COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, January 16, 2013 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90010

REASONS FOR MEETING

1. To give an update from the County of Los Angeles Department of Mental Health.
2. To give an update on State budget, legislative, and related issues.
3. To report on action items from prior SLT meetings.
4. To discuss principles for the coverage of behavioral health for Medicaid Expansion and Health Exchange covered individuals.
5. To obtain feedback on proposed outcomes and measures for the data dashboard.
6. To finalize the members of the SLT agenda design team.

MEETING NOTES

Department of Mental Health - Update	Dr. Roderick Shaner, M.D., Medical Director, County of Los Angeles, Department of Mental Health 1. Dr Shaner, speaking on behalf of Dr. Southard, provided updates to the SLT regarding the Department's continued tracking of the ongoing national discussions on gun violence as it pertains to mental health, proposals for LPS reform, preparation for 2014 implementation of the Affordable Care Act –particularly as it relates to the expansion of MediCaid coverage and the challenges related to integration of services. In addition, Dr. Shaner discussed two integration initiatives: Dual Eligible's Project and Healthy Way LA. Finally, he provided an update on the Department's implementation of an electronic health record (IBHIS), the AB 109 program, emergency room crowding and people on 5150's, and the Innovation component of the MHSA. **Feedback** A. **Comment**: Four items in President Obama's executive orders address how gun violence relates to mental health and substance disorders. Item 20 relates a letter to state health officials clarifying the scope of mental health services that MediCaid plans must cover. Item 21 relates to regulations clarifying essential health benefits within Affordable Care Act changes. Item 22; committed to finalizing mental health parity regulations and Item 23, launching a national dialogue led by Security and Duncan on mental health. **Response:** Thank you. The four items are good for us. We just have to follow it. B. **Comment:** Will there be a registry of people diagnosed with psychiatric disorders; similar to that of sex offenders? C. **Comment:** There is an opportunity for education and misinformation. The community I am building housing around is opposed to a project in south Los Angeles. We start construction in two months and a community member asked how I will deal with the mental health and the gun control issue. What will we do about security? We need to address those types of

	feelings and information. D. **Question:** Housing is important for people coming out of prison and back to the county. We need to analyze how many resources we can afford to put into fighting stigma in the community. There is already a perception that all people with mental disabilities are dangerous. Add to that that the people coming out of prison and we have a lot of work to do. **Response:** We did a good job over the last 10 years impressing on our communities that people with mental illness who commit crimes do not belong in jail. As these people come back into superior court 95, and get remanded to us for care, the amount of resources put into combating stigmas becomes a critical question to address. E. **Comment:** Instead of carving out mental health dollars it seems that those dollars need to be put back together with health dollars to facilitate integration. **Response:** Right now, nobody is inclined to do that. It is a good thing for a couple of reasons. Places that tried had problems. For example, in LA Care and Health Net, each have a sub-contract to a behavioral health carve out. The carve out serves a purpose. We should make efforts to preserve it with the understanding that we are building an integrated health system. Eventually, carving out may no longer be necessary, because we are unified enough to fully blend funding streams. F. **Question:** You talked about the LPS issues, integration; and interpretation. Does that include the interpretation of grave disability? **Response:** DMH convened a non-partisan group to analyze the 14 broad recommendations the LPS Reform Task Force put out in Los Angeles County. Various organizations assiduously read and were impacted by the materials. One key area with potential impact with a few changes in wording is 'grave disability.' The current changes in 5150 do not pertain to the definition of grave disability or the finding of probable cause. They are more technical about when 72 hour detention starts and where and who can hold people in custody. G. **Comment:** The deaf and hard of hearing inmates in the prison and jail system are a uniquely underserved population. Many try to get basic medical care. Mental health care is impossible to get. When they do they see a regular psychologist or therapist who does not understand their culture and often really mess up the cases too. Please do not forget them. **Response:** Los Angeles saw 10,000 people coming out of jail last year and witnessed the gaps in health and mental health services. We are trying to address it and have a newly appointed chief for jail services, Steve Shea, MD.. He is very good and committed. The Department of Justice feels that we are making progress in our outreach area. H. **Comment:** What is LPS? a. **Response:** Lanterman, Petris, Short were assembly representatives in California in 1967 and '68 who were interested in mental health law. The whole corpus of mental health law in California is their initials. But when people say LPS it is short hand for California mental health law. LPS, just read: mental health law in California.
State Budget, Legislation &	*Susan Rajlal, Legislative Analyst,* County of Los Angeles, Department of Mental Health

