COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, September 18, 2013 from 9:30 AM to 11:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. To provide an update from the County of Los Angeles Department of Mental Health.
2. To report on action items from prior SLT meetings.
3. To review the instructions for the MHSA Three Year Program and Expenditure Plan.
4. To issue a recommendation for the MHSA Three Year Program and Expenditure Plan Planning Process.

MEETING NOTES

Department of Mental Health - Update	*Dr. Marvin J. Southard, Director*, County of Los Angeles, Department of Mental Health A. Dr. Southard discussed the importance of partnerships as it relates to the 3-Year Program and Expenditure Plan Planning Process, LA County's successful performance in the MHSA Audit, challenges related to SB82, radical revision and expansion of the drug Medicaid benefit, and one-time funding for residential and crisis stabilization programs administered by CHFFA. In addition, he discussed DMH's participation on the blue-ribbon commission on child-welfare, as well as partnering at the state and local level on those providing services on alcohol and drug addiction. FEEDBACK 1. Question: Are you participating in discussions about rebuilding a new jail specifically for people with mental disabilities? What is your position and how does that tie into the diversion programs? a. Response: First, Men's Central needs to be replaced no matter what. The replacement of Men's Central needs to be granted and then we have a separate conversation on institutional reform. b. Response: Yes, we are participating in that conversation and looking at it in 3 ways. First, 'What can we put into place so that people with a mental illness, who should not be in jail, are diverted from jail and receive treatment?' Looking at 'co-occurring' but also persons suffering from addiction in that venue is an important part of diverting people from jail who would do better in treatment. Second, there are some people who committed a crime with their mental illness and others who developed their mental illness after incarceration. There are people with mental illness that, regardless of diversion will be incarcerated. Those individuals need to be placed in a facility with proper privacy and group settings for treatment. Neither Twin Towers nor Men's Central were designed with treatment in mind. We want a replacement facility configured such that the needs for privacy and group are taken into account. Third, under the provisions of the Affordable Care Act, there might be a better way to deal with the most ill individuals with mental illness. For example, if somebody is incompetent to stand trial or so disturbed that after adjudication that they are psychotic, a jail inpatient program may not be the best idea.

	Perhaps we can discharge to a not yet created privately run, forensic inpatient program where we can use Medicaid as part of the payer source. 2. **Question:** Are you contemplating partnering with the hospital association on beds for hard to place clients like pregnant ladies and people with a mental illness–like autism? **Response:** There are a range of partnerships that I did not speak to which relate to those questions. There are questions related to conservatorship issues and the kinds of conservatorships we could and should use. There is pressure for DMH to take on responsibility. Yes, we are looking around but there are no clear answers. 3. **Question:** With these collaborations, organizational and operational policies, procedures, and practices are not in place. This could prohibit or impede the care we want for our residents and clients. Other organizations that have primary responsibility can put these things in place. In these collaborations we want to engage that conversation in an effective and positive way. **Response:** That's a good point. We are trying to do that, particularly on issues with information sharing. We are making progress. 4. **Question:** You discussed SB 82: Investment in Mental Health Wellness Act of 2013 and the two pots of money attached to it. One was the $143 million for one-time crisis, residential, and stabilization. How much was the other pot of money administered by the Oversight and Accountability Commission? a. **Response:** Around $43 million. Approximately $18 million is what LA County would have as its share. I should also mention that not from the OAC amount but the onetime amount administered by CHFFA. b. **Response:** CHFFA was planning to short LA County by about $10 million. The public comment on that was due yesterday afternoon. I want to thank all of the partners who wrote in and told them LA County needs to have its needs met. They do not appear to have any principled explanation about how they would short us by $10 million. 5. **Question:** Are you also planning on including the SACCs for public input on the triage teams? **Response**: Yes.
Follow Up Item: Prior SLT Meeting	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division*, County of Los Angeles, Department of Mental Health FEEDBACK 1. **Question:** In terms of the CEO report being 'final report', I thought we would have some final input. We do not know if our comments were included in the report. **Response:** It was incorporated. What you got 2-3 weeks ago was inclusive--but there were only 3-4 comments that went to the CEO's office and one was from ACHSA.

