COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, December 17, 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. To provide an update from the County of Los Angeles Department of Mental Health.
2. To issue a recommendation on the proposed MHSA Innovations 2 projects.

Meeting Notes

Department of Mental Health - Update	**I.** *Dr. Roderick Shaner, Medical Director*, Los Angeles County Department of Mental Health, provided the following updates. A. **Expanded Services and the Affordable Care Act.** DMH is delivering vastly expanded services through Medicaid expansion and other funding streams and programs associated with the Affordable Care Act (ACA). The structure of the expansion includes an increase in our programs substantially across the department. The issue for us now is to ensure: (1) that those programs are operational; (2) that we are reimbursed for them; and (3) that as federal funding gradually decreases over the next couple years DMH will be in a position to continue the funding. The essence of healthcare transformation was to ensure that we have integrated health, mental health, and substance abuse services; that those programs be responsible for improving both individual and population health; that people have a good experience of mental health; and that they are done effectively and are cost effective. B. **Health Neighborhoods.** The development of health neighborhoods is a major initiative for 2015. The SLT has been central in helping DMH identify the manner in which these programs will be rolled out. The 'healthcare neighborhood' is the expansion of the concept of primary medical homes, which focuses on health issues where primary care is central and there are wraparound services to mental health homes, including specialty services like mental health. We know that health services will be effective only as far as other determinants of population health are addressed. Health neighborhoods go beyond a primary care home and encompass those other services, (medical, social, and others) within geographic areas; but they go even further than that and bring in other community resources, interests, and advocates with the idea of influencing the social determinants of health. The '*little h-n'* (i.e., health neighborhoods) are identifying naturally occurring associations of health, mental health, substance abuse services and others. The 'big *H-N*' (i.e., Health Neighborhoods) is the larger initiative that will be rolling out and identifying an initial set of neighborhoods to go forth with and jointly building specific agreements with social substance abuse health and mental health services to provide care. It is a partnership and includes health plans. C. **Jail Diversion and Assisted Outpatient Treatment (AOT).** Jackie Lacey has led a movement within LA County to look at alternatives for incarceration. Part of this is precipitated by the potential $2 billion to be spent on new jails.

So there is some potential both for improving services by diverting people from jail and also, perhaps, realizing some funding, if in fact, we do not have to build or modify jails for incarceration.

1. The county workgroup that Dr. Southard participates in is deliberating now. This is also influenced by changes on the Board of Supervisors. We are very active in the mental health courts and very active with the AOT implementation. Whether or not, or the degree to which, there may be increased funding for expansion of mental health services as part of the diversion is part of an area that we should get more information on fairly soon. The impact of AB 109 and Proposition 47 on the effectiveness of mental health courts and other diversion programs remains to be seen.

2. Earlier this fall, the Board approved the mental Health Services Act (MHSA) budget, which included funding for an AOT program, also known as Laura's Law. The cost of the AOT program is somewhere just above $10 million. The size of the program will provide 300 additional Full Service Partnership (FSP) slots and 60 Institutions for Mental Disease (IMD) step down beds and have the potential to evaluate some 500 individuals per year. There will be two outreach teams that are solely dedicated to outreaching to individuals who are identified by qualified reporters, including families, providers, law enforcement and others, identifying people with severe mental illness (which is a requirement) and who might benefit from intensive services and who have had hospitalizations or incarcerations and have not engaged in treatment.

3. These two outreach teams, which will roughly be in the northern and southern part of the county, will go out, identify individuals, and try to both assess them and bring them into services. People can stay in these services for six months. If at the end of this intensive outreach and engagement a person still is refusing mental health services and, as a result of the investigation, if the team believes that this person is "substantially deteriorating," which one might think as a step before "danger to self," "danger to others," or "gravely disabled," then in collaboration with County Counsel, DMH determines whether or not a petition should be filed to the court which could potentially result in a court order for that person to get care. Ultimately, the court decides whether or not treatment is warranted and then can enter into a settlement agreement with that individual or order for that person to enter into treatment. Our plan is to have services starting early next calendar year. That puts us in line with about eight other counties in California that are going forward.

D. **Integrated Care and the Health Plans**. In California, ACA has changed funding in a variety of ways, fundamentally. DMH is a specialty mental health provider for people who are insured through the Medi-Cal health plans in Los Angeles, LA Care and Health Net. The first one is Cal MediConnect, which is for people who have Medicare and Medi-Cal. There are multiple, now independent, health plans participating in addition to LA Care and Health Net, such as Care First, Care More and Molina. The second one is for Medicaid expansion, also working with the health plans.

