COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM MEETING

Wednesday, June 15, 2011 from 9:30 AM to 12:30 PM
St. Anne's Auditorium
155 N. Occidental Blvd, Los Angeles, CA, 90026

REASONS FOR MEETING

1. To provide an update from the County of Los Angeles Department of Mental Health.
2. To give an update on the State budget.
3. To provide an update on the implementation of the Prevention and Early Intervention (PEI) Plan.
4. To review SLT 'housekeeping' items.

Meeting Notes

I. Review Meeting Agenda and Materials

A. No objections to last month's meeting notes.

II. Department of Mental Health—Update

A. Roderick Shaner, M.D., Medical Director, County of Los Angeles, Department of Mental Health, provided an update on the Department of Mental Health, which included the State Department of Mental Health, Realignments, and Health Care Reform.

1. As the State Department ceases to exist, there may be an agency that manages State hospitals. However, there is ambiguity regarding how other functions and responsibilities of the State Department of Mental Health would be met. There was anticipation that the mental health functions at the State-level would become better integrated with the Alcohol and Drug programs, which would also cease to exist as an agency. By improving the integration of the mental health functions, the new entity may report to Department of Health and Human Services (HHS) or Department of Health Care Services (DHCS), which were likely candidates. More information would be known in the ensuing weeks. In regards to Medi-Cal, the plans were to closely operate it through the State Health Department.

2. As part of the proposed State budget, a series of realignments would affect the Department of Mental Health. Programs formerly operated by the State will now be the responsibility of the counties and hopefully funding would follow. Although there will be more flexibility in planning the programs, the success of the programs will depend on the funding.

3. AB 3632 programs will be operated by school districts that will hopefully contract in a robust fashion to meet the mental health needs of children. There is much trepidation about this but there is also some opportunity.

4. Children enrolled in *Healthy Families* will be moved to full scope Medi-Cal, which has many implications. *Healthy Families* is not analogous to Medi-Cal, it addresses needs that have not been addressed in Medi-Cal and it has a different type of funding. The details remain unclear.

5. The decrease of populations in correction facilities is a realignment that will affect mental health services. About 33,000 low-level offenders will be released and returned to counties along with some funding. The major issue is that about 10,000 low-level offenders will likely come to Los Angeles County. Some will go to jail facilities and others may be directly released into our communities. Some funding will follow and multiple County agencies are working together to support this. This is statutorily from the State. The cross-county agencies committee has been working to develop the necessary services to help this population. Most likely, this population will have high needs in mental health and substance abuse. Yet, based on experiences with non-revocable parolees (NRPs), the Department knows that this population is not coming back to Los Angeles with the intention of getting mental health services. The Department also knows that the low-level offenders who find their way to mental health services have a tremendous need for high intensity services and the Department has to be prepared. The Department will need to identify the needs and types of services and settings to best serve them.

6. The Department has to see what the final population will look like and move forward from there. The release will come over a period of a couple of years. The State has provided some funding for jail, housing, supervision from County Probation, and for other services. About $2,275 will be provided per inmate for mental health and substance abuse services. How the Department manages the benefit will be critical. The Department is working with Substance Abuse Prevention and Control (SAPC), the Department of Public Health, and others to plan how the benefit will be managed. Another concern is where low-level offenders will be seen. Does the Department use its current clinical array? Does the Department use special sites? Does the Department divide the population between high-end and regular clinic sites? These were examples of the kinds of issues that were being looked at.

7. By 2014, Medi-Cal will become a public insurance for most individuals who are currently uninsured. Thus, the Department will need to provide services to a vast new population, many of whom we have already been serving. The system in Los Angeles, especially the public system, will have to change in order to serve the needs of both Severe Mental Illness (SMI) and the new population of individuals who will have Medi-Cal by 2014.

8. In California, the 1115 Waiver is a bridge to Health Care Reform. In other words, the idea was to bring early efficiencies in health care before 2014

to save money and be able to use that money to prepare the Department for 2014. The low-income health plan, which is called *Healthy Way LA,* would start at the end of June 2011.

