COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, August 19, 2015 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. Give an update on State legislative and budget items.
3. Follow up on MHSA-related issues.
4. Give an update on the implementation status of the MHSA Three-Year Program and Expenditure (3YPE) Plan.

NOTES

Department of Mental Health - Update	Dr. Marvin J. Southard, Director, Los Angeles County, Department of Mental Health, provided the following updates on the recent Board of Supervisors Consolidation Motion and discussions on EPSDT. **Board Consolidation Motion Update** • Health Integration - The Board of Supervisors approved the creation of a health agency and set in place a process for determining what the framework for that operation might be, how it might operate, and what its priorities would be. • Strategic Plan - The process begins with a strategic plan report that is due 45 days from last Tuesday. It will not be a detailed road map; it will be the beginning statement of intent about how these various things might be handled. • Substance Abuse Medicaid Waiver - The Drug Medi-Cal Organized Delivery System waiver was approved. Substance abuse is going to be going through a historic change. • Advisory/Guidance Group - The Board also designed the agency to have an Advisory Group that will help monitor planning, give input on the agency's structure, and ensure the outcomes are what the community and public desire. **Summary of Questions and Answers** (Unless otherwise specified, Dr. Southard provided answers to questions.) **Q1:** *What will be the impact of the newly created Office of Diversion and Reentry on mental health and the mental health programs that have been working on diversion and reentry?* **A:** The initial diversion efforts for the new office are meant to be more like coordinating effort, not controlling efforts. **Q2:** *What is the agency's staffing going to look like, how many people will it have, and how is funding going to work? Will*

	there be staff for each of the six priority areas, or is it going to be more of a committee? **A:** It will be both. There will be dedicated staff in some areas reporting to the agency director. **Q3:** *Do we have an agency director yet?* **A:** No. The Board ordered Human Resources to prepare a job description because there is no position yet. That is supposed to be done within 30 days. **Q4:** *What about the rest of the staffing?* **A:** The rest of the staffing is not determined yet. There will be some staffing, but I do not know exactly how it will be operationalized. **Q5:** *How do you feel about the Board's decision to establish this agency?* **A:** I made it really clear that the responsibility for setting up the structures by which care is delivered is the responsibility of the Board of Supervisors. The department heads try to operationalize the Board's direction in the best and most positive way possible. The Board has given their direction. **Q6:** *Will the SLT have any input on the substance abuse waiver?* **A:** The Department of Public Health has already been planning for this and will obtain public input. **Wayne Sugita:** The terms and conditions for counties to participate in the waiver are pretty well defined, so there is not a whole lot of wiggle room. We want to move as quickly as we can into the implementation. We would like to engage people a lot more in the implementation because that is where the heavy lifting will occur. I left flyers on the desk with a list of stakeholder meetings we are conducting beginning this afternoon throughout the county. All County agencies will be involved, including the SLT. **Q7:** *Dr. Katz said there will be increased funding from ACA for health and mental health. I do not want them taking money that belongs to mental health community.* **A:** Dr. Katz acknowledged that in the immediate future the potential for revenue growth and expansion is greatest for the mental health system because we have existing relationships with health plans that we could build on. The problem is our networks do not have enough capacity initially to do that. We do not want to add mild to moderate clients in such a way that it displaces the seriously and persistently mentally ill, because our systems have had a history of doing such things. Whatever happens we need to make sure displacement does not happen again. Moreover, integrative care for the mental health community means a lot more than integrating primary care provided by the Department of Health Services, since many of our clients receive care from Independent Practice Associations (IPAs) and Federally Qualified Health Centers (FQHCs) that are not a part of the Department of Health Services. Our 'health neighborhood' concept is therefore important because operationalizing coordinated care will be different depending on the resources of particular communities. In some cases, the Department of Health Service will be an asset for integrative care. In others, we will need to depend on IPAs or FQHCs.