1. DMH has worked out arrangements with the health plans to provide specialty mental health services and is under regulatory and community requirements to ensure health care, mental health care, and substance abuse

care are integrated and seamless. DMH and the health plans, the Department of Public Health's Substance Abuse Prevention and Care (SAPC) have all spent a great deal of time together working through these and thus far have worked well and people are receiving services through these plans. Later the federal government will require us to measure outcomes.

2. With Dr. Southard's leadership, in order to accomplish this, we had a three-year focus of projects to ensure that we do this seamlessly. The first year, which was last year, was all about access, and the department developed a process for screening to expedite access, including new requirements that for people seeking assessment receive that assessment within 15 business days maximum; for people who are being discharged from hospitals or other acute settings, 7 days. The second year will focus on how to organize services for care management in partnerships with the health plans. Over the course of a couple of years, the department has developed a level of care system working closely with contractors and others. The third year will introduce integrated care service outcomes that measure the effectiveness and efficiency of our services.

E. **SB 82.** The Plan, funded through contracts with two separate entities to increase the number of urgent care centers and crisis residential programs. That motion was approved by the Board a few weeks ago, with solicitations forthcoming. Law enforcement teams will be increased through the CHFFA (California Health Facility Financing Authority) funding component and mobile triage teams will be funded through the Mental Health Services Oversight and Accountability Commission (OAC) component.

II. Questions

A. Question: As of January 1, 2014, there was supposed to be expanded Medi-Cal services for substance use. I am wondering where we are on that and how that fits into your conversation about what you are talking to the managed care companies about.
   1. Response: In terms of the expanded substance use services under Med-Cal beneficiaries, the State got federal approval for the state plan amendment for the drug Medi-Cal program. All drug Medi-Cal services are now available to Medi-Cal beneficiaries. The expansion of that really involves narcotic treatment programs, outpatient, drug counseling and intensive outpatient treatment. The federal government did not approve the request for expanded residential services. The state has recently submitted a waiver proposal that would greatly expand drug Med-Cal benefits. They submitted it on November 21, 2014. I think the government has 120 days to respond to that. When that is approved, it will expand to include residential services including residential detox, as well as case management and moving to a rehab model. That will have far reaching impact on counties that decide to voluntarily opt in. That is a decision Los Angeles County will have to make, whether they want to opt in to that.

B. Question: How integrated will that system be with the mental health system that Dr. Shaner described?
   1. Response: If you talk to the health plans, they refuse to use any term other than behavioral care, meaning health and mental health. Wes Ford and Dr. Southard were on a panel with LA Care at the end of last week and

	Wes talked at length about the need for a substance abuse continuum of care similar to what MHSA did for mental health including creating consistent formularies between mental health and substance use. 2. There is one other component around privacy issues for substance abuse services. If we all expand into them, it influences how we can share information for integrating care. Drug and alcohol, in terms of their funding, relative to the continuum of care, is significantly less than what mental health has. I have looked at the waiver and the big problem with the waiver, potentially, is that it is cost neutral. That is going to be the big question. Is there going to be enough money in spite of what we all want relative to a continuum of care to really do what we would like it to? C. Question: Does this specialty care include qualified and trained translators? 1. Response: The law requires that anyone engaging non-English speaking communities have trained and qualified translators so that they can get the right kind of care.
Proposed Innovation Projects	**I.** *Debbie Innes-Gomberg, Ph.D., District Chief, MHSA Implementation Unit,* County of Los Angeles, Department of Mental Health, provided an overview that highlighted the following points: A. The process of developing strategies to make them as clear in terms of their congruence with the definition of innovation and their fit with a health neighborhood. (Please see the draft MHSA INN2 Proposal for a definition of a health neighborhood.) B. Although the **definition of trauma** needs to be tightened, the INN2 proposal draws from SAMHSA's definition of trauma as 'a series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening that has lasting or adverse effects on the individual's functioning on mental, physical, social, emotional or spiritual well-being.' It also draws form the National Center for PTSD (2007) as a set of normal human responses to stressful or threatening experiences. Importantly, addressing trauma requires a multi-agency approach, hence the health neighborhood, within communities, that include education, awareness, prevention, and early intervention strategies. C. Dr. Innes-Gomberg reviewed the three **primary purposes** of the Innovations projects and described the strategies for each project focused on different age groups and the overarching questions for the projects. (Please see the draft MHSA INN2 Proposal for more detailed information.) **II. Questions of Clarification:** A. Question: With young children, you are talking about building on First 5 LA Best Start communities. However, the community readiness, organization, and infrastructure are variable across the county. You are not going to find two that are identical in terms of their preparation to engage with this initiative. How do you balance that out? If you just think in terms of just strictly building on the foundation, if that foundation is uneven, how are you going to fill in the gap and who picks that up? Has there been, for example with First 5 LA, a negotiation about investment to balance out that foundation? Or, for example with the adult proposal, if you are talking about employment, there are work

