COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, November 20, 2013 from 9:30 AM to 4:00 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. To provide foundational information on the implementation of MHSA Plans in Los Angeles County.
2. To give an update on the SLT stakeholder recruitment process.
3. To explain the structure of the MHSA budget.
4. To solicit feedback on draft regulations for MHSA Prevention Early Intervention and Innovation projects.
5. To synthesize the input on the age-specific service continuums.
6. To understand the data sent to the SAACs and the process of obtaining their input for the Three-Year Program and Expenditure Plan.
7. To clarify next steps.

MEETING NOTES

MHSA 101 Foundation Information	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health* **FEEDBACK** 1. Comment: Every month every county gets an allocation for MHSA. 80% of those funds goes to the Community Services and Supports (CSS) plan. 20% goes to Prevention and Early Intervention (PEI). The County takes 5% of CSS, 5% of PEI and dedicates those funds to Innovation. We do that on a monthly basis. 2. Question: Do we not get Capital Facilities Technological Needs (CFTN) anymore? What about Workforce Education and Training (WET)? Response: They do still exist. Those are infrastructure components in the MHSA. Each program is funded with 'one time' allocations for 10 years. Questions for future consideration: Do we want to continue those? If so, what investments do we want to continue? Have they been worthwhile? 'Capital facilities' is primarily for DMH. We cannot give the money to contractors for certain legal reasons. It is to pay for the capital components of our buildings. Technological needs pays for our own electronic health record, and to legal entities to help you either adopt your own electronic health records or create the electronic transmission between your system and ours. 3. **Question:** In this new process can we allocate funding toward any of these two or do we have to fully use the money there before we allocate? **Response** 90-95% of those funds, expire or revert if we do not use them by the end of fiscal year 2017-18. We will need a recommendation from this group and service areas about what our training needs are going forward. The group needs to recommend if we should budget money through WET, which means taking money from CSS

after fiscal year '17-18 in order to fund WET. CFTN: a similar issue. We will provide you with more information on those investments to help make an educated decision.

4. Question: CSS, PEI, and Innovation are funded monthly with whatever amount of money comes in. CFTN and WET were funded roughly 5-6 years ago? So they are static and do have to be addressed when they come to an end sometime in 2017, which means we have to consider how it fits?
   Response: Exactly. In the MHSA there is a stipulation that says that on any given year you can take 20%, to fund your prudent reserve, WET or CFTN.

5. Question: Is our prudent reserve currently funded?
   Response: Yes. Our fiscal consultant said we are being prudent right now and it is at the right amount.

6. Question: I recommend that when discussing allocation of funds we talk about outcomes. What do we achieve with those other two funds? What are the possibilities and alternatives in the future?
   Response: We are talking about how to more robustly evaluate the investment of WET projects. On an annual basis, we report the number of people trained, the ethnicities of those folks and things along those lines, but these are not outcomes. That is just a product. The January WET CiMH WET call will focus on the outcomes that we should be striving for WET.

7. Question: I am looking for the same thing under CFTN. This group made a very important investment in homelessness, services for people, and shelter and things of that nature that are important. We need to talk about those outcomes as well--technological
   Response: To clarify something, the WET funds--the county is not the only one that benefits. Part of our commitment from the stakeholder process was that those dollars be used for both county and contracted agencies as well as a large investment in terms of bringing in more peer advocates, parent partners and others.

8. Question: In regards to WET, I heard that when people get paid to go to school and only dedicate one year to the county?
   a. Response: We have several programs. One is our local stipend program that funds MFTs, social workers, and a few nurse practitioners. We look for individuals that are bilingual, bicultural and are committed to working in our under and hard to serve areas. They get paid a stipend of $18,500. Their commitment is, at the least, one year after postgraduate. The loan assumption is something different. That is administered by the state and OSHPD. Those are MHSA dollars that they received or received directly from the state. We just view the application and selection process locally. 300-400 people are funded that through this. They get a flat amount that applies to their loans.

   b. Response: I work on the MFT consortium and am very involved in the stipend program for MFTs and MSWs. It makes a tremendous impact on filling positions in underserved areas and brought in a huge number of 'bilingual.' Most stay for more than 1 year, and stay until they complete their credentialing hours because they get a salary in addition to their stipend and they want their hours.

9. Question: When we initially discussing this with the loans, grants, stipends, and pay, someone raised the issue that in

order to be competitive we had to be 'equal' and not 'more than' is required for those going through the social work program with DCFS as it was originally set up by the state. Is this correct?

Response: This is the CalSWEC tuition. We modeled it after that. We paid the same amount in terms of tuition. The obligation and commitment, post graduate, is the same. The program focuses on social workers both from children and families services and mental health. That is not our money. It is MHSA dollars but it comes from a statewide fund. Ours is just a local effort. But we also participate in the other statewide efforts as well.

10. **Question:** So, it is the 'same' and not 'more than'?
    a. **Response:** I believe it is the same.

    b. **Response:** Via email, you received the same information that was sent to the SAACs. One of the documents provides program descriptions. Inside there is the most recent information on WET and CFTN. We need to take information to the next level perhaps through a chain analysis. When you fund or reimburse someone's education and they serve in unserved areas or are from an ethnic population that represent your clients, those result in a strong set of interventions, linguistic parity; and other things making a difference in the service. CFTN: funds buildings, specifically county buildings. It does not fund homelessness, homeless projects or buildings that house clients.

11. **Question:** I am looking at this list and thinking whether there was any ethnic or cultural breakdown. Do you have the numbers of how many of each of the cultural or ethnic groups were trained?

    Response: We do. Look under WET program description and see what we have around the ethnic breakdown We also have some really great statewide information on the OSHPD funded WET.

12. **Question:** In what ways have peer advocates been part of funded plans?