9. For Los Angeles County, *Healthy Way LA* is a close collaboration between health and mental health. The Department, not Medi-Cal, will enroll about 130,000 uninsured individuals with high needs for services in a highly integrated system that provides benefits in health and mental health. The incentive for the Department was that there would be a federal match of 50 percent. Individuals will have primary care homes in primary care clinics across Los Angeles County. The 130,000 individuals will have to be enrolled in order to have the mental health benefit. These individuals would be served in the Department's system, which is prepared to do so in a variety of special partnerships with primary care. The Department will have to serve individuals effectively within 30 days and provide them with a rich series of benefits for those in need and have a severe mental illness. The Department will also have to provide services to individuals who have not been in the system but are in primary care. Therefore, the Department will use PEI funding to provide entirely new kinds of mental health services closely associated, either on site or with primary care sites. The Department will use a special evidence-based model known as Mental Health Integration Program (MHIP), formally known as *Impact.* MHIP is a kind of step therapy with case management, offered in close cooperation with primary care, and with increasing levels of mental health services as necessary. It is generally time limited but can be extended when necessary. The Department refers to these services as Tier 2 services. Tier 1 refers to the SMI population. Tier 2 refers to new individuals in primary care who may or may not have come to the clinics before, which the Department is now responsible for. Tier 3 refers to individuals who are in primary care and may occasionally need mental health consultation, but who are not the highest priority at the moment.

10. The structure of the low-income health plan did not include specific benefits for substance abuse, which was a major issue. Nonetheless, the Department will work closely to try to address co-occurring disorders.

11. The 1115 Waiver saves money for the Low-Income Health Plan and other projects by taking the highest cost Medi-Cal beneficiaries in the State, the Seniors and Persons with Disabilities (SPD) population, and mandatorily enrolling that population across the State into managed care plans. This is not an integrated care experiment; it is a physical care plan. The enrollment process will use individual birthdates. For example, if your birthday is in June and you are SPD, then you will be enrolled this month and so on until everyone is enrolled by next year. *LA Care* and *Health Net* will be the main operators of the enrollment process. These health plans have an interest in their new enrollees because they are capitated, which means a fixed amount of funding for each individual enrolled. Additionally,

the health plans are interested in the mental health of individuals enrolled because good mental health would lower physical health costs. The Department is working closely with *LA Care* and others to improve the manner in which enrolled SPD individuals can access mental health services. Everyone in the plan will know who their health care provider is, they will have a home, and they will receive good care.

12. The challenge entails identifying who is in the SPD. On one hand, many of the individuals who are SMI would also be SPD. The Department reassured the community that their mental health services would not change. Now, individuals will know whom their physical health providers are and have easy access to services. Another challenge for the Department was that within the SPD population, there are individuals whose disability might be unrelated to mental health, but they have other mental health needs that have not been addressed. There is pressure on the system to provide better access and care to a different kind of Tier 2 population that has not been served. New and efficient ways of creating partnerships with primary care, using a variety of electronic means, a variety of tele-mental health services, and others, will be the work of the coming year.

B. Feedback

1. Comment: The invitation to attend a dialogue and a discussion on Health and Behavioral Health Homes on July 13th was extended to the SLT. A flyer was shared with specific contact information and to RSVP.
    a. Response: Bringing the values of recovery within mental health integration is important. Primary care is open to the idea of peers being part of the design, planning, creation, and functions of primary care clinics and services. Unfortunately, primary care does not have a wealth of experience. Adapting the systems in order to meet the needs of the individuals served would be critical.

2. Question: When *Healthy Families* goes away, will the individuals currently being served get full scope Medi-Cal? Would anyone under the age of 21 get all EPSDT services if they were in *Healthy Families*?
    a. Response: Unfortunately, that is unknown. The major challenge was the eligibility criteria, which was higher for EPSDT than for *Healthy Families*. The array of services for EPSDT was much more comprehensive than they were in *Healthy Families*.

3. Question: How would the care be coordinated for a mental health client who had a regular primary doctor that was paid through Medi-Cal, but may have also been seen by multiple other specialists, which now are all on different plans? Since the client cannot see the original doctors because some are and are not on their new insurance plan, who has the responsibility to address this matter?

a. Response: First of all, they are making a sincere attempt to recruit primary care doctors, especially those who have been providing services to this group, into the managed care entity so there can be continuity. About 70 percent of all primary care will continue to be provided by individuals who are now in a managed care company, such as the physicians who have been doing that work. Work has been done to expand the definition of primary care to include certain kinds of specialists. An individual's primary care provider should be the same person that is treating them for their disability. These types of situations are being worked on for special needs people. Additionally, when individuals are initially enrolled, they will have three to four months to be re-enrolled more appropriately if needed. Once an individual is enrolled, they will have the opportunity to switch providers. Individuals may have up to 30 days to find a proper home. The mental health providers are unaffected by this and remain constant.