Related Issues - Update	1. When Vice President Biden put together his committees to look at improving response in the wake of the Sandy Hook incident, Senator Steinberg sent a letter urging him to look at our work with MHSA in California as a national model. Many of the outcomes that he bases the information on are from Los Angeles County. We have done well demonstrating our outcomes. 2. I want to clarify information regarding the health benefit exchange --Covered California. Several people were confused about the exchange and input process. The health benefit exchange is a state organization. You can give input by going to their website or writing a letter. 3. If you want to write letters about health care reform you can write to the health sub committees. On the handout are addresses for the senate and the assembly health subcommittee. Every LA member has 4 stars by their name. We have a special interest in contacting those people. , The best way to get a letter to this group is sending it to this address. If a letter goes to the chair of that committee, that staff makes a copy and circulates it to everybody on that subcommittee. That way it gets the attention it deserves. 4. The special session on health care reform was to start in December. It did not. Yesterday, I called the staff for the senate subcommittee on health and asked for a timetable. The governor said last week that he plans to call it toward the end of the month. We are still waiting to see the format. For example, is it going to be several days of hearings broken down into different areas? 5. In Los Angeles County, we developed priorities for any health care reform we make. Those priorities are guiding principles. We must be ready by this time next year because it is all in the regulations and policies and procedures that we put together. The infrastructure, how we will make these things happen. This year is going to be intense in that regard. 6. Last year's pending bills related to health care reform were not signed by the governor. He wanted more dialogue. You will notice in the budget last week there was no direct hit on mental health for the first time in years. The governor said in preparing for health care reform there were two options. 7. One option is that the state takes the lead on health care reform. If the state leads then counties would give some realignment funding back to the state. Last year when we realigned funds to the counties we said that if we did not get sufficient funding we could not accept that responsibility. Any change means that we need to receive more funding–not 'take aways.' 8. The second suggestion is that counties manage it all. At the CMHDA's director's meeting we discussed implications and asked, 'what does that mean?' The State negotiates whatever contracts they have with the federal government. The counties might be negotiating their own contract. For a county like LA we probably could handle it. 9. Smaller counties are barely making it and cannot assume an extra burden. Additionally, we submit our billing through the state to the federal government. If the state assumed that role, it means building another piece of infrastructure that we do