source systems. Is DMH going to pick it up? Or are you going to try, for example, to leverage First 5 LA for more money or if you go into the city or county work source system, to invest more because there is a lot missing in this work source system? (I used to run a work source center.)

B. Question: Ethnic considerations are also my concern because most of these communities are nominally better prepared for Spanish speaking but not for other groups. For example, in knowing Best Start's work, they are engaged in communities but do not have linguistic capacity to work with Korean and Vietnamese groups. I have looked at their evaluation reports. How are we going to build and ensure access to all members of that community? It is not just an English/Spanish thing.
   1. Response: Each entity or CBO that we ultimately contract with will have the responsibility of really doing the assessment within the community. An advisory committee will have the responsibility of bringing those entities together and understanding what the community has capacity for and enhancing that capacity. Each community may be different.

C. Question: Why have we not included self-help support groups throughout the projects? In particular, for trauma we have lots of studies self-help groups (and with TAY in particular) that answer the question, "Would increasing positive social connections decrease the negative impact of trauma for TAY?" There are lots of studies of adults who were children of alcoholics that show that is something that happens. Why we have not included self-help groups throughout befuddles me. The department has this way of forgetting that they are one of the most effective, almost free, ways of creating social connectedness quickly. So I would ask that they be written in on each of the proposals.

D. Comment: We are using some language that is used on other aspects of Los Angeles County or the City of Los Angeles, in particular, namely the older adult neighborhood councils; there is an established definition for neighborhood council in the City of Los Angeles. There might be some confusion about that. There are stakeholders that are elected for the most part. If you start to use that language in faith-based communities and other organizations. They may get it confused.

E. Comment: On the coordinated entry system for the employment, the coordinated entry system is a system for prioritizing people in housing. I am wondering whether or not the focus is really on the assessment tool as opposed to the system for getting people in housing. The assessment tool looks at the characteristics of the people who are homeless who are in need of housing. Based on their needs and their background, they are assigned a number then you place them in housing. Placing them into the housing is a coordinated entry system. But the tool is what tells you what the people's needs are and their levels of functionality. So when we talk about CES for job placement that does not seem to make sense because I think you are really depending on the tool and the numerical scoring for the level and type of employment, not the level of housing.

F. Comment: I am concerned that the co-occurring disorders phenomena is not as fully and broadly addressed within the planning as I know the department to be willing to do. I would like to see some more ink on it.

G. Question: On the full forensic FSP team, is that a team separate from another FSP in that neighborhood area? Or is it integrated into that?
    a. Response: It is new and separate.

H. Question: What is the innovation factor in the CES and the housing? Housing first is not an innovation. That is a standard practice now or it has become more standard. Using a systematic approach to match individuals does not seem to me as a real innovation there. There may be some other innovation in that total program but that does not feel like that is it.

I. I also agree about co-occurring disorders: it needs to be threaded through this a little bit more clearly.

J. About employment and forensic FSP team and LA County jail, perhaps it is not possible to look into it, but in terms of getting an inmate ready to go out into the community, especially if they are in that traumatic situation for six months or more, they are still largely deprived of the sheriff's education-based incarceration program. Dr. Gasco and I met with Terry McDonald and we had a NAMI meeting with them. Is there any way, even though we cannot use MSHA dollars, we could use part of the forensic FSP team to try to work with DMH and the sheriff's department to create more opportunities to train the inmates while they are there for employment, self-esteem and self-knowledge?
    1. Response: It does not meet the criteria for MHSA innovations.

K. When we vote, is this going to be like a package? I heard that the jail diversion is only going to be for Service Areas 1 and 8. How do we separate out what is going to be in what neighborhoods?

L. When you say community do you mean a cultural group? What do you mean by that? If community means a cultural group or an ethnic group then will that extend over geographically to other areas as well or is it going to be just focused in one area?

