COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, February 20, 2013 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90010

REASONS FOR MEETING

1. To provide an update from the County of Los Angeles Department of Mental Health.
2. To inform the group about State budget, legislative, and related issues.
3. To report on action items from prior SLT meetings.
4. To present the FY 2013-2014 MHSA Annual update and to receive feedback.

MEETING NOTES

Department of Mental Health - Update	***Dr. Marvin J. Southard, Director*, County of Los Angeles, Department of Mental Health** Dr. Southard updated the SLT on two major developments for the Department of Mental Health. First, the preparation and implementation of health reform in Los Angeles County. He discussed the strength of the Los Angeles County model and how the model will assist in readiness and implementation, but also addressing potential obstacles DMH faces. Second, he discussed service integration with the partners for alcohol and drugs. He spoke about the creation of a new model for Alcohol and Drug Benefit for Medicaid that would be employed as soon as possible. In addition, Dr. Southard discussed the upcoming budget presentation to the CEO, highlighting the budget implications of the EPSDT match, realignment issues related to AB109 –specifically as it relates to covering costs for individuals who lose their funding after they leave AB109 programs, and finally how to characterize and plan on using MHSA funds going into the future. Finally, he noted that Antonia Jimenez from the CEO's office will conduct a focus group process with the SLT after the April 17th meeting. **FEEDBACK** A. **Question:** On the AB109 aftercare, will that problem be covered by the expanded opportunity to put people onto Medicaid and get 100% government funding? a. **Response:** Yes, only if they fit in the right category. If the individual is disabled then it is not 100% it is 50% federal funding. We are trying to make sure that everybody who is on AB109 gets enrolled in either Medicaid or the LIHP in preparation for that. The enrollment process is less robust than we hoped. b. **Response:** We may need institutional help from mental health advocacy or organizations. I want to do an automatic signup program so that as people get discharged from jail, AB109 or not, get enrolled in programs they are eligible for. In the long run, this assists those eligible for Medicaid expansion and the kind of person that our health plan wants to enroll; young, healthy people who do not think they need medical care. B. **Comment:** At the state level, we did something similar for juveniles because Medicaid benefits were cut off when they went into Juvenile Hall. It took 45 days to re-enroll them after they got out. The state terminated their benefits instead of suspending them. We worked on two things, automatic enrollment when exiting camp or the halls and a suspension mechanism instead of a termination mechanism. The model is there. **Response:** There is a concomitant thing that happens with juveniles that we hope to extend to adults ; if a kid is in

a juvenile facility and they need to be hospitalized they had MediCal. That MediCal coverage applied in the hospital that they go to for the appendectomy or the mental health treatment. If they had MediCal before they get MediCal coverage. That does not yet apply on the adult side. We are seeing if the federal legislation can be changed to apply to the adult side. This would help our financial picture a lot.

C. **Question:** It s my understanding with MHSA that family members and consumers should be actively involved with all levels of planning. They advocated for a representative from NAAMI and United Advocates for Children to be a part of that work group.
   a. **Response:** Health care reform is not MHSA. What we are doing within DMH is having our employees develop our process for implementation of health reform. The next phase is the community engagement. But first the department needs to know what it is doing.

   b. **Response:** I thought with MHSA--the idea was to really push for family members and consumers to be active in all levels of planning. Why is it isolated only to MHSA? Health care reform is a massive change in the system. For clients and families to be shut out seems wrong.

   c. **Response:** The advocates are not being shut out. We do not know what groups are going to be formed. The goal right now is merely to figure out what kind of structures we put in place to engage community for all of the decisions you are referring to.

   d. **Response:** At this stage of the process it s internal department of mental health managers that are structuring a process to then include community representatives.

   e. **Response:** **D**ifferent managers are responsible for different things. Since last Monday and Tuesday, my group is health neighborhoods. There are 4 or 5 people that I talk to that work for the Department of Mental Health. We are discussing how we will gather the stakeholders necessary to implement a health neighborhood approach. Some will be geographical. LA is so big; you cannot do everything at once. It has to be staged. So that staging process is what I am looking to develop.

   f. **Response:** Are you referring more to the broader policy discussions on how to implement the Affordable Care Act, statewide and county specific?

   g. **Response:** My understanding is that we are supposed to be involved with all levels of the process--even the very early stages.

   h. **Response:** DMH used stakeholder process to make important decisions before there was an MHSA. And it will continue to do so. So it s not related merely to MHSA. MHSA just became the latest manifestation of a commitment to community engagement with clients and families that started with CCC, which preceded MHSA.