4. Question: Who is part of the dual-eligible population pilot projects?
    a. Response: The lead is Health and Public Health.

5. Comment: A concern that we should be an integral partner in the decision making process was shared. Disregarding what happens politically, this is moving forward in the background and the SLT needs to be part of the process.
    a. Response: One thing that makes it different is the cost containment, which is not the same as improving access. Quality is another issue. Due to MediCare, seniors have had access to extremely high cost care, which is not the same as quality. National organizations are not eager to switch tracks. Therefore, how will this be managed to contain the cost, improve quality, and keep apprehensive people engaged and cooperative? The SPD are those who do not have MediCare, which are excluded from this.

III. State Budget—Update

A. Susan Rajlal, Legislative Analyst, County of Los Angeles, Department of Mental Health, provided an update on the State budget.
    1. For additional information, please refer to the PowerPoint file titled: SLT Mtg_State Budget Update_06.15.11.

B. Feedback

1. Question: Where are mental health and substance abuse programs going to be shifted to in the State system?
    a. Response: Unfortunately, that it completely undecided. The Governor's administration has been open to hearing from DMH.

DMH needs to have in-depth conversations with stakeholders. DMH needs to have a voice in the final decision.

2. Question: Is the funding allocated for AB 3632 going to be transferred once the budget passes? Will the Trailer Bill go through on July 1st to education? Is there language about MHSA funding in regards to what will to happen to it?
    a. Response: MHSA funds will remain with the mental health department.

3. Question: How would MHSA funding be spent on education?
    a. Response: In regards to AB 3632, school districts were directed to contract with DMH and with the contract providers. MHSA funding may be part of the funding used to work with education.

4. Question: Who is working on that language?
    a. Response: Unfortunately, this is unknown. However, the question was important because of the interest of ensuring that children who receive AB 3632 services continue to do so. Currently, the plan states that county mental health departments will use the MHSA money exclusively for those children that the County is responsible for. The tracking details are under way.

IV. PEI Plan Implementation Update

A. PEI Update – Lillian Bando, JD, MSW, District Chief, PEI Administration Unit
    1. For additional information, please refer to the PowerPoint file titled: SLT Mtg_PEI Update_06.15.11.

B. PEI Outcome – Debbie Innes-Gomberg, Ph.D., MHSA Implementation Unit
    1. For additional information, please refer to the PowerPoint file titled: SLT Mtg_PEI Outcomes Overview_06.15.11.

C. Feedback

1. Question: Are we setting up a data collection mechanism to track the cost savings created through PEI programs?

2. Question: Can more information be obtained on the status of Early Detection and Intervention to Prevent Psychosis (EDIPP) and the CAPPS model from UCLA? What is happening with PEI?

3. Question: Is the fear that " this will be used to reduce the contracts" valid for the PEI outcomes? This pertains to not achieving great outcomes.

4. Question: Can detailed information be shared on the prevention only programs? Will it be an RFP process? How do they apply?

5. Question: What can the Department do to provide more support for the staff implementing additional models/programs?

6. Question: To what degree is the LGBT population being contemplated among these programs?

7. Question: When looking at outcomes, how is ethnicity and race being considered? When changes are made within an agency it hurts the fidelity of the EBP, therefore how is that taken into consideration when the evaluation of the program is done?

8. Question: How is this operationalized, using data and real-time quality improvement, as one moves forward?

9. Question: What is the plan to get to 17.5 percent for older adults from the 'Impact' model?

10. Question: Where are the savings for other age groups? Did the savings go back to services?

11. Question: Are cultural barriers, user-friendly environments, and cultural stigmas tracked in order to determine what does and does not work?

12. Question: A large amount of time, effort, and cost is associated with collecting and analyzing data, and collaborating. Will this be incorporated into the dynamics of implementing the programs?

13. Question: Is a safety mechanism being considered to ensure that staff and practitioners feel adequately trained to implement these practices?

14. Question: How will individuals be held accountable?

15. Comment: During the learning and implementation stage, we should resist the focus of becoming client needs assessment experts because there may not be a good match, which may result in not so great outcomes. Moreover, there may not be good fidelity in the agency in regards to the model.