	not have. 10. It could be very complicated if the counties took over everything. At the same time, I do not think any of us are willing to give up realignment funding. 11. Right now, in looking at the bills that are already place marked in the mental health area, there are several related to gun control issues and involving mental health clients. We are still waiting for the health care reform bills to be introduced. 12. The IMD rates we froze several years ago have lapsed. The IMDs received cost of living increases when no other provider in the system was able to in years. IMD's are getting automatic increases with the law as it is now while everyone tries to learn how to do more with less. We are working with CMHDA introduce a bill to fix the IMD rate problem. 13. The health care reform bills are going to be critical in implementing reform. We need to make sure that the benefits are adequate. As it is rolled out, current providers in the system, the private provider community, as well as the county providers, must have expertise in this area. Parity is a big deal. It impacts lots of technical details. We need to be very vigilant and make sure that we are vocal.
Follow Up Items: Prior SLT Meetings - Update	***Debbie-Innes-Gomberg, Ph.D., MHSA Implementation Unit,*** **County of Los Angeles, Department of Mental Health** 1. During our last meeting, we discussed the crossover proposal that was an addendum to our annual update for 2013. We posted that for 30 days, which ended on the 12th on January. We received no public comments and will write it into our annual update as an addendum and then repost it on our website for future reference. We will include the substantial questions and answers from the SLT minutes. 2. I want to address issues that are multi systemic --involving multiple departments and entities. Moving into health care reform and 2014, we need to think about the multiple entities that need to be at the table for information and planning. Many are represented here in the SLT, but more multiple entities will be impacting the Mental Health Services Act in the future. 3. Earlier, Dr. Shaner reported on some of the issues around stigma and discrimination. We have an internal implementation meeting for MHSA twice a month and had Ann Colantine and Sarah Brickler from the California Mental Health Services Authority (CalMHSA) come talk about PEI statewide projects. Many statewide projects are impacting LA. We want Sarah Brickler, Anne Collantine, and Stephanie Welch, of CalMHSA, to present to the SLT in April on the PEI statewide projects. 4. We also want to hear from the Emergency Outreach Bureau on their Start Program. The Start Program is funded with PEI early start dollars and is an incredible resource to K through 12 and the university system to reduce violence in schools. 5. Preparing for the 2013-14 MHSA Annual Update. Based on feedback from last year and guidance from the Mental Health Commission, we are focusing on getting information out to Service Areas so they can present it to their SAACS and then get

information back to us.

6. On January 10th, I presented to the Mental Health Commission's executive committee, the SAAC chairs, and Service Area District Chiefs or their staff. We want to present data at an age group level, but also at a Service Area level. We want to discuss 'how do the outcomes for a particular program compare with the outcomes a year prior' and information along those lines.

7. On February 20th, you will see the presentation. It will evolve because we have more information than we did during my initial presentation. On February 27th, I will present highlights of the Annual Update to the Mental Health Commission. On March 2nd, we post the Annual Update for 30 days. On April 18th we have the public hearing.

8. What is different this year is that then once the Mental Health Commission adopts the annual update we send it to the Board of Supervisors for adoption. Within 30 days of that happening we send it to the Mental Health Services Oversight and Accountability Commission.

Feedback

A. **Comment:** Terri Lewis, the Executive for our Mental Health Commission who is now an appointment to the state mental health planning council can probably help with coordination between county and state. I think we are really way ahead and believe that the county should do more to recognize her uniqueness and contribution to mental health planning in this county.

   Response: Thank you. The Mental Health Planning Council is one that we do not often call upon. But we will call upon Terri. The PEI statewide projects are suicide prevention, stigma and discrimination reduction and school mental health.

B. **Question:** Could you characterize what has happened in Sacramento over the last couple of years in terms of the Health Department in its relationship to mental health, the direction of mental health in the state, and the quality of communication?

   a. **Response:** Vanessa Baird is the Deputy Director of the Department of Health Care Services is still recruiting her mental health and substance abuse deputies.

   b. **Response:** 6 months ago the DHCS contracted with the California institute for Mental Health--to develop a business plan. There were recommendations that mirrored our recommendations locally particularly in terms of different work groups and a plan to move forward a mental health agenda within DHCS. We are trying to work very closely with DHCS. I say 'we' via the various entities I mentioned: CMHDA, the OAC, as well as the CCCMHA.

C. **Comment:** Vanessa Baird is in this position but needs to be confirmed by the Senate. The biggest thing that a health service has to do is get away from the mindset of widgets. They have done a lot of billing and compliance and widget counting. We are going to focus more on outcomes as we go down the line. I had a meeting in Sacramento with Health and Human

