COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT)

Wednesday, November 19, 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. Present the results of the first generation of MHSA Innovation projects focused on the integration of mental health, physical health, and substance abuse services.
3. Discuss and approve the second generation of MHSA Innovation projects focused on health neighborhoods.
4. Agree on next steps.

MEETING NOTES

Department of Mental Health - Update	*Dr. Marvin J. Southard, Director*, County of Los Angeles, Department of Mental Health, provided an update on key issues facing the public mental health system in the County of Los Angeles. A. *Proposition 47: Criminal Sentences. Misdemeanor Penalties. Initiative Statute*. 1. The passage of Proposition 47 as a social justice matter is an entirely good thing because it works well for the long-term health of our communities. However, there are some short-term complications that are particularly difficult to the mental health system and perhaps even more to the substance abuse treatment system, who are our essential partners. 2. For the public mental health system, there is a quirk in California's law: the restoration to competency of those who are incompetent to stand trial and for those charged with felonies is the responsibility of the State of California; but for those who are misdemeanants, the responsibility for restoration to competency is the responsibility of local government, i.e., the counties. 3. There are a number of people who are in state prisons and state hospitals awaiting restoration to competency on felonies who have been the State's responsibility. On November 5th, they became misdemeanants rather than felons. Thus, the responsibility for finding a way to restore them to competency and to provide for their well-being becomes the county's responsibility. 4. There may be as many as 700 individuals in Los Angeles County who fall under this category, but not all of them are suffering from mental illness. Some of them are suffering from developmental delays and some from dementia. However, the restoration to competency will be a huge cost issue: if we need to find State hospital beds, there are none; and if we need to find IMD (Institution for Mental Disease) beds, they are not available. There are waiting lists to get into them even if there were resources. So it is not quite clear how that responsibility will be handled.

5. Talks with County law enforcement and treatment communities to figure out how all of that will work out are still in the initial stages. I thought that the public mental health community should be put on notice that there may be a large new responsibility with cost implications that will affect our systems.

6. Since every piece of our system is connected to other pieces of the system, if one piece gets overwhelmed it affects everything else. We are working on this issue, trying to find a way to mitigate it as best as we can and to get more clarity on the actual numbers, not just the projections. For example, it could be that the people who are released from prison as 'Incompetent to Stand Trial' (IST) will be released on their own recognizance from the court. Will they come to DMH, since there will be no way to hold them for anything and they will have just been released? How do we make sure that their well-being and legal rights are protected if those kinds of situations eventuate? It will be complicated.

B. The second item is that the California Mental Health Directors took a strong stance at their meeting last week about the direction of the public mental health system.
   1. We took steps to have the 'carve-out' protected as we move forward into an integrated care system in the ways that we can best get that done. But we also took steps to initiate a process where there is a greater clarification about what the boundary ought to be between the 'specialty' and 'non-specialty' mental health care; one is the purview of the 'carved-out' system and the other is the responsibility of the health plans.

   2. There is some temptation to try to make all of these services the responsibility of the health plans, but the California Mental Health Directors have come to the overall position—though not unanimous—that the way we need to proceed is to look at this question from the perspective of the clients seeking service.
      a. It does not make sense to have the client need to know how 'ill' they are in order to know which place they need to go to get care, but rather to have as much as possible carved into the public mental health system, not only for revenue and client-care purposes but also for future system integrity. If the public mental health system is marginalized and only serves the most ill when they are at their most ill state—which is some people's vision of what it ought to be—that is a recipe for the extinction of the public system and its safety net. So we are trying a strategy that will work to protect the safety net efforts of the public mental health system by expanding our purview and making us an integral and indispensable part of the overall health care system.

C. The third item is the diversion program that we have been working on with the District Attorney. There was a successful presentation before the Los Angeles County Board of Supervisors. This program will be supported by efforts linked to the implementation of SB 82's crisis stabilization and urgent care resources recently approved by the Board of Supervisors. Those Requests for Proposals (RFP) will be going out soon. The first couple of meetings in December will be pretty complicated with the new Board Supervisors stepping in, but some time in December the Board Letter (for the RFPs) will be heard as well. That will give us the opportunity to expand our outreach.

D. The final item is that the development of our 'health neighborhoods' has continued. We have a community forum on these health neighborhoods scheduled at The California Endowment on the December 10, 2014, entitled something like

'On the Road to Health Neighborhoods.' It will describe the process of where we are now and what we believe the next steps and future opportunities might be.

Feedback

A. **Question:** What are your thoughts about the new process or regulation about the State approving psychotropic medication for minors?
   1. **Response:** If the State is going to put that in place, they need to do a better job of making it possible for the Treatment Authorization Process (TAR) to go through on a timely basis. Our concerns are not so much that there be an approval process because in Los Angeles we already have one; the difficulty we have had is that in some cases the continuation of medication that some kids have been on successfully has been impeded because the State TAP process is not yet user friendly and in place. Dr. Arroyo is working very vigorously to make sure the changes that need to take place happen. He was concerned from the very beginning about this process and raised those concerns on a conference call with the State. The State pharmacy was saying it is merely a continuation of processes that already take place and there is no need to worry. It turns out they were wrong and Dr. Arroyo was right.

B. **Question:** You talked about the plan to have the public mental health system be a robust, full system of care providing more services across-the-board rather than the traditional system for seriously and persistently mentally ill, i.e., the worst case scenario. How do you envision the public mental health system relating to the commercial system that is emerging post Affordable Care Act (ACA)?
   1. **Response**: On the commercial system that is not Medicaid based, I would imagine them contracting with us to provide the high-end care that the commercial systems do a poor job on currently. Even systems as sophisticated as Kaiser really do not do well with the array of services that somebody with schizophrenia or acute bipolar disorder requires. The rehabilitation services that we offer, I believe, are the best services available. I would hope that at least for a subset of the population, Kaiser—and systems like Kaiser—would recognize that contracting with our system to provide that care through our network of providers is appropriate.