D. PSAs – Early Start Suicide Prevention – Karen Zarsadiaz, Public Information Officer

E. Client Videos – William Arroyo, MD, Regional Medical Director

F. Youth Suicide Prevention Website – Martha Alamillo, LCSW, Partners in Suicide Prevention, Family and Community Partnerships
   1. For additional information, please visit *www.preventsuicide.lacoe.edu* .

G. Provider Panel – Successes and Challenges

1. Panelists:
    a. Alexia Jaouich, Ph.D., Director of Evidence Based Practices, Star View Community Services
    b. Elizabeth Gonzalez, LMFT, Evidence-Based Practice Clinical Coordinator, Five Acres
    c. Barbara Paradise, LMFT, Program Director-Lancaster, Providence Community Services.

2. Discussion - Challenge and Solutions

    a. It has definitely been a challenging year for providers in rolling out transformation PEI for this past fiscal year. Now, things are more settled. This year it is about sustaining, fine-tuning, and providing additional support. This year was a success. In regards to our experience, it did require sufficient changes to our systems. We currently have 95 percent of our services and our staff trained in EBPs. It went from small scale to extra-large scale quickly. Having some experience definitely helped in terms of knowing what kinds of supports are needed to implement EBPs.

    b. In regards to EBPs, research shows that practice works. However, implementing the model was a challenge. In particular, it was a continuous effort of tweaking and changing our systems. We began by changing a few of our quality assurance systems, our training systems, and our support systems. We shifted staff and supervisors to different positions to match their clinical, implementation, and training strengths.

    c. Supervisors and staff were involved from the beginning. We wanted to hear from them about which evidence-based practice interested them and where they saw their strengths in order to best match their interests to existing experiences and skill sets. This process helped increase buy-in. The buy-in from supervisors and staff was essential because they were the ones who would make it happen.

    d. We wanted to hear their concerns and questions. We wanted to meet their needs before including them in the endeavor. We wanted them to be excited and ultimately see it as a benefit to the families. It was going to be difficult but we realized that, in the end, it was going to provide more effective services to more families in a shorter-term basis. We had already seen that happen with our original EBPs through Katie A.

e. After consulting with various providers that did not have experience with implementing evidence-based practices, we realized that our motto was "support, support, support." We realized that we needed more time for training, supervision, and data collection.

f. How does one adapt the practice to meet the needs of multitudes of families, which come from different ethnic groups, socioeconomic status, and historical backgrounds, while still meeting the requirements of the model?

g. For example, using the trauma focused EBT, our supervisor and staff supported new teams, which was something they had been doing for two-to-four years. The supervisor and staff were dispersed into new treatment teams to provide support, such as providing additional trainings. All practitioners would convene once a month. The importance of learning through actual practice was highlighted.

h. Since the supervisors were learning the model at the same time as the staff, the supervisors needed to be educated quickly to understand the model in order for them to feel capable to support their staff.

i. Using the outcome measures involves a lot of support, time, and continuous conversations with DMH. Overall, we had a successful year. We felt supported in terms of DMH listening to our concerns and attempting to address them to the best of their abilities.

j. The issue of buy-in across the different levels of the agency made a difference in regards to implementation and the support from DMH and the service provider network. For example, partnering with networks, such as in the trauma focused EBP, allowed us to hold meetings with all the trauma focused supervisors from all the service providers to work and problem solve as a way to improve fidelity, while remaining flexible to the model. Moreover, the buy-in across different levels of the agency was important because of the short-term models. Agencies had a lot of support from the upper level management to support the supervisors, who were responsible for the direct implementation and data collection. Fidelity was important.

k. Support and accountability were also important. In particular, accountability is important when gathering the outcomes and problem solving the issues around outcomes. Doing thorough assessments of client's needs and then identifying an appropriate intervention to meet the client's needs were found to be successful.

l. An understanding across the SPAs, from all the service providers, in regards to what EBPs are available to better link a family is important. More collaboration and community partnerships are important.

m. Many EBPs provide a flexible service delivery structure. Particularly, Trauma-Focused Cognitive Behavior Therapy (TFCBT) is a new program that has rolled out at a large scale. In the initial learning stages, it was important to be close to the model. As practitioners gain competency, they identified that accommodating the model to be culturally sensitive to the needs of clients was doable. The supervisors' responsibility was to monitor the fidelity of adopting the model to meet the clients' needs while staying close to the model.