	Q8: *How does DMH ensure that the interests of the health systems do not supersede those others?* **A:** There are three mechanisms by which that might take place. One is the feedback process with regular reports to the Board that are being set up. The second is the commitment that the department directors would continue to have direct access to the Board, even in an agency structure, to convey concerns that might arise. The third has to do with groups like yours. The Mental Health Commission and this group ought to be the ones who look out for the well being of the mental health community because we all depend on it, whether it is law enforcement concerns or permanent supportive housing concerns. None of it operates unless the mental health system can make its contribution to the solution. It is not that we are the solution in every case but in many places we have a crucial contribution to the solution. **Q9:** *I recommend that the Commission for Children and Family Services have a place on the Advisory Group.* **A:** I will bring the idea forward. **Q10:** *How many people will be in that group?* Will it be one or more consumer representatives? **A:** The size of the group is still being determined. The bias is to keep it a relatively small and more manageable group rather than a huge group. One or two consumers for each department is what I heard. **Q11:** *What is your vision of how the SAACs will be part of this new agency?* **A:** I hope the SAACs will play a greater role in the development of the health neighborhoods as they develop in each Service Area and ultimately as joint work of primary care, substance abuse, and mental health unfurls in the venue of the health neighborhoods. This going to be a long process. Los Angeles is 10 million people. We also need to continue making stronger connections with the public health population based efforts as they operate in the Service Areas. That is one of the good effects of the work we have been doing with the health neighborhoods. Public Health Department is doing a lot of things that are very much in our interest to cooperate and tie with. For instance, the substance abuse treatment system is going to be growing by leaps and bounds. **Q12:** *If a doctor advises someone for mental health or emotional problems, would they be able to access any funding from MHSA without their being actual mental health providers?* **A:** No. Any mental health service provided needs to go through the existing service provision billing. DMH coordinates all of that, so there could not be a direct service billed for a pediatrician who happens to give mental health services unless they got certified and were eligible through the billing system. **Q13:** *Will parents and family members, not just consumers, sit on the oversight committee?* **A:** It is an important difference that we need highlight. **Q14:** *I thought it was a great win for us when the Board underscored ensuring culturally competent and linguistically appropriate care in the health agency across the three agencies.* **A:** Each of the three departments has cultural competence requirements built into law and we get monitored on whether we are meeting these requirements. One of the conditions of the

	extension of the 1915B waiver was the ability to provide linguistically appropriate and culturally sensitive services. Whoever is in charge of this field needs to know the nuances of the various ethnic and non-ethnic communities we are trying to serve as well the details of what the service requirements are in all of our regulatory structures. **Q15:** *It is absolutely necessary that hospitals and hospital associations know about what is going for greater coordination.* **A:** It is important. I just received a call from the Hospital Association of Southern California to meet with me. **SLT Member Comment:** The SLT should advocate for the following to advance the interests of the mental health community: (1) The budget coming from the department should be unfiltered by the health agency director (i.e., the health agency director should not be modifying the budget that comes from each of the three departments); (2) Let us hold them to their word that the focus of health agency is on that areas of overlap, which is very limited in scope as opposed to the health agency overseeing everything that all the departments do; and (3)Whoever runs the health agency should not be running one of the three departments to avoid conflict of interest. There should memorandum of an understanding regarding the three points presented. In addition, it was very disrespectful to hear on Tuesday that our mental health system is broken. It can always be improved but it is a tribute to this department and its embracing of stakeholders that there was such united support among the people that really matter, which is the community. **EPSDT Update** Dr. Southard alerted the SLT about a discussion occurring regarding EPSDT. The threshold for medical necessity under EPSDT has historically been lower than the threshold for adults. For example, you could get an EPSDT for treating kids who had an adjustment disorder and, all things being equal, there was not an exclusion. However, some are arguing that under the ACA, the responsibility for mild-to-moderate conditions belong to the health plans; and since mild-to-moderate conditions have been historically covered by EPSDT, therefore EPSDT should be the responsibility of the health plans. In my view, this would be a disaster for care, particularly in the child welfare system but also everywhere. We need to have kids with mental health needs getting the care they need at whatever site they go and in the way that EPSDT hitherto has allowed us to do. We want to maintain that. The counterargument is that health plans are already capitated to provide care for the mild-to-moderate conditions, including for those of kids. If that is the case, county systems providing that care may be giving a gift to health plans. Los Angeles County has taken a strong stance but over the next six months this will surface in a variety of ways. I want our stakeholder group to become aware of this issue to fight strongly together to ensure it does not erode the quality of care we have been able to provide thus far for children.
State Legislative and Budget Items	Susan Rajlal, Legislative Analyst, Los Angeles County, Department of Mental Health, provided the following update: • AB 193. Makes changes in the process by which people get referred for LPS conservatorship. This bill enables a probate court judge to refer a case with a probate conservatorship petition filed for it.

