COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, May 21, 2014 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. Provide an update from the County of Los Angeles Department of Mental Health.
2. Inform the SLT about State budget, legislative, and related issues.
3. Discuss the Regional Workforce, Education and Training Partnership Request for Proposals.
4. Provide an update from the MHSA Implementation and Outcomes Division.
5. Issue a recommendation on the SLT membership.
6. Discuss and advance the Innovations projects planning process.

MEETING NOTES

Department of Mental Health Update	***Marvin J. Southard, Ph.D., Director*, County of Los Angeles, Department of Mental Health** A. Dr. Southard discussed the current focus on diversion, which in general means, "can we find treatment options for persons in the community for mental health or substance abuse so that they do not need to be incarcerated." He talked about the importance of correctly defining diversion, the work with the District Attorney on looking at diversion systems, and DMH meetings with NAMI, Veterans, and other stakeholders on the topic. He also provided an overview of Supervisor Ridley Thomas's motion that encourages the department to look at diversion in terms of policy, and treatment resources tied to SB 82. He also highlighted the importance of this issue as it relates to the outcomes for children and impact on families and communities. He reiterated the importance of doing this work in a culturally sensitive and appropriate way. He announced the new federal grant that Los Angeles received to implement health neighborhoods in order to reduce health disparities in 4 African American, 4 Latino, 2 Chinese, and 2 rural and American Indian communities. Finally he discussed the budget indicating that as it is initially implemented service will be fine. *Question and Answer occurred after Susan Rajlal's comments.*
State Budget, Legislation & Related Issues – Update	***Susan Rajlal, Legislative Analyst*, County of Los Angeles, Department of Mental Health** FEEDBACK 1. **Question:** Is the diversion program directed toward individuals whose only identified disability is a substance use addiction or where there is no other identified mental health co-occurring disorder? Is that group in this population that everybody is talking about? **Response:** That is the new adaptation. In the last 12 months, Alisa Dunn's program evaluated about 2000 persons for diversion. Of those, she diverted treatment for about 50%. The 2 biggest reasons why people were not diverted: First is that 333 refused to be diverted. The second biggest number was because on evaluation it

was found that substance abuse was the primary issue, not mental illness. As such they were not eligible under the current conditions of our diversion approach.

2. **Question:** Regarding the EPSDT increases, will that be effective next fiscal year?
    a. **Response:** It will be effective for 13-14 as well. LA County spent enough EPSDT in the last fiscal year that we overspent the amount of state general fund match that was realigned to us. Our position has been that it is an entitlement and we must provide services. We will get money for the past year and more money in the future year.

    b. **Response**: How will that be implemented for those of us who are contract providers? Will we see an increase in our EPSDT funding?

    c. **Response:** I do not know the mechanisms and the time the mechanisms take for budget increases. The overall message is that in LA County we do not cap the entitlement because it is not proper to do so. An individual provider may exhaust their entitlement in which case the person seeking services may have to go elsewhere. We are going to see what we can do to adjust that using delegated authority. Additionally, we will institute some kind of quality control measure because we want to not just pay for services, but also want to know if they are actually doing the children and families good. There will be more money and more careful controls on the money that's there in terms of quality.

3. **Question:** When you said commitment for pre-2004 it mentions AB 3632, which is now SB 114, does that mean that DMH will get the funding and not the schools or will the schools get the funding because it is changed?
    Response: Neither. We paid the contractors that money already. We have a line in our books that says, "mandate claim." If the mandate claim did not come through we would have to pay the CEO back. Since the CEO is getting the money from the state the CEO general fund gets paid back. It is a good thing for the county, but does not do anything for either the school or the mental health department budgets.