C. **Question:** In terms of help for clients with co-occurring disorders who have a chance to have detox services, I have learned through my own personal experience with my son that there is really no place for a person with Medi-Cal to go to for detox that does not also require 2-to-3 weeks just to get assessed and then maybe another 8 weeks to get detoxed. I was wondering if you were working with the Department of Public Health to address this. If a person cannot get detoxed, they cannot function really well in order to get more help.
   1. **Response:** As you say, the detox capacity in the system now is pretty slight. The new benefit that should be in place is not yet in place for substance abuse; this benefit would provide more for a robust detox process. The good news is that I think the provider community recognizes this and is beginning to think about how that service ought to be provided and how the that service would be linked to co-occurring care. I met with a hospital from Long Beach that has plans to open a detox and addiction center in the next six or so months to dedicate beds specifically for that process. They were meeting with us to see about how those kinds of services could best be linked to appropriate mental health/co-occurring services. You are right: there is a gap in our system right now;

	the good news is that we believe that gap will be filled within the next year or so as the drug Medicaid benefit becomes a reality.
MHSA Innovations 1 Outcomes: Integrated Service Models	*Debbie Innes-Gomberg, Ph.D., District Chief, MHSA Implementation Unit,* County of Los Angeles, Department of Mental Health, reviewed slides pertaining to the first set of MHSA Innovations projects. Below are highlights of her presentation. A. Today, we are going to present the results of the first generation of MHSA Innovation projects and ask if these results are compelling enough to continue funding three (of the four) models through the Community Services and Supports Plan starting July 1, 2015. B. Our recommendation is to provide ongoing funding for three models. The specific funding amount would be determined by the DMH Executive Management Team, based on a review of funding priorities, and range between $10 and $19 million per year for the three models. (We think it would be closer to $12 million of CSS funds.) 1. The specific funding level for each agency would be determined later by DMH based on the results using an evaluation rubric (described later in this presentation). This provider-level information will be available in about a month or two from now. C. This session has four parts: (a) first we will provide background information and review results; (b) then we will briefly describe the evaluation rubric; (c) this will be followed by a panel presentation with representatives of the different models; and (d) finally we will have time to discuss the recommendation. Part 1: Background Information A. The first set of MHSA Innovations projects focused on integrated care. 1. Innovations projects are time-limited and meant to serve as a learning laboratory to test out four different models for integrating mental health, primary care, and substance abuse care. a. The partnerships were primarily between mental health agencies, community based organizations, substance use agencies and Federally Qualified Health Centers (FQHCs). b. They will conclude at the end of this fiscal year, June 30, 2015. The fourth model, the Peer-Run Model, goes one additional fiscal year through June 30, 2016. c. Todd Gilmer, at UC San Diego, heads up the evaluation team, which has been spectacular in terms of its evaluation work. The team includes the Health Services Research Center, Harder and Company (a local evaluation company), and Dr. Ben Henwood at USC. d. The evaluation has focused on the integration of services, and what is learned will then be applied to the broader public mental health system. 2. Key indicators used to evaluate these projects include the following: a. Level of service integration (a process measure) b. Health status improvement c. Mental health status improvement

d. Substance use improvement
e. Client satisfaction
f. Self-stigma
g. Community satisfaction (we have not yet addressed)
h. Cost effectiveness (which is coming out next)
i. Post-service outcomes

3. Results are based on matched pair data (the same clients – baseline vs. administration 3, baseline vs. administration 5).
    a. All 3 models have demonstrated reductions in mental health symptoms, physical health symptoms and substance use.

4. Case Western Reserve University's 'Integrated Treatment Tool' was used to gauge three domains of service integration and to identify how providers are doing in terms of their level of integration.
    a. The three domains of integration were: organizational; treatment; and care coordination.
    b. Each domain has multiple components to it.
    c. Results were presented by model, with IMHT scoring as most integrated during the first administration of the tool.
    d. Providers have been using this tool to examine where they scored well and not as well, and then consider adopting best practices in the areas where they wish to improve.
5. Health and mental health status improvements were gauged using a number of tools.
    a. The 'Milestones of Recovery Scale' (MORS): Gauges the trajectory of recovery showing how the models are impacting the mental health recovery of clients. Models have each demonstrated success in this area, with on average clients moving from poorly coping/engaged to coping and rehabilitating.
    b. The 'Illness Management Recovery Scale' (IMR): Gauges mental health status and the line going down indicate improvement.

6. Results were shown for the Integrated Mobile Health Team (IMHT), Integrated Clinic Model (ICM), and Integrated Service Management (ISM) Model (for underrepresented ethnic populations, or UREP).
    a. The ISM model has five different UREP groups associated with it: African and African American, Native American, Asian Pacific Islander, Latino and Middle Eastern/Eastern European.
    b. With the ISM, the figures are broken out by each of the different UREP groups and by each different provider, but what is being presented today is model-level information.

B. All models have been successful in reducing health, mental health, and substance use problems. (Substance use problems have been reduced a little less than health and mental health, but all models have impacted all three areas.)
    1. For the IMHT:
        a. Clients started off much more ill in terms of physical and mental health, but these were reduced significantly.
        b. There was a 47% increase in clinical improvement in terms of health care via the MORS rating.
        c. Homelessness was reduced.

i. We think this happened because we are focused on chronically homeless individuals who are highly vulnerable. The trajectory in terms of homelessness started at an average of 168 days and it decreased to about 58 days of homelessness.

2. For the ICM model:
   a. It showed clinically significant improvements with regards to IMR symptom reduction.
   b. Clients experienced reductions in stage one and stage two hypertension and in hypertensive crises.
   c. There was about a 40% clinical improvement in physical health symptoms

3. For the ISM model:
   a. Although each UREP population started out at a slightly different baseline, there were reductions in symptomatology.

4. Emergency room (ER) use for ICM and IMHT clients was reduced as well.

C. All models demonstrated a very high rate of service satisfaction.

D. There were increases of meaningful uses of time:
   1. With the IMHT, there was an increase in the number of clients attending school.
   2. With the ISM, there was an increase in the number of clients employed and attending school:
      a. Employment increased from 28% to 33.5%.
      b. Attending school increased from 15.5% to 19%.

Feedback

E. Question: Is there any comparison with regular DMH programs or a control group or anything like that?
   1. Response: We did not have a control group. That is a limitation. We decided to evaluate these programs focusing on the domains described earlier. Comparing these models to “usual care” was not part of any learning question.

F. Question: In terms of the IMHT model, how did the reduction in homelessness happen? How is the mobile health team linked to that particular outcome?
   1. Response: One of the requirements in the Request for Service (RFS) was that there had to be a housing partner to work with the service providers in order to accomplish the goal of helping people transition from homelessness to housing. Moving into housing was one of the major goals of the program because we targeted people who were homeless and highly vulnerable.
      a. It was mixed on how those relationships worked out because of timing issues. Some were project-based housing units and they had to open before we actually got the contracts in place. In other cases it worked very well (e.g., Exodus worked with the Skid Row Housing Trust). When they opened their new building, New Genesis, at least 50 clients moved into that building. The benefit for the housing developer was that

they had services on site. Moreover, each model addressed the need for permanent housing in a different way. For instance, some accessed DMH's permanent supportive housing tenant-based resources.

G. **Question:** In terms of substance abuse, was there any determination whether the individuals were self-medicating (using substances when they got into treatment or became part of a program) when there was no longer a need for dependence of substances?
   1. **Response:** If I understand your question correctly, you are asking about the reason why we might be seeing initial increases in substance abuse. Sometimes it takes building a relationship to be forthright about the degree of substance use. Sometimes you would see people under-report their substance use. When they got to know their treatment team better, they reported, "I am using a lot more than I originally had told you." I do not know that the questions we go into 'why' the substance abuse declined.

