COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, May 18, 2016 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 on behalf of the County of Los Angel Department of Mental Health.
2. Share information on the State legislative and/or budget items.
3. Provide an update on the Family Wellness Resource Centers.
4. Hold an open discussion on major DMH initiatives.

MEETING NOTES

Department of Mental Health - Update	**Dr. Robin Kay, Acting Director, County of Los Angeles, Department of Mental Health** **May is Mental Health Awareness Month** **Congratulations/Recognition to the AMI/ABLE Program for their 25 year anniversary** **<u>Whole Person Care</u>** -Included in the New State/Federal 11-15 Waiver Application. This involves looking at the very high need population and how to adjust our system to provide more comprehensive care while focusing on cost savings concurrently. -Target population includes those with mental health issues, substance abuse issues, individuals coming out of jail, etc. -There is also an opportunity to capitalize on bonus payments available through achievement of certain goals the county sets in advance. -DMS is the lead; work is being done to identify the population and the array of services that would be counted as part of Whole Person Care in Los Angeles. **<u>Drug Medi-Cal Waiver</u>** -Being rolled out in stages/waves. Los Angeles is in the 2nd wave, the application progress is being reviewed. -Full implementation plan is expected by July 2017 to complete the implementation plan, fiscal process of determining rates in Los Angeles County as well as developing staffing. -DMH is going to move forward with becoming Drug Medi-Cal certified. It is important the Drug Medi-Cal rolls across the entire system given a major missing piece for us ensuring our client is successful is often a substance abuse piece. -More updates coming within the year. **<u>Certified Community Behavioral Health Centers (Federal)</u>** -The Federal Government put out a proposal for a 2 year contract/award pilot program to involve 8 states, including California and other states exploring the application process for Certified Community Behavioral Health Centers (CCBHC). -They are looking at counties (one rural, one urban county, within the 8 states). Many counties are not applying due to the heavy

Department of Mental Health - Update (Continuation)	load of work, including: CCBHC must provide, by site, integrated mental health substance abuse and primary care services whether directly or through contractual arrangement. -This 2 year pilot program is also an opportunity for state and Federal governments to look at payment reforms. There is an emphasis on moving onto some new payment system. -CCBHC is an opportunity that Los Angeles County should not bypass. DMH submitted an expression of interest. **Dr. Alex Lee, County of Los Angeles, Health Agency – Update** **Discussion and feedback** -Our vision is we want every month and every day to be mental health awareness. -This idea of integration of mental health and substance abuse should be brought together to maximize dollars and unlock dollars into the health care system to work together to have a healthier LA. The general concept and vision is "how do we work together? How do we make it better?" It is not mainly about maximizing our dollars but pulling funds from other locations and maximizing our services to piece everything together. There are limited funds but we want to be more coordinated to make everything more efficient which could unlock funds that are in different areas which we normally do not get to for the improvement of the Health Agency. -The Health Agency's goal is to "improve the health and wellness across Los Angeles County through effective integrated comprehensive culturally published services programs and policies that promote healthy people living in healthy communities." Currently, there are a lot of things happening that drove the Health Agency, the Board, and the County Engagement to bring the three departments together. These three departments, although have great goals and have done great services for the individuals of Los Angeles County, but there are still many issues and unanswered questions such as: • How are we going to have more support for those who are homeless, such as social support? • How do we deal with issues of overcrowding? • How do we improve certain services, such as psych emergency rooms? • How do we access linguistic and cultural programs to expand our diversity? • How do we also increase the life expectancy of those individuals with mental health illness? • How do we work together to tackle all these populations, homeless individuals, mental health ill individuals, substance abuse users, and etc.? There are many different groups that are working on common goals that could overlap or work together. There needs to be good protocols and procedures set in place. If one group doesn't have correct or accurate information, another group could help or provide that. For example the registration process - We can reduce the wait time most of our clients suffer through. If a certain group holds the information of a client and this client is transferring to a new program or group, we should be able to transfer the information from the original group to the new one. The client should not have to repeat all the same information and procedures? We are going through this process of catching demographics correctly, so that we can think about reducing health issues. We want to ensure we have a good sense of inventory of our resources as a collective. How do we figure out all these resources to help individuals and our clients? There is also the issue of one client sometimes having multiple case managers and each one can ask similar questions. Why can't the case managers coordinate with each other instead of burdening the client?