4. **Question**: In terms of the discussion on diversion, most of it is regarding adults. Is there any thought of including a younger population? Is there any discussion of a pre-adolescent or adolescent diversion to probation or camps?
    a. **Response:** The short answer is that the probation department has already been instituting, in conjunction with Judge Nash, something that appears to be a diversion program. Right now adolescents, unless they have done something particularly heinous, do not go to jail. They go into the camps or the halls. DMH and the Probation Department have been looking at keeping as many kids as possible out of the camps and the halls. The question is, "Can we do more in that regard?" We probably can.

    b. **Response:** One thing the DOJ helped us to do was institute a substance abuse treatment program in the camps. When we first started this DOJ process we did a substance abuse screening as well as a mental health screening for everybody that came into the camps. If you believe the results of that survey, the drug use among the juvenile probationers going into camps was lower than the typical LA County high school. The issue is, "If you're going into a camp why would you tell the truth about your substance abuse?" We made significant changes with our

substance abuse and mental health providers--so there are now substance abuse services in the camps. The goal is to continue that very same service when they leave.

5. **Comment:** Are you talking about diverting out of the criminal justice system entirely or are you talking about diverting out of jail? As much as we love to collaborate and are really focusing on holistic representation in our office, our job is to protect legal rights and interests. We collaborate as much as we can but we do not want to give up our Bar card at the door and not protect our clients' rights because that's what we are mandated to do. In terms of felony cases, we are an office that was really instrumental in CODC working with DMH because I think it was Bob Fefferman many years ago said, "We need some of those FSP slots" because we have so many people that are co-occurring. Besides the co-occurring disorders court that we work in we also have women's re-entry program. Everyone in that program has a co-occurring disorder. Most important it is the client's decision at the end of the day. We give lots of advice not taken because the client has the right to make that decision.

6. **Question:** How do they decide the primary reason for an individual not to qualify for diversion?
    a. **Response:** These particular cohorts are people who want to divert people as much as possible. It is not because they do not believe diversion would be a good thing. They believe the facts of the case would not be supported by the judicial system.

    b. **Response:** Who determines if substance abuse is the primary reason? How is the judge notified about that?

    c. **Response:** It is the evaluation. The evaluation is based on the history and what people say. It is not impossible to determine where the primary existing problem is.

    d. **Response:** It just seems to me that they go together. I think that's something to consider. It is a loophole that can be very damaging to the person who has the co-occurring disorders if they're just judged that, "Oh well you're primary thing is substance", it goes back and forth.

7. **Question:** I was wondering about the H.R. Murphy. I noticed you are opposed to that legislation.
    a. **Response:** Where did you get that idea?

    b. **Response:** The paper that we got at the mental health commission said that DMH is opposed. I was wondering why.

    c. **Response:** No. So there are 2 bills in Congress right now that would augment the mental health system. One of is the Murphy bill and the other is the Barber bill. Susan did a deep analysis of this so she can tell you the details. In general, about 70% of the provisions overlap. They are the same bill. They differ in particular ways from the other. But they have embedded in them both a huge win for us, which would be the repeal of the IMD exclusion as it affects people with mental illness. We are absolutely supportive of it. As a matter of a fact the Board of supervisors issued a 5-signature support letter for the positive provisions of both bills.

    d. **Response:** If anyone else is interested in the provisions in these 2 federal bills we do have a schematic that

