COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, November 18, 2015 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. Provide an update from the County of Los Angeles Department of Mental Health.
2. Begin to prepare for FY 2016-17 MHSA Annual Update.
3. Discuss a proposed amendment to the Three-Year Program and Expenditure Plan.

MEETING NOTES

Department of Mental Health - Update	***Dennis Murata, Acting Chief Deputy Director, County of Los Angeles-Department of Mental Health*** Dennis Murata provided the following updates: • Dr. Robin Kay has been appointed as the Acting Director for the Department of Mental Health (DMH) on an interim basis. The selection process for Director of DMH requires input from the Mental Health Commission. • The appointment of the Agency Director has been on the Board of Supervisor's closed-session agenda for the past few meetings. • Senate Bill 75 provides full scope Medi-Cal services for undocumented children under the age of 19, giving them access to all services entitled for Medi-Cal beneficiaries. If they are considered EPSDT eligible, this will affect a lot of DMH programs due to the local match. Currently, the county match for EPSDT services is roughly 6.8 %; the State provides another 42%; and the federal government contributes 50%. DMH is confirming the county match. • More discussion is needed on how local counties will effectively implement the enhanced Drug Medi-Cal benefit, including the types of services that will be provided, documentation, claiming and billing. • DMH's Jail Mental Health programs are being transitioned to DHS. **Questions** • **Q1:** Will Senate Bill 75 include indigent children or only undocumented children? **Response**: It includes the indigent population that is also un-documented. • **Q2:** How is DMH getting qualified clinicians into the jails to address the acuity of patients? **Response:** Historically, recruiting and hiring qualified clinicians to work in the jails has been difficult. DMH and DHS are really pushing very hard to get the right staff in there. • **Q3:** I understand there is only one navigator per Service Area, and that they are so overwhelmed that sometimes people who get released from jail do not have a chance to connect them. Can two navigators be budgeted per Service

	Area? **Response:** Service Area Navigators and Jail Linkage Staff are different. DMH is creating a memorandum of understanding with DHS because it sounds like Jail Linkage staff will go to DHS. We want to be clear about roles and reporting their activities and the number and percentage of people linked to services. **Additional Topic: Mental Health Consumer Representation on the Integration Advisory Board (IAB)** • The SLT was informed that Jean Harris was not approved as a consumer representative on the IAB because she is not currently receiving services. • The SLT agreed with the Welfare and Institutions Code that allows family members and consumers in recovery (who are no longer receiving services) to be defined as a consumer. The SLT agreed to submit a letter to the IAB stating its position and also recommending that the second person be a family member/caregiver. • The motion was unanimously approved. Bruce Saltzer was asked to prepare a statement. • Note: The statement was emailed to the Mental Health Commission later that evening, November 18, 2015.
MHSA Related Items	***Debbie Innes-Gomberg, Ph.D., Program Manager III, MHSA Implementation and Outcomes Division, County of Los Angeles Department of Mental Health*** The 'Continuum of Care' tool has caught on with the County Behavioral Health Directors Association. The continuum allows us to create a balanced set of services for clients across the service continuum. As we produce the MHSA Annual Update, we will continue refine, add, and use this continuum to get the right service to the right person at the right time to reduce the likelihood of a crisis event. As with previous MHSA Annual Updates, we are targeting the SLT meeting in March 2016 as the date to endorse the plan. So, today we want to solicit ideas on how to use the next three sessions (December, January and February) and how to make the Annual Update contents as relevant as possible. The SLT's comments fell under four (4) categories. **Innovation 1: Integrated Services Management Teams** • Provide a presentation on what happened with the Integrated Service Management teams. What worked? What did not work? How we can share this knowledge across the system? • For the cultural groups, we want to know what worked to enhance the engagement of the community versus what did not work. Share the knowledge across groups. • How did things go with other models (e.g., the mobile clinic, etc.)? They may have had successful strategies that we did not think of the other models, and hopefully these can be shared across the system or other communities. Also, if something did not work, why? What are possible strategies to improve it? • Discuss the effectiveness of the Innovation models and how they are being now incorporated in the design of programs. Share the educational tools, cultural materials, best practices, protocols and other tools that programs used to achieve their outcomes. It takes time for these to be developed, evolve, and be incorporated into programs. • My understanding of the Innovation 1 investment is that the models were incubators for possible ways of improving the systems with lessons learned. I also understand that we have essentially decided to extend a few of those pilot programs. However, I do not see how we are going to extend them system wide. What are we doing to make the whole

system assimilate these lessons system wide? A simple extension of a pilot project for another 2-3 years does not seem to me to feed into that larger goal.

- What are the barriers that keep up from using the pilot program for the whole system? If this integrated approach worked better than what we have done in the past, let us stop doing that and start doing this. It is easy to take the pieces that work and adapt them; it is more difficult to pay attention to the whole system.

MHSA Funding, Leveraging, and Budget

- We have a list of programs in the Continuum that are funded by MHSA. What we do not have is information about how services are leveraging other funds? What share of current funds for mental health services is coming from local, state and federal sources? This would help us understand how much of the total system is being converted to the goals of the MHSA.
- If we look at our funding stream in total (local, state, federal), how are these funding streams put together so that we understand where our investments are and what impacts MHSA has made as it has weaved its way through the system.

Understanding Population Needs and Program Outcomes

- How do you measure change, especially for the whole system?
- We need determine how much of the total population's need we are meeting through our system. This will help us identify the big gaps and prioritize investments over time. In other words, we need the big picture of the unmet need.
- Part of the system is broken. Part of the system is not broken. It would be helpful to have information of what is working, what is not working, and how we are going to get from here to there.
- I am so glad to hear about the idea of trying to find out what is working and what is not, especially in terms of co-occurring disorders—i.e., training, services coordination, concurrent treatment, and other practices to improve outcomes.
- I want to make sure that as we look at programs that may be not meeting what they were supposed to, that we really pay attention to the reasons why they are not achieving their outcomes.