	2. **Question:** Can you resend the final report? **Response**: Yes. 3. **Question:** How will we use the report? What will it do relative to the 3 year plan? **Response:** When you read through it if there are recommendations that we could apply to the 3 year planning process we should talk about that in the next 3-4 months. I think I share the disconnect. I was having a hard time applying what was in that document to what we need to do next. 4. **Question:** Has the 4th year of funding for Innovations been approved by the Board of Supervisors? **Response:** It did not need to be approved by the Board of Supervisors. We have notified the OAC. We will also include that as part of our 3-year plan to notify all entities. 5. **Question:** Can the agencies that have that funding plan on it? **Response:** 3 of the 4 models have drafted their service request form, which has gone to contracts and budget. We just have to extend the funding. It is not about extending the program. I am drafting the Board letter for all four. That should be done by October. It will leave us plenty of time. That will include all 4 models and additional evaluation time. 6. **Question:** The report we received that said 'Draft' was really the final? **Response:** Yes.
Instructions for MHSA 3-Year Program & Expenditure Plan	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division*, County of Los Angeles, Department of Mental Health *** The SLT received an electronic copy of the OAC guidelines via email, and a copy of the PowerPoint presentation in the SLT September meeting packet.* FEEDBACK 1. **Question:** Last month, when we had the Innovation funding discussion it was stated that PEI youth were involved but the child population was not. For this coming funding period will there be an emphasis on children to receiving Innovation funds? The statute does say that they are supposed to receive Innovation funding. **Response:** The statute does not necessarily state that Innovation has to cut across all age groups. It is a County decision. 2. **Question:** Is there a consideration for children to be included in LA County? **Response:** What your question is really going toward is as part of this planning process we will want to make recommendations for our next Innovation project, which would be funded after OAC approval and all the

	prerequisite approvals. Some time in Fiscal Year (FY) 2015-16 we might be able to start our next Innovation project. 3. **Question:** The Innovation projects will not start when the 3-year plan begins? **Response:** No. Any new ones would start at the conclusion of the ones that we talked about in July. 3 of the 4 models were extended and now end at the end of FY 14-15. The peer run model ends at the end of FY15-16. As part of this 3 year planning process we will want to talk about our next innovation project, which could span age groups or focus on a specific age group. 4. **Comment:** We need to include sexual orientation and gender identity on the list of stakeholders who should be included. **Response:** This came right out of the statute. What you are seeing is the statute. The OAC intentionally did not add to anything when they did that. That last bullet, 'other relevant or important interests', is where the county then has discretion. We did that. 5. **Question:** I would like to include disability. **Response:** That was a county decision to include. We cannot change the statute. 6. **Question:** What is the process by which the groups that are meeting can know of the Children's Commission recommendations on prevention for children? **Response:** There will be opportunities at this level and the Service Area Advisory Committee level to identify what those are and how we might fund them. I would bring those comments here or at a service area. 7. **Question:** Was the client and family implementation team from the OAC involved or being informed? **Response:** They were, yes. Every committee or work group--the OAC has weighed in on these guidelines.
3-Year Program & Expenditure Plan Planning Process - Presentation	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division*, County of Los Angeles, Department of Mental Health ***Members of the SLT received a copy of the draft template developed for the Continuum of Care for the Children's System of Care.* A. For the rest of the fall and into the foreseeable future, the majority of our SLT work revolves around the 3 Year Program and Expenditure Plan. Because of this, the Agenda Design Team has not been meeting. Instead we created a SLT Ad Hoc group to help move the process forward. Our work must focus on the process. There were two questions brought up. First, 'What does integration mean?' The second, 'What latitude do we have?' I will summarize the Ad Hoc group here. On the integration piece integration is used 1, at most 2 times in the guidelines. We do not really get a formal definition around integration as a term. When it did appear in the OAC guidelines it said that, we are looking for an integrated experience for families and clients. But we really do not have a formal definition.

B. The discussion we have been having is 'what is integration?' Does it mean that we integrate the components of the MHSA plans? Or does it mean integrating MHSA into the broader systems? The group recommends that the focus for this planning process be, given the time constraints and other conditions, on integrating the MHSA components. However, the broader aim of the group is to integrate the MHSA components in the context of this broader system that MHSA is a part of, incrementally over the next three years.