	compares them and we could send it out for you to look at it.
Regional WET Partnership RFP Presentation	***Dr. William Arroyo*, County of Los Angeles, Department of Mental Health** FEEDBACK 1. **Question:** Can you review pages 10 and 11? I noticed there is a NAMI for consumers and family members. Is there funding? Why is it mentioned? **Response:** As part of our application, they wanted us to identify the folks at the county level that we engaged in discussion over this proposal. Since many of you represent different organizations and sectors other than mental health this is prepared as a draft for our response to the state. 2. **Question:** The acuity on the lack of psychiatry in our county is enormous. Any relief that we end up with will be spectacular. In a number of the activities it looked as though there was a unique opportunity to include an emphasis on co-occurring and substance use disorders. Is there an active plan to do that? **Response:** That is included in the state plan so any services that would result from this funding would include a co-occurring approach. 3. **Question**: Would the psychiatrists need competency in co-occurring and substance use disorders? a. **Response:** They would need to develop the skills to provide services that meet the co-occurring needs of the population of Los Angeles County. b. **Response:** We are recruiting from the clinical scholars program at West Central. Interviews were conducted indicating our interest in people who have an interest in co-occurring disorders as a treatment focus for the West Central area and as an outreach to faith communities in that area. The overall goal is to make West Central a center for excellence, as the health neighborhoods develop. We want to improve the quality of care that we offer throughout the system but will start at particular places. West Central is one location. 4. **Question:** In your presentation it sounded like expansion. I did not hear anything about retention, particularly of psychiatrists. Is retention a problem, and if so, will it be addressed? a. **Response:** There is a challenge with retention. We recently received Board approval to improve our salaries for psychiatrists. We hope this improves retention. b. **Response:** The real problem we have with retention is geography. Our retention issues are specific to SPA 6 and 1. Part of this effort in West Central, for example, is to create a quality program in SPA 6 that focuses on retention. The SPA 1 issue is difficult because some things we hoped to do; for example, having site-specific bonuses, we were unable to achieve through the CEO. We do a better than average job of retaining psychiatrists --retaining in hard to fill places is our biggest challenge. 5. **Comment:** On page 7 you discuss need. Point #2 is that there is a need to retain psychiatrists and then there is also a naming of the need to retain culturally competent psychiatrists.

Response: There is more work to do on this. It is part of our enhanced effort to collaborate with the academic institutions discussed in this proposal.

6. **Question:** In the core values and objective goals you discuss diversity, but when I look at the programmatic breakdown I do not to see those words duplicated there. In SPA 6, we want to see diversity and see those young people have that opportunity to come back and give back to the community. I want to see more of that in those statements around the money, the group, and UCLA, telling them that this is our expectation, especially the cultural competency piece. There needs to be training.
    a. **Response:** Your point is very well taken. A few of us, Dr. Shaner, myself, and others within the department, in fact, do conduct some of the interviews on behalf of UCLA to ensure that we get the right candidates.

    b. **Response:** Your point is very well taken and we need to do as good a job as we can.

7. **Question:** I see a lot with UCLA but USC has done a lot of work in SPA 6. Why are we not collaborating with USC around this?

    Response: The reason for UCLA in this case is because of the mechanism. We have an affiliation agreement with UCLA that lets the money flow without doing a bidding process that would take 7 years and 50,000 lawyers. Collaboration with the USC is a good point. Dr. Kay, Dr. Shaner, and I met 2 weeks ago with the USC CTSI, which is their translational research center where they try to work the best new clinical research into community settings. They want us to be one of their stars in their application process. This is a joint effort between the CTSI, the USC School of Medicine, and their School of Social Work. We will be heavily engaged with USC but not using this mechanism.

8. **Question:** Has there been consideration for what are the most common psychiatric concerns of our veterans coming back from war? According to the Center of Deployment Psychology those are insomnia, chronic pain and trauma. Although TBI (Traumatic Brain Injury) is also important, but what about these other psychiatric elements impacting our veterans. That should be part of any kind of curriculum for psychiatrists.
    a. **Response:** You are right. I would assume that would be part and parcel of any training program. We want to highlight the traumatic brain injury (TBI) because that is emerging as a much greater challenge than anticipated. It is expertise that heretofore we have not engaged in developing. But yes, the other conditions would have to be addressed in any care provided.

    b. **Dr. Southard's Response:** The genesis is that through the legal system the public mental health system is getting responsibility for people whose behaviors are uncontrolled. Some of that happens because of dementia and TBI. As a system, we believe we have 2 potential strategies. One is to engage and try to provide part of a treatment solution for people with dementia and TBI. The other is to segregate those responsibilities from our current responsibilities and make that dividing line. In either case we need to develop an expertise to know either how to intervene or how to segregate properly.

    c. **Response:** I want to see our psychiatrists and psychologists trained in those areas especially as we go forward to

make sure that we do address these very relevant needs of our returning veterans.