n. Some quick infrastructure changes were needed. Bringing in a couple of EBPs takes a couple of years to successfully implement and transform. However, it had to be done in a much shorter timeframe so we needed to look at which support services and resources were going to be needed.

o. In order to support the practitioners, different supervision styles needed to be looked at. In regards to time management, this was different because supervisors were trained in a couple of EBPs, which meant they had more group supervision. The training was lengthy. However, it has improved the quality of care and our accountability. It gave people the opportunity to hone in skills, specialize, and offer a specialty treatment and service to the community.

p. We have champions for each one of our groups, which has helped to see the benefits of the models. The beginning was rough. Now, we are getting to the point where they have been using the model often. They see the successes and have become their own cheerleaders.

q. Currently, we are looking at cultural adaptation. For example, our deaf services program is using brief strategic family therapy. They are using management and adaptive practices and seeking safety. Cultural adaptations were also needed to provide services. Working closely with the developers was important because fidelity is crucial to ensure the work is done correctly. We partnered up with the developers to ensure that these adaptations were done according to their approval. Fidelity is important for these practices and the outcome measures were helpful in figuring out and identifying the next steps.

r. We heard a lot from the families, which are our gauge for success, that the models were effective. Many families have come in and said they were happy because they were able to get this done much quicker than what they thought. A mother from PPP stated, "I really thought I was a failure as a mom…Now I feel like I'm doing this the right way." It allows us to see more clients faster in a more effective manner. We have learned how to culturally adapt the models. However, the outcome measures were difficult to adapt. Moving forward, we are working closely with DMH, whom has been very supportive. We are able to communicate with DMH as providers to work as a team and ensure we are able to do this.

s. Overall, it was successful. At first, it was stressful and rough; we were missing some pieces, but were able to put those pieces together. Most practitioners did not come into this particular area of work to do EBPs. In fact, most of the practitioners' orientation was not connected to what the EBPs had to offer. Nonetheless, seeing the practitioners' gradual shift was nice. Before, it took them two years to do what they can now do in 12-to-16 weeks, which is great. Our families are happy.

H. Feedback

1. Question: Why was the American Indian countywide funding not mentioned in the countywide evaluations?

2. Question: What are the plans for EBPs that have not rolled out?

3. Question: Is there research that is more subjective in getting feedback from individuals who are in recovery in regards to their experiences, which also documents and provides a type of outcome? If not, why?

4. Question: In regards to schools and standardized testing, how can treating to the outcome be prevented?

5. Comment: There is a shared concern over the lack of Latino, bilingual therapists to provide services in monolingual Latino communities.

6. Comment: There are about 60,000 deaf and hard of hearing in Los Angeles and if PSAs were captioned, the Department may be able to connect with a new audience that the Department did not have prior access with.

7. Comment: A comment was shared on behalf of the service provider community pertaining to the massive nature of undertaking transformation, which was certainly significant. Although it was certainly difficult in the beginning, various issues were raised and the Department

ultimately listened and that needed to be acknowledged. Flexibility was a major issue. In particular, one of the challenges was with PEI, when it was first established there were very specific processes and guidelines that the Department had to utilize. Service providers had to make major shifts with transformation in terms of how the programs ran, which was difficult to do. Ultimately, the Department listened and that was something that needed to be highlighted.

8. Question: A concern was highlighted in regards to the Department's infrastructure to make sure that, when individuals see mental health ads, they do not get told that there is a three-month waiting list. What is the Department doing to ensure that the appropriate infrastructure is established?

9. Question: More information was requested from the service providers in regards to how to address the issue of staff retention.

10. Question: More information was requested in regards to the reports on the outcomes. Will the reports be available to other people?
    a. Response: Yes.

V. Public Comments & Announcements

A. Announcement: An announcement pertaining to 'Respite" – a peer staff crisis program in Santa Cruz, CA was shared. The need to have a similar program in Los Angeles was expressed. Handouts would be distributed through e-mail.

B. Announcement: An announcement was shared over the Los Angeles County Client Coalition elections for the Department of Mental Health, which were held on Friday, June 16, 2011, at 11:00 AM.

C. Public Comment: A concern was brought up regarding teaching students in schools how to eat healthy.

D. Announcement: The Disability Rights of California will be meeting in Burbank Marriot Hotel, on June 25, 2011 at 9:00 AM.

VI. Adjourn at 12:30 PM.