the things that we have been working on. One of the big projects that we are supporting the clinical team on is the thinking of our modern call center, and Jenn is going to be discussing that in the next slide, so Jenn Hellman.

>> JENN HELLMAN: Thank you. Next slide, please, Julio. Thank you.

As Dr. Wong and Miriam mentioned, we are looking to modernize our call center. That will be a part of the change in the 3-Year Plan. The technology needs to be developed in order for the call center to really serve as a hub throughout the system in providing access to care. The goal will be that the call center will be focused on information and referral, crisis response, getting teams out where they need to go, providing support and centralized appointment scheduling.

In order to do that, we need the technology that replaces our current technology where the agents aren't aware of what the resources are in our system. The call center will provide end-to-end assistance in an efficient and client-focused manner utilizing an agent and client-centered designed design. We are really working on having this new technology designed in a way to meet the need of both the callers and the agents that are there to assist them.

The goal will be to reduce the number of software applications used by agents so that they have all of the information that they need to help the caller in an efficient way. We want to allow for integration with other systems, such as law enforcement and 911 systems, so that we can receive, assess, triage, and provide non-law enforcement responses to crises across communities. This is part of the Alternative Crisis Response Initiative.

We also want to provide integrated technology between the call center and service providers, including crisis response, in order to reduce time to care and maximize service capacity and improve coordination of services. When somebody calls a call center, we want to be able to quickly and efficiently connect them to the services they need at the right clinic

at the right time. Also, developing some self-service capabilities and alternative access points, designed by feedback from the community, so that we can design other ways that might be better to meet the needs of the community and how they access services. Have an automated call and client analytics to ensure the call center is meeting the need of the community and responding in a timely manner. We really want to be watching all that the call centers is doing to ensure access to care is being met for our beneficiaries and those that we serve.

Thank you. Rigo, I think I am passing it off to you.

>> RIGO RODRIGUEZ: Thank you so much. Thank you, everybody, for sticking with the time frame. I really appreciate it. If we can take down these slides so I can upload mine, that would be great. All right. Let me check to see. You all can see the slides?

>> UNIDENTIFIED SPEAKER: Yes.

>> UNIDENTIFIED SPEAKER: Yes.

>> RIGO RODRIGUEZ: Cool. All right. You have received quite a bit of information around the MHSA plan component. As you can see, there is quite a bit of work that has been put into this presentation and also the MHSA plans themselves.

What we are going to do now is go into the small groups so that you can have more time to really engage with the staff on some of your questions. Let me give you some instructions. Group 1 will stay here, and then Group 2 will go to the breakout room.

I will, in a second, let you know who is part of Group 1 and Group 2. Those who stay in Group 1, we are going to focus on the community planning process and the CSS plan. Those who need cart services – who we know need cart services – if you stay here in Group 1, that would be great.

Group 2, you are going to focus on the plans that you just heard. There we will have closed caption services. But really, the cart services are much fuller, and that's why we want you to stay in Group 1.

What is going to happen in your small group? We are going to have about 30 minutes. The end time for this first round will be 1:25. For those of you who are presenters from DMH, at 1:20, if you could start transitioning out so that our start time can be at 1:25 for the second round. Let me repeat that. This round ends at 1:25. If you are a presenter, if you could start moving at 1:20 to the other group, that would really help. Okay.

What we are going to do in this session is, we are going to really invite you to tell us what you liked, what questions you have, what suggestions you have. If a staff member is unable to answer your question, that is okay. We will jot down your question and I, Pinki, and Darlesh will make sure we follow up with you. Please remember that we are taking all of your

recommendations, but just know that the actual plan will be posted March 19th, so you will still have more opportunities to send in comments as well as at the public forum on April 22nd.

Now, at 1:25, what happens after 1:25? Well, you don't have to do anything. You just stay in your same group because we are going to switch the staff members. The second round starts at 1:25. If everybody from the breakout group, if you can commit to coming back at 1:55, that enables us to do the closing process, so that way you'll have at least 30 minutes for your group.

Now, in terms of groups, I ask that Pinki, if she could create two groups with a mix of SALT and UsCC co-chairs, and then we also know that some of you who need the cart services, we kept you here in Group A. I am just going to read out the names of Group B. If your name is not mentioned, then stay here. For Group B: Andrew, Preston, Bernice, Bianca, Carmen, Cody, Erica, Marcus, Penny, Sarkis, Sylvia, and Yolanda. At this point, I am going to ask John if he can give us instructions on how to get into the breakout sessions.

>> JOHN FLYNN: Correct. If you are part of Group 2 or Group B, I have already sent you an e-mail, so the 11 people on this list should have an e-mail sitting in their box. I'm also going to paste the link to that meeting in the chat here, but I want to encourage only those 11 people—and the staff members who are going to follow them—to click to join that second meeting.

Basically, the breakout room is just a second meeting. So, when it comes time for you to come back to the main meeting, you can open up your old invite. I will also be in the second meeting with you guys, and I will provide you with a link to get back into the main meeting when the time rolls around.

>> RIGO RODRIGUEZ: All right. Let's give folks a minute or two to start, to move to the other group, and then for those of you who are staying here, let's start in two minutes, so let's go ahead and take a stretcher and we will start at 12:51 or so, so we will start in two minutes. I will put my timer on just to give people enough time to transition.

[Break at 02:43:02 to 02:44:23]

>> SUNNIE WHIPPLE: Before we get started, Rigo, can you remind me what CPP is?

>> RIGO RODRIGUEZ: CPP, we're going to start in this group, Group A. You're in Group A, right?

>> SUNNIE WHIPPLE: Yes, I am.

>> RIGO RODRIGUEZ: We'll start here on CPP. If you're Hector, Jean, La Von, Martel, Nicole, Pastor Nah, Paul, Rick Pulido, Roque, Shannon, Sunnie, and Wendy, you're in

the right place. We've got 12 of you. We'll start. I'm going to lower the slides, and now it's time.

Let's go ahead and get started. Given the time constraints that we have, I'm going to suggest that we skip introductions, but you can introduce yourself when you ask the question. Then from a time perspective, I am going to go ahead, and I'm setting up the time right now.

We have 30 minutes, so let's take the first 10 or 15 minutes just to kind of talk about what you liked, any questions that you have, and then, around 15 minutes or so, we can transition over to any gaps that you see, any suggestions, et cetera. Is that okay?

[crosstalk]

>> JEAN HARRIS: Yes. Rigo, can I respond to Sunnie's question? CPP, Community Planning Process, Sunnie.