    Response: As we move forward we need to look into the composition of our work force –who our work force is and what their core competencies are. We need to examine what training they need to compete and to succeed in the services we will provide in the future. In terms of the CSS, in the RFS that went out, FSPs had to have peer advocates. Children's FSPs had to have parent partners or advocates. Field capable clinical services did not have that requirement; although there is what are called 'service extenders' in the older adult field capable clinical services programs. Those service extenders are older adult peers who get a stipend for assisting older adult clients or family. In our wellness centers, also funded by the CSS plan, the RFS stipulated that at least 50% of the workforce in a wellness center must be a peer with lived experience. In early intervention, there were no requirements around that. In Innovation, one of the 4 models we are testing is the role of peers in peer run respite programs and in providing peer run services in general that help link clients to health, mental health, and substance abuse care.

13. **Question:** In what way did we support individuals with lived experience build a capacity to become a paraprofessional? In the CSS plan and in the WET, do we have investments to help with that transition?

    Response: Yes, the WET plan has sizable investments in terms of peer advocacy training. There is also a peer institute beginning to develop that is funded through WET as well as other immersion type programs. Usually when we talk about peers we talk about peers with lived experienced. As a mental health consumer we have also

talked about expanding that to include peers who have lived experiences from a specific community or cultural group as well. There are programs like the Pacific Clinics Pasadena City College program that is trying to develop mental health rehab specialists. Many of those are not peers but they are folks from the community. They are being trained to become mental health rehab specialists. There is a tremendous need out there but current efforts are not enough. I know one other thing that adult system of care has been doing in our planning process when any new programs come online or anything that we are working on to develop which have been a few in the last few years. We have been aggressively trying to add these members to our teams.

14. **Comment:** We should have community forums especially with regards to peer run crisis support centers. Eduardo Vega suggested that there be one that take place here. The peer run crisis support center; that is going to be one of the main topics tomorrow at the OAC.

15. **Comment:** For this plan, there was a lot of peer training and mental health rehab specialists but the problem is there is no consistency in these trainings. There are people that have been hired at all different skill levels. The other problem has been is that they have over trained people. There are too many people trained for the numbers of jobs. This has been further complicated when the department changed the peer advocate position to mental health position. At our program we recently interviewed for two positions. We did not get a single person with lived experience for those interviews because of the changes in the item.

16. **Question:** Where are we with the parent advocate and parent partner funding? How much longer? My fear and concern is that we might lose this before we use it. In my experience with the respite care that we had we lost that.
    Response: The Children system of care through input from a variety of sources is in the process of making the respite program a viably funded program. We always look at is how can we best deliver the service. This planning process will articulate that. It may be that there are programs here that we do not have the right funding stream or mechanism. Or the work force needs to be trained in a practice they have not been trained in. It is the opportunity to fine tune. There is money identified through WET for parent advocate/parent partner training to develop parent advocate and parent partners. We worked steadily with the children's system of care--for the past 2 1/2 - 3 months. We have a meeting scheduled with WET next week to review a product that we developed so far that looks like it is going to become a solicitation to go out and find someone to do the training for this specific piece of the WET.

17. **Question:** It seems you all are focusing on the WET part. I have an inquiry with regards to Innovation or technology. What is currently being funded under those provisions?
    Response: Innovations are time-limited projects. Our first innovation projects that we are in the middle of right now, relates to the best strategies to integrate primary care, mental health, and substance use services. We have four models. A peer run model is one of those models to test those strategies out. In the information you received over email, there is some information about the evaluation of innovation as well as clients served and those sorts of things. Services are going to end for 3 of the 4 models. The integrated clinic model, integrated mobile health team, and integrated services management models will end June 30, 2015. Prior to June 30 of 2015, we will make recommendations for what our next innovation project will be. The final innovation project ends on June 30, 2016.

18. **Question:** I am just curious about inmates and jail mental health services. There are approximately 230. Up until recently they did not have access to education based incarceration programs. Is there anything in Innovations that addresses the need to get oversight? There are a lot volunteers from different colleges, like Antioch College, that want to come in and volunteer their Masters students to give groups and give individual therapy and creative writing classes. DMH needs to work with the Sheriff's department in a concrete way.
    Response: I will take that back to jail mental health administration. The MHSA is unable to fund parolees or individuals in the jail and in incarcerated settings. The only way that MHSA can be used is for discharge purposes; transition back into the community.

19. **Question:** In terms of discharge there are a lot of people that could come in and help. Right now, there is only one person for a number of service areas. They are just completely overwhelmed.
    Response: On page 3 from last meeting there was a question similar to the one that you asked. I encourage you to read comments 12 - 16 that explain what MHSA can fund or not fund. Also, the AB 109 group has a special class that MHSA can be used for to support. We had a discussion last time around the incarcerated population and how to better link. What I want to do is distinguish between what we have funded already, whether it is working or not, the regulations, and then your question about moving forward, "can we find ways in which we can better improve that system?" is definitely what we need to target in the context of the parameters.

20. **Question:** Clarity; I know we are working on the acronyms, but also the job titles. Do you have some kind of charter diagram that showed career paths?
    a. **Response:** In last year's update we had one. We are going to add to that. Across the state people call them different things. There are parent partners and parent advocates.
    b. **Response:** There was a list of acronyms that was sent out in the last email.

21. **Question:** I want to talk about cultural competency and what aspect that played in facilitating engagement and recovery for that client population. I have been in some meetings where that part of the outcomes are lost or totally ignored especially in the AAA UREP. This is part of the dynamics that we are supposed to be measuring. By doing these things this was supposed to enhance engagement and outcomes for the ethnic population. In this Innovation there needs to be a review of all of that as to how it has, for those underrepresented populations, because it is a category. That category deals with cultural competency and the outcomes as it relates to engagement and treatment.
    Response: Romalis is referencing the innovation model via AAA (African, African American) ISM model. Samantha Hearst was contracted with UC San Diego to be able to do those focus groups and to better understand outreach and engagement efforts that are culturally relevant. Let us look at what the outcomes yield from those focus groups and then take the next step if they do not address the questions that we need addressed.