H. **Question:** I have a question about the ISM for the different ethnic populations. Did you find any difference between those groups? I would also like to have the breakdown of those ethnic populations if possible. How can we get them?
   1. **Response:** Mirtala and Naga, who manage the ISM model, have this information broken down by model as well as by providers. In a month from now, UC San Diego will complete its evaluation and that information may actually be more valuable than what I would send you right now. What I will do is consult with Mirtala about the best information to send all of you.

I. **Question:** Have we done any cost-savings versus cost-benefit analyses to see what we saved with the money we spent for these models?
   1. **Response:** Yes, we were just on a call with Todd Gilmer about a week ago. The methodology used and analysis are excellent.

Part 2: Evaluation Rubric

After responding to questions, Debbie provided more background information on the 'evaluation rubric' for the various models.

A. UC San Diego, working with the model leads, introduced some concepts at a learning session in July to develop an evaluation rubric in as transparent a fashion as possible.
   1. Those of you who are providers know that when you sign your contract you have your service exhibit. A service exhibit includes all the requirements for your program: you have to have the staff that speak the languages that your clients do, and all those sorts of things. So, we took those requirements and weighted them versus what we expected in terms of outcomes.
   2. What you are going to see is a very impressive approach that I do not think the Department has used before in terms of really starting to weigh different elements of program expectations with program outcomes. It is more than just how much you spent and how many clients you served; it also includes the program outcomes.

B. The rubric includes client-level and program-level metrics. (See slides for more information.)
   1. The domains, sub-domains and data sources: the quality-of-care domain has mental health outcomes, access to care, client flow, clients served relative to targets, and "Did clients receive desired care?"
   2. It is color coded because different models had somewhat different expectations.
   3. This is data so is not real information, but this will tell you how we are going to evaluate the programs.

Part 3: Panel Presentation

The panelists for the IMHT and ICM models responded to questions posed by Debbie Innes-Gomberg. This was followed by a presentation focusing on the ISM model.

A. Question: What is the significance of the MHSA Innovation project to your organization?
   1. Response: We felt that the learning approach was really significant not just for our providers but also for DMH staff. It really made a difference. It affected our implementation and approach. We met for years together, all of the different models, a large group, and every single month. Once UC San Diego and Harder and Company joined us to do the evaluation, they became part of our collaborative effort. It was always very interactive; we really embraced the learning model. The learning collaborative attended many special trainings, they met on their own to learn from each other, and it was really a delight to be involved. Yesterday, we looked at our old statement of work that was part of the RFP. We had put in learning questions. To our delight, we realized that we have answered every single question we posed.

   2. Response: For my organization, Exodus, these Innovations projects were really transformative in the sense that we were able to begin to recognize from an entire system (meaning our entire system of care at Exodus) just how important the interrelatedness is for physical health, mental health, and substance use. Anecdotally, we knew that already. But to actually see this through, outcomes and to approach that care in the multidisciplinary way that we were able to do through these programs, it enabled me as someone in charge of all of our outpatient programs to infuse the spirit of integration through the rest of our outpatient system, which is really important for us.

   3. Response: The biggest learning for us as an organization was how we had to re-visualize ourselves as a care coordination agency as opposed to a mental health agency. That may come as a surprise but the folks that we serve in the IMHT are so vulnerable and unable to coordinate their own care. That has become, for us, a central service that we provide for folks. They need somebody in their corner to help them get out and reach the care that they need or for us to provide it because they cannot reach it. To repeat what Leslie said, we have taken the approach that our entire organization has to be about care coordination, not just for mental health services, but for coordinating people's physical health care as well. Although we did not have an ICM program, we actually got a grant from a foundation to provide those services to our other clients within our Village program.

   4. Response: As a member of the ISM, we learned DMH could be flexible. It was a pleasant surprise. We all approached it together and I was amazed at how DMH worked so hard to find ways around the bureaucratic

challenges. We also learned how difficult it is, at least at the ISM level, to actually integrate care. Unlike some of the other models we had to find a Federally Qualified Health Center (FQHC). These are two different systems. That was a real learning curve for the ISMs. More than anything we learned the importance of cultural competency and how to bring it to reality in each of our individual ISMs.

5. Response: We also learned that we know what model works with people who are homeless. When we developed the model and brought together all of our stakeholders (e.g., homeless advocates with a lot of experience working with this population), we had an opportunity to bring together the best practices that are happening in the nation to serve the population; and that we could use the housing first model, permanent supportive housing, and street-based medicine models. We looked at what was going on in the country and actually brought that together in this model. The great thing is, looking at the data that Debbie presented, is that it works. When I meet with our partners in the homeless community and they talk now about what we need to do, we know what to do. People point to the IMHT as the model of what we should continue doing. It really is seen as a model in our community, not just in the mental health community, but outside the mental health community as the model that works in serving people who are chronically homeless, highly vulnerable people, to help them transition from homelessness into housing and improve their lives. We can see with all of these measures (like their health improvement and substance use improvement) that we can see it makes an impact in their lives. We know what works now.

B. Mariko Kahn, LMFT, Executive Director, Pacific Asian Counseling Services (PACS), highlighted the following points pertaining to the ISM model. (See slides for more details.)
   1. This presentation comes from the perspective of someone who also has been implementing the model, primarily based on the Cambodian ISM, but it includes insights drawn from the other UREP communities.
   2. Each ISM had a target population enrollment.
   3. Many UREP communities understood from the beginning that integrated care is not just about a well-coordinated client chart; it also means well-being, which means being balanced: the mind, body, and soul need to be treated together.
   4. A holistic model of care for an ISM is also a community-defined model of care: there is collaboration between and among the providers and the community-based organizations.
   5. Medical necessity was used to provide specialty mental health, and a medical condition that required ongoing care, and/or a substance abuse issue. It was necessary to involve a federally qualified health center (FQHC) for each of the ISMs. Sixty percent of clients could be indigent, more if needed.
   6. The ISM served all age groups. In addition, ISM funding provided support services for transportation, linkages, referrals, wellness activities, and follow up, which gave us a lot of room to try different things.
   7. Holistic activities were one of the key ingredients of the ISM. The American Indian group included a whole list of traditional activities in their screening tools as part of their outreach materials. Other holistic approaches that were used were spiritual healing practices like the Buddhist blessing ceremony, acupuncture, massage, meditation, drumming, herbalists, and physical activities such as Tai Chi, Yoga, and Zumba.