FEEDBACK

1. **Question:** I missed the last meeting. I thought, in the meeting before it was a little more defined that year 1 was going to be the integration within MHSA and years 2 and 3 was going to be looking at the entire system. Did that change or not?
    a. **Response:** No, you are correct.

    b. **Response:** That is a little more specific.

2. **Comment:** This is a 3-year plan. If the task is to integrate MHSA within the broader context then that takes several years to do. The task for the first year is to emphasize the integration of the MHSA components. As you look at years 2 and 3, incrementally, we will look at integration within a broader framework.

3. **Comment:** Exactly. If you think about health care reform and coverage expansion, of course we have to do that. Dr. Southard just wanted us to be clear about the task is in front of us related to the three year plan itself--its MHSA funding.

4. **Comment:** One piece is having a clear focus on what we mean by integration. The second question is latitude. Members of the Ad Hoc Committee asked, “How much can we change?” “Are there any sacred cows that we need to know about?” We discussed this and landed on the following, "If the regulations do not prohibit us let us not limit ourselves." Instead, we will use our analysis as the basis for making recommendations. As we see gaps and strengths and issues then let that be the basis for recommending proposals. If we find that it is illegal, we will address it. The conversation on latitude shifted to thinking about, 'how will we conduct our analysis to see what the gaps and strengths are of this continuum?' The draft template for the Continuum of Care for the Children’s system provides a framework that will allow us to identify key gaps, strengths, and other kinds of issues.

5. The second area is participants. I wanted to share with you two things: one is our initial assessment of the existing stakeholder groups and representation on the SLT and then the proposal. The OAC guidelines ask for inclusion of 11 groups. 10 groups are very specific. The eleventh says 'other.' Some constituencies represented in the LA County SLT stakeholders, such as LGBT, do not appear in the first 10 categories. Using the first 10 groups in the guidelines we examined the 45 current and active members of the SLT, excluding those who are no longer active. Of the 45 that qualify as active current members, our analysis shows that we meet and exceed the 10 groups required by the state. However, we know more stakeholder representation is needed. Based on the initial analysis of SLT members that are no longer participating and other important prospective groups we developed an initial proposal with two parts. For the planning

process the recommendation is to expand this group from 50 to 60 formal members--adding 10 more people. We have five vacancies in our current group, which means we would add 15 new people. This allows us to expand the number of delegates without it becoming unwieldy and simultaneously address some key gaps existing in the SLT membership. These additional 15 individuals would not be permanent SLT members but members for the planning process. Some stakeholder gaps identified include representatives from the LGBT and disability communities, as well as SAAC representation. We recommend adding 4-5 spots for the SAACs, which might be the SAAC co-chairs or their designees. We also recommend 4 or 5 client representatives including: a PEI person, older adult, parents with children. The Ad Hoc committee also recommended individuals from the faith-based, and Native American communities, as well as someone from a Federally Qualified Health Center (FQHC). Similar to last time with the SLT, we found people who wore different hats, and represented different perspectives. These additions are about making our group more robust.

6. **Comment:** The final component of this are the timeline phases: the role of the SLT Ad Hoc group and other ways we want to support the planning process in the given the timeframe. The goal is to complete our planning process so that we implement the new 3-Year plan by the beginning of the next fiscal year, July 1, 2014. We are organizing the process into two phases. The first phase starts in October 2013 and continues through the beginning of 2014. During this time, the work focuses on identifying these continuum strengths, gaps, and examining proposals (to address those gaps). Then, beginning in January and February 2014, after receiving a proposal and drafted plan, the SLT engages in deliberation and building consensus. The October 30th, November 20th, and December 18th SLT meetings will be day long sessions. These sessions are designed to provide you with enough time to discuss, deliberate, present and review things. On October 30th we will hold a foundational session where we invite more individuals, whether or not they are members of the SLT. During this session we provide information on '1.0 MHSA'. This will provide an overview of MHSA Programs, rules, the LA County specific rules, for example the different PEI funding percentages allocated to different service areas. We want to make sure that in the morning everyone understands that the key decisions and structures for MHSA generally and then LA County. In the afternoon, we will discuss other external and internal processes that shaped the course in which MHSA has taken in LA County. That includes some key decisions and events. We want to make sure that everybody has that context. Through these two sessions we would make sure that folks both get an inventory of what exists currently and we have an opportunity to look at strengths, gaps, and issues from an age perspective, service area perspective, and population perspective as well--wherever that is critical.