D. **Question:** With regards to health reform, is there going to be a concerted effort to work with younger people in developing programs with respect to alcohol and drug since the goal is to start programs prior to January 2014?

   a. **Response:** I am trying to expedite a benefit that is available widely because I think that is the best way of implementing a prevention strategy for MHSA. I do not run or start the programs for substance abuse, the Department of Public Health does.

   b. **Response:** I want to go on record that it s important for us to really consider programs for adolescence.

   c. **Response:** I agree completely.

   d. **Response:** The general literature for adolescence says it does not make sense to talk about co-occurring disorder. Addiction and mental illness are probably manifestations of a single disorder; and, among adolescents at least, probably indistinguishable. I would support the starting of those programs in exactly the way you are describing.

E. **Comment:** That is a very strong concern of ours as well. We are intending to include adolescents and transition age youth in our service expansion.

F. **Question:** I wanted to address a point you discussed in your budget hearing with the CEO about the EPSDT match and the possible dwindling local funds to cover that. I am most concerned about wrap around as part of the services that DCFS is heavily emphasizing to serve the Katie A class. How does the scenario that you presented impact the case rate on wrap around? How do you see that impacting the case rate?

   a. **Response:** I do not think it affects the case rate. We bill EPSDT to the maximum that we can bill EPSDT. What we cannot bill EPSDT for, in my understanding, is a part of the case rate, right?

   b. **Response:** Yes. If the EPSDT is up to 50% that would mean that the case rate would be 50%.

   c. **Response:** No. So, the service has to be provided at 100% and paid for at 100%. How it is paid for is 50% federal, 50% local. So, DMH must find that 50% local from some place. MHSA, County general fund, wherever. There is no unspent amount or uncovered amount that drifts into the case rate.

G. **Comment:** What is case rate?

H. **Question:** Case rate is the non-EPSDT eligible portion of wrap around services. The 50% is really my question as to whether you believe wrap around services are only reimbursable at 50% EPSDT.

   Response: No. Nothing has changed. The part that is EPSDT remains 100% paid for by Medicaid funds. Just the portion of that Medicaid payment that comes from local sources has moved from 10% to 50%. But the part that is covered by Medicaid is still covered in this exact same way. Our hope is that the Katie A. documentation manual will give us the ability to claim more things that were dumped into the case rate

	that will now be covered by EPSDT. I. **Comment:** I want to talk about the stakeholders as part of the planning process. If we are talking about what a health neighborhood looks like without involving family and parents and consumers in it we are not going to end up with the same thing. I also wanted to ask Bruce Salser: have you been involved in any discussions about planning of health care with the Department? J. **Comment:** Providers are already getting input in terms of health care reform. MHSA should not be the only place in the department that we include the various stakeholders. I ask that the department rethink its way of going forward and recognize that all stakeholders have a interest in helping design--if you are on your three "A's"--on your triple "A's"; the best experience of care--where are you going to get that from? a. **Response:** I have had this conversation on what the department is doing with health reform with the Board of ACSA, the Client Coalition and the NAAMI execs at their monthly meeting. b. **Comment:** In terms of a planning process, the first phase is design: what do you want to accomplish, who are the stakeholders, etc. This first phase typically does happen through informal conversations. It is through the design phase that you figure out the actual structure of the planning process. The second phase, you do the planning and make some decisions around the plan and then you do the implementation phase. The way I interpret Dr. Southard's comments is that, there is a design conversation going on right now and at a future point in time, stakeholders will be formally engaged in a planning process. c. **Response:** I recognize that. I also recognize that we need to hit the ground running on January 1, 2014. We have less than a year. My experience is that if we take the design portion for months and months then the planning comes to us to complete in one or two months. I am pushing to get it happening earlier.
State Budget, Legislation & Related Issues - Update	*Susan Rajlal, Legislative Analyst,* County of Los Angeles, Department of Mental Health 1. Mental health and increasing mental health in the schools seems to be a more palatable issue for many elected folks than stronger gun control. This is a time when we can take that opportunity to teach these officials what works. There are two bills that have been introduced. One is the Mental Health in Schools Act (HR62.) You will find a summary in your handouts. 2. Congresswoman Grace Napolitano introduced this legislation. She unsuccessfully introduced some form of the mental health in schools act approximately 4 times in previous years. This year there is more momentum. We have met with her and given her some input. 3. Dr. Tony Veliz runs a program called the 'School Threat Assessment and Response Team' program. Over time, we gained a lot of incite about what works with early intervention and prevention in the schools. Please consider giving your support through writing letters or contacting these offices to help the Schools and Mental Health Act be passed this year.