M. When we talk about geographic areas, how are we going to deal with the different cultural groups and the age groups as well, which are in that geographic area? Most geographic areas in LA are mixed culturally.

N. How many of these SPA areas or neighborhoods are we going to do? That reflects on the numbers I am seeing in front of me.

O. Why is SPA 6 not included in this SPA 1 and 8 pre-booking project?

P. How many of these services are going to be culturally competent? I do not hear it reflected in the presentation in the sense of cultural competency across these programs. When you are dealing with underserved populations, you have got to do it culturally responsibly and effectively. Otherwise, these communities are not going to engage you

in what you are trying to do. I am not hearing that. It should be put out front and be very clear in all of these things if you are going to engage the culture of these communities.

Q. I know this is nitpicking but is it, "inter-generational families experiencing trauma" or "families experiencing intergenerational trauma?" You have it both ways and it is a little bit different.

R. When you spoke about the adult pre-booking diversion and mentioned that there were two urgent care centers located in Long Beach and Antelope Valley, how was South LA overlooked, especially with the big problems in that area? That puzzled me. How was it determined that the centers were to be in Antelope Valley and Long Beach?

S. With TAY, and talking about employment, what are they thinking with 16 and 17 year olds that are still in school? How do they fit in?

T. With the older adults I see a lot of faith-based organizations to facilitate activities of interest. But what I did not see here is how is this going to help family and caregivers of the older adults that burn out?

U. To echo what has been said before, how many health neighborhoods are we funding? It is not clear if it is 5 or 1. What is the selection process? I know we talk about RFS' and how we determine which one we are going to go with. If we go with the health neighborhood, are we going to go with all of the services? How are we going to determine what services are being delivered in those health neighborhoods? You talk about a strategy for one health neighborhood. Does that imply that we are going to fund one health neighborhood? There really is not a clarification if we are going with one or several. Then if we go with, let's say, one Service Area, are we going to provide every single strategy? How we going to make sure we address the needs of the community in the process that involves?

1. Response: If you approve this, it means you are funding at least one of these strategies in one health neighborhood. Part of what we wanted you to weigh in on is, "How many should we fund?"

2. Response: I understand what you are saying. Just listening to the conversation and my own hesitation is that, "How do we ensure that we are meeting the needs of the community?" You say, "one health neighborhood in one area" but what I am hearing is that there is not really any clarification or structure to make sure that we are actually meeting the needs of the community. We are actually going to do what needs to be done. There really is not a road map that shows us how we are going to do that.

3. Facilitator: Right now, the budget has one health neighborhood per age group. With some age groups like the adults, you are looking at two strategies there. Right now, the health neighborhood packages are within the age categories. So if we funded just one health neighborhood strategy per age group it affects the budget, how many more should we fund? The other part is the assumption that these grants are about serving needs first. While they address needs, they are first and foremost learning grants. So the obligation that we have is not

necessarily to serve everybody with the grant; it is about **learning** how to better serve, how to better increase access, etc. We are not tied to having to have a set of health neighborhoods in each Service Area, either. But if you want to have at least one health neighborhood per Service Area, you can recommend we take that direction.

V. It is really important as we are dealing with health neighborhoods that we make sure that cultural competency, cultural relevancy, cultural sensitivity is embedded throughout all of these proposals.

W. I want to reinforce what the facilitator said. We all have to rise above our own personal constituency because this is an experiment that we are undertaking, not a countywide deployment of everything.

SLT members asked additional questions and these were grouped into the following three 'buckets': budget questions, program design questions and implementation questions.

III. Budget Questions

A. The budget for older adults totals $803,000. How is that divided between the neighborhood council and the specialized teams? I would ask that for every item. There is not much specificity in terms of how much is allocated for each the strategies for each age group and I think it is really important to know.

B. I am confused about the budget because it looks like certain age groups did leverage and other age groups did not. So I am not sure how we can add that up into one health neighborhood without the full information. We do not know the leveraging for some of the age groups.
   1. Response: There is no leveraging for some of the age groups. The services are not Medi-Cal billable.

C. I would also like to know a little bit more about how the budget for the intergenerational strategy. Here we are talking about how the intergenerational strategy encompasses all of the age groups within a family and then also with various culturally diverse populations. I am not sure why it is that amount but I would like more clarification on that.
   1. Response: If you read the handout, each strategy has described how they would reduce ethnic and cultural disparities. So for those of you that gave us that feedback I would like you to go to the document and tell us how to make it more culturally relevant.