9. **Question:** Can you discuss recruitment of culturally diverse populations? Will it only be the 4 racial groups or will it include other ethnic groups? Outreach to those different cultural groups: is that going to be decided by the state or is it left to the counties to decide?
   Response: We are desperate for representatives from all the cultural groups in LA County. There is, at this point, no narrowing of the diverse groups in LA County. Our department will be working with the academic centers to ensure that the goals of our proposals will be met. We will be scrutinized by OSHPD who is asking for 6-month reports on this proposal as it begins to get implemented.

10. **Question:** What is the status of efforts to develop a statewide peer certification?
    Response: The overall effort is embedded in a process of the waiver to be able to bill for peer services in a different way. Peers can bill but they bill for providing mental health services in ways that others do as well rather than a specific thing that only peers bill for. There is no state plan or method right now. For the peer certification to have a statewide meaning the fruit of that would be a service to be delivered. Right now peers do different things in different county systems depending on a whole bunch of different things.

11. **Question:** How far into that state plan amendment phase are we?
    Response: That is a DHCS issue. Health reform is their first priority.

12. **Question:** Many contract providers have difficulty retaining our staff after they get their licensure. There is no question that the burnout from the paperwork is a big issue. Now you are adding outcomes as part of the evaluation process and they cannot bill for a lot of the outcome measures. The second comment is in regard to part 5, post-doctoral training and TBI-- there are refugee populations, particularly API populations, with traumatic brain injury due to torture. There is a significant amount of research from USC about that. Is there a time commitment for these residents to remain within the public mental health system similar to the stipend system that we have for MFT's and social workers?
    a. **Response:** I do not know where the negotiations ended but the beginning of the negotiations was that we would do this and if the person did not stay for 2 years then there is a payback mechanism. I do not know if we worked that out in the final contract.

    b. **Response:** Another incentive that we have worked on is identifying federally designated professional shortage areas for loan forgiveness incentives.

    c. **Response:** Are you talking about the HIPSA areas? We worked with health services on this because a lot of those are common areas. The process is so labor intensive and takes a long time. We will give you an update on the ones that have recently been cleared as part of HIPSA.

    d. **Response:** We also have MHLAP --the statewide mental health loan assumption program which your providers and staff are applying for as well because that is countywide, not just DMH, but also includes contractors and psychiatrists.

13. **Question:** In goal #1, objective C, who is considered a parent caregiver? Has the state had any discussions about it?
    Response: The state plan wants us to pay attention to needs across the lifespan. If it is a one year old presumably it is going to be a parent or caregiver of that one year old who might be involved.

14. **Question:** You have special groups there, NAMI, the client coalition--my concern is that I know NAMI's good—but most of their programs are designed for adult family members and consumers. My concern is children and especially children from 0-5.
    Response: Yes, there are other statewide organizations such as UACF that we need to engage.

15. **Question:** What are the goals or ideas for specifically addressing the barriers to recruiting or retaining psychiatrists in SPA 1?

16. **Question:** What is driving the overall shortage of psychiatrists? How are we addressing that external pressure in our retention plan?

17. **Comment:** Years ago we had a shortage of teachers especially in my community. USC had a program that our volunteer bureau was involved with. We had them recruit people that were undecided on what they wanted to do. Second, we let them know if they wanted to come to Compton, East LA and other places, that we had families volunteered to let them spend a week so they could see what life was like. Once you get the people, have them live in the community to understand the community and how it works.
    Response: Maybe there is a way to do that in terms of exposure to the culturally diverse groups in Los Angeles.

18. **Comment:** When you pay someone you ought to be able to say how long they have to stay. We should ask for at least 5 years if we pay for your education.
    Response: I am not so sure about your second point with respect to tying them down and making them stay here for 5 years beyond the funding stream. There are some programs that we need to get more information about, Dennis Murata's staff may be working on this, whereby entire loans for professional schools can be forgiven if the person stays in a federally designated area for 10 years or more. We need to look into that more systematically.

19. **Question:** One of the county's regional needs talks about the monolingual Spanish speakers and the fact that it is hard for us to recruit or find doctors that speak another language. Here it talks about Spanish but it could also be for Chinese or other languages. Have we considered doing language education or immersion programs for our doctors?
    Response: Your points are well taken.