4. Senators Stabenow and Blunt introduced the Excellence in Mental Health Act (S264). It would establish a federally qualified community behavioral health center. This could be very important s because the FQHC have the option of obtaining funding that is not available to us because we do not have FQHCs.

5. If this passed potential available resources could fund the electronic health records. Another option would be funding capital facilities in communities. We want to support this bill and follow it.

6. Steinberg has gone to Washington and New York two weeks ago, as well as several other states talking about the successes we had with MHSA in California and how it could be a national model for delivery of mental health services and how early intervention and prevention works. He was received positively. He met with Vice-President Biden and has had a lot of inquiries.

7. At the state level, we are in the special session on Health Care Reform. The special session on reform has thus far dealt with bills that increase access to MediCal eligibility by relaxing some of the rules. For instance, instead of monthly status reports there would be status reports twice a year. In addition, there would be presumptive eligibility. This would be a different way to compute eligibility and exclude the resource limits that existed in the past.

8. When thinking about health care reform we remember the larger goals that we have as mental health advocates. We can never lose sight of them. Truth of the matter is, right now, Sacramento is trying to set up basic structures before they even get to the part that includes us. We are following everyday to see what has happened.

9. There are 15 bills related to health care reform, right now. When you look at the summary you will see that most do not discuss mental health. We must review every line in every single bill because if we are not there then we should be. I they have put something in eligibility regulations or in some primary care regulation that would exclude us somehow, we need to be aware so that we can express our opinion of what should happen.

10. A lot of the health care reform will not occur in the special session on health care reform but as we churn out the changes and code, the bills, and as the budget is enacted. It s going to be a process where the county is watching all the time to see what the set up of structure by the state so that we can respond.

11. We do have some principles: : inclusiveness, the rehab model, and cultural competence--that we are trying to make sure that everyone on the health care sub committees know about. We are watching all of these bills very intently.

12. The only bill that I wanted to call to your attention is SB22. This is a bill from Jim Bell, who has had a parity bill every year for the last 5 or 6 years. This year his parity bill focuses on enforcing compliance with mental health parity by setting up some standards to evaluate for.

13. The way that compliance was evaluated in the past is that if there were no complaints to the state agency that monitored then everything is okay. We know that everything is not okay. They are going to develop some new standards to see if people

are served and to see if there are indicators that quality is delivered.

14. Approximately 3 weeks ago someone from CMHDA sent out a bulletin that said that the governor's home page showed a transfer of $37 million from mental health growth funds to cover CalWorks. We started looking into that and it seems that the Department of Finance worked with the governor to do that. The Department of Health Care Services was unaware and was not in favor of it and neither was Senator Steinberg. We want to make sure that that realignment deal that included the earlier realignment is not undone; that they do not recapitulate it in any way because we have an agreement regarding the funding. We want to see that it is enforced.

15. Daryl Steinberg is going to carry the LPS reform bill. Many are concerned about the proposal for LPS reform that came from the California Hospital Association because they felt it was one sided, only looking at the hospital's point of view. Daryl Steinberg indicated that he is going to carry this legislation, and that the wording will be released later this week or early next. He is very intent on hearing from everyone that is a stakeholder.

16. It is not going to be a bill that just reinforces those recommendations that came from the study group. There are many issues that he is concerned about that, in LA County, we could have solutions to.

17. There are lots of solutions to problems. Just because we are doing it one way does not mean that any of the counties are because every county is different. I encourage you to engage in the dialogue on this LPS reform law because many people willing to hear your input.

FEEDBACK

A. **Comment:** I want to call your attention of AB 252: it s the Yamada bill that is looking to reserve the payroll title of social workers to those that have a Degree in Social Work.

B. **Question:** You said to keep an eye out on some of these bills. Is it time to write letters? Or do we wait and see?
   a. **Response:** Right now we do not have the language on everything. We are getting it. We are looking at it. If it s time to write letters I will let you know. Usually I send out an email to stakeholders.

   b. **Response:** As the language progresses on these bills, can alerts go out to the SLT email list?

   c. **Response:** On the federal bills: now is the time to write letters.

C. **Question:** To get more information on the federal bills can they contact you directly? What is the best mechanism?
   Response: You can contact me if you want. But if you go on the internet and just type in the name of these bills you will get a lot of information.