>> RIGO RODRIGUEZ: Oh, I missed your question, Sunnie. Yeah, so that would be questions about the committee planning process as well as the community services and supports plan. That's what we will focus on first. Then, in the second round at 1:25, we will then focus on the remaining MHSA plans. Thank you, Jean, for helping me out. Thank you. Thank you.

Okay, so why don't we do this? Why don't you just raise your right hand if you want to start with any comments, what you liked, any questions that you have.

>> JEAN HARRIS: Are we raising hands or just speaking, Rigo?

>> RIGO RODRIGUEZ: Raising hand is best. If you have a problem with the raising hand function, let me know. Paul, I see you. Let's start off with you. Okay, here is the order. I have Paul, Jean, Roque, and Pastor Nah. We will start with the four of you.

>> PAUL STANBURY: I just have two comments or questions. The first one was, Dar Darlesh mentioned that the PEI, the funds are – they can be served anywhere, so it would be also helpful to know where the clients are coming from, what zip codes they are coming from, where they are being served. It may help to know, when we are trying to address disparities or issues, if they had to drive a long ways or what is happening, the process with that.

Part of the data would be if they are being served in one service area but they really come from another one, where are they coming from? I think that would be helpful. Also, just knowing; I would like to know, with the funding, how we are doing with funding as we address the needs because they may be able to spend more money on certain areas if we need to, if there is a great need. Especially, I think part of the issue in our area is with the … [indiscernible, 02:47:45] and Latinos is immigrant population with the past administration. There was a lot of concern about immigration issues, and so that may be – we may have more

of a chance to address that now.

>> RIGO RODRIGUEZ: So, Paul, the question on PEI, I am going to punt that over to the next part when we have PEI in our group, but the second question is around how do we--? Go ahead.

[Crosstalk]

>> PAUL STANBURY: Not just PEI. It's for all programs. It is for all programs, not just PEI.

>> RIGO RODRIGUEZ: All right, so then who would like to take those two questions, which is, how do we track where clients are coming from, and then how do we make adjustments, particularly around funding, when we see emerging needs, like the example that Paul gave? Paul, was that a restatement of your question?

>> PAUL STANDBURY: That sounds good, yes.

>> RIGO RODRIGUEZ: Okay. Who would like to take those two questions, from our staff, from DHMA staff? You can ground it in the context of your plan as well, so I see Maria, Lisa, and Amanda, and then Kim Nohl [phonetic, 02:49:01].

>> DR. WONG: I am sorry, Rigo. My audio dropped out for a minute, so I missed the question. I missed part of the question. I only got the very end of it.

>> RIGO RODRIGUEZ: Okay. Here is the question that I am hearing from Paul, and that is, how do we track where clients come from that are receiving services? I imagine, Paul, that's geographically, correct?

>> PAUL STANBURY: Correct.

>> RIGO RODRIGUEZ: Then the second question is, how does the department make adjustments, particularly around funding and services, for emerging needs? The example Paul gave had to do with the immigrant and undocumented population. How does that happen, particularly in the context of, let's say, CSS. Any thoughts on that?

>> DR. WONG: I can speak to that some. In fact, you know, we are kind of in the middle of an exercise on this now, because we are planning a potential North Hollywood satellite, so what we did was we looked at one of the existing programs in the area. We have the ability to go through the data and start by zip code, so we can see where clients are coming from and how many of them are traveling a greater distance and would be closer to another area. Then we were able to determine, by doing that, the size of the satellite we might put at North Hollywood. That's one thing that we have done.

I know it is a little bit different for PEI because a lot of PEI services can also be like community outreach events or things like that, so they have a different process of finding where people are coming from. Sometimes there are sign in sheets or things like that. A lot

of our PEI that is community outreach, they are not open cases, so we don't have the same kind of database that I referenced where we can sort by zip code.

Another way we utilized this to look at disparities is we did an exercise with our inpatient psychiatric hospitals because I wanted to find out. In Service Area 3, we have a huge number of discharges every month, about 1,400 a month. I wanted to find out where are these people coming from, when a 5150 is initiated, and where they get discharged to, so that we can plan who needs to be at the hospital to make the connections and get them back to their HOME programs.

We do use a lot of data in terms of looking at where people are and trying to make things as convenient to them in their communities. I think we do the same thing in terms of other types of needs, like you had mentioned around immigration or other issues like that.

>> RIGO RODRIGUEZ: Yes. Dr. Wong, it sounds like the department already uses data and data analysis around, for example, zip code, et cetera. That is great to hear. It sounds like, if I could read into Paul's question and also the CLT, I think, moving forward, it might be good for us to kind of ask you and others to come in to kind of share where that data comes from and what that looks like, if that is okay.

>> DR. WONG: Yeah, we would love to, and we are getting better at using the data because one of the big problems, as I mentioned earlier, was a lot of times we get aggregated data and sometimes aggregated data is not as useful as looking at it at the local level. The department might look like one thing all across the board but different pockets look different from that average. I think that is where we are diving in more now.

>> RIGO RODRIGUEZ: I imagine that that data is also used to plan for emerging needs and shifts in services?

>> DR. WONG: Yes, exactly. As I mentioned, now piloting, doing that API pilot, because we were finding that we had a lot of unmet language needs.

>> RIGO RODRIGUEZ: Okay. Paul, if you'll permit me, let me go over to Jean. Here's the list: Jean, Roque, Pastor Nah, and then Rick.

>> JEAN HARRIS: Great. Jean Harris here from Service Area 1 SALT. First of all, to answer your question, Rigo, I am feeling really excited to have this really in-depth opportunity to go over the 3-Year Plan with DMH staff to get a lot more information than I have been able to access before. It is a wonderful thing and I am very excited and hopeful to be able to work on that more robust community planning process.

[crosstalk]

>> RIGO RODRIGUEZ: [Indiscernible, 02:53:39 ... last time, Jean, and it won't be the last time because I think what we are trying to set up is to that we are continually getting

this engagement. Sorry to interrupt you, Jean. Go for it.

>> JEAN HARRIS: That's okay. I don't know if you want us to move into comments already. Other people have, so I will. I didn't see a lot in the presentation this morning by DMH about youth services, in-patient youth beds. I saw adult beds addressed, but I do believe that we have a big problem with beds available for in-patient services for youth as well, and I would like to make that comment.

LGBTQ+ demographics have not been seen in the reports in the past, especially as far as who is getting served that meets those demographics. I think that there is a huge need there that is not being addressed. I think that, going forward in the future, that we need to do our best to address that data as well.

School services, I don't exactly know how DMH can incorporate in schools. I know that there are other funding sources besides MHSA, but I know there are MHSA dollars available for school, not necessarily CSS, but probably more PEI, but there is CSS too because there is a lot of kids at all levels—elementary through high school and college—that are not only dealing with their own mental health issues but those of family members that we need provide supports to. Thank you.