	C. Strategies 1. One (1) learning was related to outreach and engagement. You have to have the right staff. That is your face. That is the most important thing. It is not just about being bilingual. It is about having people on your staff and in your CBOs who understand the community they are serving. a. It is crucial that you have materials that are targeted to the socio-economic and educational level of the folks you are serving. If you use big words, it is not going to happen. We spent a lot of time doing it. 2. Another lesson was to have a "no wrong door" approach. 3. Another one was that you really have to help the people where they are. That meant addressing concrete basic needs. a. This really happens in stages. One thing we found was very effective in our ISM was that in outreach and engagement, the community navigators worked with the prospective clients for a while. 4. Another lesson was to have different outreach and engagement strategies that any group could use, such as media outlets and social media. 5. We also discovered the importance of seasonal engagement. One of the programs we did was a ‘healthy and fit group’ for Cambodian young men over the summer. It was very effective. 6. ISMs also must ask clients what they think about mental illness, not just depend on what you think you know. In the Cambodian ISM, they also wanted and felt that recovery to them meant that they would be treated in a respectful way, listened to, and could pass their knowledge onto their children. You would not think of that as necessarily as what recovery looks like. 7. The screening tools used by the American Indian group brought in a different element in its screening process to talk about historical and multigenerational trauma. Each ISM had to find the right words in order to identify and explore these needs. They really got it. ‘Building the Village' concept worked with the African group. a. We also welcomed new ideas. We just started a ‘passion for cooking’ class in our temples. It is also a way to bring in people who are not quite decided about whether or not to join. It fits into the cultural traditions and the spiritual healing practices. D. So why is outreach, education, and engagement important? 1. Disparity. You need to have people going out in order to know what people are dealing with. This has to be ongoing and responsive to UREP communities' needs because there are always new populations coming in. If you use the right type of strategies, you can overcome stigma and reduce disparity. 2. Outreach, education is beyond just the mental health sector. We have not been able to measure accurately the impact on the community besides just mental health. That is the impact that will lift a community up. We know

that ethnic communities need to be educated about mental illness. They need to know that recovery is possible. We know that urban intervention and even prevention is going to raise the community's well being, and more importantly, it is going to bring hope and reduce individual suffering.

E. Dave Pilon, MHALA:

1. Video 1 - http://youtu.be/rPL3zBm9Mqc - "HIP Video" by Mental Health America Los Angeles]. What you can see is that this is somebody who is really typical of the folks that we do serve in the IMHT: multiple co-morbid conditions. One of the things I take from this video is the fact that he was willing to consider taking the medications again after it had been such a bad experience before. He said, "Well, if Dora asks me…" Dora is a nurse practitioner who provides the physical healthcare on the team; and it is having that kind of health home--that belief that you have somebody in your corner that will help you through this—is really the hallmark of this model.

2. A couple of years ago, after we had already been in implementing the IMHT, I was so sold on this model that I decided we really needed to bring better physical healthcare to all of the folks that we serve; not just the folks that are most vulnerable out on the streets. The California Community Foundation gave us a $100,000 grant to bring physical healthcare into our Village program on a two-day a week basis. We hired a City of Long Beach physician, Dr. Torno, on a two-day a week basis. We got amazingly positive results with our members, many of whom had not received care in years.

3. The next video shows the experiences of the members. This would really apply to the ICM and our attempt to do it. We do not have an ICM project but I am so sold on this model that we decided to bring this in. [Video 2 - http://youtu.be/CpsYZAkIM44 "Physical Health Services at MHA Village in Long Beach, CA" by Mental Health America Los Angeles]. The biggest learning I had from that video was having the right staff: our members love our staff and Dr. Torno, an amazing physician. The biggest surprise to me was that I thought when we established this in-house ability to receive primary care I thought none of our members would ever want to leave. However, he is wonderful at assigning and finding primary care out in the community so they do not stay with us forever. They actually integrate into the community even better. Both the in-house provision of physical healthcare and the IMHT have just been wonderful experiences for us. I hope the data convince you that these are programs worth continuing.

DISCUSSION & RECOMMENDATIONS

A. Recommendation: The recommendation is to approve ongoing funds for the three models that you just heard about. The specific funding is to be determined by the DMH executive management team based on a review of funding priorities with a requested range of $10-19 million per year. The specific agency funding level is to be determined by DMH based on the results of the evaluation rubric.

B. Question: The amount of money is $19 million per year. That is for the total?

1. Response: We are asking for a range between $10 and $19 million. It will probably be about $12 million of

MHSA funds for all three models (i.e., ICM, ISM, IMHT) to be able to continue these programs. It does not include the Medi-Cal match.

C. Question: You are talking about funding it through CSS. Is there no PEI component for this?
    1. Response: There is no PEI component. We would potentially add a new work plan called something like 'integrated care' for maybe the ICM. Additionally, the Outreach, Education and Engagement (OEE) category would probably be the best fit for some of the outreach and engagement and other services for the ISM,

D. Question: In other words, there are already OEE resources, right?
    1. Response: Yes, you can proportion that money.

E. Question: In the past, you have indicated that the innovation money mainly targeted TAY, Adult, and Older Adults. When you talk about CSS funds, are they only going to be serving those three populations and leaving the Children's money intact?
    1. Response: We should not disturb the Children's money. I think what you are asking is that Innovation 1 projects focused more on Adults and Older Adults than it did on Children and younger TAY. You are right, that money would then go to Adult services to continue these programs as opposed to some other funding priority.

    2. Response: For the current funding, we are open to accepting all age groups, like what happened with the ISMs.

    3. Response: When the data were presented a year ago, it really showed that although children were accepted into these programs, the bulk of services were really for adults and older adults.

F. Question: It seems we are being asked to vote on a 'feel good' basis. There is no comparison with ongoing programs or a control group. So of course we all feel good about what is going on. We can all just vote 'yes' but there is also a cost associated with that vote which is somewhere around $12 million per year by continuing to fund these programs. Well, if these programs did not continue there would not be any marginal cost associated with those folks you are serving now and receiving services that are already available in the regular FSP or a regular CSS programs.

G. Question: All of these providers are amalgamated in those improvement lines that you are showing in the data. Did everybody do well? Or are there some that did not do as well as others? What is going to happen to the ones that did not do as well? Are we going to have any of that information before we vote?
    1. Response: Your vote today is not at the provider-level performance. Your vote today is at the level of the models that were implemented by different providers. In about a month or so, we will have provider level outcome information and will complete the evaluation rubrics referenced earlier. Then the EMT will make some decisions in conjunction with the model leads. Today we are focusing two broad questions: about: Are the three models that integrate physical, mental health and substance abuse services effective? Are they worth funding with ongoing CSS dollars?

H. Question: I understand clearly that if we vote on this item that DMH is going to make that call whether or not the

providers meet the outcome requirements. My concern is that if you decide not to fund a provider due to its performance…that the community it was serving does not lose the support it was receiving through this model. In other words, let us say an agency totally missed the concept. I do not want the community to be without support because of what an organization did not do well.

1. <u>Response</u>: Through evaluation rubric, if an agency does not meet the criteria for a specific model as we look at the data, unfortunately you are right, that community will lose out. I do not know how else to make those decisions. That agency would not be funded and that community would have an impact, presumably. The other argument would be that maybe they have not been serving their community well. Regardless, the learning of successful models and providers will be disseminated for all providers and communities to adopt, should they choose to.