D. **Question:** On HR628, can you give us a short synopsis of what it is asking for?

Response: This is a bill that would give grants for mental health services funding to local school systems. If they get money for mental health services we want them to use evidence based best practices for prevention and early intervention for school violence. In addition that the money be used not only for students identified as being victims but also the bullies--that it be used to educate students and also family members. We want grants to be used to educate the school personnel in identifying who these kids are and when there should be an intervention and what the interventions are.

E. **Comment:** One clarification regarding the LPS reform meetings. Urgent cares are a great solution in terms of dealing with non-emergency mental health issues for people that need services. At times some individuals are released from a hold early in order to make more room. I think urgent care centers are great. I'd like to see those resources expanded.

Response: Certainly. We know that in LA County. If there are solutions that you think of please do take the time to submit them.

F. **Question:** The LPS legislation seems to be against the current law. I work for patient rights and the multiple holds really goes against clients' rights and freedoms. If this does get passed and challenged in court, how do you foresee that? Or is the law going to change?

a. **Response:** Many of the things that exist in law today were written in 1978; today, we are talking about a recovery, resiliency based model. We are not talking about restricting people's rights unless we have to. The language should reflect the current system of care that we have in improving that.

b. **Dr. Southard's Response:** The law could be changed in ways that make it easier to hold people than is currently the case. There are two energy flows in regards to this. One is, 'just clarify the law to make it clear to everybody what the actual law really means ' The other stream of energy is, 'let's make the law clearer but also give greater ability to take action for cases in which we believe people ought to be treated involuntarily." In addition, there are a host of technical issues associated with both of these streams. You could go in stream A or stream B and have technical things that cause problems for hospitals, law enforcement, or mental health. In some ways, that is why some things have stayed the same because any change hurts somebody's viewpoint. We will watch to make sure that not clients, not hospitals, not law enforcement, not mental health, end up feeling an undue burden with whatever changes might take place.

G. **Comment:** There is a third stream of energy and that is to adjust the law so that it is uniformly applied across the state rather than the very major differences in county to county, district to district, which is a mess. I also wanted to point out that there are now 45 cosponsors for 628. There are also cosponsors for S264. A major point of activity would be, on S264, to bombard our senators with letters urging co-sponsorship.

H. **Question:** You said to "push for best practices." My concern is that a lot of the best practices do not serve some of our cultures. What about promising practices?

Response: We include promising practices as well.

Follow Up Items: Prior SLT Meetings - Update	N/A
FY 2013-2014 MHSA Annual Update	Debbie Innes-Gomberg, Please see MHSA slides included in SLT Meeting Handouts. CSS PLAN A. **Question:** With the navigators, do we have data on how many clients are actually connected to services through the navigators? **Response:** We do not at this time. It is a resource issue but we want to address this question. B. **Question:** On slide 13 why are there so few services extenders for older adults? a. **Response:** Service extenders are a very small part of the budget. The numbers are fairly consistent year to year. C. **Question:** When are we going to start breaking out the Middle Easterners and Russians from 'White'? **Response:** That question comes up about once a year in this meeting. It s an IT issue that I will bring back to IT. [Subsequent to meeting – the "white" category will have greater definition once our Electronic Health Record is implemented] D. **Question:** On slide 36 and 37, when we look at PEI and housing situation are we controlling for age? If we are just getting older PEI who are living independently that looks weird. **Response:** No. The way we do housing outcomes is that you look at the client the year prior and compare any changes, positive or negative, so that may or may not be a function of age. It s a limiting factor in the sense that somebody may start at age 17 and then at 19 they are still in FSP but get housed. It s hard to know whether that was solely a function of age or, the fact that they were in FSP that helped. We cannot say that definitively. E. **Question:** Have we looked at the FSP dropouts and what happened in terms of services used the year after the dropout? **Response:** We have not, but that would be a great thing for a graduate to get involved in doing. F. **Question:** Is there an explanation of why the amount of children served went down while the adults and older adults went up? **Response:** When comparing clients served in Fiscal Year 10/11 with those served in Fiscal Year 11/12, the number of children served in Fiscal 11/12 decreased by 7%, TAY increased by 23%, adult increased by 6.5% and older adults had no change. G. **Question:** If you just love this data and want to look at more of it is there a website or is there a way to look at past years'

reports both within the county, and maybe this would be a question for Richard, statewide; can we compare one county to the other?