	Services Agency, which has oversight of general evaluation approaches and they are not very clear as to what needs to happen yet. The example has been set in Los Angeles, which has been exceptionally good, and will get rolled out at the state level.
Principles for Coverage of Behavioral Health – Feedback	N/A
Dashboard: Outcomes and Measures	***Debbie-Innes-Gomberg, Ph.D., MHSA Implementation Unit,*** **County of Los Angeles, Department of Mental Health** For additional information, please refer to the DMH Data Dashboard PowerPoint, **Feedback** A. **Question:** Regarding the wellness slide, how do these coincide with the domains for wrap around? Where do education, and abuse fit? **Response:** We will discuss the domains later in the presentation. For example, education fits in meaningful use of time. Safe and stable housing is where abuse fits in. During the table discussions you will comment on 'does this look like a good first attempt or do we leave things out?' B. **Question:** With the physical health world behind on outcome measurement is there movement to standardize? Is there a similar movement on a national level in relation to mental health, and if so, how do these play into that? **Response:** At the state level we are trying to create common measures across counties. A strict statewide approach is probably not going to work for small counties or a county as large as LA. We are trying to calibrate measures that might be different but similar enough that they map out to a common domain or area of interest. Several groups including CMHDA, the OAC and its evaluation committee are looking at that. The planning council and CMIH have a role as well. **Response:** We are in the process of harmonizing this with NOMS, the national outcome measurement system or standards, run out of SAMSA. Physical health does not understand this total health outcome system but they will get there with health reform. We do need one system nationwide which has similar outcomes so that we can do cross state comparisons and cross population comparisons. C. **Comment:** We are going to have a lot of people moving between the insured system and the MediCal system as jobs change and as circumstances change. We are going to need real flexibility between these systems. D. **Comment:** From the physical health side I am concerned about the independent development of the mental health EHR when there are so many physical health products that get market share. The flexibility between those systems is essential to managing the whole health approach. We need to make sure that these indicators are easily captured in a physical health EHR as well as the mental health one. **Response:** I agree. There are efforts that may test parts of what you just said. The types of questions you are asking

came up in our work group. We are focusing on is what DMH is collecting right now. It will take awhile for the state and federal direction to occur and for counties to determine how they are addressing that. We are initiating this process, and perhaps LA can influence the state.

E. **Question:** Do you envision any use of a subset of the measures to track over time whether the profile of clients in the public and private systems for adverse selection into the public system. For example people who are more likely not to have house, having a greater likelihood of substance abuse problems etc, that become higher cost selectively over time, higher cost patients coming into the public system rather than into private providers?
   Response: That's a wonderful question and goes a little bit into social determinants of health. I would like to talk to you more about that because I think it will be increasingly important.

F. **Question:** Have you considered out of home placement for children because of either foster placement or group home placement. (under outcome 4)
   Response: I am going to note that. Please talk about it at your table.

G. **Question:** Does that appear as a measure under FSP or FCCS whether or not there was an out of home placement for the child?
   Response: For FSP it is under living arrangements. You could look at group home involvement or you at clients not living with family members. I could check to see if there is a specific question around out of home placement.

H. **Question:** This outcome is only specific to families for outcome number 5?
   Response: Yes. It is a nuanced question because the client is the identified individual but it was in the context of a family.

I. **Question:** 'Strong Families', number 2: 'Is the client living arrangement suitable?' Who decides what is suitable?
   Response: It is not unilateral. It is usually the client. But if the therapist or the team, in FSP for example, they may push back a little bit but it is usually the client.

J. **Question:** With children, 0-15, even 16 and 17, they are still under the control of their parents or caregivers. Who makes the decision? I love what is being done--but I am having a very hard time with judgment. Some of these questions are judgmental. It depends on who is making the decisions.
   Response: That is part of the data agenda. For example, Jim O'Connell reminded us about the quality of data collection, including the self-reporting issue. If you look at point 5 under our data agenda it is a continuous effort to go back to each of these measures that we select so that the quality of that is clear including these questions of who makes that decision and how do these decisions get made. That was noted as part of the process and moving forward around each of these measures that is selected.

K. **Comment:** Just last week, a national study pointed out the contradiction. The thought that children up to TAY (transition age youth) were not getting therapy. It found that most of the kids who committed suicide had therapy, many, for at least a year. Their findings are that the methods we use for therapy are ineffective and need to be looked at.

L. **Question:** In terms of the definition of suicide, will the measure also capture self destructive behavior or murder by police officers because in a suicide by police officers puts themselves at a risk that ultimately will end in their demise?