>> DR. WONG: Amanda, do you want to take adolescent beds and then I can take LGBTQ after?

>> AMANDA RUIZ: Certainly. Thank you, Dr. Wong. In terms of beds for youth, we did add beds, in-patient beds for youth, this past year, and we had been monitoring the utilization of beds for youth over the past year. Actually, the utilization of beds for youth has gone down, which we think was associated with the fact that many of the minors weren't going to school and didn't need in-patient services quite as much. Other types of services were utilized in other ways and did go up, but in terms of in-patient services, weren't utilized quite as much, but we are monitoring it and ready to add services as needed.

Another thing that we have on the horizon and in the pipeline are crisis stabilization units, so urgent care services for youth, because that was a gap in our system. We are really looking forward to putting in an application for additional funding to add that, both in the northern part of Los Angeles and in the southern part of Los Angeles, so that we can add that specialized service for our youth.

>> RIGO RODRIGUEZ: Dr. Wong?

>> JEAN HARRIS: The urgent care center in northern Los Angeles County, which is what I represent, if you have youth come in, in a crisis, to the less than 24-hour facility and they do need in-patient, then they are not going to find that in this community. They are going to be transferred to hopefully an open bed in LA Basin or in another county, and the impact of that on the family is huge and I think we just need to look at that data. I have had

so many families sit three days in the hospital emergency room with a child in a crisis with nowhere to go, and then they get transferred 100 miles or more away. That prohibits the family from engaging.

>> RIGO RODRIGUEZ: Jean—

[crosstalk]

>> AMANDA RUIZ: I am so sorry to hear that. I am definitely listening, and we will have to address that.

>> RIGO RODRIGUEZ: the way I register that is kind of the concentration of those services in SALT 1 area. Yep, okay. Thank you, Jean. I think Dr. Wong was going to respond to the second part around LGBTQ. You're muted.

>> DR. WONG: Sorry about that. I am really excited to bring to the group that the department has started a special work group on LGBTQ+ issues and it is being led by Dr. Rebecca Gitlin. It is a sadly new effort for us. This is something I think we should have had more focus on for quite a while, but we are doing it now.

In terms of finding out what the needs and the data are, we find out through talking with our consumers, our stakeholder groups, doing surveys and things like that. It is not a mandatory data point that we collect. Another issue with that is a lot of times our clients might not feel very comfortable disclosing, at first, or disclosing for data to be put in a system, so it tends to be more sharing on a personal level, or in sessions, or bringing it up at stakeholder events or things like that. We are starting with the work group and they are doing some exciting things around supporting the LGBTQ+ community.

>> RIGO RODRIGUEZ: I have Roque, followed by Pator Nah.

>> ROQUE BUCTON: Hello. This is Roque Alas Bucton, Access for All co-chair. I have some issues to bring up regarding accessibility and ... [indiscernible, 02:59:53]. Overall, in regard to technology and how the state is approaching compliance in regard to website accessibility, platform accessibility, and very specifically, within the deaf community, how they are now switching to virtual ASL platforms. The client feedback is that they are having challenges with the platform.

Two, they are also having issues with the choice of who the ASL sign person is. Meaning as an example, a woman that has experienced domestic violence from a male and then has to use a male sign language interpreter in order to do her therapy. That is one issue.

There is a larger issue of just the overall platforms that the DMH has, and accessibility to those various platforms, in particular, now on the Microsoft Teams, and also the social media platforms.

One very specific challenge in the department that I'd like to get your feedback on is

regarding ADA coordinators. In the literature within DMH, they state that there is an ADA coordinator and for any questions to contact them. But that position isn't filled, and so I wanted to know if, at the state level, there are other ADA coordinators within other counties. If so, how are those set up or funded and sort of like what the best practices are in regard to an ADA coordinator, regarding a department. If there are, could we get in touch with them and to find out how they develop their various, let's say, subdivisions within the department. Thank you.

>> RIGO RODRIGUEZ: I am getting -- oops. Do I need to repeat the questions or did you get them? Okay, so I'll start off backwards first. In terms of an ADA coordinator, it sounds like the position is unfilled. Any thoughts on that? Who would I turn to on that one? Is anyone muted?

>> UNIDENTIFIED SPEAKER: I think we are going to have to get back to you on that one, Rigo, so we can identify where that vacancy is and what the plan is.

>> RIGO RODRIGUEZ: Okay. Thank you. Thank you for that response. Again, that's a valid response. We are registering the questions. I will also work with you, Roque, to follow up on that.

Any comment on the broader question around how DMH is meeting the state requirements around accessibility, particularly the virtual platforms and particularly deaf and hard of hearing, or is that something we'll get back to him on?

>> AMANDA RUIZ: Again, I think that is something we are going to have to get back to him on.

>> RIGO RODRIGUEZ: Okay.

>> AMANDA RUIZ: I know, specific to the subacute facilities that I oversee, we're providing some incentives to the contractors that are planned for July 1st so that the contractors take patients that are hard of hearing and have issues with vision. But, as a department, I think we will get back to him on that issue.

>> RIGO RODRIGUEZ: Again, I want to emphasize to those that are CLT members, we have our quarterly meetings. We can even have those every two months, and so we will schedule updates that don't depend necessarily on the MHSA calendar, the public hearing. We can always schedule folks to come back to us on those things. On the list, I have Pastor Nah followed by Rick. I see two more folks. That's Sunnie and Wendy. We have about ten more minutes, so go for it, Pastor Nah.

>> PASTOR NAH: Yeah. This is Pastor Nah. I am SALT 4 co-chair. [Speaking a foreign language.]

>> INTERPRETER: Hello, everybody. This is Pastor Nah. I have two things. First

of all, the call center, the help line, I am wondering if we can designate a language specific number for different communities and cultures, because people are having, especially the Korean-American community, are having a hard time accessing a help line or call center. That's my first point. My second point is—

>> PASTOR NAH: [Speaking a foreign language]

>> INTERPRETER: Okay. So, earlier on the chat link or chat room, I put up a list of items, about eight to nine items, where I was introducing you with different case scenarios or actual cases that happened in the Korean-American community. What is going on, basically, in the Korean-American community is that when a minor child is being admitted to the hospital or they are trying to access the system for services and resources, their parents are having a tremendous difficulty trying to access the system and trying to utilize the system. They don't know what to do. They don't have enough information and they don't know how to access the program and resources. So, I am wondering if we could set up a designated team for each language in order to deliver a unified approach on mental health services for parents on prevention and different services.

>> RIGO RODRIGUEZ: Thank you. Go ahead.