Department of Mental Health - Update (Continuation)	We want to work towards reducing excess/overlap and increasing where services are truly needed. We need all the departments to be more in sync.
	
	Discussion, Q&A
	• The slide is too busy, is missing a column about the education of the people upstream, the prevention. I do not want to be caught behind but we need to educate individuals as these changes are being made. How do we educate for all these issues to go away.
	• HIV is on the list of chronic diseases. Who and how are the high risk populations identified?
	  o We need a good way to identify these individuals, whether it is homosexual or heterosexual activities. If we don't have a good way to identify, then we cannot do screenings and then we can't education the population on this issue.
	  o We can us working groups to dive deeper brainstorm how to work more effectively in this and other areas/topics/issues.
	  o Dr. Robin Kay and Dr. Alex Lee can contact these work groups regarding the status on these issues.
	• Mechanisms and structure for participation and information flow:
	  o These will all be posted on the SLT website.
	  o Is there a possibility to have a centralized location for all these work groups for individuals to participate or gain information about different activities?
	• What would the timeline be in implementing a joint information base among all three departments because it is accurate on how the clients are getting asked the same questions from whichever program they are enrolled in and this delays any progress they could possibly be making.
	  o Initial work has been done, that information we have collected is the same. Those communities are working on joint forms (i.e. the universal consent form). We also have to make sure how the forms are transferred through all three departments when needed and who keeps the forms. But we do need some more time to figure out the timeline.
	• Foster care youth and children can experience trauma when taken out of their group homes, causing displacement which can result in runaways. Studies have shown that this occurs due to the lack of mental health services for these individuals. Is this going to be addressed? What is being done?
	• What is the timeline on the increased joint safety training within concurrent disorders and how DMH, SAPSI, and Health Services would implement that? Would the Medi-Cal waiver pay for it?
	  o There are currently a number of different trainings (i.e. developed health training) we have conducted through UCLA. Currently, we are cross training but mainly focusing on identifying first and from there we can advance.
	• How are community members going to be integrated into these activities and processes? How are departments going to really understand what the community thinks?
	  o We are always looking for opportunities to engage the community such as we do at the SLT meetings when we listen and hear what individuals have to say. Then we bring back our findings to the work groups and move forward from there.
	• Will Whole Person Care include individuals involved in regional centers?

Department of Mental Health - Update (Continuation)	○ No decision yet on the populations we are going to choose to focus on within L.A. The opportunity of regional centers involvements falls under CCBHC due to Whole Person Care's focus more on population that already are in "high need." • What is the health agency doing to find out if Obama Care is really helping individuals? ○ We have seen a huge impact; more individuals are insured now more than ever. The main issue here is improving the quality of care, not just the quantity of care. • How will this Whole Person Care work for people with dementia? ○ There is no specific call for the senior population by the board, but I think a lot of the services going into the programs will improve the situation for a lot of the seniors. ○ I believe the way things are managed involving dementia is not coordinated at all. • Is there a committee, other than jail, to send people that have co-occurring disorders? ○ There are two related initiatives by the point of implementation: 1. Looking at diversion of people with mental health and substance abuse issues. Where they can divert people before they can get arrested. We are building urgent care centers to serve that purpose. 2. The other is for people who have been arrested but have been identified to have health and substance abuse issues can be referred to CC Courts with the idea of diversion to a treatment program to get them out of jail faster. • Are you taking what those committee's are working on to DMH? ○ We are working on that now.
State Legislative and Budget Items	**Susan Rajlal, Legislative Analyst, County of Los Angeles, Department of Mental Health** • May's report isn't going to be long due to no budget cuts • Medi-Cal Funding will be stable for the next 3 years • Governor Brown believes that the budget might downturn a bit and it is a bit of a concern but it won't affect this year's budget. Two Significant changes: **No Place Like Home** -Gov. Brown supports "No Place Like Home" and felt that using MHSA funds for this purpose was one of the best uses. Although, using the money in this way could cause other programs to be cut sometime in the future. This is significant due to the fact that we should be thinking about how we could make this as successful as possible. -The only known facts of No Place Like Home: • Gov. Brown supports the usage of the money in this way • It will provide permanent housing and rental assistance and technical assistance -Things look okay at this point but the language still hasn't been posted yet.