20. **Question:** Are we making any efforts to find a way for doctors that are trained in other countries that are not acknowledged here as doctors to get their training validated more expeditiously rather than having them have to go through a whole medical school education again when they already have a medical school education?
    Response: Insofar as reciprocity of professional training from one country to this, as you may have read in the media there are efforts underway with people who have been trained in some of the professions but I have not heard anything regarding psychiatrists.

	21. **Question:** Can you comment on the fact that these different organizations have come out against the HR Murphy? **Response:** In the analysis that we did, both the Murphy and Barber bills, we pointed out the strengths and weaknesses of each. The Murphy bill in particular had a couple of things that we were dubious about. One of the things that we were dubious about is that it restructures SAMHSA that threatens the block grants. The block grants for LA County are not huge, about $14 million for mental health, but there is about $71 million for the substance abuse side. Any threat to the block grants needs to be taken seriously which is why the Board of Supervisors did not unambiguously endorse the Murphy Bill but rather pulled out those components of the Murphy bill that it supported, highlighted those, and then moved forward.
MHSA Implementation and Outcomes Division – Update	***Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division*, County of Los Angeles, Department of Mental Health** A. Our current WET plan ends at the end of fiscal year '17-18. In our next 3 year plan or even a little bit before we have an opportunity to look at whether we want to dedicate some Community Service and Supports (CSS) funding to WET because our 10 year allocation will have ended. Our public comment period for the three-year plan ended a couple of weeks ago. We received 10 or 11 public comments. I want to share the public comments here. B. About half of the comments fall into this first category, which related to funding of PEI statewide projects. Several years ago counties put funding into CalMHSA, our joint powers authority, to fund 3 types of PEI statewide projects. About a year ago CalMHSA presented to the SLT on those projects. The projects are suicide prevention, stigma and discrimination reduction, and school mental health. C. Part of the CalMHSA project on stigma and discrimination reduction allowed community colleges and universities to apply for mini grants. 5 or 6 colleges in LA County received mini grants and did quite a few things with those grants. That money ends at the end of this June. Several graduate students as well as several administrators from those schools weighed in on public comment and said how the funds helped their counseling services as well as helped create forums to get the word out about mental health services and the need for entities like the DMH to come together with academic institutions. In essence, they said, "We really think these have been beneficial. Can you continue them?" D. The reality is that we cannot put any more funds into CalMHSA at present. If we did we decided to continue those projects, DMH would seek approval from the SLT and the Board would have to be supportive of those investments. Any money would come from our PEI allocation which means taking funding away from direct services. CalMHSA has yet to demonstrate results that counties have seen around the efficacy of those statewide projects. For those reasons we are not able to continue to give money to CalMHSA to continue to provide the mini grants at this time. 1. **Comment (Bill Arroyo):** I wanted to share something with you and maybe we could put it on the agenda at a future SLT meeting. There are a handful of evaluation reports by RAND that were just published a week ago. They have to do with the student mental health initiative as Debbie mentioned K-12, community colleges, and UC system. Some of the findings there are rather compelling. We will share these reports with you which are very brief in their format in lay terms but I think that if you get a sense of what has been found I think it may better inform our planning process locally. I would like to bring those for the SLT to look at. They are quite compelling.

E. There were two or three comments regarding a new program proposal under CSS–the Promotoras program. The comments said the Promotoras specifically seemed to indicate that a specific ethnic population, in other words, the Latino population might be served over other ethnic populations in terms of the outreach and engagement and the cultural brokerage that would happen related to model. I heard this through public comment and then went to the Mental Health Commission SAAC co-chairs meeting where it was discussed further.

F. We went back and agreed on a couple of things. We agreed that the name, Promotoras, needs to be changed to be more ethnically inclusive. The origin of that word is mental health promoters. With your approval, we want to call this the "mental health promoters" program as opposed to Promotoras. [A recommendation was subsequently made to title the program "community mental health promoters" which received no objection from SLT members.]