Response: The program will assess for that, but it is not a measure that is reported for FSP or FCCS. One of the things you can do when you talk amongst yourselves and make recommendations is, 'is decreased suicide the right domain?' Do we want to look at it more broadly? Suicide is the ultimate thing but there may be parasuicidal behaviors that we want to take a look at.

M. **Question:** So if 4 includes volunteering, what does 5 mean by involvement in the community? What are some things that are contemplated by involvement in the community?

Response: It is what the client defines. They may go to a yoga class, or go to Starbucks every morning with a group of people that goes at the same time. They play softball at the park. It is broad.

N. **Question:** Number 3, 'is the client obese?' Does this also include the fact that some medication increases the weight on some clients. How is that measured because an individual may be large because of consumption of calories or whether it is because of medication?

a. **Response:** There is no distinction made. It is literally obesity and it is to no one's fault. Martha Long used to make this point a lot and that's the medications create syndromes that are very hard to control and you should not blame folks for that. We want to address the issue of weight if it is possible. There were a lot of feelings around that.

Group Discussion

Responding to questions 1 – 8 domains

A. **Comment:** Gun Control outcome 8: safe and stable housing. I believe there must be a need for gun control in America. There were incidents related to this problem. Usually they blame mentally disabled people right away. How can you help on behalf of SLT?

Response: That issue was brought up earlier today around how the focus on gun violence and that the overlap with mental health is now creating pressures at the local level around housing.

B. **Comment:** The one comment directed toward the overview was the circle strong families. The thought was that families was too narrow looking across ages. Families are important for adults too. We would eliminate 'preserve children in families' because you want strong families for adults. The suggestion was that we talk about support systems or support networks of which the family is a key support system or network.

C. **Comment:** Our table had a very spirited discussion on the emotional well being outcome. The biggest concern is that, there are not a lot of measures for that; and it is going to be subjective, and based on self reporting on whether or not that is valid. There was concern that you cannot derive data that is only self reporting. Some believe that self reporting is the only valid measure for this particular outcome.

D. **Comment:** Except preverbal or limited verbal (children).

E. **Comment:** We also want to have the family and providers' input into that too to make sure that, by society standards, a meaningful use of time is occurring. I have come across a field of psychology called positive psychology. I think that is going to provide us with perhaps a better framework than what we are looking at right now.

F. **Comment:** We discussed outcome 8: safe and stable housing. Is the client's current living arrangement suitable? Is your family stigmatizing you or bothering you? Is the client's current living arrangement free from abuse and neglect? Well that really should be the answer for number 1. Is the client being taught life skills to maintain their apartment correctly? Is the client satisfied with their current living arrangements?

G. **Comment:** (Question 1) The other area that people talked under kids and families; financial indicators. There was no attention to any spiritual domains. Harm reduction is an issue in both substance issues and emotional well-being, partly because we are looking for progress not just static answers.

H. **Comment:** The key data that we think is necessary across the different specific domains is self-reporting data. It was emphasized that the qualitative nature of what's going on can best be captured by developing a self-report for inclusin with the harder data.

I. **Comment:** The effects of the isolation of deaf children in their families when the parents are not able to sign so they grow up not being able to communicate with their families. In general, the issue of disability and how that affects wellness. We think that we could ask the living arrangement questions under housing and put some other questions more reflective of strong families in number 5.

J. **Comment:** For the last one, the stable housing, there is no measurement on whether or not they are paying a disproportionate amount of their income for rent.

K. **Comment:** There was a suggestion made that in all of the different measure that we separate adults from children and youth across measures; to look at them separately.

L. **Comment:** On the freedom from addictions issue from the beginning; living with an addicted person rather than just the client being addicted with children and the issues around other addictions: sexual, gambling. We do not do anything other than substance abuse right now. We do not do prescription drugs or count those.

M. **Comment:** There is a need for continuing monitoring of the data quality as being consistent within an agency over time and between agencies over time in order for it to be valid for comparison and selection purposes

Synopsis of Table Discussions

****These notes are transcribed from table worksheets and Ad Hoc Committee feedback on the small group discussions they participated in.