22. **Question:** I am interested in all of those populations: API, the Indian population, the Latino population, and the Eastern European population. I want to know, "did that make a difference?" in engagement and completion of treatment so that it has a positive outcome for those clients.
    Response: Absolutely. Those focus groups are happening for each of those groups. We will bring that back.

SLT Stakeholder Recruitment Process Updates	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health* FEEDBACK 1. Question: One of the biggest issues for the SAAC representation that I was trying to bring to the SLT is that the SAACs are being reorganized with only two family members and two consumers, out of 30, with two law enforcement members and two people from DCFS and two people from education. I think that the SLT was not aware of that. I do not know why it did not get into the minutes. Response: Each SAAC does not have to stick to that specific criterion in terms of "this number of this and this number of that." The way we moved forward is that the SAAC has the ability and responsibility to nominate someone to be a part of this planning process. At the last ad hoc work group one of the things we took a tally of those that identified themselves as consumers or family members. There was a strong distribution of consumers and family members among the SLT as well as the new members. 2. Question: We need to know what percentage of the SLT are providers. I think it is important that no one constituency reaches that 60% threshold because it impacts consensus building. If you read the guidelines for the SAACs in one place it says, "this is an example of what it could look like", and in another place it says, "these are the people you have to have" These issues need to be resolved. The other issue is the role of how we are doing planning in the department. Is the SLT only for MHSA issues? Are the SAACs only for non-MHSA issues? How is all of that working out? In the SAAC guidelines it says the SAACs report directly to the executive management team. We used to do planning for both MHSA and the non-MHSA money. Response The issues raised here around the SAACs are very important--but we need to distinguish the different layers. One part of this conversation is about making the SLT more robust, going from 50 to 60, and to get as much diversity as we can. For that very specific task we try to bring in 15 additional people to the SLT. This is the task that we have as we move forward with the planning process. However, there is a concurrent process designed to strengthen the SAACs and the multi stakeholder system of input, which includes the SLT and the mental health commission. Yvette Townsend and her co-consultant are trying to help strengthen this system by improving the way the department receives input from the public. Part of this effort includes launching a process within certain SAACs of reconstituting the membership, being clear about the purpose, etc. Some SAACs, and more are adding themselves to this process, are starting to reconstitute themselves. There are a number of really important questions that are a part of that. For example, "Are the guidelines set on stone for this membership? Do we have flexibility?" What I want to distinguish for the purposes of today's discussion is that what we are providing an update for the purpose and membership. 3. Question: We need to also discuss "What is the role of the SLT in the department and what is the role of the SAAC in the department in terms of what we are doing?" Response: That can be incorporated into that discussion. 4. Comment: I am new to SAAC 4. My feeling was that there is a template in place in terms of what the membership should be. My question at the SAAC was does 'one size does not fit all.' We used the template of another SAAC to do SAAC 4. It

	should reflect what that community or what that SAAC is. **Response:** Experiences in each SAAC are different. Let's create a space to hear from each other and make sure we distinguish between what is fact and the perspective we have about the process. 5. **Comment**: Over a year ago there was a decision made to revamp the SAACs. Three SAACs decided to be pilot programs. The three SAACS have not completely finished. They wanted to get involved now before the finish. This is the kind of stuff you get when you do not let a pilot complete what they are doing to get the stuff together. 6. **Comment:** We should just table this and discuss in December. I do not know if these are an isolated event or a situation versus other SAACs but my experience for SAAC 6 is very different.
Understanding the MHSA Budget	*Dennis Murata, MSW, Deputy Director, County of Los Angeles, Department of Mental Health* FEEDBACK 1. **Question:** Unspent money refers to money unspent in that year but can be used in the next year to make up the money that did not come from the state. Is that correct? Does the unspent money end up spent? **Response:** Yes. For us to submit a budget we must have the dollars available to us. I am not a fiscal officer so I cannot give you much detail, but the dollars from the prior year--we spend those dollars first. It is called 'first in, first out.' Let's say we had dollars leftover from the prior fiscal years. We will spend and use those dollars first to avoid reversion. The dollars that we get each year, if it is unspent, we will push that forward. Now we hope that in probably '15-16 and '16-17 things will line up properly where we are spending at our current level of what is allocated. 2. **Question:** What is the basis of your projection in terms of the allocation? **Response:** We get projections from CMHDA. Some of those projections are fairly close. But, once again, it depends. It is like when we try to budget for a realignment fund for our general county programs projections are estimates. 3. **Question:** How reliable have his projections been in the past? **Response:** It depends. We are talking about millions of dollar. He's actually been fairly accurate. We get our allocation like we do our realignment dollars. 4. **Question:** These are the total amounts of money. We all delegated a certain amount of money to age groups. Out of all of the age groups how much money was actually spent on these age groups? **Response:** If that is something that the SLT wants to see in that detail we can do it. We have that information. I was not prepared to talk about that. 5. **Question:** My question deals with the interest. What happens to that money and why is it so low? **Response:** Well I would be happy if I was collecting that interest for myself. You are right. That is a question I would like to know as well. I will talk to our CFO about that.

6. **Question:** Where are some of those large funds are getting 6%? Are they out buying municipal bonds?
   Response: I do not think it is as easy as our department being able to select. I am sure that the county has probably a very--almost risk free--stable kind of investment.

7. **Question:** What is the total budget for DMH?
   Response: Gross dollars, $1.9 billion.