Response: The annual updates, to the degree that we presented the data in the same way, would be able to give you snapshots, fiscal year by fiscal year. Most of those on our website--one of them is probably archived--but I have them all. We could do a neat analysis.

H. **Question:** On slide 51, there is a notation on the right – "lost contact." Have you looked at whether the lost contact is due to the family, I am talking mainly about children and PEI, not feeling comfortable or not feeling that their needs are being met through the services provided. Under the full service partnership, slide 51, when we say 'discontinued' and 'lost contact' is there any way within the OMA, to differentiate some of the questions asked or any comment section.

Response: I am going to check in with children system of care because, on an annual basis, they do a customer service satisfaction survey with FSP families. They may look at that. I am not sure. But it's a good question. I think that could tie into the quality improvement effort that I think we might undergo.

I. **Question:** In terms of the move, I I read a DCFS case in which the child had been referred for services, and lived in Santa Clarita, and then the family moved to Palmdale. And there was no link. Do you look at the link being referred from one service area to another or one provider to another?

Response: We do. It s actually part of the transfer process in FSP.

J. **Question:** Regarding information on the urgent care centers: where did the clients come from? If they are referred from the hospitals or walk-ins, the police? Do you have that?

Response: I know we do at least for some of them, for example Exodus Recovery reports on that.

K. **Question:** Inevitably, these tables will be taken out of context from the report and show up elsewhere. Have you looked at listing sources and dates, even small, on these individual examples so that you can know where it really came from--with the date, etc?

Response: We draw the data at a certain point. We draw the outcomes from the outcome measure application. Or, in the case of the urgent care centers we get that from Mary Marx. So we have documented how we got the information. The annual update itself should sufficiently address how we do that.

L. **Question:** I have a general question about the proportion--the number of older adults served, proportional to population. And I do think that is a question that should be on the table.

   a. **Response:** Claiming analyses demonstrated cross cost growth for each of the age groups from FY 08-09 through FY 11-12, despite decreasing MHSA allocations. Proportionally, older adult gross and net costs have decreased though from FY 08-09 through FY 11-12.

M. **Comment:** A comment on 25% with older adults: given the limited number of older adults in full service partnerships, as some of the older adult providers have been transitioning to EHRS, including our own, there are clients that were kept on the record in FSP because of a transition process, billing process, things like that--so I think there may be a little of a data glitch in that 25%.

N. **Question:** I am curious about putting these numbers in context. Any program the client actively participates in, I think, is going to be successful. What is our jail rate is for people with mental illness? What is our incarceration--arrest rates? And has that changed since MHSA has been implemented? That would be these numbers in a context of the system as a whole.

Response: We did a lot of research when we did the CSS plan and of course when we did PEI. We may be able to go back to look at some of that data.

O. **Comment:** I liked Jim's question comparing data from years prior to this year. I hope I can get that information. When, I look at some of the API rates and it s always less than 1%--you know at least we have some absolute numbers so I appreciate that.

Response: It s a quality improvement issue. What I am hearing several of you say is, maybe I will bring this to the MHSA implementation meeting, because if we can have a couple of age groups agree to do some sampling, take a look at the clients that dis-enrolled for those particular reasons, and then go to providers and find out if there is more information, we can glean why this happened and how to prevent it in the future? It is a good idea.

P. **Question:** On slide 62, it talks about clients reported activities--social, spiritual, all that, recreation activities--do you have a question about actual participation; not just having the opportunities?

b. **Response:** After reviewing the instrument, the question does not ask about actual participation. ASOC has indicated they are reviewing this instrument.

Q. **Question:** On slide 61, access to stable adults: does that include living and not living with the client?

Response: Access to a stable adult is broad. It could be parent, a friend, or somebody you are living with or not living with. It is broad, intentionally.

R. **Question:** What are your written conclusions from your data analysis such as the outcomes or effectiveness of services or the impact on the clients, so forth and so on? If you talk to the general public, or a client, or someone that is concerned about outcomes this can be confusing. Can you tell us what you are getting out of that data that tells us if we are moving in the right or wrong direction? What is the department thinking around these numbers?

Response: I could give you an assessment, but I prefer that each of you take this data back and have a conversation with your constituents about what it means to you. My interpretation though is that we have to do a much better job as a system at improving. First of all, giving clients experience in the community, and integrating them into the community. In a way, that changes the role of the treatment team. I think FSPs excel in reducing some of these negative outcomes but then it s that transition to really getting a full life--where we need to go next.