>> PASTOR NAH: [Speaking a foreign language]

>> INTERPRETER: For example, Service Area 1, we currently are servicing English language and Spanish population, but for Service Area 2, we have different needs such as Armenian needs, Arabic needs, Farsi, Russian, Spanish dialogue. But those needs are not being met and I am wondering if we could set up a designated team for each language in order to deliver a unified approach to mental health services to communities. What do you think about that? I wonder if this is feasible.

>> RIGO RODRIGUEZ: Thank you. Pastor Nah, thank you for your recommendations. I'm hearing two things. One is the call center that is linguistically specific to the Korean language – I am just summarizing – and then the second one is related to a designated team that also has that linguistic capacity that targets communities based on their linguistic needs. In this case Pastor Nah has mentioned the Korean community. Any thought on that? And again, if it is something we can just say a little bit on right now, but we can always follow up with a more in-depth. I really appreciate the scenarios that you posted, Pastor Nah. Dr. Wong or Amanda, who would like to take this?

>> AMANDA RUIZ: In terms of the designated teams, we can definitely look at that and see what we can do. I would be happy to look at that with my team and circle back. Thank you very much for the input and definitely for the cases. Those are very, very helpful.

>> PASTOR NAH: Thank you.

>> RIGO RODRIGUEZ: This is another one that we will circle on. Again, I remind you we are being recorded. What is being said right now, we will make sure to follow up on. Next, I have Rick, followed by Sunnie, and then Wendy raised her hand, so why don't we just – let's get your questions first before responding to them so at least we hear the questions, and then I will proceed to walk us through those questions. Rick, can you pose your question?

>> RICK PULIDO: Yes. It is going to be more like a commentary, doctor, so we we don't have to pose so many questions. But it is my chance to give – I have been waiting patiently. I want to say a few things.

My stuff is so that this will enhance our solution process as we go along here. I believe that we have a deep stated mental health situation going on regarding the increase in opium and heroin. We are going have to address that with especially the young adults and specifically, like Jean said, the youth, the suicide rates, how we are going to address that?

I did receive a map today in the mail from the Southern Poverty Law Center and it is called the Hate Map of 2019. There are over 940 active hate groups, and this is creating a lot of anxiety, as you know, and a lot of frustration and disparity for our community.

Here in California, specifically in LA County, we have over 20 different active hate groups, that means Neo-Nazi, KKK, racist skin heads, anti-LGBTQ. Hate, in general, is one of the biggest, and black separatists. Please note that we are going have to address that within this MHSA funding source.

Also, I would like to say, this is the key point. Post coronavirus, what are we going to develop and build into our priority list with the post coronavirus, directly? Not just the great vaccines that are coming through for all of our people of color, finally—it has taken a while—but for all people. We have to develop a project and a plan of action that will help the families, the victims that have lost the little ones, and family members who lost their moms and dads, grandmas and grandpas, and lost half of their clan, half of their family is gone, and now they are out there. There are thousands of people that died in the last year. We have to be cognizant, as we all are. Dr. Ferrer [phonetic, 03:11:01] said it very well. It's creating havoc for our little loved ones. How are we going to work and produce some type of solution for them?

One other thing I want to say is the ATI, the alternative to incarceration, Brittney Weisman, our executive director for NAMI, gave a great presentation. I think we need to discuss that more at length, if we could, as far as where we are going to go with that and how can we collaborate with the Measure J? I know they are different funds and different entities, but MHSA will cross over with the housing. I heard that a lot today, and I think the Dr. Sherin's strategy plan for ten years, as he said, let's move our hearts forward on what we are doing. We are all compassionate people, as you know. We need to address that and need to

address it very quickly, because it is part of this plan.

Lastly, the tourist project and peer resource center, the kids at schools when they get back in, we need to have mental health workers or, if you will, representation there at all levels of elementary through high school, even in the college level. This virus is really taking an impact on people, and we're all Zoomed out. We're burned out, but we have to get back on track with that.

Those are my comments, really. I have few more, but I will save them for later. As stakeholders and as grassroots advocates, we believe what you guys are doing. Dr. Debbie was excellent in her review of the CSS and the innovations. All that is great, but it is now coming down to the grassroots of implementation and making sure we get our fair share for people of color and for all folks, of all communities of color. I want to work with you guys and let you know that you guys are doing a fantastic job and looking forward to getting a comprehensive project that Dr. Rigo, I know, is putting together. Thank you, Dr. Rigo, for your efforts. We as stakeholders and me as a SALT 7 chairman, I would love to say, again, gracias.

Lastly, hours of operation. Paul and I have talked about this and so have others many times. DMH has to have a pilot program or, better yet, a standard managing practice regarding hours of operation. We need to change it to 9 o'clock at night. Thank you.

>> RIGO RODRIGUEZ: Got it. Thank you, Rick. At this point, given our time constraints, let's just hear what you all have to say. I have Sunnie, Wendy, and we will end with Hector. Okay, so go for it, Sunnie.

>> SUNNIE WHIPPLE: First, what is the time check?

>> RIGO RODRIGUEZ: We have like five more minutes.

>> SUNNIE WHIPPLE: My name is Sunnie Whipple. I'm the co-chair of the Cultural Competency Committee. It's more of a comment. I'm going to say this as a consumer.

I am a Native American. With this whole community planning process and the whole COVID, a lot of individuals, especially inner city—this is pre-COVID and now they're in post-COVID—as a Native American community and being of Native American, we went through this before with the smallpox. Now, the mental anguish of us losing all of our elders, our wisdom carriers, and that's affecting the youth now.

I think that's why I was interested in the community planning process. I know that your staff won't have any answers for me because, I hate to say it this way but, we have always been invisible. But then, we have to, just like Rick said, the grassroots have to step in and take over and bring this forward. Thank you.

>> RIGO RODRIGUEZ: Thank you, Sunnie. I should be more clear. At 1:25, the

folks here will transition, but we can make sure we register everything that folks are saying. I caught the part about the invisibility, and I caught the part about the importance of the community planning process grassroots, especially the impact that COVID-19 has had on wisdom carriers in your community, so thank you for that. Wendy. I think you may be muted.

>> WENDY CABIL: Thanks. Hi. This is Wendy Cabil, and I'm one of the co-chairs for the black and – [loss of audio] – African Heritage…. I'm grateful for this moment that we have coming together collaboratively as we should. It's unfortunate it has taken us so long.

My concern, being in my new position in this leadership position, and I am still a consumer, is how to engage my peers and how to get them to come to this table. However, I'm seeing, by history and lived experience, that the table needs to be prepared well and needs to be welcoming, in a welcoming environment. I need help in that area, and whatever works for me can easily be used for others. I am open to suggestions. That being said, then I am still concerned where my peers are in my SALT at the table as well. We need some strategic efforts here.