7. Between now and the end of 2013, is an opportunity for us to learn, explore, and understand and get a sense of the whole system. In January and February the SLT is involved in deliberation because we post the plan in March, do the public hearing in April and May with adoption by the Board in June. In order to do this, we need to support the process with a couple of important mechanisms. One is the SLT Ad Hoc group. An Ad Hoc group is a task and time specific group. This group meets in between sessions to analyze and integrate information. The information that comes out of each session comes back to the Ad Hoc group where we are able to say, 'what did we learn, what things did we see? The other function of the Ad Hoc is to propose principles to guide our deliberations and priority setting process. If there are constituencies that we just did not have the opportunity to include in our membership then the group also figures out to make sure that there is input--for example, the service areas or any other community. Finally, one of the responsibilities of this group is to develop an initial proposal or plan by the January session. Finally, to support the process the SLT Ad Hoc group has already begun to develop a framework that will allow us to make sure that as you are receiving

information it is organized in a way that is fair. It is robust analytically and then ultimately helps us get into specific analysis and proposals.

8. **Comment:** The "Continuum of Care" document starts to conceptually address how we think about our MHSA investments, and about our entire system. We have to think about either a continuum of care, an array of care, a set of services for a specific age group that addresses the services within a geographic community, ethnic group or age group. We went through the timeline for this process. If we identified and approved 3 new children's prevention strategies. Because this is a budget neutral process we would need to implement these 3 new prevention strategies in place of 3 others or ones that cost equivalent amounts of money. We will provide our best estimates of what are MHSA revenues will be so we can make those decisions.

9. **Question:** This document we have now only refers to children. Did the group come up with recommendations for adults?
   Response: No. We wanted to start off with just one age group to give us a sense of 'does this framework work?' A similar framework will be developed for TAY, adults and older adults. Representatives of the adult, older adult, and PEI affirmed that the framework would also apply for the other groups.

10. **Question:** I am not seeing Innovations on this framework. Will it be stuck in wherever they best fit within the framework? We are going to include innovations in it as well I presume?
    Response: Yes. That would be for adults. This content is more children focused. But you are right. Wherever innovation makes sense in the adult or older PEI we will place it there.

11. **Question:** Are we not planning for innovations in the next 3-year plan because we already have innovations or only for the last year of the 3 year plan?
    Response: What this represents--and it is not perfect, is a continuum of services that goes from PEI to more intensive services. Thanks to Robert Byrd and his children's age group colleagues we filled in the contents related to kids services. So we are going to see MHSA as well as non MHSA services here. When we do this for adults we will put in our current innovation programs because they are a part of the continuum.

12. **Question:** This is what already exists?
    Response: Yes.

13. **Question:** The gap analysis is not there yet?
    Response: The gap analysis is on the last two pages. It took awhile to develop continuum that made sense across age groups. This is the initial draft of what a continuum might look like. They plugged in illustrative examples of programs that fit underneath each component of this continuum and at the very bottom some initial gap analysis. During the October, November, and December SLT meetings we will ask you and additional stakeholders to help us review gap analysis plus supplementing that with additional data. We need to see, 'are there components missing within the continuum?' As we pointed out there are flow issues. So even if there are programs for each component sometimes people cannot access the service from one to the other. The idea is to have an analytical framework that allows us to deepen our understanding. What we envision for innovations

specifically would be looking at services provided, what the outcomes look like so far and that final thing you said: 'What might that next innovation project be?' It might be different from what we are doing.

14. **Comment:** Contextually, if you look under child welfare, how can you evaluate a children's system of care without looking at Katie A. services or something that is not funded at all by MHSA? We have to take those into account. It is just we are not going to make recommendations on that.

