COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, October 17, 2012 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90010

REASONS FOR MEETING

1. To give an update from the County of Los Angeles Department of Mental Health.
2. To give an update on State legislative and budget issues.
3. To follow up on questions and concerns from September's SLT meeting.
4. To explain the process for mid-year plan changes, including the role of the SLT.
5. To provide information on the FSP Integration Pilot.
6. To present the SLT Ad Hoc Workgroup Report.

MEETING NOTES

Department of Mental Health - Update	***Robin Kay, Ph.D., Chief Deputy,* County of Los Angeles, Department of Mental Health,** provided an update on behalf of the Department of Mental Health. Dr. Kay informed the SLT that the MHSA Housing Program, now in its fifth year, received recognition for its ability to leverage millions of dollars in housing funds. She also informed the SLT about two collaborative projects with the Department of Health Services (DHS), efforts to prepare DMH for health care reform, and the implementation of the Katie A. Settlement. 1. **Question:** Is the need for IMD beds coming from conserved clients through the Public Guardian's Office? a. **Response:** It is a requirement that you be conserved in order to be in a locked facility. 2. **Question:** Can one IMD bed be replaced with eight slots for a MHSA Full Service Partnership (FSP)? The data presented earlier suggest that if somebody is taken directly from a hospital setting and put into a FSP, good results will ensue. A 1-to-8 ratio—which is part of a FSP—might create more capacity in the system. a. **Response:** The idea of capacity building is great and it is time for the SLT Budget Mitigation Work Group to consider capacity building, as this is a very serious need. The Board offices, however, have been emphasizing IMD beds to address the problem of a lack of IMD beds. Capacity building is the right concept. 3. **Comment:** We have been accepting IMD clients for 20 years at our agency. IMD beds that cost $50,000 to $75,000 each are a waste of money. On a different note, DMH is currently a model at the State level of how to do things well, as viewed from the Oversight and Accountability Commission (OAC). Los Angeles stacks up well in producing good outcomes, having good data, and doing things that help people recover. The FSP-FCCS integration pilot was a remarkable success, partly because this Department paid more attention than most counties to serious stakeholder involvement and pulling ideas from stakeholders. Congratulations are in order.

a. **Response:** On behalf of the Department, thank you for the compliment. Stakeholder engagement has changed the culture of the Department. It has been enriching on both sides, not just the opportunity for stakeholders but also for the Department to get broad input and create transparency in what we do.

4. **Comment:** I also want to add that DMH's efforts to giving voice, listening, and engaging underrepresented ethnic populations is the most powerful I have seen in this county and state.

5. **Comment:** I respectfully disagree with some of the people who feel that IMD beds are unnecessary. Often, hospitals get rid of people because they do not want the individual to be in a hospital bed for a long time. These clients are not getting the appropriate service.

6. **Question:** Regarding the Department's initiative to expand psychiatric emergency capabilities, specifically Alternative Crisis Services, could you provide more detail on what is happening in that area?
   a. **Response:** There are a number of programs under the MHSA heading of Alternative Crisis Services (ACS), including Urgent Care Centers (UCC). The approved Prudent Reserve Plan establishes another UCC on the Martin Luther King (MLK) hospital. We are currently working on the design of that UCC and ultimately will put it out for a competitive bid. The UCC is needed because the existing UCCs are handling more demand than anticipated, including demand from the area served by the MLK hospital. A significant area of the county is not being served by UCCs.

      Also included under ACS are other MHSA-funded services like the IMD step down programs. Those IMD step down programs offer an alternative to IMD-level care for people ready to leave. We evaluate people's readiness to leave an IMD but who still need some level of support before moving on to more permanent housing. Over the years, we have increased both the number of programs delivering IMD step down beds and the actual number of the beds. The services on the back end help with decompression on the front end.

7. **Response:** Is there any consideration of expanding crisis residential treatment services?
   a. **Response:** Yes. When we worked with the Board offices on the development of the Psychiatric Emergency Services (PES) decompression plan, we developed a menu of options including crisis residential programs but elected not to prioritize them at that moment because of expense. The idea of crisis residential programs is not off the table. However, the way they are currently licensed and funded does not fit into the limited funding available. We have crisis residential programs in Los Angeles, which are part of a portfolio of other programs all the way from IMDs to other less intensive residential programs. At this moment, we have not increased them largely due to limited funding