D. On the budget, page 16, I need some clarification there. If you take the bold elements and add them up, that is where you get the $6.5 million for one health neighborhood. Are not the Medi-Cal line items, those are leveraged dollars right? So if you get some Medi-Cal income, then you can reduce the MHSA innovations cost. That is the way I would read it. Is that how you read it? If so, then the $6.5 million should be lowered by all of the un-bolded items that you've got in the proposal.

E. I was just wondering, for all of the different age groups it seems that there needs to be an oversight person so that

it can be coordinated. I was wondering if in the budget you specifically have somebody to try and implement this so that everybody can be on the same page throughout the community.

1. Response: That is in the next slide. They are called DMH strategy leads. Each strategy will have a DMH lead similar to Innovations 1.

F. Where did the $1 million come from for evaluation? That seems like a lot of money.
   1. Response: This estimate comes from our experience with the evaluation cost for Innovation 1.

G. Three of the strategies, children, TAY, and intergenerational propose no leveraging; and CES coordinated entry, no matching. However, the pre-booking and older adults do propose leveraging. The total program for pre-booking is $2.9 million, but that presupposes $1.2 million of Medi-Cal as a total program. We are only drawing $1.7 from MHSA.

   1. Adults: One of the first things we wanted to point out for adults is even though this is a strategy for one health neighborhood, we did budget for two. That $1.7 million is for services for two different areas. If you break that in half, per neighborhood, it would be $853,775. This piece of the budget is an actual service. For the Forensic FSP Team, all of those services can be leveraged by Medi-Cal. So this is the money that can come forth that does have to be provided by INN funds.

   2. Older Adults: For older adults, we envision the two strategies being intertwined together. There is also some detail written into the proposal that addresses cultural competency. However, in terms of the council, I heard the input regarding the name, we envision approximately $260,000 being for the council and approximately $670,000 for the host team. As this council goes out and begins to increase awareness regarding trauma for older adults including abuse, neglect, fiduciary abuse, and so on, we anticipate that the number of individuals requiring care will increase. There is a lack of culturally competent as well as clinicians that are trained to address trauma for older adults. So this host team is very important.

   3. Children: For the children, basically half of the budget is dedicated to staffing, related services and supplies and the other half goes directly to flex funds or community outreach services. That is the kind of, "whatever it takes" funding serving a number of families. Among the staffing, the staff would be an overall coordinator, a tentative total, a coordinator, a manger of the group, along with 4 client care coordinators, 4 parent partners and then a program analyst, someone who could look at budget and the funding behind it and managing those aspects of it. We looked at DMH equivalent positions but our expectation is that this will be contracted out by a provider agency or community based agency. We are looking within this total funding scheme though, of how for our 2 strategies that they will be both clearly integrated, a target community we have yet to identify, although we are using Watts - Willow brook as kind of a model of a best start community that is moving forward, has already picked a [inaudible] factor like social connections--any number of models are possible. But again, this was designed around one specific community.

4. TAY: For TAY, similar to child we looked at DMH equivalent items that we would see to solicit this out to a contracted agency. There is no Medi-Cal math. We are envisioning that this is purely a community based outreach effort. So approximately $42,000 is for flex fund type of activities, the TAY led events, the outreach activities, education, and trainings, as well as incentives for the TAY to actually participate in the events as well as to participate in some of the neighborhood meetings. When we looked at a health neighborhood we did not particularly look at one service area being a health neighborhood. We thought of it on a smaller scale. We would have 4 paid positions for TAY peer counselors or leaders. The rest would go to supervisor and support staff. Our first proposal was $560,000 for that. I think one of the items got rolled over into the overall innovation project lead.

5. Intergenerational Group: For the intergenerational, as far as the staffing we estimated about $382,000. That includes the program director position, administrative assistant and 4 peer/community advocate positions. We used DMH equivalent salaries to estimate that. As far as the operating expenditures that is where we had close to $171,000. This is mainly to really provide those intergenerational mentorship classes, those knowledge classes, and the skills building classes. So we estimated about $44,000 for each age group to cover across all age groups for the annual costs. The additional expenditures were around $6,500. It is very specific and culturally appropriate. It will be specific to one ethnic group and the strategy is designed to have that culturally competent piece in it.

H. It would be helpful to have a grid relative to strategies and how the funding is going to be allocated.

I. For the Three-Year Plan, we spent a lot of time trying to figure out in a very detailed manner how the money was spent in terms of staffing and all of that. The concern I have is that there is very little time and we are not getting that kind of information to be able to analyze it to make a decision.