State Legislative and Budget Items (Continuation)	**Continuum of Care Reform for Foster Youth** -There are a lot of elements not yet defined -Although, we know every foster care youth will have a family/child team and each team will have a mental health individual. The services needed for the individual will be defined by the team themselves. -We don't know the full range of services that will be required. This is a significant work load increase. -We will be using therapeutic foster care families instead of residential facilities. -We believe that there will be an element of teaching individuals on how to provide these new services. -Mental health will certify the participants. -Unfortunately, the budget proposal only has about $6.4 million fund and the estimated amount needed is around $300 million.
Family Wellness Centers - Update	**Kalene Gilbert, LCSW, Mental Health Clinical Program Manager III, County of Los Angeles, Department of Mental Health** **Family Wellness Resource Centers** -Basic information of the program provided within the fact sheet: development of the centers, splitting the funding, and the developing of two pilot resource centers (these will not be standalone centers, but part of continuum care). **Drop in Services (part of the Resource Centers)** -These are just examples of services that might be brought in from other collaboration groups -Examples of collaboration services include yoga, cooking, etc. One will be located in the San Fernando Valley region. The South will be located around Service Areas IV, VI and VII. These are expected to up and running the following fiscal year. **Discussion, Q&A** • It is important that we include language that includes the LGBTQ and cultural competency in this, including the fact sheet. • Given the discussion before and the amount of money being used, it is important to not spread it out among five to six pilot programs. It is better to select just two pilot programs and then scale up from there. • Given the drop in services would be using volunteers, would it be for all the services listed? o It will depend on the region; such as what is needed while the pilot programs are relying on contracted and county volunteers. • What is the projection on who is going to be using these centers? o They will be open for ages 0 to 21. We wanted a little bit of overlap but we don't know the full breakdown. Part of the pilot is to see where the services are truly needed, including which age groups).

DMH Initiatives – Discussion	**Bryan Mershon, Ph.D., Deputy Director, Children's System of Care and Irma Castaneda, Ph.D., Deputy Director, Emergency Outreach Bureau.** **Continuum of Care (CCR):** -Major children system of care currently being worked on based on Assembly Bill 403 -The intent is to provide intensive trauma services to youth who need to be in group homes but decreasing their time in group homes and moving them into community. This will be done with resources families such as foster families, adopted families, and relative caregivers. -Monthly meetings have occurred between DMH, Probation, and Department of Children and Family services. -CCR has two main parts to it: 1. There's a selection process for those group homes who are interested in becoming Short Term Residential Treatment Programs (STRTP). They need to be a level 10 and able to deliver Medi-Cal Specialty Mental Health services themselves. 2. For those groups who are lower than a level 10, they probably will no longer be able to deliver group home services. This will be in effect on January 1, 2017 **Foster Family Agency(FFA)** -FFA will have an opportunity to work with these children and resources families, even as they leave the group homes. -FFAs have two options in obtaining access to mental health services that children and families will need. They can become Medi-Cal certified to deliver mental health services or make a formal written agreement with another entity that is already certified. **Current Challenges:** There are challenges in implementing this. States have not been given additional funding for this new system. At the current point, existing resources are being used in order to implement this. There are current pleas taking place in order to obtain more funding. The availability of resource families, specifically foster families, is a current state wide challenge. Los Angeles County has currently lost many of these resource families. There is recruitment underway for these resource families for the implementation of CCR. Another issue, the current STRTPs that are not currently certified will need to apply and this process can take a while. It's hard to review and certify all these places that are currently applying. **Discussion, Q&A** Since many of these questions involve follow ups from DMH and DCFS, a separate meeting and/or presentation was suggested on the terms of funding, cultural competency, recruiting, training, etc. • How does this initiative fit with all the work the county has done on Katie A.? • Are there other expenses focused on due to the limited funding that is available? o There is an administrated expense for all the counties in bringing new providers to do the Medi-Cal certification and to monitor these contracts. The state doesn't have enough funding to do this, thus, they are currently looking at the analysis to examine the cost for every county. So far nobody has been able to do that analysis completely. • Is there anything being done to help the parents the same way it is being done to help the resource families?

