

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM MEETING**

Wednesday, May, 18 2011 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA, 90026

REASONS FOR MEETING

1. To provide an update from the County of Los Angeles Department of Mental Health.
 2. To give an update on the State budget.
 3. To discuss recent developments with Health Care Reform (HCR).
 4. To increase understanding of the MHSA outcomes and evaluation framework.
 5. To review SLT 'housekeeping' items.
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MEETING NOTES

I. Reviewed Meeting Agenda and Materials

- A. There were no questions or corrections to the meeting notes from April 20, 2011.

II. Department of Mental Health – Update

- A. Marvin J. Southard, DSW, Director, County of Los Angeles, Department of Mental Health provided an update on governance and the budget.

B. Governance Update

1. How will alcohol, drug, and mental health programs be governed at the state level?
 - a. The State Mental Health Directors proposed to work with the alcohol and drug coordinators to advocate for the formation of a State Department of Behavioral Health. The proposal involved having alcohol, drug, and mental health together in one department, which would report to the agency director.
 - b. An alternative proposal entailed forming alcohol, drug, and mental health programs as sub-departments within the Department of Health Care Services, either together or separate. However, there would be greater opportunity to have a voice if the programs remain together but as a separate department that reports directly to the agency director. Nonetheless, the State administration may view this as an opportunity to consolidate departments and eliminate two existing State departments. The case for a separate Behavioral Health Department at the State level would need to be advocated for.

2. The governance piece is critical because the Department needs the State Mental Health Director to be accessible and not inundated five levels within a department that has no policy-level authority. This representative should have policy level authority in Sacramento, CA, and should also ensure that the State mental health programs operate reasonably well. Incentives should not exist for people to move from county to county to obtain better mental health services. In particular, the representative should be capable of negotiating with the federal government to get a better alcohol and drug benefit in Medicaid. The representative should be someone who has power and authority to voice issues, someone who can look at and present county and Statewide level outcomes.
3. Some of the decision-making authority the State Department of Mental Health had on local programs will likely be devolved to other entities, such as the Oversight and Accountability Commission (OAC) and the Systems Leadership Team (SLT) in Los Angeles County. The decision-making authority structure has not been finalized. The decision-making structure should be collaborative and produce the best opportunities for mental health, wellness and recovery for clients and their families. Therefore, in order to attain the outcomes sought for, collaborating with the alcohol and drug colleagues is essential.

C. Budget Update

1. In regards to the local budget process, the financial books for this fiscal year will close properly. Next year's fiscal outlook is more optimistic due to the fact that the State will be using Proposition 63 funds to fully pay for everything they would otherwise pay for at a lower rate.
2. Regarding the mandate to provide AB 3632 program services, this responsibility will be transferred to school districts by fiscal year 2012-2013. The 2011-2012 fiscal year is a transition year in which Proposition 63 funds (\$98 million) plus Federal IDEA funds would be used to fund the AB 3632 program.
3. California leads the nation in preparation to implement a robust mental health reform program by 2014. Los Angeles County is at the forefront in regards to implementing the 1115 Waiver.

D. Feedback

1. Question: What is the possibility of MHSA funding going to everything in health?
 - a. Response: MHSA rules would not change per se. Actually, if the State DMH were a sub-department within a larger health agency, then the

State DMH voice will likely be less powerful and not necessarily know whom to complain to.