FEEDBACK

1. **Comment:** In other areas where the Promotoras Salud Mental have worked they have sometimes translated it as "community health workers." The original proposal reads, "Promotoras de salud / community health workers." But the literal translation is promoters of mental health.

2. **Comment:** At everything we do at [inaudible] high school we do it both Spanish and English. So I do not see anything wrong with putting both there. It is the English translation of the Spanish word.
   Response: We are trying to implement and adapt a particular model, which is the Promotoras. We know that as we adapt the model to other ethnic communities it may change to be something relevant to that particular community

3. **Comment:** If we added the word 'community' to it, "community mental health promoters", it makes it a little less ambiguous.

4. **Comment:** What I get from Jim's idea is that community makes it very clear that we are looking at mental health promoters that come from a community, which is one of the key ingredients of this model. At the same time it does not reference a specific ethnic community so as a title it opens it up for adapting the model to different communities. Any objections to that change toward community mental health promoter? Since there are no objections let's move on.

   Note: the new title for this new CSS program is "Community Mental Health Promoters"

G. The other comments related to planning, outreach and engagement. They discussed incorporating learning from the innovation ISM model, in particular, the non-traditional healing approaches as well as adding community informed social marketing approaches. Then there was one comment that basically asked for more clarification around implementation issues.

H. The Department is in the process of determining implementation timelines, including which programs will be directly

operated and those that will be contracted or both. We are looking at the methodology for service expansions. There have been some programs--Child FCCS is one of them--where they said the expansion capacity would focus on the 0-5 population. Children's System of Care will then have to say, "Will all providers get an equal amount of money or will there be some other methodology used?" We want to bring those methodologies back to the SLT standing committee to help us work through them.

I. When Board letters are necessary, we are looking at staging those board letters according to the implementation schedule. The other thing that has come up in the last month has been creating leadership within the SAAC and being able to align interests in the SAAC with the interests of the SLT. In the appendix of the 3-year plan one of the appendices is all of the feedback we received from the SAAC's related to 3-year plan.

J. So we have an opportunity to look at the information and the ideas and the interests of each SAAC as it relates to the 3-year plan, in particular, those parts of your recommendations that are about making the programs better.

K. Yvette mentioned that some of the SAAC's have been interested in receiving more outcome data more routinely than annually. We will probably be looking at quarterly. We will be interested in your feedback about its usefulness. Some of the data does not change very much on a quarterly basis as you may have seen. We will be interested to know, "Is this of help to you? Are you looking for other sorts of information and data that we haven't given you yet that we have access to?"

FEEDBACK

5. **Comment:** I think we need training on what advisory committees are. I always taught my group years ago that advisory means just what it says. You give the people the advice. They take it or leave it. But at least they gave you an opportunity to give them the advice. Any smart department will take your advice.

6. **Comment (Dennis Murata):** A few months ago, similar to what we did for CSS, we talked about using some of the unspent dollars—an amount of $30 a million a year for the next 3 years. I also said we would do the same thing for PEI along the lines of $15 million a year for the next 3 years. At the next meeting, I came back and said we are not doing that because our estimates are showing that we could not make that kind of commitment based on what the expenditures were. Today, I am here to say that based on the numbers now, we do anticipate having unspent dollars that we could use for PEI for next fiscal year. We cannot make the commitment beyond that at this point. According to our budget office, we are looking at, at least about $20 million that we would feel comfortable at least for next year. However, out of that $20 million, similar to what we had for CSS we also have some things that we have to take care of. That is actually the PEI services that are being provided now to our legal entities. That roughly comes out to about $13 million that we need to continue at least for one more year. We have to incorporate those expenditures. The net result may be as much as $5 million that we can start with in terms of planning for next year.

7. **Question:** Are you looking for feedback from the SLT before June 30th?
   Response: It is an announcement. Actually I thought it was a bit of good news that at least to start planning that there will be dollars. These are not ongoing dollars.