Number two, I am concerned about peers like myself who have physical disabilities, and I am glad we now have the other subcommittee, Access for All, on the scene. I am trying my best to stay up-to-date, but I am in a unique position in that I also qualify for IHSS. My first-year experience was quite a learning experience. I didn't know what to expect.

Well, now I am in need of another caregiver, and so I am going to need assistance in that area, understanding how best to screen someone who can come and assist me in my home. I am using myself as an example because then we can learn together how to help others.

I guess the last thing – oh, and what is to become of our – or if it still on the map – a peer division chief? Who is there to support us as peers in DMH? What is the vision here moving forward? Last but not least, what is the purpose of our patient advocate, whatever that division is? I would like to get a better understanding of how to use that particular service. That's it. Thank you.

>> RIGO RODRIGUEZ: Thank you, Wendy. Thank you so much. Let's move over to Hector.

>> HECTOR RAMIREZ: Okay. Sure. This was very disorganized for me. I just want to share my experience. I participated with Rigo to plan this. This just felt like a bait and switch presentation, so it was very difficult to even comment in an honest—

[crosstalk]

>> HECTOR RAMIREZ: …one of the things that we saw in the plan is that Latino folks are … [indiscernible, 03:18:15] significantly both as the folks in need and the folks

utilizing the services, particularly ... [indiscernible, 03:18:21] and so much of what was presented today ... [indiscernible, 03:18:26] the comments and issues that our Latino community is facing, the needs that we have presented to the department continuously, and the processes that we have been forced to utilize.

[Indiscernible, 03:18:42] ... going into conversations with MHSA. IHS feels like we're probably going to be utilizing the same disingenuous process, so I really want to request, once again, a better CPP process that is actually based on ... [indiscernible, 03:18:58] values ... consulting agency. Nothing personal ... fantastic, but this approach is ... my community needs help. It's just, we ... based on all the work that we have done. The UsCC has done so much work.

None of this really comes to represent the fact that we are prioritizing conservatorship services instead of helping out our people. The fact that we still have ... which is a waste of money, instead of providing ... for our community right now, it shows a lack of value, a lack of vision, and the leadership is missing here. I'm so, so disappointed. There is definitely a lot of work to do. The fact we are having to do it this way, it is a significant barrier for my communities that I represent.

We are not at the table. The technology divide has really limited our peers, and there is truly no way for this plan to really address the issues. This is perhaps a great step forward, but I feel like so much of the work that we have done was really disingenuous and....

We're looking forward to engage with somebody else who will listen to us, and we will go wherever we need to be. We want our community, our Latino community, to be helped right now. This doesn't do it.

>> RIGO RODRIGUEZ: Thank you, Hector, for your comments. I really honor and appreciate your comments. Most of your comments really focus on strengthening the gaps that you perceive and you feel and you see in the community planning process, particularly the need to trace back the work to the Latino UsCC—I imagine others as well—so that we can make sure that those needs are adequately and sufficiently represented in the plan. I appreciate your comments and also the need to keep working at this.

At this point, I am going to ask. I think staff are transitioning from one to the other. Again, as I pointed out earlier – so, at this point, feel free to lower your hands on the participant list so that we can start again. I am going to see who here is from DMH. Let me get the participant list here. Darlesh, are you here in this group?

>> DARLESH HORN: I'm here, Rigo.

>> RIGO RODRIGUEZ: Okay. In terms of other folks from PEI, Innovations, are we here already? I see Debbie. Okay.

>> DARLESH HORN: We need to bring Kanchana Tate (or Kanchi Tate) over.

>> RIGO RODRIGUEZ: Okay.

>> DARLESH HORN: She's also a presenter for PEI.

>> KANCHI TATE: I'm right here.

>> DARLESH HORN: Oh, you're there. Okay.

>> RIGO RODRIGUEZ: Okay, so let's start off with the same thing that we did last time. Feel free to raise your hand and then what we are doing now is we're shifting focus from the community planning process and the community services and supports the plan. Now we are shifting over to PEI, and also to Innovations, to the workforce education and training plan, and the capital facilities and technological needs. For that, I see Wendy's hand went up first, followed by Pastor Nah.

What we did, just for those of you that are joining us now is, even if we can't answer the question fully, we are registering the questions. Again, there is a commitment on my behalf, Pinki, and certainly Darlesh around this project to make sure that we document and we follow up with you. Wendy, go for it.

>> WENDY CABIL: Well, I didn't really. I forgot to lower it.

>> RIGO RODRIGUEZ: Wendy, you go first and then Paster Nah and then Roque.

>> WENDY CABIL: Well, no. I'll let Paster Nah go because I forgot to lower my hand.

>> RIGO RODRIGUEZ: Okay. Pastor Nah, go for it, and then we'll go with Roque.

>> PASTOR NAH: Thank you. [Speaking a foreign language]

>> INTERPRETER: Okay, so earlier, I put up a case list in the chatting room, but I wanted to bring up one case from that list. One of the patients went to the pastor in his or her church seeking out for help and treatment, but that pastor in the church didn't know anything about mental health services that are out there in the community.

>> PASTOR NAH: [Speaking a foreign language]

>> INTERPRETER: About three to four years ago, up until three to four years ago, there were information provided to the faith leadership in the Korean-American community by DMH, but now that has disappeared. And so, I would say about 90% of the Korean-American population is connected to church in some way and when they go to the leadership in the church, they are not getting connected to the resources that they should be.

>> RIGO RODRIGUEZ: Okay.

>> PASTOR NAH: Thank you.

>> RIGO RODRIGUEZ: Darlesh, what I am hearing is, what is DMH doing to work

with faith-based organizations to help pastors and others to be a resource around mental health, with an emphasis on the issue that Pastor Nah brought up. Any thoughts?

>> DARLESH HORN: Sure. There are two efforts. One that has been a little bit more long standing in DMH. We have always had a faith-based collaborative, and I am not sure if Pastor Nah is aware of that collaborative. It has been going on in DMH for some time, including MHSA program staff and even department staff that are not with MHSA or around MHSA. Essentially, those faith-based collaboratives meet monthly. There are regional meetings, so maybe we need to get you connected with the actual collaborative that meets and when it meets in your area.

The other effort is the incubation academy or what we call Transforming LA. A big part of that effort was to engage the faith-based community to understand what type of services or supports that you offer within your place of worship that we could train you to provide preventative, from a mental health perspective, preventative strategies with that support that you provide to your congregants and your communities. We really did reach out and want faith-based organizations to come forth and become a part of that effort. If you would like to reach out to me, I am happy to get you connected with both strategies or both groups so that we can support you and your community.