8. **Question:** When will the planning process for the Integrated Plan start and how long will it take?
   a. **Response** Two years ago, we heard we would need to develop a 3-year plan and that we should wait until

	the state issued guidelines. They delayed it twice over the past 2 years, and we were told last spring that we would start the planning this fall for this plan because we expected the release of state guidelines early in this fiscal year. It did not happen. Now, we were informed that guidelines for the development of the 3-year plan would be coming out later in the year with the planning process starting next year at this time. This was a state delay. What we will talk about today is planning for mid-year corrections, changes and modifications to the plan, not the 3-year plan. 9. **Comment:** Regarding IMDs and emergency services, the client may have both a chronic mental illness and physical conditions. A lack of places for clients needing long-term continuing care may be creating a backlog. a. **Response:** That is a great comment. DMH and DHS are interested in sharing a facility in order to address those needs, especially as we prepare for health reform. Both departments are almost ready to issue a joint Request for Information (RFI) for a facility addressing the needs of people with both mental health and physical health issues.
State Legislative and Budget Update	No updates.
Follow-up on September's SLT Meeting	***Debbie-Innes-Gomberg, Ph.D., MHSA Implementation Unit,*** **County of Los Angeles, Department of Mental Health** 1. We will review action items and key themes from the prior meeting to increase continuity from meeting to meeting. We will also establish a subcommittee that helps develop agendas in the future. The following are action items from September. 2. One action item was to follow up on the concern with the adequacy of outcome measures for children 0-5. We researched measures that might be relevant for the 0-to-5 population. If we find particularly good measures, we will bring them to the SLT and might pilot them with via FSPs. If outcomes are particularly poor in that area, it may entail additional data collection. 3. There was a question about who was focusing on school dropouts and what we are doing to address this issue. Dr. Bryan Mershon is looking into that issue and will hopefully report back at next month's meeting. 4. There was another question about cost analysis for FSPs. The OAC has a contract with UCLA to conduct a cost analysis of the FSPs at a statewide level, as well as for each county. That information is useful and will make some of us feel good about the efforts we have put into FSPs. We will try to present the information at a future meeting.

	5. Additional questions were asked about the concept of emotional well-being and its eight elements. I will make a list of the data elements we collect and how we collect them. For example, I will identify if the data elements are self-reported by clients and whether they are collected through the Integrated System, our billing system, or the client or clinician. I will do that for FSP (which is the most intensive program), Field Capable Clinical Services (FCCS), Prevention and Early Intervention (PEI) and Wellness Centers. This document can guide future discussions. **Feedback** 1. **Comment:** Regarding school districts and school dropouts, is it possible to include school expulsions, too? Sometimes a child or youth is expelled from school for a variety of reasons, which may be due to social and emotional issue. a. **Response:** We can collect that for FSP programs and we may collect it in some of our PEI programs. I have to take a look at the specific measures, and well inform Dr. Mershon about school expulsions. 2. **Comment:** About 6 months ago I raised the issue of clients who are very difficult to treat. You let me address the issue with the MHSA Implementation Team. I appreciate this and am looking forward to the next step. 3. **Dr. Southard:** Adding to the Department's report, I attended an AB 109 implementation meeting with the Probation Department, Department of Public Health, and the Sheriff to discuss how to report the program outcomes in a sensible way that shows what is happening to the flow of clients. This way we can draw policy recommendations for improvements in the treatment and follow up processes for that population as we try to address their mental health, housing and substance abuse treatment needs. We made good progress. 4. Action Items • Ask Dr. Mershon to look into school expulsion rates and school dropouts. • Dr. Innes-Gomberg to present information from the cost analysis of FSPs in a future meeting.
Mid-Year Plan Changes and the Role of the SLT	*Debbie-Innes-Gomberg, Ph.D., MHSA Implementation Unit,* County of Los Angeles, Department of Mental Health 1. We talked about the 3-year Integrated Plan earlier. Now we want to inform you about the important role the SLT plays when there is a proposed mid-year change. Most counties make changes to MHSA programs via the MHSA Annual Update, mostly due to efficiency in the planning processes and public postings. In Los Angeles, we also try to include changes into the MHSA Annual Update. In terms of the process for proposed mid-year changes to MHSA programs: a. Any stakeholder group—including the Board of Supervisors—can recommend a mid-year change based on

situations that arise or events that happen affecting the public mental health system and with partner organizations.

b. The proposal comes to SLT, and the SLT can adopt the proposal as presented or recommend changes to the proposal. The SLT's final recommendation goes to Dr. Southard, as Director of the Department of Mental Health.

c. The SLT's recommendation is posted for 30 days to obtain public comment. For a mid-year change, however, a public hearing is not required. Nevertheless, we do consult with the Mental Health Commission to ensure they are fully apprised and supportive of the efforts.