PEI & INN PLAN

A. **Question:** We discussed including promising practices but I do not see it listed here.

Response: Sometimes we use the 'catch all' phrase evidence based practices. It includes every PEI practice that we do, including promising and community-defined evidence practices.

B. **Question:** When we were talking about housing for PEI and even for adults, you were saying that the number represented those who are receiving services. Is that for people who have applied for services in housing? Or is that the number of people who actually received housing?
   a. **Response:** Are you referring to FSP outcomes or are you referring to PEI housing?
   b. **Response:** PEI housing.
   c. **Response:** That is the number of clients served by housing.
   d. **Response:** They are actually in their own housing? Or is that including multiple patient live in situations?
   e. **Response:** It is anybody outreached and served to get housing.
   f. **Response:** That is the distinction I wanted to hear. They were served to get housing but are not necessarily in housing.

C. **Comment:** I wanted to make a statement regarding EBPs —and promising practices.' It was stated that those are included. It is our experience that if it is not clearly stated in whatever you are trying to do then it will not be included. Make sure that promising practices is stated.

D. **Question:** In terms of law enforcement, what is the interaction between CSS and law enforcement?
   Response: Many of our programs, particularly our FSP program and our Start program are funded through PEI and have strong contacts with law enforcement. If a consumer is detained by local law enforcement they will work with that jurisdiction to help that client not go to jail. Several FSP programs give their clients cards that say--and they can choose to keep them and put them in their wallets or purses--but it says, 'I am a member of 'this' FSP program. If you need to contact my case manager. Here is their number.'

E. **Question:** I had a question about the crossover motion of allocation of funds. Would that have come from PEI? You said earlier that there was not any change in PEI funding and therefore you did not have to include that as a request for approval. But wasn't that a prevention?
   a. **Response:** No, the crossover proposal was funded by the Community Services and Supports Plan. That was a midyear adjustment to the FY 12/13 Annual Update.
   b. **Response:** And really the reason for that is the service being offered is for somebody who is already affected by mental illness. It is preventing crossing over but it is not preventing mental illness. So the prevention that PEI refers to is preventing mental illness, not preventing incarceration. That is why, for a programmatic reason, the funding came from CSS.

F. **Comment:** The data system, state wide, is this old Legacy system--that it does not get this information and we really need to change that whole data system. The state should copy LA because LA has figured out how to do it in terms of the data issues. There needs to be a more serious push toward using some of the state money that is left, which is a hundred million plus, toward some consumer and family employment training. There has not been sufficient input from the consumer and family organizations to the new WET plan. It would behoove NAAMI folks and client coalition folks, etc to get involved in this because it is out of mental health's hand. It s over at OSHPID, the state health planning department.

Response: In response to Richard's observation, I just got an email today that Angelita Diaz Akahori from our Training Division was appointed to the OSHPD advisory group on this matter. So contact Angelita and she will have access to getting information about things we want in that plan.

G. **Question:** How are you breaking out the Hispanic compared to how the census is now collecting that information? Are you not counting them in the sort of 'Whites' or 'African Americans' because you are counting them as 'Hispanic'?

a. **Response:** Correct they are counted as Hispanic or Latino

b. **Response:** The census data is counting them as separate but you are not.

c. **Response:** That is our information system. I am not sure if that follows CSI or not. That is our information system.

H. **Question:** With respect to slide 78, will the SLT have to wait until March 1 when the update is to find out which contracts will continue and which will not ? For example, the $100,000 grants that were given out under PEI? Dr. Southard, at an earlier meeting, had indicated that some of them were up and running and others were not . There was an impression that some might not. But is there an idea as to who is in and who is not in, in terms of money, not only at the $100,000, but other monies?

Response: First let me point out that for next fiscal year we are going to see a drop in overall funds related to this fiscal year due to that one time bump up. So as a result of that, we are not going to be making a lot of changes. We are going to be using carry over money to sustain us. In terms of the prevention funds you are talking about those programs are being evaluated now.

I. **Question:** Does the SLT weigh in on recommending a continuance or not of these programs? Does the SLT get involved in the program level discussions or is it more at the provider level?

Response: I think that at the provider level, if I understand you--we would not be--but I do think that it would be fair in an upcoming SLT meeting to bring the results of the evaluation of the programs.

J. **Comment:** In regards to the FSP children decline, you mentioned it had to do with satisfaction or evaluations with the parents or something?

Response: I did mention that children system of care does an annual satisfaction survey.