2. <u>Response:</u> Well, that is an administrative decision. I understand that. But I am saying there is always more than one way to skin a cat and to do things. You had a number of bidders that were in there to do it. I do not know what the policy is for DMH but maybe you can go to the next bidder and continue to test the concept and see what is going on.

3. <u>Response</u>: This is really about the model. I think what you are getting at is a level of detail that we are not asking you to weigh in on at this point with regards to providers that may or may not continue to be funded based on performance.

I. <u>Question</u>: It is related to this comment on whether or not we could ask for certain monies to be earmarked for certain populations to ensure that the service is provided. On this topic, I think we probably need to make a recommendation later when the time comes because I feel the same way as the speakers before me. My question is about outreach. You said something about education that I agree very thoroughly. We need education for mental illness. Aside from that, did anything come out strikingly as being important in our outreach efforts to involve the CBOs or those who need treatment? Did anything come out as unique or different?

1. <u>Response</u>: We learned a lot. One of the things that I learned was how important it is to half the medical component when you do outreach and engagement. It is very attractive to many of our folks to be able to get medical treatment. It is amazing the number of folks who will not avail themselves of it because they are afraid for other reasons. The education goes beyond the mental health. It has to build trust and respect.

J. <u>Question</u>: We are talking about multi-year funding. How many years are we talking about? How is it compared to the current level of funding? Is it flat funding from the current iteration of the three models?

1. <u>Response</u>: We do not know that yet. The EMT would have to weigh in for successful models where providers met certain criteria. Key questions include: "Would they get full funding? Would they get partial funding?" I think it kind of depends on looking at the DMH’s priorities in relation to the need to continue models that have demonstrated successful outcomes. We would do our best to make sure that whatever funding was given to an agency that it was enough to continue the good work that they are doing. You would not want to reduce it so much that they could not continue the model that is successful for them. Regarding the number of years, the request is that the funding would be "ongoing."

K. Question: This is a funding question. If we fund this as "ongoing" funding, does that come out of the Innovation dollars? How will that affect the new Innovations programs?
   1. Response: For an Innovation project that you want to continue, it has to be through alternative funding, not Innovations. In this case, the source for ongoing funding would be CSS.

L. Response: Has there been any consideration as to how that will affect other CSS programs, like FSP or FCCS?

   1. Response: The funding would be in addition to the existing services. Every year we look at our service mix, programs and work plans. It may be that at some point a recommendation comes to combine some of these different programs. This vote today is really about continuing a successful program.

   2. Response: At the end of the Three-Year Program and Expenditure planning process, the SLT's Standing Committee and the SLT indicated that as soon as the Innovations planning process was over we would get back to the task of focusing on program-level assessments to know what programs were working or not. This is the next phase of the work that all of you will be doing. If these are ongoing funds, the programs will be subject to an assessment like every other program funded by MHSA. That is the accountability work that you will be doing.

M. Question: My question relates to the geographical location of where these programs took place. One of the areas I am concerned about is Antelope Valley, which is generally left out. Was the model implemented there? Or will that be taken into consideration?

   1. Response: We did not implement it in the Antelope Valley. It was open to anybody to apply, but we did not have anyone apply from Antelope Valley.

N. Question: I think peer engagement is essential with new clients. Is that across-the-board with everyone on the panel? This is one of the things I would recommend. I know from experience with my son when he was in the Diversion 50 Program, I kept emailing them, "Please introduce him to a client that has more recovery, a peer who could take him under his wing or something." I think the very beginning part of any kind of program is getting someone engaged.

O. Question: So there are Service Areas that do not have this program, not just one? Can there be a plan to expand it to the other service areas?

P. Question: I am more interested in the process that we are using as opposed to the vote on the models. I think there is an issue of when we average, if we have got somebody at zero no matter what the other people do, it will never look good. I am also concerned that we do not have an evaluation of cost savings because we are not comparing these numbers to other programs. I do not know if you gave somebody housing first, whether or not you would see more or less or the same amount getting better. We already know that person will get better. How are we going to deal with these questions? This is the first time we are doing Innovations. How are we going to deal with these more complex issues?

Q. Question: So the question of clarification is around the process by which we are making the decision and particularly

	around certain information that you want to get, such as cost savings? 1. <u>Response</u>: The premise here is that all 3 models are successful with regards to the stated goal of the Innovations projects, which was to improve the integration of health, mental health and substance use services in order to achieve better outcomes for clients. That is where we are starting from. Moreover, the rubric actually takes into account all of the different program expectations in the RFS as well as the service exhibits. If you have five providers within a model, and one of them is horrible, it does not impact the model itself. It just means that if somebody is not collecting the data, we are not going to consider them for ongoing funding. 2. <u>Response</u>: But that is the way that it is now. There are other models that will come up in the future where we do not have five. That is where I think we have to come up with principles that we are using to make these decisions. That is where I also think that you have to look at, "Yes they were all positive, but do we know if you do anything else things will also get better?" That is the Hawthorne effect. You make the lights brighter, things get better. You make the lights dimmer, things get better. If we are not comparing it to anything, that is an issue. If we get the same results by just having a peer outreach team go and bring people into the clinics, then do we want to be spending money if we do not know if it is not compared to anything? R. <u>Comment</u>: The response to that question-of-clarification regarding the recommendation-making process for today is this: for today, the comparison information is not available nor was it built into the evaluation framework for these models because it wasn't part of the learning questions. That is where we are at from a factual standpoint. S. <u>Question</u>: With the three models, I want to make sure that we have funding set aside for interpreting services for all people. I do not want, historically speaking, any of the CBOs or individuals to have unequal access because there is no funding available for that. T. <u>Question</u>: So the question is whether there are resources dedicated to linguistic access, such as interpretation. 1. <u>Response</u>: I do not know if we need the resource. DMH does have a policy on making sure that everybody has access to services including people who might need interpretive services and ways to get that support. We are able to serve anybody that needs the service. It is not a barrier to the service. U. <u>Question</u>: The funding would be coming from CSS. I thought we had allocated all of the available CSS funds? 1. <u>Response</u>: The Medicaid expansion dollars are freeing up some MHSA funds. So there are a variety of opportunities that present themselves for use of those funds. This is one of them. V. <u>Comment</u>: The grants funding MHSA Innovations 1 end on June 30, 2015. So one of the reasons to have this conversation at this time is that the Three-Year Program and Expenditure Plan you all endorsed included the continuation of the these programs but you only allocated $1 million. The SLT indicated that it would come back to this group around what it really would take to continue these models based on the outcomes that were going to be presented. This is kind of a follow up to that agreement. W. <u>Response</u>: I appreciate that. I think this is fine. The only question I have is how much more money was freed up? Maybe