Feedback:

1. **Question:** I do not have a problem with the process. I have a problem when we are presented a large document with only fifteen minutes to make the decision. I request more timeliness so that we can obtain input from our constituents beforehand. We do not want the SLT to become a rubber stamping organization.
   a. **Response:** Because many of you have to go back to Service Areas or other organizations and constituents that you represent, timeliness is very important.

2. **Question:** What stakeholder groups can propose a mid-year change to a plan?
   a. **Response:** A stakeholder is broadly defined and includes anybody that has a stake or interest in an element related to MHSA and the broader public mental health system. AB 1467 specifies the stakeholder composition for the SLT.

3. **Comment:** Just to review, if a stakeholder group wants to propose a mid-year change, it would come to the SLT and present the proposal. The SLT would hear the proposal under the right conditions (e.g., enough time to deliberate) and in the end would recommend moving forward or not.
   a. **Response:** That is correct.
   b. **Dr. Southard:** This could happen in two ways. The first way is relatively clear. The Department gathers input from the Board and other interested parties, and we present the proposed plan to the SLT, making sure you have at least two weeks to review that proposal, know where it came from, and what the intentions are. The SLT can also consider a proposal from one of the constituency groups on the SLT. The group can ask for a place on the agenda and present a proposal. The second way is not as clear, that is, it has not been completely worked out procedurally. Do you want to entertain changes from any group? If so, how do they get proposals to the SLT? Who screens these proposals? Is there a screening process? Should there be a threshold in terms of entertaining proposed changes? How would the SLT engage in decision-making? These are the procedures that need to be worked out. We would look to the SLT to provide guidance on how

	to handle those proposals. 4. **Comment:** I have been in this room when we found out there was a committee of providers and Department staff meeting for several months, and we were given fifteen minutes to make a decision on an item. We need to say that is not acceptable. a. **Dr. Southard:** Yes, I agree it is not proper to do this. And I disagree with your characterization. I do not believe that what you described happened here and it would not be proper. 5. **Question:** If I represent my Service Area, I need to see information with enough time in advance to talk to my Service Area Advisory Committee (SAAC) and receive input. a. **Response:** I appreciate your comments. It is important to have enough time to make an informed recommendation. 6. **Question:** My understanding of the process is that you work together to articulate a plan, then you bring it to us and we make comments. Consumers and family members should be involved in that early stage and that is not the case now. a. **Response:** Your point is well taken. Many of us have been involved in these planning activities. For instance, the Service Area Navigators came from meetings in Service Area 8. Were we as inclusive as we needed to be at that time? I do not know. Maybe we were not, but your point is well taken. 7. **Question:** The Department does not want to waste people's time in coming to the SLT too early. However, approaching the SLT earlier is better in order to keep people informed. The SLT might say to a proposal 'you have to go and do some more work.' But it is much easier to build feedback at an early stage in a constructive way than to interpret feedback as criticisms at a later stage.
FSP Integration Pilot	***Debbie-Innes-Gomberg, Ph.D., MHSA Implementation Unit,*** **County of Los Angeles, Department of Mental Health** 1. In a prior meeting, Dr. Southard described the way the MHSA was implemented locally. It was a very sequential process. The State Department of Mental Health, for instance, first created ideas for each MHSA plan and established guidelines to develop a plan. (This was the case for all MHSA plans.) After receiving the guidelines, our Department initiated a planning process by breaking into work groups and developing plans that were ultimately submitted to and approved by the State. 2. We created buckets for specific programs funded with specific components of, in this case, the Community Services and Supports (CSS) Plan. The buckets were quite functional because they allowed us to create a system of care at a time when our larger system of care was falling apart due to realignment reductions. We currently have a

system of care and programs called Field Capable Clinical Services (FCCS), Wellness Centers and TAY Drop In Centers. These programs were not well integrated into a seamless continuum, in part because of the funding (albeit the funding is only one element of the problem). This approach worked for us in 2005, 2006, and maybe through 2008, but then it stopped working as well. This situation will likely worsen as we think about the implementation of healthcare reform, funding models, and presentations from national experts. There is a clear sense that how we currently fund and look at programs will change drastically in the upcoming years.

3. I will present a pilot project that is intended to generate insights on how to create a more seamless continuum of services. I will explain the concept behind the pilot project, the regulations that allow us to conduct it, the differences regarding how we look at the FSP target population now and how this would change in these six programs. I will also describe the continuum of services and to give you a sense of why the idea of integration has gained so much support the last couple of years. One of the provider participants will discuss about the benefits of this one-year project to the consumers her organization serves.

See PowerPoint Slides included with October 2012 packet.