K. **Comment:** Right. There are a lot of declines and that it s something I do not think we can capture.

L. **Question:** What is a decline?

M. **Comment:** People getting out of FSP; disenrollment. It is not a question you can ask because no one will respond. We just know about it. There is a fear that parents have, that a provider will go on and get involved and before they know it their children will be removed. Truth or not truth. That is not that the agencies are doing something wrong or that the family is doing something wrong. It s just that they have that fear.

Response: I will tell you that the parent advocates are part of that process. That has helped that.

N. **Comment:** Because we continuously look at this data one of the things that we have to look at is what happens to the system as we sequentially roll out programs. What is of significance is the relationship between CSS and the PEI implementation for children. In the past, we have had certain kinds of very high intensity mental health services but not the advantage of short-term evidence based practices for children. Children got what was available. We now have a continuum of care for children. So we witnessed exponential increase in children being served by, first FCCS programs, when those rolled out and then with PEI programs, once we implemented the PEI services. It means we are delivering the right amount of service to children at the right time. What is also important--if you look at the numbers--although the numbers of children seen in CSS programs declined slightly the dollar amount of the services rendered continue to rise. That supports the hypothesis that children that really need high intensity services get high intensity services. I think we have to look not just at the individual programs but the system as a whole to try and understand some of the data. It may not be an explanation that is contained within a program.

O. **Question:** What is happening with the WET funding—for example, the action items we had, some of them have not come out. . What happened to that funding? Has that already been taken and put somewhere else?

Response: No. You will see this in the annual update. We have a table that has the status of each of the WET projects; because WET had a, I think it s a 10 year reversion program, as opposed to a three year. Some of the WET projects were not implemented as quickly just because of resource issues.

P. **Question:** My concern is the use of the Evidence Based Practices (EBPs), the tables that you have for the EBPs. There are a lot of those--most of the cultural groups are included in those tables. They are not separated as we see. A lot of those EBPs are not translated or adapted to different cultures.

a. **Response:** Yes. In our outcome reports, there is an ethnicity break down. Once CIOB creates the XML process then you can look at your raw data and start to do the analyses that you are talking about. We are reporting on ethnicity. As you do see with PEI, there is a high percentage of clients that are Latino. As we drill down into that data, we will look at which practices are effective and for what populations. The biggest issue with PEI right now is the lack of post outcome data. We need to get enough matched comparisons so we can do the analysis that you want us to do.

b. **Response:** How are you going to do it when you do not have the translations?

c. **Response:** We actually do.

d. **Response:** --Well there are no translations for Armenians for EBPs. We are having a problem with using it with the

Armenian population. Others like the Arabic or the Russian populations. They may be having some problems with that too.

e. **Response:** I hear two questions. The one question is about which EBPs have already been translated to these target populations. The second question is for those that have, what are the outcomes and how can we find out what kinds of outcomes?

f. **Response:** No, my question is not about outcomes. My concern is if we do not have the data and the translation of those EBPs for the different cultural groups then we may drop some of the EBPs that can be very useful for the different cultural groups.

g. **Response:** This is something that perhaps when we meet with the UREP leadership. We need to do something about it. We have taken a look at a lot of these EBPs and promising practices as well as so called CDEs. Especially for the EBPs, some of these developers; the translation is just not available. They are proprietary. So we have to go through that whole dance with some of them. Some of them we can translate. We need to dedicate some time to figure out which ones--and money yes--but I think that is something that maybe we can talk about and have as part as something we commit to move things forward.

Q. **Comment:** American Sign Language is pretty much accepted as the fourth most common language here. Why is it not on your list? Why aren't you tracking that?
Response: ASL is included

R. **Question:** The intent of the Mental Health Services Act in Prop 63 was to expand mental health care. Is there data on the unique number of individuals served by the MHSA? Is there data that we could look at for the number of individuals served by the DMH across all funding sources and then compare the number of people served today compared to 5 years ago when the MHSA was implemented? Is there some measure of unmet need, to see in fact, if we've actually made a dent in unmet need or have we really expanded the mental health services in a way that the act was intended?

a. **Response:** That is a great analysis. It is one of those things that I think we will have to undergo in our next planning process for the integrated plan; whatever that might look like.

b. **Response:** You can look at the information sent to CMIH that showed that client counts. We saw over the past few years there are less folks served obviously in none MHSA funded--so that whole thing shifted over time--so if you want we can send that out with the minutes if you want to take a look at that.

c. **Response:** Right and then the real careful nuance is the extend to which criminal justice data is included or not included because if you include the jail mental health programs and the probation programs the end goes up sharply in various compilations of data through the years. Sometimes it s been in and sometimes it s been out. That is one of the things that we would need to be careful; that we are getting a uniform data source for that. The point is well taken that it would be a valuable thing to look at.