2. Question: Has the task group been working on AB 100 to finalize where the key constituencies would sit?
 - a. Response: The three options include the Bureau of Mental Health Services, a combined independent department, and Public Health. However, Public Health is not a strong department at this point. If an entire public health approach were taken towards behavioral and physical health, it would be in a strong position.
 - b. Response: There were several discussions on this matter in regards to a federal bill that would set up outcome systems across the federal government. At the State level, SB 93 was sent to human services for an initial hearing, which may mandate that the entire Health and Human Services Agency (HHSA) develop an outcome-based system. However, the outcome system may rely heavily on the Children's System of Care and Proposition 63 outcomes, which focus on how programs affect people rather than on the delivery of services and/or process measures. This issue has to be settled by July 1, 2012. By that time, SB 93 should have a chance to move forward.
3. Question: Is LAC-DMH and/or LAC-DHS considering applying for one of the four pilot projects for dual eligibles?
 - a. Response: Yes, Los Angeles County has a task force specifically on this matter. The Department of Public Health may take the lead. In order to qualify, there needs to be a radically different program than what is currently in place. Thus, the alcohol and drug benefit in Medicaid was a prime candidate. SAPC (Substance Abuse Prevention and Control) would take the lead for the health cluster.
4. Question: Will there be a stakeholder process on the dual-eligibles issue?
 - a. Response: The stakeholder process was complicated by the grant writing process, which involved both the County and the State. Since the State currently does not have the capacity to write the grants, the Counties would need to write the grant but the State would submit it. Los Angeles County decided to write the grant.
5. Question: How can clients support the process?
 - a. Response: The Mental Health Directors are asking the same question. Client and family member concerns would be a strong addition. When the venue becomes clear regarding who needs to be talked to, the client leaders will be informed and they can share opinions on that matter.

6. Question: Will the LAC-DMH be applying for the community transformation grant? The federal grant offers an opportunity to fund high priority interests in Los Angeles County.
 - a. Question: Who would be an eligible applicant?
 - i. Response: Los Angeles County would be an eligible applicant. The website will be forwarded for more information.

III. State Budget – Update

A. Susan Rajlal, Legislative Analyst, County of Los Angeles, Department of Mental Health provided an update on the State budget.

1. Currently, there is a \$10.8 billion shortfall in the State budget. The May 2011 budget revise builds on the actions that were taken in March 2011. The one-time redirection of MHSA to pay Los Angeles County DMH for EPSDT and AB 3632 is still in place. Although schools are able to contract with counties to provide AB 3632 programs, ultimately the school will have the responsibility to ensure the AB 3632 program services are provided.
2. The discussions on ‘realignment’ are continuing. These discussions will be contingent on the extension of the State sales tax, personal income tax, and vehicle tax.
3. A new State Department for State Hospitals was created. Healthy Families was merged into Medi-Cal. The State DMH issue continues to be important as far as long-term advocacy and representation. The Department of Health Care Services is unfamiliar with the types of issues that DMH had in the past in regards to audits and advocacy on behalf of Los Angeles County.

B. Feedback

1. Question: How will the AB 3632 program mandate affect children and families? Are schools going to be resistant?
 - a. Response: Schools would like to have more control of the funding and how it is used. If school systems want to provide mental health services, they can still contract with their community providers or with DMH. However, schools will manage the funds.
2. Question: School districts are taking responsibility for providing AB 3632 program services. But is this in the best interest of children?
3. Comment: I have a concern over the checks-and-balances assessment and referrals. The purpose of AB 3632 over 25 years ago was to address the lack of mental health services in the schools. The responsibility for identifying, assessing, referring, and determining what services are available creates a fiscal incentive for school to do less rather than more. Checks and balances were needed to ensure that there was oversight,

particularly with referrals. When schools realized that they were going to be responsible for the services, schools stopped making referrals.

4. Comment: Schools may find themselves unable to fund the provision of services and may keep children from getting any services at all. Families want mental health experts for their children.
5. Question: Beyond the fiscal responsibility, does the issue include the capacity of schools to deliver services?
6. Comment: The primary issue was fiscal responsibility. The language implies that DMH had been delivering rich but 'unnecessary' services. Schools will presumably ensure that students receive services that reflect the educational needs of the students.
7. Comment: The opportunities and risks will be in the details of the checks and balances that will be built in the final stages. If schools think they can abolish services, then they will spend a lot of money in court.
8. Comment: Los Angeles Unified School District (LAUSD) wants to implement its own program. The challenge will lie in the negotiation and transition process and finding out what the other school districts in Los Angeles County want to do. Nonetheless, DMH will do what is best for the children and their families.
9. Question: How will schools be held accountable?
 - a. Response: The partnerships that operated in Los Angeles have been robust. LAUSD may want to use the AB 3632 mandate to stabilize the school system and integrate services better than what had been done before.
10. Question: Will schools receive additional funds?
 - a. Response: Yes.
11. Question: When mental health was under health services, mental health was not getting anything done. So, why go back to that system?
 - a. Response: The problem was at the state level, not the county level.
12. Question: What will happen to the California Mental Health Planning Council (CMHPC) now that the State DMH was eliminated?
 - a. Response: The CMHPC would have a larger role in the revision of MHSA Plans. However, there was uncertainty around which entity CMHPC will be attached to.
13. Question: I am concerned with school districts having control of the AB3632 money and being the determining factor on whether or not

children receive services. How will the disability and educational rights laws play into determining how this money is spent?