	we should be talking about it in the context of all of the various needs. I do support this. It is just that what are the other needs? We are not talking about that in a comprehensive way. X. <u>Question</u>: I have a question about the models. They are all impressive. It sounds like health is being defined very broadly, which I think is positive. But when I first think of integration of health, mental health, and substance abuse, it is kind of just looking at a person's physical health and substance abuse in relation to mental health. It is not necessarily housing, education, and employment, which are all positive outcomes. It sounds like it is a positive thing. But in terms of the model, I was not aware of the breadth of that. When you think of the integration model, you do not think that they are not necessarily going to incorporate those other areas. I was unclear about how much of the funding is allocated to those other aspects, such housing. Of the MHSA Innovations dollars dedicated to these programs, what percent went to mental health, toward physical health and other services? What went to these supplemental types of services? 1. <u>Response</u>: Each model focused on a slightly different aspect to integrative care. The IMHT was the one that was most different in terms of focal population. You had to have a serious mental illness. You had to be chronically homeless and meet a vulnerability index score. That is very much a FSP sort of population that was homeless. That was probably the most unique model in terms of focal population. Of course you want to measure the impact of the housing investment and housing first model. 2. <u>Response</u>: Some of the things you are talking about with regards to supplemental services were leveraged. A big part Innovations was the leveraging of service. For instance, housing was leveraged. Although we did allow some health services that were not paid from some other sources to be paid through our model, most FQHC services were leveraged. That was a big part of the learning that we set out in our learning question: leveraging and braiding funding. Y. <u>Question</u>: Debbie mentioned about $12 million. Is that equally allocated among the three models? Do they each get one third? How is that going to be decided? 1. <u>Response</u>: The ISM has more providers, provider sites, and funding associated with it than the other two models. But then the IMHT model costs the most per client because it is the most intensive model. So we would use the evaluation rubric to make the determinations around that question. 2. <u>Response</u>: It is still unclear to me how you would allocate funds among the three models. <u>Round Two: Deliberation</u>: Facilitator provided instructions for the deliberative round. A. <u>Comment</u>: I think these programs demonstrated terrific outcomes. I think continuing them makes a lot of sense and we should. But these were funded through Innovation dollars and the goal of the Innovation program was not to find three new programs and fund them. It was to learn lessons that we could apply to the whole system. While I am supportive of continuing to fund these projects, I do not think they are done contributing to the whole system. That learning collaborative that has been going on has to be dedicated to the question of, "What is happening elsewhere? What are the things that we can learn?" David's presentation was terrific. Because they had multiple programs, they learned something and they changed their other programs. But the system is supposed to learn things and change the system.

As we move forward, I think we need to continue this but continue to treat it as innovation as opposed to, "Now it is part of the CSS Plan and now it is just another program." We have an investment. You all have spent a lot of time figuring out what works and what does not work. We need the whole system to learn from that.

1. **Facilitator:** I am registering that as a recommendation: to continue fostering the learning system-wide.

B. **Comment:** I, too, am supportive of continuing the project funding. I want to add a recommendation that DMH present to us a plan for how they will take the lessons learned and effective practices and adopt them system-wide, not only in the mental health system but also in the substance use and physical health systems, too.

1. **Facilitator:** I am registering that as a recommendation: to present a plan on how to continue fostering the learning system-wide.

C. **Comment:** I am in favor of this proposal albeit I feel that we need to have better information on them. One of the things I noticed on page five is when we were looking at how well they had integrated social support we are only just beginning there. That is something that I think all of the models achieved. We now know that 40% of health is from social support. So I think we need to make sure that going forward all models are using social support.

D. **Comment:** I have had the privilege of working closely with the IMHT model. I want to encourage support of that because I have seen the outcomes first hand. I think it is also very important to recognize that, since our experience has been—and I know Dave shared integrating into other models—that particular model is now becoming a model for other types of systems of care within our community. I think it is bleeding out. That is an important thing to recognize. We may not always have the documented outcomes in the way that would show cost savings, for example. I think they exist but we have not quite shared them. But I think it is also important that it is really setting precedents because people have seen first hand how well it works.

E. **Comment:** I fully support the perspective of the provider of the ICM program, specifically to the LGBT population. Without sounding dramatic, this program has been both transformative to our agency and life saving to our clients. The agency I work for is an FQHC and we have primary care, mental health, and substance abuse. We are a few floors apart with an electronic medical record. This program absolutely broke down silos even though we were steps away from each other. This was forced collaboration and a continuum of care for our clients that we have never seen before. From a client perspective, to give you a really heartfelt example, we had a client with full blown AIDS living in basically in public restrooms. Homeless, everything. One year later he is employed, stably housed, sober, working. And that is a really common story in our ICM program.

F. **Comment:** I support the continuation of the models. The only question I have is the dollar amount. It is a huge range in terms of allocation. It would be helpful to know if it is $12 million. It would be helpful to know how much would be allocated per model.

1. **Facilitator:** I am registering that as a recommendation: clarity on the amount per model.

G. **Comment:** I would recommend it but expanding it to other Service Areas and expanding the learning system-wide.

1. **Facilitator:** I am registering that as a recommendation: expanding to other Service Areas and expanding the

learning system-wide.

H. Comment: I support the model. But I just want to have some idea of how it is going to be expanded or extended to different geographical locations. There is nothing in Antelope Valley. Also, to my colleague here who mentioned different populations: if a program did not meet the evaluation rubric with regards to serving a particular population, that population would not be eliminated from receiving services.
    1. Facilitator: I am registering that as a recommendation: a population not lose services if a provider's performance does not meet criteria and extending services to the Antelope Valley.

I. Question: We are basically going to be voting on these three models and the other aspects of this recommendation, such as letting DMH determine the providers. I am a bit concerned about the third part of the recommendation. I know Debbie presented the basic overview of the evaluation rubric. But I am weary about signing off and giving DMH the car keys to say, "This is the way it is going to be." For my community, it could have very weighty consequences. I know part of the evaluation is based on the service exhibit elements, etc., but I am still a bit worried.
    1. Facilitator: The way I am hearing your comment is that you are concerned about a community losing support if the provider's grant is not renewed.
        a. Response: That would be it.

    2. Facilitator: Okay. So there someone has already recommended that the DMH find a way to still serve the community even if the provider is not re-funded.

J. Comment: I think that all of those models should continue because we are not yet done with the learning. We have a lot to learn still from what is going on with the communities and what we should be doing with them to make things a lot better for the communities. I would like to recommend that we come up with a procedure for the following: if an organization does not live up to the criteria established in terms of funding, that we still need to find out what is going on in that community through the Innovation program and that the money will not be taken away from the community. The ISMs were given to target specific communities.

K. Comment: My recommendation is that we need to maintain the population that the funds were earmarked for in the approved service plan. That can be done in different ways. We all do not want someone that does not 'get' our community or 'get' what we mean by cultural competency. We want someone that is going to really demonstrate it and do it. My second recommendation is that we do a road show that presents the success of our effort of what our outcomes are and that we make a recommendation to the legislature and policy makers to improve the integration process and cut the barriers that keep us from all doing this the right way.
    1. Facilitator: I am going to include your recommendation under the plan to disseminate the learning to systems, but in this case to include policy makers, too.