8. **Question:** That is including the match?
   Response: Yes

9. **Question:** Do we know what the net is?
   Response: DMH draws down about $1.8 billion in revenue, it is about a $100 million difference and that is for various mandated programs the county has to fund. The department is very self sufficient in terms of paying for their programs, our salaries and staff.

10. **Question:** The $1.8 billion is a gross and not a net?
    Response: That is net total revenue, including Medi-Cal.

11. **Question:** What is all MHSA in terms of the budget?
    Response: Amazingly enough back in 2004 MHSA was roughly 10%. Now we have more state allocation in MHSA than realignment dollars.

12. **Question:** The money that is unspent and pushed forward to the next year: who is in charge of deciding how that unspent money is spent the next year?
    Response: There is generally no decision for us to make since we committed to keep our funding and budget level the same. The variation of state allocations went down and then back up but never to the same level--what we committed to in terms of our programs for CSS. Our net budget is roughly 270 or 280 for CSS. Then we added on year to year. The new programs that we added on--we have had those discussions on an annual basis because we just cannot add things without going through public comment period. It has to be part of our own annual update each year. Any new programs where we might shift from one fund to another that you are asking who decides how we fund those things--all those things have to be part of our stakeholder approved process. For the most part unspent dollars goes to maintain our current funding level in order not to cut.

13. **Question:** Does this group have any oversight?

14. **Question:** Not on the programs. For those there is an annual update where you can comment. Is there any oversight on the details of how the unspent dollars go to this program versus that program?
    Response: That is a very good question because others are thinking the same way. A more recent example is when Dr. Shaner came to present about the possibility of implementing Laura's Law. Last year, we talked about pulling money out of the prudent reserve to increase our services to TAY and crossover youth. They

have to be incorporated and have a public comment period and public hearing and then be part of our annual update to the state.

15. Comment: Yes, we do have the input of the changes. For example, with the Innovation Program, they were late getting started so this group voted to keep funding that program so they would have the full 3 years.
    Response: The SLT has not been involved in the details of these kinds of budgetary decisions on an ongoing basis. In that case, the SLT made a recommendation. The perspective of the SLT usually gets exercised at the annual update when you look at all of the programs, how they are doing, and then it is at that point that the SLT can give comments on also the budget but not on the details.

16. Question: That was the context that you said--that they had been holding dollars.
    Response: The state had also taken whatever their share of MHSA dollars to support the infrastructure to fund other types of things that are supposed to be aligned with the MHSA. For example, the AB 2034 program that we had years ago? That used to be a state funded program. When that program ended the counties were given some dollars but not enough to cover it. The expectation is that we then cover the rest to keep that program or transition those clients into our FSP program.

17. Question: What is the methodology used to establish the prudent reserve?
    a. Response: There was a state information letter that provided a state DMH interpretation of how much. At that time you could put up to 50% of your CSS dollars into the prudent reserve. In the early years we were required to fund that prudent reserve. Now they have lifted that where we can fund more of it. Mike Geiss, who is the CMHDA's fiscal consultant--we think $127 million is a lot of money. Believe me it is a lot of money. But compared to other counties our proportion or percentage is lower than what other counties, if you look at in terms of how relative our dollars are to theirs. So we funded the prudent reserve with unspent dollars. There was really no formula in there. The amount that we funded was, at that time, whatever the state allowed us to do.

    b. Response: The state has given us guidance over the years through info notices. I can compile those info notices. We can make them available. What you are going to find is there are logical inconsistencies between them.

18. Question: So the unspent dollars--that does not include the prudent reserve?
    Response: Correct. The unspent does not include it because we now consider the prudent reserve as part of the spent dollars. It is not part of our expenditures. That line that shows there does not include the prudent reserve. It is the green line. Those dollars do not include the $127 million. But for our purposes to the state--to avoid reversion--they are considered spent.

19. Question: There can be a onetime funding initiative for a new program with the unspent dollars not including the prudent reserve funding? For example, if it is an innovation project and it is proven to be effective then can that 'one time--maybe not from the same set of funds being the unspent dollars--but can that initiative be funded via other funds?

a. **Response:** The innovation dollars are not included in this CSS chart. That is a separate funding or separate plan. Since those innovation dollars along with the WET and capital facility dollars were 'one time only'--those funds are considered separate and not part of CSS. When it becomes part of CSS, when those allocations for innovations for example are no longer given to us, then what we have to decide as stakeholders is, "how much of our CSS and PEI funds do we want to allocate for innovation programs?"

b. **Response:** There might be two questions that you are asking. Each year we have to dedicate 5% of PEI and 5% of CSS to Innovative programs. Our innovation project is a time-limited project probably not to exceed 4 years. Again, it is up to the county plan as to how long that project goes on. The funds revert after 3 fiscal years. Each year we take 5% of CSS and 5% of PEI and that is our Innovation program. It is about $17-19 million. In future years it could go up as much to $21-22 million.

20. **Question:** Can the unspent Innovative dollars be used to recruit other programs?
Response: No.

21. **Question:** What constitutes a new program under this graph?
Response: A new program is something that is currently not in our approved CSS plan. You can also use those dollars if we do not need them to maintain our current budget for CSS.

22. **Question:** If an Innovation plan really worked and we want to continue it, where does that come in that you can fund?
Response: If we find that our innovation programs then we have the option to fund those through CSS or PEI, whatever is the most appropriate. The other thing that the OAC has talked about is that there are certain cases where you may not even need additional funds to apply the learning that comes out of innovation. It may be something that you just do. So if you are trying a specific approach to coordinated care management or something like that you may not need additional dollars. I suspect that we may need additional dollars in our case.

23. **Question:** When we first started we planned one program at a time. There was money that we needed but we needed a plan to draw the money down. Is that not true?
Response: Yes.