- a. Response: The defining law is the IDEA. The federal law states that every child has the right to a free and public education. Any services that children need in order to make use of the free public education would need to be provided, which may include special education, interpretation and mental health, among many others. Due to the FAPE (Free and Appropriate Public Education), each State has the responsibility of providing children in public schools with mental health services to make good use of their education.
 - b. Response: California is the only state in which the responsibility to provide mental health services is not at a statewide level. Therefore, the transfer would move California in the same position as the other 49 states, where the state administration is responsible for fulfilling the legal obligation.
14. Comment: Children need to get Individualized Education Plans (IEPs), and mental health is part of that plan. Children need to get IEPs and receive the services they need.
 15. Question: Can a better system be created through the schools? Is there a countywide planning process? Is the school going to lead a process that creates a system that works at the school level? Does the SLT have a role?
 - a. Response: The process will not involve a local decision-making issue. The legislature will manage the operational decisions statewide. The SLT may be useful in helping think through the management of the transition. Schools are represented on the SLT.
 16. Comment: LAUSD has a planning group that has met for the last several months. The planning group is available to listen to community and educational concerns.
 17. Question: Is there a law that holds school districts accountable? Is this responsibility part of the Single Plan for Student Achievement (SPSA)?
 - a. Response: LAUSD may have known this was happening before anyone else and planned for something that came as a surprise to the mental health directors. Possibly, LAUSD had leverage to be included in the early development discussions. The Department is interested in understanding what the next steps are. In particular, what the Department learns from this transition can be applied to other school districts.
 18. Comment: There are two models being considered. In the first one, the school districts would take over responsibility and provide the program services through a combination of contracted providers. In the other model, the schools would mainly use the County to provide the AB 3632 program

services until the infrastructure is set in the schools. Some school districts, such as LAUSD and Long Beach Unified (LBUSD), have a robust infrastructure and may be able to take over fairly soon. Other school districts do not have an infrastructure and may devise different models. Both models would get articulated promptly in order to have a meaningful dialogue that would not leave children and families out of the decision-making process.

19. Comment: Obviously, this issue sparked energy in the SLT. If there is interest in this topic, additional time can be allocated after the meeting to identify a key set of issues.

IV. Health Care Reform – Update

- A. Marvin J. Southard, DSW, Director, County of Los Angeles, Department of Mental Health, provided an update on health care reform.
 1. Addressing the needs of Tier 2 clients was the main issue for health care reform. Tier 2 clients need more services than the medication provided by primary care, but have not yet been disabled by their mental illness. The low-income health plan creates an opportunity to provide services until 2014 for Tier 2 population, with 50 percent federal match.
 2. Los Angeles County has funds to invest in the low-income health plan. Los Angeles County has provided services for individuals enrolled in Healthy Way LA, which is Los Angeles' version of the low-income health plan. However, the billing process was unknown. Nonetheless, there was money for services that were already provided, which would be reimbursed at 50 percent. We need to invest to expand and improve care.
 3. Care for the Tier 2 population would be improved and expanded in three different ways. First, there would be an expansion of DMH co-located staff at the comprehensive health clinics run by the Department of Health Services. Moreover, DMH co-located staff may also be expanded to specialty clinics that operate out of county hospitals. Secondly, partnerships that provide funding to community mental health agency partners would be encouraged to link up with primary health care clinics and provide Tier 2 services at the primary health care clinic site. Third, by funding the primary health care clinics, staff can be hired to provide Tier 2 services. The *Impact Model* was envisioned for Tier 2 services. A training contract with the University of Washington was established. The Board approved the training and it will be available to community agencies, primary health care clinics, and DMH staff by July 1, 2011.