DMH Initiatives – Discussion (Continuation)	○ There needs to be a proper way to handle young individuals and children that have behavioral problems due to the continuing trauma they face from being with foster families whom the lack the proper training. • Is there a plan to increase resource families within different cultural groups due to the difficulty of individuals with different cultural backgrounds such as language differences? ○ This model, the Child and Family Team Model, could be applied to all age groups across the board. • How has RBS project helped to know the challenges of continuing care reform within Los Angeles County? Is trauma increasing or decreasing, if there isn't a good system of implementation plans? ○ The original intent of the RBS project was to deliver services for children who are in group homes by linking them to wrap around providers hoping to link them to the community. So far there have been excellent outcomes from the pilots here in Los Angeles County. We will talk and see what they have learned that can help with the CCR. • Is there any training done involving cultural to keep a child attach to their roots, such as cultural, heritage, language, and family since many children come from a diverse background? • My concern is matching of families to the certain child needs such as language, cultural, and etc. ○ We would anticipate that a number of kids would be involved with a mental health provider during their transition. The intent would be for those providers to work with the child while they are still in their group homes and are waiting for their discharge. This will allow the provider to get a sense of what kinds of strength and challenges that particular child could have. I encourage whoever is working in this project to use the strong network of mental health providers located within Los Angeles County for both Foster Care and Mental Health.
	Irma Castaneda, Ph.D., Deputy Director, Emergency Outreach Bureau Primary Homeless Outreach Programs: **1. <u>Home Program</u>** 1. This program sees and offers help to about 2-3 thousand individuals annually. If they aren't mentally ill, the program tries to link them to other resources. The program works intensively with about 300 individuals, but more intensively with about 68 individuals per year. Those that say they are interested in our services, are linked with Full Service Partnerships and are followed until they are fully linked. **2. <u>PATH Program</u>** 1. A multidisciplinary program conducts outreach and uses critical time intervention and evidence based practices. If a client agrees to be housed, they work with them for about nine months to ensure they are successful in housing they are linked to. 2. The program so far as outreached close to 800 individuals and enrolled close to 400 hundred, assisted 58 individuals to move into housing and 44 individuals with security deposits. **3. <u>SB 82 Mobile Team</u>** 1. Have been in existence for a few months 2. Currently have 172 clients and have been working intensively with them to link them. 3. Some teams are focused primarily on housing while others are not, such as our LAPD team, etc. **4. <u>C3 (Community, City, and County)</u>** 1. They work mostly in Skid Row and are divided in quadrants; each quadrant has a team of five staff: nurse, substance abuse counselor, health clinician, loss individual, and a peer from AmeriCorps.