Feedback

1. **Question:** Why did you leave out 'drugs and alcohol' as a measure?
    a. **Response:** It is important to recognize that most clients have co-occurring disorders. However, co-occurring disorders was not actually in the FSP regulations. I took the measures right from the regulations.

2. **Question:** How are older adults defined? In some cases, people use 55, 62, or 65. I have never seen 60. Where did that number come from? Do we have to create a separate system to track older adults using 60 using DMH's definition?
    a. **Response:** The State DMH came up with the age groupings presumably with community input, but I do not know exactly where it comes from.
    b. **Response:** The Older Americans Act defines older adult starting at 60 years.

3. **Question:** What does un-served, underserved or inappropriately served mean?
    a. **Response:** Un-served persons are those who have never been in the system before or only get mental health services when they go into the hospital or go into the jail. Underserved are people that require a level of service that they have not been able to access because the county could not provide it or had so little of that service it just was not enough. Inappropriately served refers to people who are not receiving the right type of service.

4. **Question:** A needs assessment completed in 2008 revealed a higher risk for suicide risk and isolation for older

adults. Did these measures also fall in same category of substance abuse?

a. **Response:** They are absolutely part of this priority population, even though they are not specifically called out here. For those at risk of suicide, they will go into the hospital and that is how it is characterized here.

5. **Question:** I love the concept behind the pilot project, but am not happy that you are stymied by regulations. Regulations were never passed by the legislature, so they can be changed. Have you asked the OAC for a change in the regulations?
   a. **Response:** The California Mental Health Directors Association (CMHDA) made recommendations to the Department of Health Care Services (DHCS) and are still in discussions. I do not know where the OAC is with regards to changing regulations.
   b. **Response:** The OAC needs to be involved in all regulation changes.
   c. **Response:** There were multiple efforts over the last couple of years to address 'underground' regulations. Certain regulations were put in place that we are held to, until DHCS notifies us otherwise.

6. **Question:** Separate from this pilot (but not captured in this chart) are the current FSP practices that classify people at different functioning levels. There are some people at with higher levels of need and services than the average and there is a different rate that gets paid. By having the right rate, you could actually capture different levels via the scale.
   a. **Response:** What you are proposing (i.e., different rates) fits within the current FSP.
   b. **Response:** Your data can be used to figure out what the real rates should capture, and tell if some people need a more intensive support and others need less intensive support.
   c. **Response:** I want to use the data to start thinking about what FSP should be, but the challenge is that some of the work that needs to be done in FSP is not done in FSP; it is done in FCCS. There is a different treatment team as the transition happens from FSP to FCCS. A disconnect can happen.
   d. **Response:** Let us not create a system where consumers are transferred from one provider system to the next due to funding requirements. The system that you are now trying to fix led staff members to terminate consumers in order to make room for new clients. For me, the answer is to create more FSP slots and make sure people do not have to be moved just because of funding requirements.
   e. **Response:** When defining dollar amounts and levels within the FSP, there is an administrative barrier that limits the flexibility of the dollars. There are folks who are stuck in the FSP system. I can provide a concrete example from a week-and-a-half ago at my organization. All FSP slots were full, but we received a call from the Older Adult Bureau asking that we accept seven people into FSPs. I indicated we could make room in our programming but that we had no more FSP slots. So I asked about what I should do and I heard back, "I do not know, you need to take them right now." More specifically, we could not discharge people from FSP into FCCS (a lower level of care) do to the need for housing dollars available via FSP. It was not because they needed the clinical services. I asked if we could go above our FSP slot number, because we had clinical room and capacity in FSP to go above our slots. I was told 'not yet' even after pointing out that we were

working on this pilot. So I said, "Ok, that is fine. Give me the names. We will take care of it."

7. **Question:** What does MORS mean?
    a. **Response:** MORS stands for the 'Milestones of Recovery Scale' and it is an 8-stage recovery scale developed and copyrighted by MHALA.

8. **Comment:** Continuums work great when people move in one direction (i.e., from worse to better), but people sometimes revert back or people sometimes fall into the middle of the spectrum between FSP and FCCS, where they need intensive level of services in some areas but not in others. This is part of our struggle in our Service Area: people get stuck and may never move from the FSP level of care. We need to tweak the sub-categories to have flow. The Integration Pilot will address that.