>> PASTOR NAH: Okay. Thank you. [Speaking a foreign language[

>> INTERPRETER: Actually, you know what? Darlesh, thank you for that. I am actually participating in that faith-based leadership and I am a part of the executive community there. What is happening is that a lot of those meetings are not supported in language. We don't have Korean translators available for that, and a lot of Korean pastors are not able to attend those meetings and fully utilize that information that they should be obtaining. So, you know, thank you for pointing that out.

>> RIGO RODRIGUEZ: You are muted, Darlesh.

>> DARLESH HORN: Thank you so much for pointing that out. I wasn't aware that there was a need for additional language support, so I will definitely bring that back to DMH executive management to see if we can address that issue.

>> PASTOR NAH: [Speaking in a foreign language]

>> INTERPRETER: Oh, actually, you know what, Darlesh? We are getting the translation service at the FBAC meetings. Sometimes we don't get that interpreter but mostly we are getting that interpreter. But what I want to emphasize was that we need more information that is going out to the faith leadership in the community and we don't get that. The faith-based leadership in the Korean-American community, they need to get more information, and they need to be more aware of the resources out there so that they can deliver that information to their congregation.

>> RIGO RODRIGUEZ: Thank you.

>> DARLESH HORN: Okay. Yeah. No worries. Maybe, if possible, you can share—you can even drop it in a chat box—some of the things that would be helpful in terms of distrubuting – [no audio / on mute]

>> RIGO RODRIGUEZ: You are muted, Darlesh, for some reason.

>> DARLESH HORN: Sorry. Within that, maybe some suggestions like if there is information that we need to translate in order to distribute through the Korean community. You can even drop it in the chat if there's something in particular or suggestions that you have that we can take back and try to address that.

>> RIGO RODRIGUEZ: Okay, so that would be great.

>> PASTOR NAH: Thank you.

>> RIGO RODRIGUEZ: Again, I can envision us following up on all of these items in our quarterly meetings with the CLT, so thank you. I have Roque, Sunnie, and Paul. It is 1:35, so why don't we just – let's hear your question first, your comment, and then I will circle back to staff. Let's get all of the questions in first before we respond. Let's go with Roque, Sunnie, Paul, and then Rick.

>> ROQUE BUCTON: Hi. This is Roque. Just to follow up on this same issue of translation, we've identified that there is a large service gap in terms of ASL and the other threshold languages. Currently, there is American Sign Language. Just based upon sort of the randomness of the skill of the ASL interpreter, you may be able to get Spanish. There is a high likelihood, but the other threshold languages, let's say in this prior case Korean, there are none available. In the other threshold languages, let's say ten of them, there are no ASL services. That's an identified service gap.

To connect that to the WET, we have requested that a workforce development plan be developed to cultivate the training in ASL and to encourage those who are already certified clinicians to take on language training and ASL. There are very few classes to learn ASL, so we need support in that regard to promote the education of ASL and bring that to the, let's say, equity within various communities.

>> RIGO RODRIGUEZ: Thank you.

>> ROQUE BUCTON: In regard to the accessibility of the access center, I would like to know how they are addressing how the deaf community will address a phone line in regard to getting services. Thank you.

>> RIGO RODRIGUEZ: Thank you, Roque. Again, we are registering these and, if we have time, I'll circle back for responses. I have Sunnie, followed by Paul and Rick. If we have time, I'll ask for some responses on these questions or comments. Sunnie.

>> SUNNIE WHIPPLE: Yeah, thank you. My question is, during Greg Polk's presentation during the PEI, he used mild, moderate, and severe mental illness. My question, overall, I know that is a Western model of doing things, but is it culturally sensitive? Again, like I said earlier, I am a Native American, and the Western approach to working with me doesn't work a lot of times. If you have any info on it, I would like it. You don't even necessarily have to answer it, but I would just like literature on it.

>> RIGO RODRIGUEZ: Yes. Is that distinction between mild, moderate, and severe, which we know is grounded in a Western culture, is that sufficiently or even culturally sensitive, particularly to your community and other underserved communities? Is that correct?

>> SUNNIE WHIPPLE: Yes.

>> RIGO RODRIGUEZ: Okay. Paul. You are muted, Paul.

>> PAUL STANDBURY: My question has to do with the connection between the PEI efforts (prevention and early intervention) connected to Innovations 8 early psychosis program and how that's going to work out. It seems to be an important connection and I am just wondering how that is going to be developed.

>> RIGO RODRIGUEZ: Okay. What's the connection between PEI and then Innovations 8, the early psychosis innovations project? What are those connections, if any, right? Okay.

Then I have Rick. Maybe after Rick, we will circle back to getting some responses to the questions. Rick.

>> RICK PULIDO: Real quickly, my commentary, and there are some questions in here for Dr. Debbie and other DMH folks. I like your approach, Dr. Rigo, with the big picture.

We need to get deep, deep into the levels of the feedback that we're doing today and I appreciate that very much. The follow through is going to be the question that I'll have.

How do are we going to comprehensively--? I know you are probably going to have to do all of this work, doctor. I'm sorry. But it is going to be needed to show a complete synopsis, as well as a good comprehensive report, on what we are doing today.

My points that I want to continue on is, I agree with Sunnie that Native Americans need a comprehensive PEI and innovation approach, expansion of their funding and expansion of their projects on what he's doing and how difficult it is without having that funding source.

Somebody from DMH mentioned client incentives, earlier in the morning. Client incentives are very important for treatment. What I want to suggest, and I know we have transportation. I know we give vouchers and stuff, but we've got to go a little further – maybe. Home visits, I know, is on the plate, but we have to go a little further and get out to

the hotspots on Fifth and Skid Row out there, and all of the hotspots around the LA County area. Bring food and bring basic hygiene backpacks and kits. We're going to have to be a little bit more innovative in that sense.

I know Dr. Debbie talks about it in many years past. We're just going to have to reach out because all of these folks are hurting right now, especially children. Children need clothes and hygiene.

I also want to bring up two more things. Those are the inner cities I am talking about in the impacted areas, but the TRIESTE Project should be in all SALTs. The undocumented families and members out there that have post-CEV, coronavirus, we have to expand our efforts there, Dr. Rigo. Undocumented families are not getting enough attention. It's unfortunate, but it is only because the coronavirus has really cut them off totally.

Those are my thoughts. I appreciate what everybody is sharing today. It is really solution-oriented. I really respect all the comments. Thank you.