24. **Question:** All of our funds are currently allocated?
Response: Yes, for CSS and PEI.

25. **Question:** We have no new money, but we also have Innovation programs where we learn new things. We have to come down to complete the circuit. Either we become very efficient with the new learning that we have had and fine tune or we remove a program in order to add a program.
Response: Or we reduce the funding for an existing program. That discussion is going to have to happen probably within the next year or so in terms of the innovation program; which ones should be sustained.

26. **Comment:** There is another way to fund new programs or to fund innovative programs. We are projecting growth in the

income from the state. So each year depending on how the economy is going there might be a big or even a bigger bump up. Those bumps represent the opportunity to create new programs.

27. **Question:** Initially we were planning for the MHSA, which is defined by the expenditure of MHSA dollars plus the dollars that are leveraged. This becomes part of the MHSA plan. Dennis brought in the new population of individuals where there is no match at all. In a sense they are neither MHSA nor the other source of main funding for the match, which is the realignment funds. They could potentially be planned for in either system. I wanted to raise that issue so that we are clear that our planning does include this new population who we want to get recovery based services for.

    Response: Prior to January, and starting in November of 2000, we were involved in a low-income health plan called Healthy Way LA. Those are our indigent population, general relief--when we take a look from their expenditures from the beginning of our Healthy Way LA program where we served 10,000 individuals per month at an average monthly cost of $6.8 million. That includes 24-hour care; urgent care centers, the emergency rooms, and outpatient. Out of that $6 million a month, what were providers including directly operated programs, using to serve them? This is a federally reimbursed program--or at least half of it. With the Healthy Way LA population 50% is covered by the feds. We have not seen those dollars and based on how they claim for that, we may not see it for a couple of more years. That means providers in our directly operated programs absorbed those costs. The bulk is funded under CSS with some dollars provided by the Innovations program. Those individuals who were Healthy Way LA will become, January 1, 100% federally reimbursed. Finally, disability is based on you establishing disability for SSI.

28. **Comment:** The projected amount of time that you are going to be disabled is 12 months. There is a difference there. We tend to put people on after they have come to see us for a year which means that our people who go to a different clinic every time never get benefits.

    Response: The point I am trying to make is that of those individuals that we saw, between 35,000 and 40,000 from December of 2011--roughly about 10% of those went onto SSI. What happens is that when they go on to SSI after January 1 they are no longer 100% covered by Medi-Cal. They will go back to their 50% coverage. As more folks from the Medicaid expansion come in our work force is not going to expand significantly. They will draw on our current resources. We know that the 100,000 or so that are projected to be newly enrolled occur during the first year. There will be a slow wrap up in terms of folks getting onto the Medicaid expansion.

29. **Comment:** A large number of those individuals are indigent. They are undocumented immigrants. Some older adults, for PEI are undocumented. Even with the TAY, we have the Dreamers, the young men and women who benefit from the DREAM Act.

    Response: Thank you for mentioning that. We still have individuals who are going to be residually uninsured. They are not insurable because of the requirements. Medicaid expansion is 19-64 year olds. Not everybody will benefit. But the individuals who will include our older TAY population, the 21-25 year olds. Unless they were able to establish and qualify for the traditional Medi-Cal or are on SSI, they had no Medicaid coverage for them. Now they would. Folks who could not meet the current requirements to establish their Medi-Cal benefits will now have access to it.

Regulations for PEI and INN Projects Feedback	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health* FEEDBACK 1. Question: One of the reasons to differentiate is to try to decide which of these programs are working and which are not. Your proposal will not do that. It will say, "Is the state working generally?" and maybe there are multiple programs that somebody has implemented but they only mention one of them. There are a lot of concerns…In the mind of the folks putting this forward--they just spent a lot of money at Cal Mesa to hire RAND Corporation to come up with what I think is a pre and post event kind of test to test exactly what your proposal tests only it is supposedly based upon one 1 hour presentation. "What were your attitudes before the presentation? What were they after?" Again I do not think that captures very much other than, "Was it a good presentation?" I agree with your proposal but we need to think about how one can say, "How can we potentially otherwise rate different approaches in fighting stigma and discrimination?" a. Response: [inaudible] add county specific activities related to stigma discrimination reduction. For us this includes the Metta World Peace campaign or Profiles of Hope –would that be better? b. Response: Somewhere where people could actually rate different things proposed to them as to how much impact it had on them and their attitudes. 2. Comment: I think you are on the target. However we might want to differentiate how the media campaign versus the outreach campaign at a community or the service level effort impacts the person receiving the information. That way you can actually see which is the most effective way to do it and which ones have the greatest desire to continue to actually engage the system. Information may not, in essence, enlighten you enough to say, "I want to do this." Others may have greater impact because you may have met somebody that had an issue and was an outreach in a community level strategy like you were talking about. I cannot compare other counties to what LA County is doing. I cannot see us doing something at a statewide level that we are doing more in a countywide level than they are. Some counties do not even begin to do what LA County is doing. a. Response: That is true. But I think also there are statewide approaches that impact LA. b. Response: You can ask a question about that because they are state programs and not county programs and see which falls out. 3. Comment: I am all in favor of having the state measure stigma and discrimination across the board in the state. I think that is important. As a social scientist, I hope that our questions are done in a more sophisticated way. The department did a study of themselves a few years back. They found that the people within the department had higher levels of stigma-induced discrimination against mental health consumers than the general public did. We need to start addressing the stigma and discrimination that is within our system and to find some creative ways of changing that and clearly transforming our whole system to deal with that. The should be part of our plan going forward is to reduce stigma and discrimination amongst the people who are providing services to our consumers and family members. Response: At some point maybe through this process reevaluate our SDR plan.