J. Facilitator: There are more questions about the budget but this budget proposal says the following: if you fund all age group strategies in one specific geographical area, it would amount to $8.5 million, roughly speaking.

IV. Program Design Questions

A. **Comment:** Regarding cultural competence, anyone who has a concern that these strategies are not grounded enough in cultural competency, what we would need from you is to look at the reducing disparities section of the proposal and tell us specifically where we need to build on those.

B. **Responses to how Co-Occurring Disorders and Peer Services are addressed in proposals:**

1. Adults: We have community guides that we would like to see as part of that, but that is the one-on-one. So there are also liaisons to the community and self-help support that is available out in the community throughout either client-run centers or individual, very different, self-help support groups that are out there. Since it is a

forensic FSP team we are building on the FSP model, which assumes that there is a need for COD services, self-help support, housing, employment; all of those components that are available in the FSP. We are building upon that. We recognize that this is a forensic population. It is very likely we are going to need to provide intensive COD services. We want to make sure that peer support services and self-help support groups are available in the community and we really want to promote community connections. We do not want to build it within the program; we want the client to go out there and connect and build relationships in the community.

2. TAY: For TAY, it is not basically that these TAY peer leaders would be providing the service but it would be linking them within the community, connecting them with services including self-help support groups as well as COD services within the neighborhood that they TAY may not be aware of or reluctant to go; so these TAY peer leaders would act as agents to provide the connections to those services. For employment we did include self-help support groups. It is on page 30 of the proposal. We called out that we were working with people with high barriers and that this strategy is to help people overcome those high barriers. So maybe we need to add something to really call it out because we know many people who are homeless have substance abuse issues. We can call it out in the actual proposal to indicate that it is an issue and that is one of the high barriers that prevents people from getting jobs and how we would work with that.

3. Intergenerational: Definitely the intergenerational families will be the community peers and they will form the self-help support groups. The COD supports are also addressed through part of the network.

C. **Question**: Why is the jail diversion model only in Service Areas 1 and 8? The second question is around the CES. What is the innovation? Is the emphasis more on the assessment tool or the housing placement?

1. Response: The pre-booking diversion proposal has been an involving process. I think we had in the first round of proposals something had come forth and then when we stopped and looked at health neighborhoods. I think we continued on that string and looked for work that was already being done in the community around pre-booking diversion. The board of supervisors and Jackie Lacey are very interested in these kinds of projects. This is a highly collaborative project. We really need police departments and the UCC's involved, and we want to ensure in every Supervisor's district that those resources are ready and available. This was really around capitalizing on work that is already been done, an interest in pre-booking and making sure that we had. We have a price tag for these service areas and we are more than open to expanding it if folks want us to take a shot in other service areas where we have the UCC's and pull the police departments together. I think we are open to exploring that. But I think this is where we have the sure shot collaborations that are ready to go. It was not an exclusion. We worked with the resources that were already there and present.

2. Once the person has agreed to the service and is in the program they are able to drop in, check in and provide support. That person would also be responsible for doing some training within his or her own police department in collaboration with the social worker. We know there are a lot of great models out there like CIT where they are really trying to do some training on mental health and police department, so this person can play a variety

of functions. But that is part of the budget. So we would continue to work. They would be part of the team. So they would continue to play a role even after the person has joined the program.

D. **Question:** Is the emphasis more on the assessment tool or placement and what is innovated?
   1. **Response**: At its core, CES, as it relates to housing, is using a standardized assessment tool to determine the right housing intervention and then to match people to housing. It is using those concepts in an employment setting; we would have a standardized assessment tool to determine the right employment intervention and then that would be used to match people to the employment opportunity. Part of the job is doing a lot of job development in the community to get employers to dedicate jobs to this cause. That is part of the social enterprise model, to find people that have businesses that are interested in social justice issues to help people with high barriers have job experience. It is to develop that side so that we have job options. When we have the stakeholder group there was discussion of having a menu of potential jobs that people then, using the assessment tool, can be matched to the job. That is what it is. It is not using the same assessment tool we are already using. It is just using the same concepts and methodology to match people to housing. They are already in housing and have been matched to housing. It is also capitalizing on the regional coordinators and the work that is already being done; the infrastructure that is already in the communities and trying to use that infrastructure, in whatever neighborhood we are in, to do this.