Communication

- We have to start telling people out there who we are and what we are doing. I think now is the time to do it. How we present the picture of what we have accomplished, how we have grown, what we see as future opportunities and challenges—this is all very important.
- I know it is a huge thing but if we do not shine light on how we spent all of these hundreds of millions of dollars and all of the strategies we have looked at, then someone is going to say down the line that you wasted a lot of money and I know we have not done that. People outside of this group do not always get the community strength and its importance. But they like to talk about numbers that relate to the magnitude of leveraging, the magnitude of diversion, the magnitude of wellness, how many people were helped, what did they do, did they relapse, if they did not relapse, what was happening.

MHSA Three-Year Program and Expenditure Plan	***Debbie Innes-Gomberg, Ph.D., Program Manager III, MHSA Implementation and Outcomes Division, County of Los Angeles-Department of Mental Health*** Dr. Innes-Gomberg explained that the Three-Year Program and Expenditure (3YPE) Plan allocates $738,000 per year to fund additional Field Capable Clinical Services (FCCS) for Adults for Directly Operated Clinics. Adult System of Care (ASOC) representatives want to propose a change to this item. If the SLT endorses the proposal, the change will be posted on the DMH website for 30 days. Assuming no significant public comment to the contrary, the ASOC would move forward with the proposed change. Wendi Tovey presented the following proposal: To use the $738,000 originally allocated for FCCS for Adults delivered through the Directly Operated Clinics for Full Service Partnerships (FSPs) Level 2. This proposal thus establishes two levels of service within FSPs that enables consumers to access different intensities of service within FSPs. The idea establishes two levels of services within FSPs builds on the experience of ASOC providers and lessons derived from an earlier FSP-FCCS pilot project. (This proposal does not affect the FSP-FCCS pilot.) The SLT discussion focused on the following three (3) themes: 1. <u>What is driving the proposed change?</u> The main impetus behind this proposal is to create a system of care that helps consumers move forward in their recovery as far as they possibly can, with the least amount of system barriers. Although the proposal in part responds to the reality that managed care requires being explicit about the average cost for a particular level of service, this proposal is driven by a desire to ensure that clients with the most intense needs receive the most intense services but are also not held in a program for any other reason than that. Thus, this proposal creates a system where clients can continue in their recovery and step down their services, while still having access to housing, employment and other supports within FSP that are not available via FCCS. While financial outcomes are important, client recovery is the primary driver. 2. <u>Ensure that clients receive both levels of FSP services seamlessly</u>: The proposed change adds more flexibility to the provider to provide the level of service necessary without having to jump through as many hoops. During case conferencing, the FSP team will be able to determine if a person receiving FSP level 2 services needs a higher level of care without having to wait for the person to be in the hospital for 30 days or decompensating further before accessing more intense services. 3. <u>Ensure that the number of slots is not diminished</u>: The number of FSP level 2 slots is 405, which is higher than the number of FCCS slots for the Directly Operated Programs in the original 3YPE Plan. As explained in the proposal, the increase in slots is in part a function of resource leveraging. Moreover, as part of the 3YPE Plan, FCCS slots were increased with many legal entity agreements with FSP programs. 4. <u>Differentiation between this proposal and the Integrated FSP Pilot</u>: Questions were raised as to how this approach is different from Integrated FSP that 6 contractors and 1 directly operated program are participating in. Integrated FSP

	uses the CMHDA ASOC levels of care classification system (utilizing level 4 and 3 for FSP) and uses the Determinants to aid in service classification and decision-making. The proposed program will not use either classification approach and will continue to have an authorization process for FSP (Integrated FSP has only a notification process). **Additional Comments:** • **Dr. Innes-Gomberg:** The proposal to have FSPs include two levels of service will help Los Angeles County meet the State's definition of FSP focal populations. Los Angeles County's FSP focal population definition, which focused on high service utilizers, is stricter than the State's definition. • **Comment:** As the DMH lead for veterans, I want to say that this proposal will the allow Veterans Program to actually provide housing and employment supports to veterans. The Veterans Program is not funded via Prevention and Early Intervention (PEI) as an FSP program. This proposal would allow us to be more flexible and see more veterans, especially those who do not qualify for the Veterans Administration (VA). This would enable our Veterans Program to meet the need that is out there and do some good work. **Approved – 14 Strongly Support; 5 Support; 3 Neutral Votes; 0 Votes Oppose/Block**
Public Comments and Announcement	**Comment:** The Nathaniel Project in New York diverts people from going to the jails. Regarding the definition of consumer, I suggest you talk to Disability Rights California and have them bring a lawsuit. DHS needs to change the language: you can be a consumer and not necessarily receive services. There will be a webinar on State Peer Certification on December 10, 2015. On December 14, there is another one webinar called Helping Families in Mental Health Crisis. Also, please support the Certified Peer Specialist bill, which is Assembly Bill 614. **Comment:** Hi, my name's Malia Fontecchio. I am a program coordinator with Project Return peer support network. I just wanted to say that Project Return does support MHLA and LACCC in our definition of a consumer. We do not think that you need to be actively receiving services. If you are in recovery and no longer needing services, we should applaud your recovery. Thank you. **Comment:** I want to circulate a sign-up list for people who want to be put on the Mental Health Commission's list if you are not currently on there. You can also email me at mentalhealthcommission@lacounty.gov. I also want to announce that on December 17, 2015, the Mental Health Commission is having its Annual Town Hall. This year, the session will be in Service Area 3. All are invited, especially if you are from that area. We will be focusing on Health Neighborhoods and listening to the consumers in that area.