4. The details over the billing process need to be worked out. The billing process was complicated by primary health care clinics, such as the FQHC's specific rates. The Department does not want to be in the position where it will pay two different rates for a similar service. Additionally, there were other details that needed to be worked out, such as charters, consent, and others.

B. Feedback

1. Question: Can the expansion of health care be clarified, particularly as it relates to children? What definitions will the State adopt pertaining to the essential services that were to be covered under the expanded Medicaid benefit? Would the State pay for all the essential services under the expanded Medicaid benefit?
 - a. Response: Children have not been the focus for Medicaid because the incremental difference is the SCHIP population.
2. Question: Would an incentive be created for the State to not adopt the Medi-Cal benefit? Is the issue being dealt by anyone within the mental health director's community?
 - a. Response: Yes, the issue is on the radar. Part of the solution would be in the negotiation of a benefit package that makes sense in a managed care environment. On the adult side, the Department was in a better negotiation position because the data were clear. In particular, if mental health and substance abuse services were provided to adults, there would be radical savings in other parts of the health care system. However, the cost savings data associated with providing children's mental health services was unknown. The shape of the expanded benefit was also unknown. However, it will resemble SCHIP.
3. Question: Can the SLT provide feedback on the *Impact Model*?
 - a. Response: Unfortunately, not at this time. The *Impact Model* has a registry by which to measure outcomes for both the physical health and mental health sides. The data will be tracked to see if it works. Something else will be done if it does not work.
4. Question: In terms of outcomes, would the *Impact Model* be looked at?
 - a. Response: Since the *Impact Model* requires the collection of data, it allows the opportunity to take a robust look at it.
5. Question: What role will the SLT have on this matter?
 - a. Response: The outcome data will be sent to the SLT as part of the public review process.
6. Question: Is there a 30-day mandate to receive services through the 1115 Waiver? If so, why is there not a corresponding mandate for individuals who

have Medi-Cal? I am concerned that a stretched system may not be prioritizing individuals who are seriously ill.

- a. Response: There was ambiguity about the entity responsible for providing Tier 2 services for the SPD (Seniors and Persons with Disabilities) population.
7. Question: Is there a mandate for electronic records with the health care reform?
 - a. Response: The Board will submit a letter to award a contract for the electronic medical record for the public mental health system in Los Angeles County. However, training staff on how to use the electronic records may take a couple of years.
 8. Question: Besides the integrated care model, what was the status of the other model that was discussed in the MHSA INN plan?
 - a. Answer: A decision point may come to the SLT next month. Contracts were on the verge of being awarded. The amount of contracts awarded and the timing may depend on the time limits for reversion of INN money under MHSA.
 9. Comment: Two contradicting interpretations were stated regarding the reversion of INN money. On one side, the reversion would take place at the end of 2012-2013. On the other, reversion would not happen. Los Angeles County will plan as if reversion were a possibility. If reversion does not happen, Los Angeles County will use funds to continue to do whatever produces the best outcome for that population.
 10. Question: Is there an update on the status of the INN Plan process?
 - a. Response: The mobile health clinic review has been completed. The ISM review team continues to complete their reviews. Some panels have completed the informed averaging of scores for some SOWSs. The ISMs should be completed by mid June.
 - b. Response: In regards to the integrated clinic model, the reviews should be complete in a couple of weeks. In regards to the peer-run model, contracts were being worked out and revisions to the RFS will be sent to County Council.

V. Understanding MHSA Outcomes: Presentation/Discussion

A. Debbie Innes-Gomberg, Ph.D., Implementation Unit, County of Los Angeles, Department of Mental Health, provided a presentation on MHSA outcomes. For additional information, please refer to the PowerPoint slides titled, "Improving Client Service Capacity and Quality of Flow ICSC Pilot Project."