   2. What is innovative about this strategy? We thought it was very innovative. It is using a coordinated entry system that I just described that has a standardized assessment tool, which is doing outreach in the community to develop jobs, and then to use that to match people to jobs. We are not aware of where that is being done so we thought that was at it is very limited. I did not describe the whole model, but at it is core that part is very innovative; using what we are doing in housing, to match people to housing, to do the same thing with jobs, to try to really improve our employment outcomes because I think we have a lot of improvement that could be done in that area and to help people become self-sufficient which is ultimately the goal.

   3. Comment: I think it is very innovative. I just think it is very confusing when you say CES because you are saying we are using a similar system. CES is a system. So I would call it something else. I think it is extremely innovative. I think it is a great idea. I just think the nomenclature is confusing.

E. Question: For TAY there was the question of 16 and 17 year olds. What happens with that group in the context of your proposal?
   1. Response: Is this in relation to the paid TAY peer leaders? I do not think the 16 and 17 year olds would be excluded as long as they met whatever the criteria or agency or community based organization outlines. I do know that they would probably have to go through some of the labor laws that deal with minors and full time employment but they are not excluded from the TAY led events, participation in the health neighborhoods; we did build in the incentives as incentives to bring out more participation amongst TAY, 16-25 years old.

F. Question: For intergenerational there was a question about, "Are we talking about intergenerational trauma? Or

trauma with intergenerational families?"

1. Response: I would imagine it could overlap and probably involve both. I think it would be meaningful to include both.
2. Response: I am okay with that. I just think you have to be consistent in the wording. We can go back and do that.

G. Question: How many of these are you talking about for intergenerational?
   1. Response: If you go the geographical route and you select a neighborhood, the intergenerational project would then figure out, in terms of intergenerational families, these are families who have a trauma that is being reproduced and retransmitted across multiple generations. So you look at families and neighborhoods that we are working with that have been impacted by drugs, gang membership, etc., multi-generational families that get blamed for these things rather than seen as victims of trauma. Another approach is that you look at the intergenerational families within this neighborhood. Another dimension to this is that you can select an ethnic group within this neighborhood or multiple ethnic groups within this neighborhood but, again, the focus would be on these families that have intergenerational trauma that often results from whatever set of social determinants we are looking at. I hope that brings a little more clarity to this question.

H. Comment: The point is well taken that if this goes out to the bidders we have to be clear that it is not necessarily that we are going to use the LA's neighborhood council but the strategy of a neighborhood council. So we have to clarify that.

I. Question: There is also a question about caregiver burnout that we still need to address at a later point.
   1. Response: Around caregiver burnout, we envision that this forum, this senior council will provide multiple resources, training, and forms to the community including those on elder abuse, neglect, fiduciary, and also care giving is part of that. There will be information, training and resources for caregivers as well.

J. Comment: I thought about changing the CES name. We could call it Coordinated Employment System. We can develop a name. The concept will remain consistent.

V. Implementation Questions

A. Question: There were two questions that were asked about the uneven capacities in these communities.
   1. Comment: Clearly you can look at it from a learning point of view, but if you are sticking with the budget kinds of questions, it is going to take some dollars. I do not see how you can separate them out. It is nice to throw out, as a former contractor, who says, "I will do the cultural competence thing", but then when you translate that into implementation, if you do not have a good understanding of what you are going to be wrestling with. I am also really uncomfortable with the employment question. Having run a work source center, trying to employ youth that the city used to want to get incarcerated individuals into jobs and the difficulty the city had as a city work source center to say we are going to hire a couple of people to do this is unrealistic. I think that you will not

have the success. You are talking about creating a menu of jobs. It is hard to get those employers. It is hard to get the match up. You have soft skills that you have to match up with these youth to get them to a place. If you are talking youth, pre-booking, or anybody, just general employment is a challenge.

2. Facilitator: I want to point out that I also have questions but that is why they are innovations. We do not know if they are going to work. But you have to rely on two things. When there is a bidder's conference and when we put out these contracts out to bid, we have to be looking for organizations or collaborative that demonstrate the cultural or other kinds of capacities to put forth the best proposal.

3. Comment: I also want to say that the beauty of doing this within a health neighborhood is using the resources and bringing together the resources that already exist in a health neighborhood. We want to work with the work source centers within the neighborhood. So it is bringing together within a health neighborhood all of the people that can help us be successful. You are right. We have not done this before. It is very unique and I think it is going to be very hard on the employment. That is why we want to (1) test it and see if it works and (2) bring in the people that have expertise that can work with us to be successful in doing this work.