9. **Question:** The application of MORS seems so subjective especially when you look at 'engaged' and 'not engaged.' If you look at your continuum, you have MORS scores 1-6 between 4 and 3. What are you really measuring? Is that telling you anything?
    a. **Response:** When the CMHDA created the 'Levels of Care,' we reviewed two specific instruments: LOCUS (Levels of Care Utilization Scale) and MORS. The LOCUS tends to focus on the lower level, i.e., getting people out of institutions. (Mary Marx, for example, would probably really like LOCUS because that focuses on housing and institutionalization.) We may learn that the MORS does no tell us as much as another instrument. We are planning to use MORS to see what utility it may bring to decision-making.
    b. **Response:** It is great to be open to the possibility of other ways of doing this. Maybe MORs might not be answering our questions and there might be other ways and approaches to capture the information we need.

10. **Question:** Many people here may not be familiar with MORS. Is it possible to provide more description? For example, what is a 4.1 versus a 3.5? Do you need to monitor individuals on a monthly basis and measure which teams are more effective in their approach and professional preparation? If you look at physical medicine, some teams are overqualified for what they are asked to do. We need as much detail right from the start and always use that same one input. We have to measure resources, effectiveness and costs.
    a. **Response:** CMHDA's Levels of Care describes a service continuum. Level Four is the most intensive level, generally with very low staff-to-client ratios. Level One is really self-management, when a client is fully integrated into the community. Using a recovery scale to guide treatment is critical to advancing recovery services and increasing flow.

11. **Question:** Where do current FCCS clients fit in on the MORS? I understood it starts at like a five or six. Is that more accurate?
    a. **Response:** A five or a six.

b. **Response:** FCCS on the lower scale would start at a five or a six?
c. **Response:** Yes. But we do not have a tremendous amount of data to support this. These are working assumptions at this point. I think every provider here who is familiar with MORS would say that our FSP clients come in at a one to four.

12. **Comment:** Regarding the comment about the different rates, the idea is to make sure the care was based on individualized client plans. Ideally, when the individual is in the pilot, they receive services based on an individualized client plan. We want to get away from more compartmentalized thinking. We do not want to set up separate rates and service arrays. That defeats the purpose, if you create new buckets. If they are in the pilot and eligible, whatever their client plans dictate is what they should be getting.

13. **Dr. Southard:** My questions are not for immediate answering, but I hope the group wrestles with them: (1) Are there significant differences by age group in terms FSP and FCCS that we should pay attention to? (2) How will we track to make sure that this plan is not impeding access to the most ill? (3) How are we making sure there are no incentives built into moving people prematurely from FSP to FCCS or lower levels of care?

14. **Comment:** A fourth concern to add to Dr. Southard's list would be this: how do ensure we are placing people in appropriate level of care, versus a level of care that has nothing to do with their treatment plan. Putting people into a FSP—because it comes with housing dollars—does not make sense if they do not need that level of care.
    a. **Response:** I do not think it is happening the way you are describing it. What happens is that you first have a FSP client that needs that level of care. But when the client can transition out of the FSP to another program, the client gets stuck because the housing money does not exist in other programs.
    b. **Response:** It is like you get somebody off the street into housing, and he gets stabilized and better. But he is not ready to be discharged from services and needs ongoing housing support. The intensity of mental health services could be significantly decreased, but it is hard to them out of the FSP program because we need to continue to access the housing dollars. That is not right, but it gives you an idea of the problem.

15. **Comment:** I have seen this process work both ways. I have seen a FSP provider move somebody into FCCS who was not ready to be moved because the provider did not want this client anymore. The client eventually left that provider and went into another FSP program. So, it is important that we not only track people who transition out of the FSP but what happens afterwards. We need to track what happens to people after they leave a particular agency and FSP, so that we can halt the creaming process. We need to avoid agencies saying, 'oh this person's just too hard to deal with and therefore I am going to him to a lower level of care.'
    a. **Response:** We have done that before. When a client moved to the community in ICSC, we tracked that for 3 months. We could incorporate that into the pilot, maybe using a sampling technique.

16. **Comment:** How are you doing with cultural differences? Does that come into the picture? What are some of the

things that can be done to look at the success for the different cultural groups that we are treating in the FSP program?

a. **Response:** Every age group puts together a summary of referrals authorized by countywide administration on a monthly basis for FSP. It summarizes the total slots by provider and Service Area, what client falls under in terms of their focal population status as well as their ethnicity. We look at the targets that we originally created that may or may not be applicable. We look at providers as well as the Service Area, whether they have met the target for that particular ethnic group. We will continue to do this. As we examine the data, we may discover interesting trends that are either very positive or that we want to address.

17. **Comment:** Regarding the pilot project, I did not see if funding could be used flexibly based on the individualized client plans. That is a critical element because we want to maximize revenue use to ensure people get what they need based on level of need.