	• AB 1400. Focuses on reforming LPS but lacks clarity in some of the areas. The Steinberg Institute is seeking to develop consensus with stakeholders on areas for reform, how to make sure people are not clogging the hospital rooms, and honoring people's rights. • AB 1299. Deals with out-of-county placement for foster care kids to ensure they are linked to the treatment that they need. • SB 296. Seeks to reduce documentation for specialty mental health. • SB 416. Gives peer and family support specialist a standard statewide training and certification. • There are two bills on peace officer training. Nobody is against better mental health training for peace officers, but the cost for these trainings is astronomical. There is also a lot of interest in foster care kids and psychotropic medications this year. The bills that came out on this issue are somewhat problematic. **Questions and Answers** **Q1:** *Doctors at most of hospitals will not refer for conservatorship because of health insurance not covering them. It is a financial reason not a medical necessity reason.* **A:** I do not understand why a doctor would say that. I ran the conservatorship program for ten years in Kern County and insurance never had anything to do with the referrals. That doctor was probably misinformed. The current alternative is the assisted outpatient treatment program. That is a step below conservatorship but it is also something where a person is ordered into treatment and the treatment is intensive. **Q2:** *Is there any type of legislation coming up regarding the undocumented community, especially here in L.A. County*? **A:** SB 4 would have given Medicaid benefits to adults and children of undocumented. That bill sort morphed into the budget bill. The way that it worked out was that the children would be covered by Medi-Cal but not the adults.
MHSA Related Items	Debbie Innes-Gomberg, Ph.D., District Chief, MHSA Implementation and Outcomes Division, Los Angeles County, Department of Mental Health, provided updates on two items from prior sessions: FSP Rental Subsidies and Innovation 2. • **FSP Rental Subsidies.** Regarding the average expenditures on FSP rental subsidies for adult FSP programs, contract and directly operated rental assistance, which includes security deposits, the average monthly cost per client is $690 for fiscal year 2014-15 for 429 clients a month on average across our system. The average monthly overall cost for these clients is $296,000. Dr. Innes-Gomberg agreed to follow up on the following: how long on average people receive the subsidy; the percentage of housing of the total flex account; the type of housing units (i.e., apartments, board and care, emergency shelters, etc.).

	• Innovation 2. The Innovation 2 implementation group has been meeting since the OAC approved the plan in May 2015 to prepare two RFSs. One is for the strategies for the lead agency and the Department aims to release this RFS in January to get contracts in place by July 2016. The evaluation will be bid out as well, which is on a similar track. Moreover, presentations have been given to SAACs to inform them about what Innovation 2 is about and how to get on the DMH Master Agreement List for either RFS. If a particular group is interested, connect them to Dr. Innes-Gomberg.
MHSA Three-Year Program and Expenditure Plan	Debbie Innes-Gomberg, Ph.D., District Chief, MHSA Implementation and Outcomes Division, Los Angeles County, Department of Mental Health, provided an update on the MHSA Continuum of Services Template, MHSA Implementation for Fiscal Year 2015-16, and the MHSA Expansion Plan Public Comments. **MHSA Continuum of Services Template** Dr. Innes-Gomberg presented a draft template (see handout) to understand where the MHSA-funded services fall along a continuum of care to guide MHSA planning and monitoring. SLT members provided the following feedback and suggestions. • *This template gives us the full picture of our service investments and where they lie on a continuum.* • *We can see out whole system and see where the gaps are in the system.* • *Recommendation to insert clients served and corresponding budgets.* • *Request to add substance use services, however, we can only show co-occurring disorders on this template because substance abuse is not an appropriate expenditure either for MHSA or for realignment.* • *We also need to acknowledge duplicated and unduplicated clients.* • *Housing was omitted from the continuum due to lack of clarity as to where it belongs. Recommendation is to put housing in with the FSP and the FCCS because I think that is where the services are going into.* • *Recommendation to show the non-MHSA money with MHSA.* • *Clarify when the services are for both children and adults or just children.* **MHSA Implementation for Fiscal Year 2015-2016** Dr. Innes-Gomberg informed the SLT that there is going to a tremendous amount of implementation this fiscal year linked to the MHSA Three-Year Program and Expenditure Plan and the $84 million expansion. • This includes FSPs for special populations, integrated FSP (i.e., the FSP-FCCS pilot), assisted outpatient treatment, the integrated mobile health team (which morphed into a chronically homeless FSP program), and intensive care coordination (which is part of the Katie A. Settlement). The department will continue to look at FSP outcomes and differences by focal populations. • FCCS is also growing enormously linked to the Skid Row expansion of FCCS and to creating continuity after FSP

disenrollment. For instance, FCCS was added to any FSP provider that did not have it in order to create continuity.