4. Comment: We are assuming that we can identify neighborhoods that can do some of these things effectively and, again, unevenness amongst work source centers and how they even gauge some of our targeted communities here, again, I have been in the work source system. Likewise, when we are talking about the best resourced communities, how they really engage, I just want to make sure we are walking in and saying--yeah it is a nice idea and idealistic if we did all of this in one neighborhood then we would really be looking at a neighborhood but I think, "Do we know exactly what we need?"

5. Response: We have to remember one thing: MHSA is about 20% of our total budget, and INN is 5% of CSS and PEI annually, so this is 1% of the mental health programs in LA County. We have a Board of Supervisors who tends to try to divide by 5. I have observed a tendency here to try to divide by 8. That does not work when you are looking at how to do an innovation and make it actually work in a community. What my recommendation is at this point is say, "Yay" to the concept and then send it back to our SLT Standing Committee to work out some details that have been raised today that have been raised so that we have a start so that committee is coming together in January to put the final touches to it. But I think we can spend a million hours trying to figure out whether Service Areas 8 or 6, or 3 or 2 or 5 or 7 or 1 ought to have a particular thing. We cannot figure that one out because we do not know as a cluster, as a whole group, how much readiness there is in any given service area or neighborhood. The important thing is what is really unique about this, and having watched these innovation grants from the OAC's standpoint for the last 5 years, this is incredibly creative. This is taking us to a step where no one has dared go yet. I think it is very important that we want to make sure that when we do these, and we will probably do 3 or 4 of these, if you look at the total costs of the neighborhoods and you figure there are some other dollars that can be dropped into this, that we have a shot at setting a paradigm for the rest of the state is not even sure that it needs to do yet.

	6. Comment: I just want to read a quote from an email that I got yesterday that I think is really important and supports what Richard said. It says, "Our common goal is to serve those in suffering and we all let our hearts drive our heads to put this together. Now we are ready to roll up our sleeves and keep moving forward to achieve this goal." I think we are at that place of paradox where the rubber meets the road. We have gotten this far. It is innovative. It is creative. We do not know how it is going to work. So in theory we want to figure out if we can do this but there is going to be a lot of work to get it done. 7. Comment: I move that we approve the concept in the format so far; that this be referred to the SLT Standing Committee for final adjustments in January taking into account the various points made this morning. 8. Public Comment: They are doing a similar thing in San Mateo County and in Ventura. In Michigan, they have mental health recovery courts. They have brought in the wellness recovery action plan. Those people who are in those courts have a choice of either going to jail or going through a wellness recovery action plan. The consumer has to go through that plan if they want their charges dropped from a felony to a misdemeanor and people with misdemeanors can have their charges dropped completely. This could possibly be included in the diversion strategy. 9. Public Comment: I do have some concern around the equitable distribution around these tax payer dollars per ethnic population. However, my concern is around some of the dollar amounts that have been allocated. Under the assumption that TAY is the most endangered and hardest to reach group, I think the number allocated is totally insufficient. I would like to see some of the dollars allocated to the children's program transitioned over, particularly given that in the 3-Year Program and Expenditure Plan there is focus on a community health worker to the tune of about $1.5 million annually across those age populations. I am also concerned if you are suggesting that these Innovations proposals are limited to the five health neighborhoods that have been discussed, because quite frankly, Compton-Watts is not the center of South Los Angeles where there is a great need for support for young people. With that, I am hopeful to be able to participate in the SLT Standing Committee because I have a lot more to say around what has taken place here today. B. **Voting Results** 1. 94% fully agree or agree
Public Comments & Announcements	**I. Comment**: A. National Mental Health Self Help Clearing House announced there is to be an advanced directive webinar to take place December 18th. B. Star Center to do a 90 minute Webinar called "Reflections on Ferguson: trauma informed care" and it is going to be on Thursday, the 19th. C. SAMSA is accepting statewide network consumer grants.

	D. Substance Abuse Center for Social Inclusion is providing 8 sub contracts of $40,000 to peer run organizations. E. Recovery occupational center put together a book called "Facing Up" which covers health and mental health. **II. Comment**: A. Due to culturally appropriate strategies for intergenerational proposal, multiple “health neighborhoods” need to be considered. The effectiveness of strategies will be different for the UREP population. Therefore I encourage you to fund multiple UREP populations for intergenerational strategies.