4. **Question:** We need some measures about cultural competency and outreach. It is very important. What kind of culturally competent measures brought about the change?
   Response: In a moment we will discuss the underserved population component. One concern we have about this proposal is that it will take money away from services because of the amount of information that counties will be required to track and report--that does not happen in a budget neutral sort of approach. We have to do this in a manageable away.

5. **Comment:** I understand your concerns about measurement and agree. But more fundamentally, I am concerned that prevention is not required. If it is impossible to measure if prevention is working in any short time frame--that combined with the fact that there is pressure on the system to provide services and not prevention--it seems we are taking a step backwards from what the MHSA did which was mandate that prevention be included for the first time. It is only by prevention that we ultimately make the system a balanced system.

6. **Comment:** There should be training to all staff that is brought on to work in the mental health field; not just clerical but all because I find a lot of that, especially for peer advocates that become employees.

7. **Comment:** Some stigma is due to the language we use: for example: paraprofessional whereas in the recovery movement in general the word paraprofessional is being phased out. Those are things that we can do to improve the situation and to reduce the stigma.
   Response: We are talking about regulations; not mental health programs in LA but regulations.

8. **Comment:** You are bringing up a very important point, which is the cost factor. I agree with you. I would rather have funding go to services than to do these evaluations, which, by the way, most are statewide initiatives. The advertising, are geared toward the TAY population. I would be in favor of having the state do these? The other thing is in terms of outreach for the early signs of mental illness I like the idea that they are trying to engage different responders. I think that is a 'positive.'

9. **Comment:** I wanted to look at the aspect of training the trainers. Sensitivity needs to be taught across--the sensitivity issues--there is no 'across the board' sensitivity training. That has to be worked out to where DMH has to understand this is a time to work together.

10. **Comment:** I look forward to reading through these proposed regulations in detail. One thing we are hearing today is that the regulations need to incorporate a lot of what we are talking about here. We need to build into the policies that deal with our staff so that there are regulations that address those kinds of issues. Where their ability to manifest appropriate anti stigma and discrimination behaviors are built into their performance evaluations.

11. **Comment:** I am thinking about the clients we have had through different API prevention programs. To even try and collect these data from them would be problematic. So, I think if you are concerned about consumer feedback it will be pretty strongly against. There will be a lot of resistance.

12. **Comment:** Censuses do not work. Samples are better. To ask, "How long has your mental illness been going on?" it is not

	appropriate in all settings. Need to recognize that this is not a medical model where the doctor's sitting down with a person each time. In fact, we should be transforming away from that. 13. **Comment:** My concern is not as much linguistic as is cultural. A lot of our terms may not be translatable because words are loaded with values and value]. We are learning in serving the older adults in the PEI; unfortunately although adults at a lot of EBPs, older adults only had that beginning 4. Now we have 6 EBPs and the majority is not culturally sensitive because a lot of the forms are actually wrongly translated. They do not make sense. 14. **Question:** It says that in order to apply for the Innovation funding the new program should not have already proven its effectiveness. If it is proven to be effective in San Francisco and I bring it down to LA would it qualify? **Response:** Counties had to address that early on in our first planning process. There would need to be something different about San Francisco versus Los Angeles. Usually, we address that as urban versus rural. San Francisco is a little harder to make that that huge distinction. You would need to implement it differently. That would be the innovation. 15. **Question:** On page 7 they break down race as follows: it looks like they have new indicators of White by descent as Eastern European, European, Nordic, and Other. Then as you go down they're under Hispanic, Middle Eastern, African, non-Hispanic or non-Latino. Are those going to be new categories in which you are going to be tracking people that we are not tracking now? a. **Response:** We do not know where they came up with Nordic and some of these--Caribbean--because they are not part of the CSI system. The Department of Health Care Services, who collects that information, was not part of drafting of these regulations. b. **Response:** So you are going to share with them, "this is not a 'go.'" c. **Response:** Yes. CMHDA has already done that. There is a clause in here somewhere above--because LGBTQ is another one that is not collected right now, it is not a CSI data element--some counties do collect it. 16. **Question:** I am curious why they have not put something for bicultural, biracial, since there are many families out there that are bicultural and biracial. They have children that are growing up and you are asking them to pick one of these when maybe they identify with both. **Response:** We will raise that with the Department of Health Care Services when they start to re-examine CSI data elements related to this. For some counties that was a category.
Age-Specific Service Continuums Synthesis	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health* FEEDBACK *ADULTS* 1. **Comment:** Under housing --people sometimes miss is that it is important to have housing and housing available but I

	also think we need to have supportive programs to help keep people in housing. 2. **Comment:** Reducing stigma among DMH and provider staff is not there and was mentioned. **Response:** On page 3, 6c it is there. 3. **Comment:** When I look at cultural competency my question specifically with the LGBTQ population is, "What qualifies as cultural competency?" You can call an agency and say, "Are you culturally competent for an LGBTQ community?" and they are like, "Yeah we do not discriminate." "Well what specific services do you have?" "Well we just treat everybody the same." That is not culturally competent. What are the standards? 4. **Comment:** Number 11, page 4. There are lots of clients who could benefit from the FSP program. How would you capture them and bring them into the program? 5. **Comment:** How about the pregnant adult women? There are no resources for them. 6. **Comment:** On the topic of #2, healthcare integration I think the way that it seems to be discussed here there could be a role for a peer to play on the team if you are talking about coordinated care. **Response:** So expanding and deepening the role of the peer in that coordinated care would be an issue we could pursue. 7. **Comment:** Better paid jobs for clients. **Response:** Under 5, employment, we will add also better paying jobs as well. 8. **Comment:** On page 4, 11f, For people who are very seriously in need of being hospitalized having a family member or conservator to be able to call FSP on an emergency basis to help work together to get that person help before more damage is done. 9. **Comment:** Training or stigma reduction or understanding any of the Middle Eastern or Muslim religion competency for services provided to any of the adults, children, or youth who are under extreme scrutiny and pressure. 10. **Comment:** Having fully staffed FCSS team. **Response:** Page 4-12 11. **Comment:** Under #6 for cultural competency, addressing the spirituality and making sure that we have a spiritual competency. 12. **Comment:** Across the board: the Skid Row residents are not mentioned. 13. **Comment:** Regarding the FCCS, on 12b, the second part says, "establish staff to client ratio and expectations for treatment."