18. **Question**: Can clients enrolled in the pilot project receive Wellness Center services without dis-enrolling from the pilot?

19. **Comment**: I want to focus on the new clients who are in the highest need category, if we are combining the FSP and FCCS population. There needs to be further discussion about what we mean by 'at least 10%.' What does that mean? It is a very vague statement because at least 10% can end up being 80% or 90% in practice. If we are combining the FSP and FCCS population at 80% or 90%, there is not enough resources to serve everybody. From our perspective, we want as many people to get in to FCCS before they get to the very highest level. So if FCCS becomes too restrictive in terms of the level of resources that are for the very highest need, people just below that need might not be able to access the services. That is why we think the pilot has merit.

a. **Response:** Flexibility is key and the work group, which now has Service Area representation, will address these details.

20. **Question:** On the subject of drugs and alcohol, it is important in terms of how clients succeed or not with FSP. Can your measurements show how people with co-occurring disorders do in FSP, any why?

a. **Response** The outcome measures for FSPs include use of drugs and alcohol. We can examine FSP outcomes in relation to these measures. Looking at the slide about service array and the key services, we need to look for models that integrate services well to be successful. We will bring the data back to Service Areas on a monthly basis to this committee and others to help us look at whether we are on the right track or not. I want this to be transparent.

21. **Question:** I have two points. First, creating flow is important to all of us but we are concerned about whether this approach is really going to create flow or actually work in the opposite direction by restricting the number of true

FSPs, or old FSP clients that are going into the providers. I have two points. First, the District Chiefs discussed that the 10% would actually lower the capacity of admission for most of your clients. When we did our math it looked like we would lose about 600 FSP slots across the county, and we have 330 people waiting for an IMD bed and people in hospitals that cannot get out because there are no IMD beds to move them to. Second, from a regional District Chief perspective, it is not clear how this is going to be managed. Will it be managed centrally? If so, that takes away from regional management, particularly the flexibility to use any slots from those particular providers. Since many of the providers involved in this project are the bigger providers in our Service Area, it takes away about a third of the slots that I manage.

a. **Response:** Service Areas do not lose capacity. Your navigators can still refer any client to any of these six programs. The data or the reports that I will give you on a monthly basis will help you manage service intensity in your Service Area. I need your help crafting what reports look like and choosing what data elements will be most helpful to you. We do not exactly know what that balance here is because the intervening variables, at least in part, relate to how successful the programs are in terms of providing interventions that make a difference. ICSC and the second learning collaborative on advancing recovery practices focus more on the implementation of evidence-based practice through strength-based assessments. They are learning in that project that using a strength-based approach and evidence-based practices also makes a difference in flow and capacity. There are a lot of variables to consider.

22. **Question:** I represent SEIU and have a question regarding staffing. Has there been any analysis regarding the type of disadvantages and advantages a combined program will have?
    a. **Response:** As a service provider involved in this project, we have examined this issue over the past six or seven years in both counties we serve. We conducted staff satisfaction surveys, a weighted caseload analysis, and other activities of this sort to ensure we have a balanced caseload to make sure nobody is overwhelmed. We have found that our staff satisfaction goes up so much more if they have a balanced set of folks they are working with at various levels of recovery. I believe strongly that if you do not have a healthy staff and work on burnout prevention, you are not going to get anywhere.

23. **Question:** Are there any disadvantages to having a combined program with regard to staffing?
    a. **Response:** When everybody is having a crisis and your caseload is a little bit higher than it should be, then that is a disadvantage. You need to provide extra support and be very well aware of that constantly. If you went to my staff without me there, they would say they really enjoy the combined caseload. For instance, we tried to pull out PEI caseloads from the overall caseload, and they mutinied. They all wanted to learn about the EBPs.
    b. **Response:** Didi Hirsch also found they had to make sure training on FSP and FCCS was available to all, because the staff associated with FCCS did not have all the details of FSP and vice versa. We are not going to use FCCS as a language anymore for these 6 providers. It is going to be FSP and training helps with that.

24. **Question:** I do see our staff members who work countywide benefiting from this kind of pilot project. With this pilot project, countywide agencies can combine their FCCS and FSP budgets into one budget and then the slot allocation would be similar to a guideline of what they should achieve. At the beginning, we are seeing them four times a week, and then as the situation calms down we begin to get along well because we established a therapeutic relationship.
    a. **Response:** Exactly. When you think about health care reform, it is likely to be something similar: you receive a pot of money with a set of expectations and outcomes attached and it the provider's responsibility to figure out how to best achieve outcomes.
    b. **Response:** For Asian/Pacific Islanders (APIs) countywide, this project would be a huge benefit because the slot allocations by Service Area are still trying to do countywide work, which has been a huge barrier. I hope it brings us some good results.