B. Feedback

1. Question: What does *MORS* stand for?
 - a. Response: Milestones of Recovery.
2. Question: What is length of service?
 - a. Response: Length of service refers to the length of time a client has been in FCCS, FSP, and Wellness. However, the metric has not shown a great deal of information yet. There is no mechanism in the metric to identify transitions. For example, if there are individuals that have not been discharged from the IS system because they continue receiving few services, such as through peer support, service extenders, or community resources, the transition metric is not visible. Some of the rules developed may not be appropriate when thinking of integration.
3. Question: Would individuals discharged from an FCCS or FSP who later return be considered new clients? How are these individuals labeled?
 - a. Response: Although it may vary across agencies, new clients refer to individuals that have not been in the system before. For instance, a new client could mean someone that was transferred or referred by another agency. In other words, they could have been in the IS system at some point but not in our system before.
 - b. Response: To clarify, there is a difference between new clients to the system as opposed to the agency.
4. Comment: In specific, there are more similarities than differences with the adult population, which are over 90% new clients.
 - a. Response: Potentially, it may entail clients who are new to the system as opposed to the agency.
 - b. Response: The issue would be investigated. There were three service providers. The issue may be that a client is underserved and the intention was to be flexible.
5. Question: Why would the transition total not include individuals that transitioned into the community and for whom the goals were met? What is the difference?
 - a. Response: First, transitions within the mental health system were intended to lower levels of service. Second, transitions into communities.
6. Question: Are the clients completely out of the system as opposed to transitioning to a lower level of care within the system?
 - a. Response: Exactly.
7. Question: What is the period of time?
 - a. Response: The project started in February/March of 2010 and this information was from three weeks ago.

8. Question: Is this the data for the whole program including all of FCCS and FSP?
 - a. Response: No, the data is for the four providers associated with the project.

9. Question: Are the transitions a subset of new clients? Are the client transitions that met goals a subset of all transitions?
 - a. Response: No, transitions were separate. Transitions that met goals related to the percentage of clients that transitioned within the mental health system. Transitions into the community represented clients who transitioned from the mental health system to the community.

10. Question: After individuals transition back into the community, for how long does the Department follow up?
 - a. Response: Three months.

11. Question: What happens after the three months?
 - a. Response: These types of improvements would require more resources.

12. Comment: How will long-term issues be addressed?
 - a. Response: As part of the project, there was a suggestion to start looking at clients who transitioned 12 months ago.

13. Comment: A successful story of an individual in an FSP was shared.

14. Question: In regards to the appropriate mix of staff, does that include cultural matching, such as language and so on?
 - a. Response: Absolutely.

15. Question: Is there data on the amount of individuals who transitioned but require additional services?
 - a. Response: Yes, the data was tracked. For example, if providers took the risk to transition individuals to a lower level of service and it did not work; providers must have the capacity to bring them back to a higher level of service. Flexibility was created through working with the adult system of care, which took the lead on changing some of the protocols.

16. Question: What does DIY stand for?
 - a. Response: Do It Yourself.

17. Comment: The development of a statistical data program with the SAAC as the venue in which programs are able to present quality improvement data and obtain ideas on how to improve was implied.

18. Question: If resources were available, would it be a good idea? Are there resources to support that in Los Angeles?
 - a. Response: AB 100 reduces that share of the State administration from 5 to 3 ½ percent of MHSA funds. However, the amount that is now dedicated to the State administration is about \$4 million shy of the 3 ½ percent. What is going to happen to the \$4 million? Should some of the \$4 million be dedicated to produce the evaluative structures that are needed? These discussions would happen in the next months.
19. Comment: A suggestion was made to bridge both responses.
20. Comment: First, there have been discussions with the Joint Powers Authority leadership about doing a joint project with the Joint Powers Authority in the OAC and CHMDA. Building a good structure would not take a lot from each county. Second, the CHMDA executive's counterpart is concerned about the outcome system on ADPA. The suggestion was made to interrelate the outcome systems. The desire to merge ADPA and DMH into a single department of community services was suggested. ADPA does not have a State commission that concentrates on evaluation. Therefore, having OAC's charter expanded to address the evaluation issue was recommended. Building the collaboration will be essential. SB 893 was pulled from the government reform committee and moved to the human services committee. SB 893 would mandate a single evaluative structure and framework for all of human health and services by the end of 2012. The bill is important because the mental health system needs to have employment and housing outcomes. An integrated set of outcomes was needed.
21. Question: Are all the clients asked the questions in six months?
 - a. Response: Correct, all the clients in FCCS.
22. Question: In what setting are clients asked whether they are satisfied with their living arrangements?
 - a. Response: The various settings may include Starbucks, the board and care, parks, clinics, and others.
23. Comment: Clients should not be asked if they are satisfied with their living arrangements while still living in the board and care.
24. Question: Who were the faculty experts?
 - a. Response: The faculty experts included Keris Myrick, Steve Wilson, and Connie Davis.
25. Question: Are the faculty experts in the field of mental health?
 - a. Response: Some faculty members are associated with physical health.