15. **Comment:** If we can get those words, 'we are not making recommendations about it' into the explanation I think that will solve our issue of whether we are only looking at MHSA or looking at the whole system with MHSA.

16. **Comment:** In terms of participants here is our analysis: we are recommending going to 60 members. Any feedback?

17. **Question:** W should be very careful. When we did get a lot bigger it was a lot harder to do things. I do have one question about the SAACS. All of the others are distinct groups. The SAACS are cross representatives of all of the different groups. What 4-5 additional SAAC members would we bring relative to the constituencies since, again, the SAACS themselves are providers, clients, community, everybody?

.

    a. **Response:** The SAACS are part of a stakeholder system. The SLT is a stakeholder group and then there is also a stakeholder group at the regional level. The SAAC plus the SLT constitute a broader stakeholder system. We identified in the last Ad Hoc process that the formal SAAC representatives are missing. We do have folks from the service areas but the connection between those that are part of the service areas and the SAAC--that has been very weak.

18. **Comment:** That is one of the things we have looked at before in terms of members representing other constituencies. To the extent let's say we have among the people already representatives from each of the SAACs, that is a possible way to look at getting that feedback without adding 5 new members?

19. **Comment:** There are people from service areas here. But they do not attend the SAAC meetings. They do not report to back to the SAACs about SLT meetings.

20. **Comment:** bring a unique knowledge of the communities, where they are, and what their issues are to the table that are different than high level [inaudible] kind of looks at the system. Each SAAC bring a different perspective based on their community geographic issues and dynamics that are important in the decision process of how those communities receive services.

21. **Comment:** I understand the 10 plus the 5 that are missing. Did you say 5 for client representatives? I want to make sure that they are not lumped all together.
    a. **Response:** We do not want to collapse. We said 4-5 to try and get that perspective directly here as opposed to collapsing. For example, it includes possible TAY, parent with special needs, etc.

	22. **Comment:** Your point is well taken. I think that the SAAC representation is critical when they report back to the community. My concern is that there is no mention of LGBT or veterans or disability community. 23. **Comment:** Let us add formally people with different kinds of disabilities, plus LBGTQ onto the list. We can have a longer list than just the 15. What we did last time is that we may end up finding someone who represented PEI and LGBT. They could have different perspectives; not that we are trying to collapse people but as you look at the applications people wear different hats. 24. **Comment:** We need to think about ethnic representation as well. 25. **Comment:** We have 15 slots which we will fill with as much diversity as possible. Right now, we want to name the diversity that we are looking for. 26. **Comment:** I want to encourage everybody that is here that we all bring our own special interests. Somehow we have to rise above that when we get involved in this process otherwise it breaks down, it gets vituperative, it becomes a mess. 27. **Comment:** Regarding PEI, sometimes we need to reach out to PEI. So many times what I see is that sometimes as adults we are being judgmental toward PEI rather than embracing and encouraging them to feel comfortable to come in and be representatives. 28. **Comment:** I am speaking on behalf of the District Chiefs. I want to support the idea of a SAAC representation because I really believe that is the most grassroots stakeholder group. It is the people of the community, from the community, knowing exactly what that community needs, and not all of the communities need the exact same thing. You cannot have one SAAC speaking for another SAAC. 29. **Comment**. The Ad Hoc group will invite you all to find people that you want to recommend. We have to go beyond saying we want this and actually you identify people and sending them the nomination form. The Ad Hoc team will invite nominations. The Ad Hoc reviews and recommends members to Dr. Southard who makes the final decision. That is the process we have been using. The key point here is that the Ad Hoc group will try to use those 15 slots in building as much diversity as possible. Any final questions or comments on the planning process itself? 30. **Question:** Are you going to be adding members to the Ad Hoc committee? What is the process for that? a. **Response:** Yes. At the end of today if you want to join the Ad Hoc give us your name. We have your contact information. We will contact you as we are setting up the session.
Public Comments & Announcements	1. **Comment**: OAC meeting next week in Long Beach Sept 25-26. 2. **Comment**: Disability Rights CA meeting: Marriot in Burbank 3. **Comment**: Mental Health commission meeting: Next Thursday