S. **Question:** I wanted to go back to field capable clinical services. It seems like the markers that were used at baseline, were all pretty favorable and then there was not much change at the point where they looked at the end of the year. I am wondering has there been any thought as to whether these are actually very good markers for judging if this program is actually effective or not?

Response: It is a great question. We have not spent a lot of time addressing your question yet. At a certain point we realized that the first 4 or so 5 indicators do not tell us a lot then we probably need to re-evaluate our evaluation strategy. We selected these based on what we thought FCCS would yield and it has evolved over time. I would suspect that in the next year or so that we could re-evaluate how we evaluate FCCS, maybe as part of the integrated plan.

T. **Question:** Why is there is such a large number of known or unknown EBP?

Response: I think it is a function primarily of providers ramping up in terms of understanding--this is from 11/12, this is last fiscal year--but we have talked over and over again about importance of identifying--at the point at which you say this is a PEI client--the practice that you are going to provide that client and then indicating that in the EBP field. And clearly, as of last June, providers are still struggling with that.

U. **Question:** Why is there is no uniformity between the different service areas in EBP? For example there is no grief counseling in one of them or parenting in another. Who decides which EBP is offered?

a. **Response:** When we originally went through the PEI process, service areas selected their priorities in terms of evidence based promising and community defined practices. When you compare the planning process to the children's implementation of PEI it differed a little bit because of transformation. But, one of the things I think would be a really rich discussion at the service area level would be to go back to that plan and say, 'for your service area, is this the right mix of services?

b. **Response:** As the service areas chose the menu but then the provider chose the entrees from the menu because some providers did not implement choices that they could have picked from the menu of services available. In the implementation some of the providers did not have the workforce to actually implement a particular practice. That is why it did not happen.

V. **Comment:** I want to get on record that the WET training for parents, family, and peers did not involve evidence based practice training. I know the department is taking steps to change that. So I am just putting that out there; that we need to make sure that we are doing EBPs at every level.

W. **Question:** With WET, does it include students that may be in school that may want to be in that program?

Response: It does. We have sent a number of folks back to school, including participation in the mental health loan assumption program, which is now overseen by OSHPOD.

X. **Question:** With Innovation, I know originally you said it was going to be like 3 years. Is it 3 years from the time they start?

Response: For Innovation, at the moment, we got a pretty late start; so at the moment the services are still going

	through FY 13-14. But we realize that the learning may take longer than that so we are exploring options. Y. **Question:** As far as the service area advisory councils--how much time do we have to give input into your final update? **Response** You have until the annual update is published to do that. So obviously the sooner you can get comments in the better. You have until April 18th. Each service area should go back and review all the service area data that is in the annual update. But, basically go back, in terms of PEI, take a look at the practices in your implementation. Does it meet the needs of your service area? Is it consistent with how you thought PEI would be implemented in your service area? Z. **Question:** How does this play out against health care reform because a major portion of that is about prevention. Health has some prevention programs that they have and use to try and prevent the onslaught of major issues as time goes by. But the question is we need to make sure that our effort around prevention is strong and clear in mental health portion of that as well because we have a lot to say about that. So, hopefully that is being taken up as a part of this redesign. **Response:** In the last couple of months the focus and the understanding of what prevention and early intervention are has really risen, in part, due to some very tragic incidents. The focus on how you prevent mental illness from occurring or how you prevent violence from occurring has really risen nationally.
Public Comments and Announcements	A. **Question:** On slide 10, the service to children declined--could it be related to the laws that give children to ability to choose whether or not they have services? Could that be tracked? **Response:** I do not know. Given the relative lack of change in terms of the number of clients served I really would think not. But I do not really know. 3180 versus 3104; a little bit of a drop in FCCS but I think not. B. **Announcement:** regarding free dental care (flyers available). C. **Announcement:** LA community college partnering project is having a mental wellness day: bridge the gap to empowerment. It s about education and employment. We are doing a collaboration with DMH and LA trade tech college. It s going to be Wednesday February 27th from 8:30 AM - 4 PM. D. **Announcement:** There is the 14th annual [inaudible] hope and recovery conference: building wellness. Tuesday April 9, 8:30 AM - 4 PM at the Doubletree by Hilton in Culver City. (flyers available)