>> RIGO RODRIGUEZ: Thank you, Rick. Let's start off then with Roque's point. At the high level, he was asking a question about the translation ASL services not being available in threshold languages beyond English and, if you are lucky, Spanish. Then the second question that he had was around the WET plan and the training in developing a workforce around ASL. Then the last one has to do with the access center, the call in around how would deaf and hard of hearing folks be able to access that. Darlesh, can I hand it over to you and you tell me who would respond?

>> DARLESH HORN: Sure. I think, in terms of the access—I don't want to put anyone on the spot—Jenn, can you speak to the access center question? I am not sure we even have someone on the phone that can speak to that from DMH.

>> JENN HELLMAN: Yeah, so a couple of things. One is, part of our call center modernization is also going to include a chat, an online feature, so it is not just going to be about calling in. I think one of the areas we have really identified as a department is the need to look at other access points other than just the phone line, whether it is e-mail or chat or self-service options. That is certainly part of it.

I did make a note about ASL for other languages. I know the access center, one of their roles is to ensure that we have an ASL, so I did make a note of that to take back as part of our making sure that we are going to be able to account for that. Then we are also in the process of making sure that all of our providers have the – I apologize. I'm going to get this acronym wrong. I think it's the TTY capability. I know that is antiquated, so that is the requirement with the state and the Feds, and so we are looking at other opportunities and trying to get the state to also modernize what the requirements are. I made notes of those, and so I will make sure that we incorporate that.

>> RIGO RODRIGUEZ: Thank you, Jenn. Any thoughts on the WET plan and whether the WET plan could be used for building a workforce around translation, interpretation?

>> DR. DEBBIE INNES-GOMBERG: Yes. Rigo, this is Debbie. I would take that back to Ann ... [indiscernible, 03:38:29]. I know that there has historically been a WET project around interpreter training, but this, I think, is a little deeper than that, so I will take that back.

>> RIGO RODRIGUEZ: Okay. Thank you, Debbie. That would also apply to and speak to the threshold languages. Okay.

Then any thoughts on Sunnie's question around what do we know about the degree to which the mild, moderate, and severe distinctions that are made, you know, how that meshes with being able to serve folks that come from a non-Western cultural orientation? Any thoughts on that? And the literature, is there any literature on that?

>> DR. DEBBIE INNES-GOMBERG: Rigo, this is Debbie. This came from the State Department of Healthcare Services, and so I think that in negotiations and in feedback around calAIM, which is the extension of the waivers, that would be a great thing to bring up in the behavioral health workgroup would be this distinction around mild to moderate, especially in mental health, and how it may have an adverse impact on certain ethnic populations.

>> RIGO RODRIGUEZ: Debbie, I will link it to you then on that one. Is that okay?

>> DR. DEBBIE INNES-GOMBERG: You can do that, yes, and I can pass it on to those folks in the department that are closer to that.

>> RIGO RODRIGUEZ: Thank you for that response. What I heard is that there is a place in the department of behavioral health workgroup where that question can be posed and explored, the extent to which these distinctions could have adverse effects and impacts on populations. Yes?

>> DR. DEBBIE INNES-GOMBERG: Mm-hmm.

>> RIGO RODRIGUEZ: Okay. Paul had a question around the connection, if any, between innovation data around early psychosis and then PEI, more broadly.

>> DR. DEBBIE INNES-GOMBERG: Yes.

>> RIGO RODRIGUEZ: Debbie, thoughts on that?

>> DR. DEBBIE INNES-GOMBERG: Yeah. This is Debbie. In prevention and early intervention, one of our early interventions is the peer program, which is the Portland Identification and Early Referral Program. As I think some of you might know, there are five providers across the county that are providing early psychosis or what we call coordinated specialty care, comprehensive mental health services to people that either are clinically high

risk or who have had just their first psychotic break.

We have opened up that a little bit to expand the population, but those five providers are part of Innovation 8, and Innovation 8 is a learning healthcare network with UC Davis. What we are doing is we are, I think now, one of six counties that are involved in the early psychosis learning healthcare network, which is Innovation 8. What that allows is that it provides the opportunity to collect real-time data on clients that clients enter on a tablet, and that data then can be used by clients to help monitor their symptoms as well as health clinicians provide more comprehensive real-time treatment planning.

The data elements that will be collected will be statewide data elements, so all counties that are participating will collect the same data. This project, this piece of work is tied, actually, to federal work as well. The hope is that California would join a number of other states that are part of an early psychosis data collection and treatment effort.

>> RIGO RODRIGUEZ: Paul, let me follow up with you. Did that clarify your question?

>> PAUL STANDBURY: Yes. I know they are working with the schools and early intervention, so would that be able to tie the schools as they identify young persons who may be starting to have some issue and tie it to the RAIS network?

>> DR. DEBBIE INNES-GOMBERG: Absolutely. Yeah and, in fact, I think Samantha Wood-Mooney [phonetic, 03:42:44] who is a clinical psychologist that works for me, she is the head of the project of the program, and she has been working with Kanchi and other folks to really make sure that we are able to get into the schools and offer this service. Of course, with COVID, it has been a little bit more challenging. But we have noticed, over the last two months or so, that the school referrals are increasing.

>> RIGO RODRIGUEZ: Then I also had – Rick had a number of comments. Rick, I'm just going to highlight some. He was asking about client incentives, but also strategies that target hotspots. Again, this is a comment. He framed it in the form of a comment, so feel free to kind of jump in. He mentioned the TRIESTE being available at all SALTs. I don't know if it is available in just one or a couple. Then an emphasis on children. Then lastly, he mentioned undocumented families and COVID having a heavy impact. It was a cluster of comments. I don't know if anyone here has a perspective on how Innovations might impact those concerns or PEI, early intervention. Any thoughts on that with the cluster issues?

>> UNIDENTIFIED SPEAKER: I can definitely speak to the needs of children and what the department is doing around schools, if that would be helpful.

>> RIGO RODRIGUEZ: Perfect.

>> KANCHI TATE: All right. With the prevention division, we are really working

closely with the school districts that have been impacted. As you know, many of the schools are going back, so we have created a triage and linkage process, making sure that kids who need specialty mental health services are linked to our legal entity network.

We are providing an array of training to teachers and staff at the schools to help them identify kids who are in need of mental health services. Then we are also working with DCFS and the Prevention Aftercare Network to address a lot of the prevention-related needs of kids from food to clothing to tutoring, things that impact somebody's mental health. Those are just some of the initiatives around children that the department is involved in.

>> RIGO RODRIGUEZ: Thank you for sharing that. How about any kind of information on how these services, like PEI, in particular, any overlay with the hotspots, areas like Skid Row? Does the department match an area, a hotspot, with services? How does that work?