Response: Similar but I caught a slight difference. One would be one staff to two or three clients. That would be a staff to client ratio. I think what she was referring to was the team. So not just myself but maybe someone else as part of the time. So it is not just the ratio but also the composition of the team as well.

14. **Comment:** Training or co-occurring disorder groups or approaches.

OLDER ADULTS

1. **Comment:** I have senior housing options such as younger clients helping seniors in their home. This is not a paid position. It is keeping seniors in their homes by having other clients living in the home that can provide support for the seniors in their homes.

2. **Comment:** Transportation for seniors.

3. **Comment:** On 10 (housing), this is something that is already happening. FCCS does not have flex funds for housing. The idea of implementation of Promotoras de Salud. The idea that for certain populations the indigent, monolingual and undocumented, there is a higher need of noncore services for them. For PEI, for example, there is a limit of how many services can be provided that is noncore services. We find out with the indigent population there is a high case management need and more noncore type of services.

4. **Comment:** A growing problems that is happening with the senior population--obviously not only the mental health needs--but also in terms of safety within the home. If considering what sort of options or issues that need to be addressed--a senior adult, because of physical decline needs to have more supports in the home to provide a safer environment.

5. **Comment:** Under cultural competency, under A, it says, "API need more services." I think we need to expand that to the UREP needing more services as well as outreach. One of the things that we talked about was having more culturally competent community based practices. Also, addressing the spirituality issues of this population.

6. **Comment:** About cultural competency, add people with physical disabilities--counting all of the age groups.

CHILDREN

1. **Comment:** On page 8, not "b-5" but "0-5."

2. **Comment:** Additional training for clinicians and paraprofessionals to identify underlying needs that are driving behaviors. More service for indigent children under 6. More services are needed for children who are dually diagnosed, developmentally and mentally.

3. **Question:** FSP, 9c, page 10, it says, "Historically clients would transition to outpatient services." Why not put the word "children" in there instead of clients? When we are addressing clients the automatic response is adults. When you say, "children" at least we know you are talking about a child.

a. **Response:** I think the meaning of that is it used to be that you would take someone from an FSP. When they transitioned you could get them into outpatient services. The fact of the matter now is with the outpatient being cut there is not money to cover them. So how do you have them transition out? It is a gap.

4. **Comment:** Add service needs specifically addressing homeless children.

5. **Comment:** We had suggestion for both children and TAY together. It is self-help support groups for kids and parents, and the evidence based best practice self-help support groups, Our Rainbows for kids starting in preschool with trauma, La Leche League for parents and kids 0-5, Because I love You for parents of teens with mental health issues, and Alateen which now accepts kids that have other dysfunctions in their family including mental health issues. The other one is family centers, which are wellness centers for children.

6. **Comment:** The need to increase family involvement and treatment for the children and also addressing, across the age groups, the spirituality issues; being more culturally sensitive.

7. **Comment:** Family support #3 on page 8, there are a lot of children being taken care of by their grandmother because their mother might be seriously "out there" with drug addiction and not be safe for the child.

8. **Comment:** I do not see anything in regards to bullying. I think it needs to be addressed somewhere.

9. **Question:** There is a question around, "Is there an advocate role specific for children or is that embedded in the service navigator?"

   Response: When we did the system navigators they put a community worker item out there. What they said was, "if possible we are trying to get parents on that item but they do not have to be." So you have both. You have a navigator maybe in one place that is a "navigator general."

TAY

1. **Comment:** I would like to see on the more of development of intervention strategies to address the needs of commercially sexually exploited children. Add it to services under #9.

2. **Comment:** I think that same of these cultural competency issues are in #9 but there is not an actual category as it is in the other age groups. I would like to add that. I can see that the underrepresented, the LGBTQ, and the blind and hearing impaired services need to be put up there. I would also like to add to the spirituality component.

3. **Comment:** With TAY there is a lot of mention of "over 18 years old" and also "over 17." Maybe they fall through the cracks. My concern is 16 and 17 year olds. How are agencies addressing that when they have to be serviced in different agencies? How the parents are included in those 16 and 17 year olds.

4. **Comment:** I would add bullying into this category as well. The other issue I would bring out in terms of LGBT youth and 'coming out' and as our society becomes much more sensitive to those issues--and youth are coming out earlier and earlier--it also presents significant problems if the family is not accepting. At the center we deal with a lot of LGBT youth

who have been kicked out of their homes because they "came out."

5. **Comment:** Add peers with lived experience with foster care working in the system for TAY and possible children as well.

6. **Comment:** For both this age group and younger children include family therapy kinds of treatment so the family could get healed as a system and not try to treat one person.

7. **Comment:** Adding another category that says "transition services." There are so many different transitional issues that need to be addressed in this age group that I think it is worth its own category.
   Response: It was brought up last time that particularly going from 17 to 18, a minor to an adult, but even though you are an adult at 18 it does not mean that you are ready. So there is this 16-17, 17-18, then up to 21. Maybe exploring those kind of institutional demarcations that we have already laid out in terms of funding.

8. **Comment:** Skid row teens.