L. Comment: As far as continuing funding for those programs go, should not that best be in competition for Innovation 2? You cannot fund everything. We cannot just come up with some magic CSS funding that nobody else knows about and allocate it to this without looking at the other options for the total funding basket.

M. Comment from Dennis Murata: We are asking you if this is a model that should be supported and continued. Regarding the amount of money, we still have to take a look at in terms of our expenditures, how many dollars we are going to get from the State, and the effect of the Medicaid expansion to determine if that will free up any dollars. We are going to present all of this because we have to consider this recommendation along with other DMH priorities. This is going to have to be part of our MHSA Annual Plan, where we discuss how many dollars are available and then prioritize services. But at this point, we really want to know is if there is going to be enough support for us to consider these models as part of our priorities as well. That is what we are looking at this point. Also, as mentioned earlier, it may be that certain programs or agencies within the model will not continue. We are going to have to deal with how that will impact the community. Is there something else that we can do instead of funding that program under Innovations or is there something else we can use? For example, I know of one good example where their individual outcomes may not be as good as others, but the community can still continue to get outreach and engagement support because that is what the community needs at this point. Maybe there are some other ways to support them. Also, keep in mind that this was a research grant. This was a learning grant. We are still learning. What we learn from this could be applied to other types of programs that we are currently implementing. We did the same thing with everything we have done with MHSA. Look at how much we learned with Full Service Programs (FSPs) from when it was initially envisioned to now that we have it implemented for several years. This is also the case with Wellness Centers, Field Capable Clinical Services (FCCS). We are still learning. The learning is not over. It is just a continuation of that.

N. Comment: One of the things that understand is part of the whole innovation concept is about is experimentation: learn some lessons, do this analysis, pick out the good parts, and then the department will pick it up and implement it. For example, look at our clinic redesign.

O. Comment: I fully support the Innovation models, especially the IMHT, because I firmly believe what they are doing is top notch. One recommendation I do have so that we can at least make sure we go forward with that program is, "Should not we approve each of the models separately instead of having one blanket approval?" I am listening to other people who may have some reservations about other programs. It would be good to have an idea if we are going to expand this program and how we do that. Is it going to be a solicitation? Are we going to allow other agencies, other Service Areas, and Directly Operated clinics to take part in this learning network?
    1. Response: At this time, what we would like to go is continue the models we have currently in place. We do not want to stop what is going on now.

P. Comment: Of course, I support the recommendation. But I wanted to say in terms of comparison, one thing that stood out in the ISMs when I looked at the API data is that normally you see about 2-3% utilization rates. In the Asian Pacific Islander (API) ISMs it jumped to 12%. So talk about a good comparison, which is good in terms of impacting the system. There is no question that the system has learned from this; effective ways to do outreach and engagement and education, particularly in the UREP communities. This should not be lost. Secondly, we managed to incorporate non-traditional healing practices as part of the mental health system. This is innovative, important, and needs to be continued.

Q. Comment: I really think the three models are good. But I would like to add that we need more outreach to the children

and families because I do not hear that. If they have a next round, I would like to see the families included, not only the older TAY but also the younger TAY with their families and the children. I know it is for everybody, but this was actually mostly adult. I would like to see the family in there; the parents and the children.

1. Facilitator: I am registering that as a recommendation: serve children, younger TAY, parents and families.

R. Comment: I wanted to reinforce what was said about talking about increased culturally competent social support activities. That contributes to 40% of someone's health, as someone pointed out earlier.

S. Comment: I am delighted that we are having such a struggle because we are so successful. I think it is a phenomenal challenge, and I totally support the idea of finding a way to take this forward. We are pushing against the fact that innovations is one-time money and we have learned so much that now we do not want to throw out the 'baby with the bath water.' How do we take what we have learned and inform and change the system? If we do not find it now, four years from now when we are at Innovations 2, we are going to be having the same problem and have to look at it again. Right now, we are going to have to look at, "How do we take perhaps all of the learning and can we make foundational changes?" We are talking about how it has affected outreach, education and engagement. How do we take this through the whole system? I do not think we just have enough of a picture. But I totally support the idea of the discussion.

T. Comment: I am also going to support the idea of providing support to our children and TAY. We have a lot of children and TAY that are still in a very vulnerable area. I want to make a recommendation that we have discourse around that.

U. Comment: I want to make a small recommendation. Being the homeless coordinator for the county, and having been in the Department Health Services prior to that for the past 10 years, we know that the mentally ill out on the street need street-based engagement. We are not going to reach them otherwise. We know that they need housing. Even though the IMHT is innovative, it is also at this point a proven strategy. Along those lines, I want to recommend, because there are other teams that DMH has that work with the homeless as well, I want those learnings to look at the whole system and figure out how we integrate what we are doing with the home team, of course. I think DMH should be doing more street-based outreach but that is whole other discussion. We have other teams that are doing very similar work. But systemically, I think we have to look at that on the whole. I recommend that to the Department.

V. Comment: I want to pat you on the back for recommending something that you proved worked. I have been part of programs spawned over the years. As soon as that funding ran out, it exists no longer. At least you are looking at what you learned and you are going to try to implement it. That is really important. I have been a part of one of these learning projects, intensive case management. We had a small program and it really worked. We really saved a lot of money. They took a part of it, not the whole program, and funded it and watered it down and it did not do the same thing that we were doing. I was on that advisory committee. I know we saved a whole lot of money. I also want to say that I hope that DMH does not do what they did what that one. My recommendation is—before they say, "no, we are going to do this and going to fund that"—is to come back to the SLT where you have a lot of voices who can critique what you are saying.

	Final Reflections from Debbie and Dennis before requesting a vote. A. **Comment:** I wanted to underscore what I heard several people talk about in terms of learning. I think we do need to think about how we infuse the incredible amount of learning and the approach to outcomes throughout the entire system from children to older adults. We will do that. We have quarterly learning sessions that have been incredibly rich. We are not doing a good job of conveying what we are learning to the broader system but we will do that. B. **Comment:** These programs really are the beginning steps. Prior to when healthy neighborhoods was being talked about we were focusing on integrated care. It is not that we are doing something and going off in a different direction. We are moving in the direction of health neighborhoods because of our experience with integrated care. We are also looking at outcomes and holding folks accountable to those outcomes. We are also targeting an underrepresented community, in one of these models, that does not get a lot of attention or funding at this time. These things have proven to be effective models. That is why we are recommending that it continue. C. **Facilitator:** Debbie, what I am hearing is that folks would be supportive of the initial recommendations if the following conditions were integrated into the proposal: 1. The first one is what you just mentioned: a clear plan around further disseminating the learnings system-wide and policy makers, including the cost benefit comparison and things like that. 2. The second is to ensure that culturally competent social support continues to be integrating in the models. 3. The third is to provide greater clarity around how much would be allocated to each model. 4. The fourth was to expand the model to Service Area 1, but also to other Service Areas not currently being served. 5. The fifth is to maintain a commitment to the populations being served and to not conflate that with the provider performance. 6. The sixth is with regards to the provider performance, make sure that the procedure is clear to ensure how it is that a provider would be evaluated. 7. The seventh is to ensure that children, younger TAY, parents and families are actually served by these models. Are these suggestions amenable to you? Are they consistent with the original proposal? D. **Comment:** I think what we could do at this point is that if you approve this approach we could come back in January, granted there is a time cost here, with the results of the evaluation rubric. We would have to think about how to do this because the January learning session for Innovation 1 will focus a lot on the results of the rubric. So we will be walking providers through the results of the evaluation rubric. We could probably come back in January and present those results. But, we are not going to is say, "ACME provider should be funded". We cannot get to that level. E. **Facilitator:** Yes, that boundary is clear. The SLT does not make provider-level decisions. Given that clarification, anything else you want to comment on this feedback from the SLT members? F. **Comment:** Regarding Services Areas, Dennis' point was a really good one. We cannot think about expansion in a vacuum. If we can think about this expansion in the context of other efforts, and include the Directly Operated programs, there is