26. Question: Eliminating the barriers between FSP, FCCS, and Wellness Centers in order for clients to have individualized planning and client driven care with maximum flexibility was recommended.
 - a. Response: This will be taken to the Executive Management Team next Tuesday, May 24, 2011.
27. Question: Is the analysis specifically looking to understand why the transitions were not successful?
 - a. Response: That needs to be done.
28. Comment: MHSA funding has been an extraordinary value in making the Los Angeles City Housing Department competitive for State funding. The Los Angeles City Housing Department has been able to fund significantly more housing units for homeless individuals due to MHSA being part of the system.
29. Question: Are *MORS* scores being used to look at housing health outcomes? Are the housing health outcomes being achieved? How can housing health outcomes improve? The evaluation criteria and how to integrate it into the system was underscored.
30. Question: What tools are used to measure the cultural relevancy of services? How is outcome data captured for children and youth in the juvenile justice and foster care system?
 - a. Response: Dedicating an entire SLT meeting around these issues was recommended.
31. Question: In regards to the three-month follow-up of transitioned clients, would there be work done to follow up for 12 months?
 - a. Response: Yes.
32. Question: Can the conversation include health and substance abuse individuals?
33. Question: Can peers collect the data? Can capacity be expanded through the use of peers?
34. Question: The culture in the clinics and in the SLT is completely different. How can the organizational culture be changed?
35. Question: Using peer advocates was a great idea. However, the lack of cultural acceptance was a roadblock. How will the culture be changed?
 - a. Response: The idea was to implement this in the SAACs, county-to-county, and provider-to-provider.
36. Comment: The data on the deaf populations is often buried and lost underneath general data. The data needs to be separated and analyzed.

37. Comment: A book that looks at different quality indicators would be shared at a future date.
38. Question: How can culture and ethnicity be incorporated in a meaningful way? A presentation on cultural competency was suggested. The learning that derives out of the integrated manager model for INN would be critical in terms of moving forward with specific ethnic populations.
39. Comment: A concern over API providers and the Alliance was shared.
40. Question: The barriers were related to the finding that there were more similarities than differences in terms of FSP and FCCS. Would it help if FCCS clients could be considered for FSP?
41. Comment: The system should be modified to be flexible and avoid pigeonholing people into the program.
42. Question: How can different elements of data be relocated so it can be managed? A powerful learning from the ICSC project related to the use of *MORS* scores to think about service trajectory.
43. Comment: The suggestion to use peers for data collection was compelling. The self-management strategies from the ICSC project were good.
44. Comment: In regards to transformation, clients felt as if they were dragged and that their voice was not heard. The use of engagement strategies, partnerships, providing and using data for quality improvement would be critical.
45. Comment: A crisis is a good time for change. Organizational cultures will need to change. A recommendation to use data to change the culture of organization in a way that serves clients and families better.

VI. SLT Housekeeping Items

A. SAAC Liaisons

1. Cynthia Jackson volunteered to be the liaison for SAAC 3.

VII. Public Comments & Announcements

- A. An announcement about AB 100 was made.
- B. An announcement about a support group meeting date was made. The month of May was Mental Health Month. Flyers were available upon request.

- C. An announcement regarding the *Walk for Life* in Glendale, CA was made.
- D. Flyers were available for *Community of Friends* in Panorama City.
- E. A moment of silence was held for Dr. Southard's mother, Mrs. Elsie Southard, who recently passed away.

VIII. Meeting Adjourned at 12:30 PM.