25. **Question:** You talked about the part of the budget that goes for non-mental health, for instance the rent subsidy. Will that pot be the same amount and be extended to the whole population so that it could be used for rent subsidies? Or will it be increased so that you serve more people. Does this involve an increase in funding for the programs?
    a. **Response:** That issue involves contract amendments and addressing this issue is part of our next steps. That negotiation happens in the next two months. For instance, it is likely that providers will say they are going to need X amount of additional dollars. These funds would likely come out of their service dollars, though, because we cannot increase MHSA funds.

26. **Question:** How are peers utilized throughout the pilot project? My understanding is that the MORs does not introduce the use of peers until a score of about 3 or 4 on the scale.
    a. **Response:** When you said it does not utilize peers until a 3 or 4 score, do you mean in terms of the services?
    b. **Response:** Yes. If you have a score of 1, it gives suggestions of what kind of "interventions" can be used. Around a score of 3-4 or 4-5, peer services are introduced. My view is that peers can go throughout the MORS scale as a recommended or suggested intervention from a score 1-8.
    c. **Response:** Thanks for raising this issue because we are going to learn a lot from this pilot project that helps us think about how to best use the MORs. I did not create the MORS but the role of peers has probably been underutilized and undervalued.

27. **Question:** Where are the checks and balances? A lot of providers will understand the approach and will do exactly what needs to be done, but others will not understand or may not want to do what is in the best interest of the client, family or whoever they are serving.
    a. **Response:** One thing we learned in bringing providers together over a year and a half was that the level collaboration, cooperation and accountability was truly amazing. More prominent in this project than in ICSC

	is accountability related to data and outcomes. With monthly reports going back to these providers, the Service Areas, and the Department as a whole and maybe even SLT, we will manage the data in different ways than in the past. Managing data is a critical part of accountability in this process. 28. **Question:** Is there an expectation regarding the percentage of service delivered in the field? I heard some complaints from clients who are FCCS who are disappointed that more of that service is not delivered in home. There is pressure to come to clinics. How does it relate to the project? a. **Response:** The percentage of services delivered in the field was worked out with ACHSA. As clients move forward in their recovery, we might learn about trends pertaining to the increased or decreased need for field-based services. We hope that clients use community resources more so they can eventually successfully transition to a Wellness Center. 29. **Comment:** I suggest that training on MORS scores be offered to peers so that they can be part of the evaluation process. a. **Response:** It is a great idea. 30. **Comment:** Regarding FCCS percentages in the field, ACHSA's position has been that it should be whatever the client needs, whether it is 5% or 100%. There should not be a fixed percentage; it should be based on every client's individualized needs. If every client needs it in the field, everyone should get it there. If half of them want to go to the clinic, half should receive it there. 31. **Question:** Are you accumulating enough evidence from the programs involved in the project to make a good case for housing as an independent category resource, so it can move where it is needed regardless of the place on the MORS? a. **Response:** This is a really good and it goes back to the earlier comment about advocacy at the state level to eliminate that regulation.
SLT Ad Hoc Workgroup Report	**Jim O'Connell, SLT Ad Hoc Committee Member** A. Provided an update on the SLT Ad Hoc Committee. Our charge was to put more power into the SLT. We want the SLT to have meaningful feedback loops, so that we are an active part of providing suggestions and guidance to the Department of Mental Health. B. We have tons of data dumped from directly operated programs and contract providers. Our first job is to get a handle on the data we have available to us and from that data extract indicators and turn it into a dashboard consisting of a series of meaningful and significant outcomes and a priority set of measures. Hopefully, we are not going to create any new data, but rather extract a series of measures from existing data that looks at the system at

various different levels: How are we affecting the community as a result of the work we are doing? How are the various systems that serve our clients doing (i.e., Probation, Health, Public Health, etc.)? How are programs doing? Ultimately, how are individual consumers doing?

C. This dashboard will allow us to share data with multiple stakeholder groups, including the SAACS. This information can be discussed at the Service Area level and the SLT subcommittees which will have an opportunity to utilize these data in doing their work. Other stakeholders like NAMI, the client coalitions, UREP populations, and others can begin to examine what is happening from their perspective and can provide feedback. The SLT can also review information and make suggestions to the Department. Contained in this proposal is the idea that this is a continuously evolving process. Lastly, at no time would this become a closed reporting system. It would always be open to the idea that other measures can be added later date.