	A. The response was quite favorable in general. B. Big Picture –changing label "families" to "Supportive families." Try not single out children when measures apply equally to adults. C. Emotional well-being: Need self-reported quality of life measures. Rely on how patients think they are feeling. Including more self reported data is important to process of data collection. D. Another suggestion for a new domain (bubble): Something about how people are "maintaining wellness." Wellness includes not only current stage but the future as well. E. Under outcome 2: add a measure about having financial health/ adequate health. F. General point made: like to see the same number of objective and subjective measures for balance of quantitative and qualitative analysis. Need more subjective measures to balance out. G. How do we use the data? H. Important to highlight in the introduction of the dashboard. The data does not necessarily translate across all cultures. Data measures may mean different to different groups. Particularly important to note that there is no discussion of how to change to meet cultural contexts. I. Group provided some suggestions on how to separate youth and older adult data. J. Looking at employment –some in group were concerned that employment might not be an adequate indicator because it's

based on external factors. For example, if bad economy then employment down all around.

K. More measures regarding the outcome of treatment.

L. Measures are not sufficiently culturally sensitive. They suggested to add a sentence or two to take care of cultural differences among the respondents.

M. Complex discussion, it took time for the group to understand and accept the parameters and restrictions the work group was operating under, the discussion became productive.

N. Concern expressed about what this dashboard would be used for given the limitations of the measures that FSP and FCCS provide. There was a little distrust that the dashboard will be used to make decisions when some questioned the data to begin with.

O. Ad Hoc members noted that dashboard is designed to help the SLT spot trouble areas and chart progress. There is access to more data if the dashboard indicators show an area that is not doing well.

P. There was a strong feeling that the dashboard could be strengthened if more outcomes weree broken down by age groups, especially for emotional well-being.

Q. For Decreased Suicide, looking at crisis calls, SiR's, Police, or calls to Smart Team.

R. For School measures, consider looking at current grades, and IEP. Are you sorting for Public v. Non-Public School?

S. For Outcome one, want to expand 'addiction' beyond substance abuse so it includes other measures like gambling, or prescription drugs.

	T. Outcome 2: consider looking for a measure that looks at progress towards harm reduction. Look at MORs. U. For Meaningful Use of Time, look at the skills at or below grade level for youth. V. Need to add financial or spiritual domains. W. Need to include or some how include information for individuals with disabilities. X. For family measures, are they only looking at biological families? **Action Items:** 1. Is there a measure for out of home placement
SLT Agenda Design Team	The SLT approved Ruth Hollman, Jim O'Connell, Carmen Diaz, Romalis Taylor, and Jim Randall as the SLT Agenda Design Team. The design team will assist in the development of the monthly meeting agenda.
Public Comments and Announcements	1. **Comment:** Health Care Reform, outcome 5: strong families. I am doing fine on my medication but recently the insurance has not covered medications such as Abilify. Otherwise I should pay $1000 for a month's medication alone. Can you impose a law regarding the client's medication and the need for insurance coverage? 2. **Comment:** Phyllis, graduate of speakers' club of older adult systems of care: April is the last session for the training of the speaker's club. Request to maintain funding for speaker's club. 3. **Comment**: $1500 for pacemaker, Health Net and Medicare won't pay for the whole bill. 4. **Comment**: disagree with proposal. Need more consumers on board--looks too top heavy.

	5. **Comment**: LACCC: innovations conference in June. Public Comment Card Notes: 6. **Comment**: There is a need for gun control in America. There were incidents related to this problem and they usually blame the mentally disabled. How can you help on behalf of the SLT? 7. **Comment**: What is the future of health care reform. Is it getting better for us when we have health services? What is going to get us back to work in the future? Our skills are being wasted. Increasing taxes and closing businesses means we pay more. 8. **Comment**: Bad diets are a reason for incrased health problems, overweight, ADD, ADHD.