	8. **Question:** Is that in addition or separate from the already allocated onetime funds that we heard about for PEI, like at the legal entity meeting? **Response:** No. The $20 million will include what we have to commit to for the legal entities.
SLT Standing Committee	THE SLT Standing Committee presented a motion to: 1. Expand SLT Membership from a maximum of 50 members to a maximum of 60 members. 2. Reclassify SAACs as 'system perspective' members. a. SAACs select their own representative b. SAACs receive accurate information c. SAACs are clear about conflict of interest rules 3. Include new SLT members who joined for the 3YPE planning process as full SLT members. FEEDBACK 1. **Question:** On the check off list, do you just have the service area or the service area advisory committee? **Response:** In the original check off list we basically just had the service areas. This motion will put the SAAC's as an organization under the systems perspective. Each SAAC would have at least one representative. But more people could come from the different service areas as diversity perspectives. 2. **Question:** There will be a representative from each SAAC. There will also be a representative from the service area? **Response:** Automatically you are going to get representation from the service area because the SAAC person already represents a service area. However, when you apply we also ask you to tell us which service area you are active in. 3. **Question:** In terms of getting the accurate information regarding the rules and the conflict of interest rules are the SAAC's going to have written guidelines to refer to? a. **Response:** Yes. They're going to be basically the same ones that we have here that we are developing. We already have some basic conflict of interest rules. But they need to be consistent. b. **Response:** There is a certain amount of additional work that we need to do on the conflict of interest rules that I learned as we were going through the 3 year plan planning process that we are going to have to make more robust here on the SLT. Those are the ones that will get communicated to everybody including you. Would someone like to block this particular motion from going forward? Seeing that no one is blocking then it moves forward as an agreement. **Vote: The SLT motion passed 34-0**

	The SLT received a diagram, which outlined the new Innovation Program Planning project in their SLT packet. 4. **Question:** On September 15th we will do the solicitation review, contract process, and the Board of Supervisors would approve Board letters and all of this by October 2015? **Response:** Once the OAC approves it in November/December then the idea is that from January to September, within a 9 month period we complete certain tasks, solicitation reviews, contracting process and then board letters; so within a 9 month period be able to achieve that so that by October 2015 it is put before the board of supervisors for approval. 5. **Question:** It is my understanding that the current plan that we are operating with the vendors that are on board has been extended for 6-8 months or a year. Is that right? a. **Response:** Yes, a couple of months ago the SLT agreed to extend that. b. **Response:** That extension was for how long and for what reason? When you take those answers to those two questions into account then you'll understand why the timeline is very short in your proposal. 6. **Comment:** Last July the SLT approved a motion basically that said that each of those models had 3 fiscal years to participate in that particular one. I think Tony's point is that it takes a while to implement these programs. Depending upon how many projects that we end up funding, how connected they are, how many are directly operated versus contracted, and then we will have our time frame known. But my intention is to push this as quickly as possible after making decisions about what these projects are and to work within our department to move these forward as quickly as possible. **Response:** I understand that. But if we answer those 2 questions that I raised then you will understand why the current proposed timeline is a very big challenge. 7. **Comment:** I would not be concerned with that at this point. The timeline is what it is. If we start to slip one way or the other we will come back to you and let you know.
Public Comments	1. Comment: Encouraging the title of "CCR/health/wellness" workers instead of "Promotoras" to reduce stigma associated with the phrase "mental health" after fielding opinions and a petition from mental health consumers. Time requested for a presentation regarding empowering mental health consumers and fighting stigma. 2. Announcement: Fri, May 30: California Institute of Mental Health Summit. "Building the Evidence." Planned by diverse populations. Crown Plaza Anaheim Hotel in Garden Grove. Flyers available. 3. Comment: Regarding the standing committee there were 3 categories: implementation of work already done, innovation of work that we want to do, and challenges that we need to solve in order to move forward. It is easy to focus on what we are talking about and forget about the other pieces. Bring into awareness the categories so awareness is always maintained that there are other things out there to be worked on. 4. Announcement: Mental health and spirituality conference on Thursday, the 29th. New location: convention center.