- In addition, through 'PEI right sizing,' services will be realigned for different target populations. More CSS dollars will be used on an ongoing basis for people who were not really prevention and early intervention.

- As you receive implementation updates, it will be good to know—beyond the numbers—what information you would like that is relevant to you, your SAACs and your constituency groups.

MHSA Expansion Plan Public Comments

Dr. Innes-Gomberg highlighted key issues in the public comments pertaining to the posting of the $84 Million MHSA Expansion Plan.

- One concern was whether we should be investing in this Plan given impending Board consolidation motion. To clarify, regardless of the Board's vote, we are still bound by MHSA regulations, AB 100 and AB 1467. The fact we are now under another agency does not change our planning.

- Another concern was that the dollars would change without stakeholder involvement. To clarify, if any part of these plans change, whether it is the dollars or whether it is directly operated or contracted, we would have to come back to you to talk about that and to say why we would recommend the change and whether you would approve that.

- The third concern was how to ensure that funds are equitably distributed to the providers and to each of the UREP communities. To clarify, the distribution of funds happens within the department, but the larger question is how to ensure that individuals that are unserved or underserved from different ethnic and cultural communities are better served. This is really the role of the UREP Leadership and the Cultural Competency Committee.

- The fourth concern was regarding the evaluation of the Assisted Outpatient Treatment (AOT). To clarify, we have always been collecting the State-required outcome information and the evaluation proposed in the $84 million MHSA Expansion Plan goes beyond that. It really looks at the quality of the outreach and engagement and whether that impacts the need for involuntarily component of AOT.

- There was also question about why we are expanding FCCS for the Katie A. to include care coordination and in-home intensive, rather than intervening early. To clarify, we are doing both: 65 % of our PEI Plan is related to Child and TAY for those purposes.

	• In addition, there was a request for mental health law enforcement teams to ensure they operate in a culturally relevant, culturally competent manner. It would be great to have suggestions beyond what we do currently. The Cultural Competency Committee might have some suggestions as well. • Finally, there was a question about why is there an administrative line item for DMH. The answer is that you cannot expand programs without expanding infrastructure to some degree. The administrative line is actually only 5 percent of the net and much less than that in terms of the gross.
Public Comments and Announcement	Recognition: On behalf of the Los Angeles Police Department, Detective Dempsey presented Dr. Southard with a certificate of appreciation for his leadership and support of mental health training for front line officers. Dr. Southard stated that the recognition belonged to the training bureau, including Dr. Beliz, Irma Castenada and Linda Boyd. Comment**:** Bruce Wheatley, Inner City Industry, stated that from a systems thinking perspective the Board's consolidation decision was not fundamentally systemic change. He also requested to see the proposal vetting process to be conducted by or include reviewers outside of L.A. County for the health neighborhoods investment. He proposed inviting individuals outside of L.A. County and possibly outside of the state to serve as proposal reviewers, not DMH employees or and contract providers in order to create a more level playing field to address the power of influence by those who are within the system. He also pointed out that he had not received responses to his questions from last month, including one regarding a special project for PEI that took place in 2012 and the other was about the criteria for determining early prevention projects that received ongoing funding. Response: Dr. Innes-Gomberg noted that DMH uses an extensive process to select people to score RFSs, but DMH has been thinking about who, in addition to, individuals within the department might be on the scoring committee. A challenge with going outside of the department is some people expect compensation and DMH does not have a budget for doing that. Announcement: The Alternatives Conference is going to be from October 14-18 in Memphis, Tennessee. There are ten scholarships that will be available. The National Mental Health Consumer Self Help Clearing House is in danger of closing. Announcement: This weekend is the NAMI conference in Newport Beach. It is going to be a conference for the whole state.