DMH Initiatives – Discussion (Continuation)	2. Within the first month of operation, they have engaged 193 individuals and provided housing for 55 individuals, while they have provided permanent assigned housing to 44 individuals. 3. Their outcomes have been quite well. **5. <u>VALOR Program</u>** Large decrease in the homeless veteran population, have quite a well in interacting with about 224 individuals on the street. Unfortunately, there has been a 5.7% increase in homeless population: 30% of those individuals have been reported to be mentally ill, • 23% have reported to have a substance abuse issue • 17% have reported to have a physical disability • 7% are reported to have had a traumatic brain injury • 6% have reported to have a chronic health issue. **<u>Strategies of the SB82 Team: (64 staff across the county)</u>** -The teams have been tasked to coordinate with other homeless outreach providers in their service area. It is a very efficient approach, for example, the county library has met with the SB82 Teams to coordinate outreach within the libraries. Our librarians are concerned with our children going into the libraries and interacting with homeless individuals inside. -We have determined a central number for each of the SB82 teams and there will always be a human voice that answers in each service
	Law Enforcement Hope Team LAPD is currently developing "Hope Teams" and are currently piloting a Hope Team within the Valley Bureau Division. They have 10 police officers and one supervisor dedicated to work on the homeless issue. SB82 has met with them and will be partnering with that hope team part time (not full time due to the lack of resources). -This model will be replicated in all the bureaus (four in total). -DMH is involved in that planning -LAPD has requested a bureau justice grant to do jail in-reach at the city jails to identify individuals with mental health illness and link them with mental health services. We are also interested in seeing any alternative strategies **Discussion, Q&A** • How do police officers, who aren't within the Star Team Programs, find out about the resources and numbers to call? Is there some training for those police offers to know about the awareness? o There's currently a 16 hour long course that is being provided across the county o The Teams have a 48 hour trainings, specific to homeless o Officers have a list of the homeless resources that are located within their city

DMH Initiatives – Discussion (Continuation)	• It is a great frustration for many individuals in trying to access services and interact with someone who is mentally ill and homeless. There is a discussion on assembling a team that could be available to homeless individuals who don't have mental health illness. We do have a lot of programs and some ways it does make it harder in knowing how to access them. • What happens to the family of the individual that is within your program especially if this individual is the provider of that family? Do you have any programs that benefit the families who become homeless? o There are Homeless Families Solution Centers and their mission is to rapidly rehouse homeless families. We have seen a decrease in homeless families and we have mental health providers stationed in those Homeless Families Solution Centers. This is a one stop shop for homeless families. We can share information on these with you all as follow up. • We have been doing a lot of work with homeless people for a long time and it looks there is going to be an expansion within different programs. Have you reached a certain model that works best to use in moving forward with other programs? o Based upon the path and C3, it looks like a multidisciplinary team is the best to deal with this. • We have a lot of information based on what we have done in the past, maybe collecting this information, we can come up with a template to see what we can do as new money becomes available. Next time we can present some of those outcomes. Right now, one of the concerns is that there's a large amount dedicated to outreach but you need to outreach and engage individuals to do something. One of the main concerns is there is support of people once they get into housing. We have the front door, but we also need the back door as well. We don't want to create a revolving door. • I've had two conversations with a LAPD officer and a paramedic. Both have asked me how they respond to critical situations due to the lack of training or no training. o We were approached to provide some training for the paramedics • How many individuals are assigned to each team on SB82? o 2 individuals per team, in total of four teams • What is the plan for more teams with such a low number and such a large area? o We don't have any more funding/money to create more teams, but there are 3 answers to that question: 1. There are many outreach teams, such as LAPD, providers, etc. We really have to take a look at who is doing what and where. 2. It may be that we need to use the outreach resources to reach further. 3. Is it necessary to expand outreach at this moment or take into account what comes next to see if we have those resources available. We have to be careful that we do outreach and have resources to fulfill that promise. We have to be mindful of juggling all the pieces of the puzzle. • I think one of the most important things, beside the cost, is to have the support and resources available once you get individuals into the housing.

DMH Initiatives – Discussion (Continuation)	**In Summary:** **Highlighted issues/discussions present throughout the SLT Meeting.** • An interest to ensure that there is a clear way of working with homeless individuals and support services from the back end. • Front end with outreach and engagement • Making sure that the coordination integration of the tams and also a core practice model is clear • How much outreach and engagement through the back end is needed? • Linkage and access to services: does it make sense to have such a team shared county wide? Or is there another way to have the ability to ensure access? • What does the services and supports look like at the back end to ensure that you deliver on the promise? Including the scale of that as well.