Feedback

1. **Comment:** We see this as a continuous learning environment for everyone including the providers, contract providers, as well as the Department. We can see how to improve the services and outcomes for our clients and the positive impacts for the community as a whole.
    a. **Response:** I agree. There was a wonderful sense of the focus that this dashboard aims to provide. It can provide better services to our clients and ultimately produce a more significant community that we all believe in.

2. **Comment:** This is a great start for a model. I want to thank the Ad Hoc group for its work on this project. In order for this to really be effective we need a representative from each SAAC on the SLT. I want to really encourage that to be part of that process.
    a. **Response:** There is complete agreement with including the SAACs.

    b. **Response:** The SLT Ad Hoc group that looked at representation agreed we missed the train on not having SAACs designated formally as organizational representative who can name their representatives on the SLT. Beginning in January, we will begin the process of renewing the SLT membership to correct for that.

    c. **Response:** Whoever takes that SAAC position has to be in attendance at the local SAAC meetings and be a two-way communicator, bringing to the SAAC what is happening here, and bring here what is happening in the SAAC.

3. **Comment:** Services for different age groups and information on what works and what does not work for each age group is missing. Sometimes it seems we are trying to fit a program that does not work for an age group. That might be good data to collect.

	4. **Comment:** In partnership with the Department, the Ad Hoc group will be reviewing an inventory of all the data elements collected in order to recommend priority measures to the SLT for feedback. Our role is to make sure the data will be meaningful for you and stakeholders you represent. 5. **Comment:** We want to use this information as an opportunity to inform the group to improve a process, a service or a system; it is not about a blame game.
Agenda Design Team	1. **Comment:** We need to form an agenda design team. The agenda design team is not an all-powerful, executive committee. These are individuals we can contact as the agenda is being designed so that it addresses your interests and concerns. We need to nominate individuals, and at the last meeting you nominated Wayne Sugita, Ruth Holman, Jim Randall, Nina Sorkin, Jim O'Connell, Carmen Diaz, and Romalis Taylor. Today we will open up nominations to identify the top five individuals. After the top five individuals are identified, we will see if the five people with the highest number of votes can adequately represent your perspectives. If not, we can conduct a second round of voting to make sure key interests are represented. 2. **Question:** I am confused. Are we are setting up a subcommittee to set up agendas for this group? a. **Comment:** Yes. This was a recommendation that came from you and approved in the July SLT meeting. To reiterate, you wanted a group we could contact to consult about the agenda. Results are as follows. i. Top five: Ruth Holman (20); Jim O'Connell (18); Carmen Diaz (17); Romalis Taylor (17); and Jim Randall (17). ii. Next five: Nina Sorkin (11); Wayne Sugita (10); Marlong Young (10); Mrs. Lamont (9); and Keris Myrick (2). 3. **Announcement:** Our next SLT meeting was originally scheduled for Wednesday November 21, 2012, which is the day before Thanksgiving. It was a complete oversight on our part. Rather than meet the day before Thanksgiving, we want to meet on Monday, November 26, from 9:30–12:30 PM. a. **Response:** Would it be reasonable to assume that when a meeting scheduled as much as a year in advance gets moved, our inability to attend the rescheduled meeting would not serve as black mark against our attendance? b. **Response:** Yes, let us make an executive decision.
Public Comment	1. **Announcement**: Power of Advocacy announcement. Find the results of client surveys posted in clinics. 2. **Announcement**: Power up the Vote for 2012, Oct 18th, 6 PM. Flyer Available. 3. **Question**: Question for Susan Rajlal. I am confused about the proposals. How would Propositions 30 and 38

affect MHSA monies?

a. **Comment:** There is no direct relation between Proposition 30 and MHSA. If Proposition 30 does not pass then Governor Brown has a tremendous problem on his hands. One could imagine that the Legislature might want to take a look at MHSA.

b. **Response:** There is a fundamental effect because a portion of every county department's budget is county general fund dollars. So, while Proposition 30 does not affect the MHSA dollars directly, if Proposition 30 does not pass then education and law enforcement will be affected. Much of law enforcement is funded by county general fund dollars and some specialized dollars, not substantially different from the way DMH is funded. If the money is not coming in on the state side, there will be less money available via county general funds.

4. **Question:** I also asked about Proposition 38.
   a. **Response:** If Proposition 30 does not pass, every department in the state will be affected. If Proposition 38 is passed, the money will go to education but it will not help the rest of the departments, such as fire, police, etc.

5. **Announcement**: Register to Vote

6. **Announcement**: Los Angeles County Client Coalition (LACCC) meeting on Friday, October 19, 2012, from 11 – 2:15 PM in the second floor conference room, 550 South Vermont.