9. **Comment:** Cultural sensitivity and counseling for LGBTQ on FSP and FCCS; not just peer run support but that they have counseling if they need it there in those places, page 12, item 6, and family education for people also for LGBTQ.

10. **Comment:** I was looking at #14. You were talking about linkage to community colleges. I did not really see if there is any other--not just community college but I think we should connect them to other colleges and other trainings including, "independent living skills."

CROSS-CUTTING ISSUES

1. **Comment:** There are a ton of different specialized navigators and outreach types of people. It is clearly not practical or fiscally possible to have that many specialty navigators in each of 8 service areas. There needs to be more cross training among that segment of our professional staff so we can handle the issue. We cannot build a million--we just do not have the capacity to take care of all of these specialties in each of the 8 service areas.

2. **Comment:** Under cultural competency I think we addressed a few things that were across all the different age groups like definitely the LGBTQ, the disabled communities, and then also addressing the spirituality issues of the communities as well as really looking into the community based practices that usually are more culturally competent for the Europe populations. #2, page 14. Also, family engagement.

3. **Comment:** The cross training--peer veterans are doing that with people--they are the ones who have the experience. That needs to be peer to peer at that point.

4. **Comment:** Include clergy training since they are also the first line of defense.

5. **Comment:** Integration of self-help support groups across all of the age groups so that there is empowerment.

	6. **Comment:** Escalate the look at the cross system. 7. **Comment:** I do not think this is directly covered but implied both in 3a and 4a. Both talk about transitioning out of services in a way. One reason may be that they are getting their medications from their primary care provider now. But they want to continue some services offered by one of our programs. This is not handled consistently. Transition because of the insurance changes, especially with the Medicare clients. If they get an Advantage plan for some reason because it offers more medical benefits. They are being cut off from services. Their Advantage plan may not apply all of the services that our department provides. There needs to be a way that they can still access those services. 8. **Comment:** For all age groups that are coming out of some kind of incarceration like juvenile justice; to have re-entry help for them and also to try to prevent youth and any age group from going to county jail or prison by working with a family member and possibly the public defender and also the mental health court. 9. **Comment:** Under housing, #5, do not forget about people who, if they need housing, they might have issues we do not want to forget about like IHSS, people who have kids, people who need their houses adapted, and when they need increased access to housing. 10. **Comment:** #4 employment. I want to make sure that stays with the welfare codes for the level of engagement. That is got to be specific because if you are getting jobs you have make sure that whatever they have been charged with will again be able to be used to get individual's get back together. What did we mean by better branding of service names? **Response:** The branding one suggests to me how we name and label the services can be very stigmatizing in and of itself. When I heard the report out, we have to be really strategic about not further stigmatizing through the branding of the services. Also that came up with regards to the affordable care act. As we begin to compete the public system competes with the private system of being able to mark it and brand it in ways that will also generate that kinds of enrollments into your system. 11. **Comment:** More money for permanent supportive housing.
Service Area Data and SAAC Input Update	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health* FEEDBACK 1. **Question:** Has Bob Greenless gotten input on the flow basis from the discussions that are going on here? What we want to measure at some point, unless it is built in now it is going to be impossible. Is the system that is being developed including all of these things that we identified both as carrying on and we want it? **Response:** We meet with him periodically and his staff around the outcomes and how they will be eventually incorporated into our electronic health record. Those conversations do happen. The service gaps and eventually outcomes that we will collect that we are not collecting now we will obviously need to meet with him. 2. **Question:** Is there a sample? There is a lot of information. How much data do you provide? a. **Response:** What I heard Debbie do is describing the information that is going out. This last part is the

questionnaire to generate information. What I am hearing is some support around making the process of presenting and obtaining input as effective as possible. Debbie will go to the service areas first, give then information, but SAACs have until early February to turn it all in.

b. **Response:** That is the process. The first part is really orienting your SAAC to the information. Based on the experience of that, and what I have heard here based upon the gaps that have been identified, I could provide a sample.

3. **Question:** Perhaps show a template of the questionnaire of the template. Prelist them on the questionnaire because not everybody might be aware of all the different programs. I am talking about our SAACs that will be filling this out.
   Response: What I can do is talk with the service area district chief about their preference around that.

4. **Question:** Thank you for this document because it is what pulled everything together. A key part to me was the 45 minutes of the way the cash flows through the grid this morning. I know that we have got a whole lot of other information. 5-10 minutes describing the way the moves through the programs would help everybody see how the whole thing works.
   a. **Response:** By the cash flow do you mean the discussion that Dennis led?

   b. **Response:** Yes. When I actually saw this and it was described I could see that we were no longer just talking about dollars and cents. We were talking about a current that runs through it. With seeing the current then ok we can see there is a little more or a little less.

5. **Comment:** Copies of this for the SAACs would be great.
   Response: I will do that.

6. **Comment:** Is there any way of getting a hard copy of this document? For some of us it is easier--we are old fashioned. It is hard to print out something like that.
   a. **Response:** Are you a part of any SAAC?

   b. **Response:** I am part of SAAC 2.

   c. **Response:** You are going to get that during the presentation.

   d. **Response:** Maybe next meeting you could bring some too?

   e. **Response:** Yes or send it to you in the mail.

7. **Question:** There is a commission meeting tomorrow. Can you pick out a few significant pieces of paper that can get to the office so they can replicate it for tomorrow's meeting and have it passed out so it can kind of bring them up to date?
   Response: I can do that. When I get back to the office I will pick out some relevant documents. I will send them Kai, Terry, and Larry and copy them to you.

Public Comments	1. Comment: Hacienda of Hope and Recovery peer run respite center wants advertising and outreach 2. Comment: Retreat, flyers available. 3. Comment: Call from Susan Rogers about certified peer specialist trainings going into the jails in Pennsylvania. A suggestion to get this going in LA.