>> KANCHI TATE: Yes. We've done – with the Advancement Project, we have looked at 30 cities that have been really impacted by the pandemic, and racial inequity matters. Those are the cities that we are working very closely with, with the Innovations 2 program and the community ambassador network. The schools that are in those areas also are a high priority for us.

>> RIGO RODRIGUEZ: Okay. In light of the time, we have three more minutes. Are there any final questions or comments from the DMH staff or maybe we have time for one more before we transition?

>> PASTOR NAH: It's Pastor Nah.

>> RIGO RODRIGUEZ: Go for it.

>> PASTOR NAH: Yes. [Speaking a foreign language]

>> INTERPRETER: Okay, so three pastors from the promontory program have applied for it and one of the pastors has now been approved.

>> PASTOR NAH: [Speaking a foreign language]

>> INTERPRETER: But I think the typical thing was a lot of the materials and even the interview process and the whole procedure was done in English and there was no language support. I am wondering, if we can provide in language support, a lot more Korean pastors can apply.

>> PASTOR NAH: Thank you.

>> RIGO RODRIGUEZ: Thank you. Any thoughts on that or a response to that request?

>> DARLESH HORN: We can certainly bring that request back to the DMH staff at our meeting for that effort to make sure support is coordinated for the Korean community

to fully access the promontory opportunity.

>> RIGO RODRIGUEZ: Okay. Again, point well-taken, Pastor Nah. What I am hearing is that there will be a follow-up on that question and that request so that at least there is a response to your question. Okay. Let's take another question until we see -- it is 1:55. Why don't we pause here and then we will wait for folks to come in from the other group. Let me check in with the other group for a second.

>> UNIDENTIFIED SPEAKER: Yes. The other group ended about five minutes ago, Rigo.

>> RIGO RODRIGUEZ: Okay. Have they joined us here?

>> UNIDENTIFIED SPEAKER: I have.

>> UNIDENTIFIED SPEAKER: Yes, they have.

>> RIGO RODRIGUEZ: Okay. Perfect. Okay. Then let's go ahead and begin the closing process for today. Let me upload this. Okay. Can you all see the slide?

>> UNIDENTIFIED SPEAKER: Yes. Closing.

>> RIGO RODRIGUEZ: Okay. Thank you. All right. First of all, we have been together for about four hours, so thank you for hanging in there. It has been really important for us to kind of spend this time.

I just wanted to say, again, that the purpose of today's session was to obtain feedback from CLT members on this draft MHSA 3-Year Plan. You heard a presentation on the CPP and CSS—we all now know those acronyms—and then on the other plans.

There is a deeper purpose, of course, to us working together, and that is to strengthen the partnership between DMH and CLT. This is with a broader Your DMH effort.

I also want to say that, as a consultant to you all, those of you that have gotten to know me over the last six months, and also with DMH staff, I am truly, truly committed to strengthening and building a stronger relationship across the board, because we all are on the same side. I know that there may be moments where there are glitches and misunderstandings. If at any point over the course of today's session what you thought you were going to get today is not what you got, that's okay. My apologies if I did something on my end that didn't meet your expectations. I certainly am always open to hearing from you and to working with you through the good times and the tough times.

My interest is now to just let you know that is not the only time that CLT members will have a chance to provide input and feedback. The plan will be -- the close to final plan or the department's final plan will be posted on March 19th. What I mean by final is that they take all of this information and they do their best to create a final version. That gets posted on March 19th and there is a 30-day review, so you can still go in and give more input. Then at

the public hearing is where the department gets the last set of inputs and feedback and then makes some final, final decisions on the plan. April 22nd, I remind you, is the public hearing. For members of the CLT, we will shoot out information to you.

Lastly, I am committed to continuing to work with Darlesh, who is managing part of this work, and also Pinki, to ensure that we fully document today's session. Just know that for CLT members, as we continue to meet on a quarterly basis, as we continue to strengthen the organizational infrastructure for the CLT, we, at least I plan to invite, continue to invite, DMH staff to continue to follow up on these matters as we move forward.

To close, I would like us to use the chat box one last time, if you can. Just in one word or short statement in the chat box, if you can just share one word about how you feel about today's session. You are not trying to make me happy or sad. It is just kind of where you are at. It helps us register that. After all, we are the Department of Mental Health, and so emotion and social emotional wellness is important – kind of where you are at.

Also, if you can write down what is that one thing you don't want me to forget to follow up on. If you don't have a burning one, no problem. But if you have a burning item that you don't want me to forget, just put it in the chat box.

With that, we will close. Gregg Polk had to go back to the Board of Supervisors meeting, and so I am going to go ahead and close today's session and invite you, again, if you could put in the chat box what is that kind of one word about how you are feeling. If you would like, go ahead and put that burning issue that you don't want us to forget about.

We have recorded this session, so we have a copy of today's session. Thank you so much for attending today's session. I am going to hang out here until folks exit, but thank you, thank you, thank you so much. I appreciate your time and your commitment to this work. Bernice, Pastor Nah is saying great. Bernice feels more connected. Thanks, from Darlesh.

>> RICK PULIDO: Thank you, Dr. Rigo. Excellent. Very educational and good follow-up.

>> RIGO RODRIGUEZ: Thank you, Rick.

>> UNIDENTIFIED SPEAKER: I guess I can say fun. [Laughter]

>> RIGO RODRIGUEZ: Good. [Laughter] Thank you. Informed. I'm hearing today was very fruitful and I would like to follow up on particularly the FSP progress. Carmen feels hopeful. Thank you. Claudia feels – thank you so much for facilitating. This was a great dialogue. La Von feels informed. Paul feels productive, but also wants the data disaggregated by SALT to reconcile the data. Yolanda, what stood out to Yolanda is the incubation academy, outreach to the housing authority, and a request on that.

Then Jean, thank you for the opportunity and all of the work. Grateful to all. Pinki, glad so many of us CLT members were able to attend. Darlesh indicates she is grateful.

[Indiscernible, 03:54:53] Perkins mentioned encouraged. Bianca, it is a good start but let's not forget about the importance of that continuous progress. We do need to stay on this, and please make sure to address the CCP input documentation. That came out loud and clear today. Thank you so much.

Sunnie is feeling moderate. Thank you, Sunnie. I think that refers to the conversation we were just having earlier around mild, moderate. Then La Von, thank you. We are not alone, Pastor Nah is saying. We are also happy to be together.

Thank you, thank you so much, everyone. Have a wonderful rest of your afternoon and wonderful weekend. We will see you later. Thank you so much.

Thank you…. I am going to exit now so that everyone can have permission to go back to the other room in your house. All right. Take care. Thank you to—

[Recording ends at 03:56:00]