	no reason we cannot create a data system for the Directly Operated programs to start collecting physical health outcomes if the investment was there. There is no reason that could not happen. Through the Health Care Reform Outcomes work group, we talked about moving in that direction, looking at data about whole-health outcomes that providers would collect. We could also implement learning opportunities for the rest of the system that was not able to take advantage of this. G. <u>Facilitator</u>: So whether or not a specific program is in every area, the learning and practice could expand across all Service Areas? H. <u>Comment</u>: Yes. We could work with Service Area District Chiefs, SAACs and Yvette Townsend on that. I. <u>Comment</u>: For Children and TAY, what we would want to do is go back. Part of the presumption in Innovation 1 was that the majority of the clients had to start out at uninsured. That was part of the Low-Income Health Plan (LIHP). But we are in a different funding atmosphere now because of the Affordable Care Act. What I will agree to do is take that back to the Innovation models and talk about the opportunity to be able to do include children, younger TAY and parents. In some cases, some ISMs do it more robustly. <u>Facilitator</u>: Asked the SLT members to get ready to vote and requested everyone attached to an agency that receives funding for the IMHT, ICM, and/or ISM to raise their hands to be identified and asked them not to vote on the recommendation because it would constitute a conflict of interest. A. <u>Facilitator</u>: Let us see the results. One person pressed an 'E,' while 74% pressed A and B, 15% were neutral, and 7% were a D. The person who pressed E, we will ask you to share your rationale and provide an alternative recommendation. B. <u>Comment</u>: Basically, I feel that the set of recommendations are premature. I cannot vote on them for a lot of the reasons that we discussed and that you have reviewed here. C. <u>Question</u>: What is your alternative recommendation? D. <u>Response</u>: The alternative is to put this recommendation on hold and come back with some of the other details that you have been discussing that might be coming forth in the future; whatever the rubric is and stuff like that, the comparison with other programs, etc.. The recommendation is not so much to keep these folks going forward, but to incorporate the lessons and the wealth of information that has been gathered in this process and figure out how to make it system wide, for example, by incorporating all of the good stuff into the department's clinic redesign efforts. E. <u>Facilitator</u>: I am going to summarize what you just said. According to the process, we are going to consider the alternative recommendation and then you will have a chance to discuss it and use the gradients of agreement to determine if you as an SLT want to adopt the alternative recommendation. If the proposal does not pass, then we will go into the voting process. For that, we need 60% to support the recommendation. Those of you in the minority will have an opportunity to

have your views written.

1. The recommendation is to put the agenda item on hold for a future time, and between now and the time that it comes back to you, provide the information that you requested such cost-effectiveness data, a plan for system-wide dissemination, etc. Any discussion on that?

F. <u>Comment</u>: What happens if, say for an American Indian there is only one project, and there are not two or three providers? What happens if they do not meet those standards? Does the American Indian community get left out in the future of funding?

1. <u>Response</u>: That question was already addressed in an earlier recommendation pertaining to not conflating the community to be served with the performance of the provider. Debbie already agree to explore that issue. We are considering the recommendation to postpone the item to a later point.

G. <u>Comment</u>: This is where the learning comes in. When you think about our services as a whole, there are opportunities to infuse American Indian programs with successful learning. We cannot continue an agency that has not demonstrated success in terms of the model it implemented. There are alternatives that would involve learning.

H. <u>Question</u>: When you looked at the agencies and found that they did not come to your expectations, did you weigh in all of the reasons before you took them out?

1. <u>Response</u>: We did. This project has done more in terms of providing training in technical assistance than any other program I have ever seen as well as assistance from UC San Diego in terms of data entry and analysis.

2. <u>Response</u>: Maybe if you just started up and are trying to hire people and you cannot get them hired in six months you will not show the quality of results as other people.

3. <u>Response</u>: The model leads have been very good about that.

I. <u>Comment</u>: Are we ready to vote on the alternative? To summarize, the proposal is to postpone issuing a recommendation on these models today until the information is provided.

J. <u>Question</u>: One final burning question. Are there any adverse problems if we do not continue to fund these models?

1. <u>Response</u>: If you postpone this recommendation, what will likely happen is that there will likely be a gap in service. Let us say we come back in January and you re-evaluate this. The department will not be able to do contract amendments in time. Basically, what would happen to the successful providers is that there would be a gap in service. The question becomes, "What do they do with the clients that they are serving?"

K. <u>Facilitator</u>: The alternative proposal was blocked by six people pressing an 'E.' So now we come back to the original proposal and we will be using a Yes-No voting procedure. Do you support or do not support? "Yes" is 'A'. 'B' is "No."

1. The result is the following: 85% said 'yes' and 15% said 'no.'

L. **Note**: The facilitator asked the SLT members to vote on the alternative proposal, but SLT members indicated that it was

	no longer necessary. The facilitator asked the person who proposed the alternative recommendation, and the person was fine with not calling for a vote.
MHSA INN 2: Health Neighborhoods	To be discussed in the SLT's December 2014 meeting.
Public Comments & Announcements	A. Comment: I would like to see a mental health recovery court take place in LA. There are similar programs in Michigan and northern California. B. Comment: I would like an opportunity for public comments after Dr. Southard's remarks. Also, the perceived success of the ISM is not as solid given their inability to reach children, youth, and the non-integration of colocation with a key issue of stigma. That is a concern going forth. Also, there are concerns about moving forward with the 'carve out.' The messages coming from around the room regarding system changes are incorrect. The objective is not to transform the system in four years but to develop policy and then move toward implementation and making continuous improvements. Many folks are being left out, particularly African Americans, in the Three-Year Program and Expenditure plan. I am hoping for a better focus on African American needs, given historical trauma, much like inclusion of undocumented children within the plan.