STATEMENT OF PROCEEDINGS
FOR THE MEETING OF THE
LOS ANGELES COUNTY
PREVENTION AND PROMOTION
SYSTEMS GOVERNING COMMITTEE

500 WEST TEMPLE STREET
LOS ANGELES, CA. 90012

Wednesday, October 2, 2024

10:00 AM

VIDEO LINK FOR THE ENTIRE MEETING. (24-4708)

Attachments: VIDEO LINK

1. Call to Order, and Los Angeles County Land Acknowledgement. (24-4260)

Chair Dr. Jackie Contreras called the meeting to order at 10:06 a.m. followed by the reading of the LA County Land Acknowledgement. There was a quorum of in person members present.

There were no in person, virtual, or public comments.

Attachments: PUBLIC COMMENT/CORRESPONDENCE

Present: Chair Dr. Jackie Contreras, Vice Chair Brandon T. Nichols, Member Dr. Barbara Ferrer, Member Peter Loo, Member Karla Pleitéz Howell, Member Dr. D'Artagnan Scorza, and Member Dr. Lisa H. Wong

Absent: Member Fesia Davenport, and Member Cheri Todoroff

I. ADMINISTRATIVE MATTER

2. Approval of the minutes from the September 18, 2024 meeting. (24-4262)

On motion of member Dr. D'Artagnan Scorza, seconded by member Dr. Barbara Ferrer, this item was approved with the following roll call vote:

There were no in person, virtual, or written public comments.

Ayes: 7 - Chair Dr. Jackie Contreras, Vice Chair Brandon T. Nichols, Member Dr. Barbara Ferrer, Member Peter Loo, Member Karla Pleitéz Howell, Member Dr. D'Artagnan Scorza, and Member Dr. Lisa H. Wong

Absent: 2 - Member Fesia Davenport and Member Cheri Todoroff

Attachments: 091824_PPSGC DRAFT MINUTES
PUBLIC COMMENT/CORRESPONDENCE

II. DISCUSSIONS

3. Prevention and Promotion Coordinating Implementation Team (PPCIT) Updates. (24-4297)

- Dr. D'Artagnan Scorza, PPSGC Member and Executive Director, of Racial Equity, County of Los Angeles
- Carlos Pineda, Manager, PPCIT, Los Angeles County Anti-Racism, Diversity, and Inclusion (ARDI) Initiative

Chair Dr. Jackie Contreras stated that the PPSGC and PPCIT are making a concerted effort to ensure coordination among departments.

Member Dr. D'Artagnan Scorza gave an update on the PPCIT's efforts, and shared that the goal was to operationalize the aims of the Systems of Care (SOC) and PPSGC while working closely within/across departments and external stakeholders to maximize efficiency and reduce redundancy. He shared the teams will work on three priority areas: 1. education, 2. workforce, and 3. wraparound supports for at risk and systems impacted youth and youth between the ages of 16 and 24.

Concerning the structure and process of the collaboration, Member Dr. Scorza stated that the PPCIT will help anchor the Transition Age Youth (TAY) Table Design Team and work concurrently on the three priorities in response to the Board's directives and support the motion directed Report Back due mid December 2024. The PPCIT will leverage the PPCIT Data Workgroup for the data sharing piece and the User Journey Mapping (UJM) Workgroup to assist with the assessment scan and analysis, and operationalizing outreach and engagement. He shared that the UJM and Data Workgroups are comprised of PPCIT member departments and other stakeholders, including non-County partners.

Member Dr. Scorza mentioned that work of PPSGC members and departments have a direct relationship to the TAY population. Dr. Tamara N. Hunter, Interim Executive Director of the PPSGC, informed the group that the goals are still in alignment with the behavioral health domain, which is to address disconnection throughout populations, both among systems affected and those not involved in the system, and agreed that it is prudent to leverage the PPCIT to establish a TAY Table as a coordinating vehicle and offers an opportunity to design a lasting Table that is meaningful and not duplicative. She added that the only way to do it is in partnership with community stakeholders, through the various subcommittees being created in the TAY Table Design Team, and the focus will be on the at-risk

youth population to promote connection before they become an opportunity group. She shared that the table will maintain authenticity through access, as the engagement subcommittee is co-chaired by a youth subcommittee and the Department of Youth Development (DYD). Member Dr. Scorza explained that the implementation team will create and leverage resources for functional alignment while simultaneously bringing departments to the table. for the added benefit of20+ Departments present to identify their role and the focus populations to help structure their work.

Carlos Pineda, PPCIT Manger, further explained the nature of the Data Workgroup and confirmed that it will convene mid-October to discuss cross departmental data sharing to support the Youth Connection motion directed report back to the Board. In addition to facilitating the production of relevant cross department data, it will also produce a data plan for service delivery across departments, which will have a focus on exploring the most pressing needs and developing solutions using the TAY Table as a use case. The motion directives and/or Gap/Barrier identified is "creating a dynamic, public database, in consultation and partnership with the Chief Information Office (CIO), that shows, at minimum: 1. the number of TAY in County Care; 2. the demographic breakdown of TAY, including sexual orientation, and gender identification; 3. the number of TAY with a history of homelessness and housing insecurity; incarceration and correctional supervision and child welfare; and 4. the number and types of services TAY is receiving." Member Dr. Ferrer asked if they are working with Member Loo, CIO, and Dr. Scorza confirmed. Member Dr. Ferrer then asked how TAY will be defined. Vice Chair Nichols explained that the Department of Children and Family Services (DCFS) has operationally defined TAY, and that it is not an all-encompassing definition. Chair Dr. Contreras stated that the operational definition of TAY does not only include those populations in system-based transition, but also all individuals at risk in that age range. Dr. Hunter confirmed that this aligned with the PPSGC/PPCIT definition, which includes those impacted by County systems and those transitioning out of the system. Additionally, the PPSGC/SOC/PPCIT will have to further identify specific populations based on the granular data shared. Member Dr. Scorza stated that department heads of respective implementation teams would receive data sharing information. Dr. Hunter acknowledged there could be delays here, as some departments had yet to assign data operations specialist when they began the data sharing protocols.

Mr. Pineda shared that the UJM is set to convene in mid-October. The initial foci are to coordinate collection/submission of data related to client experiences/feedback on services received for respective departments, and to promote outreach, engagement, access, and support for PPSGC/SOC.

The integration follows a parallel track, as the CEO ARDI has initiated contract negotiations with a UJM consultant to initiate the UJM process. If negotiations are successful, it will be up in 2 - 3 weeks, and an agreement signed within 30 days. Dr. Scorza informed that the UJM will focus not only on TAY youth, but also on non-TAY youth, homeless older adults, and any population focus this body decides. They will be able to create a UJM for all populations, in addition to different "persona" types within each group. Also, the consultant will respond and report directly to this body.

Mr. Pineda informed the group they will be engaged, along with member departments, including non-County partners, in the development of the PPCIT – TAY Focus Assessments Scan and Analysis. The focus of the assessment scan and analysis is to create a crosswalk of existing strengths, needs assessments, and case planning tools related to education, economic well-being, and related wraparound supports to identify opportunities for streamlining and alignment, with the goal of moving closer to a universal assessment tool and unified case planning approach (if possible). The motion directives and/or Gap/Barriers identified is to "include robust and consistent assessments for the creation of tailored success planning and comprehensive and frequent independent evaluations and audits of DCFS TAY oriented services, programs, and providers – including services that promote stable housing, educational achievement, workforce development, life skills training, health and behavioral health supports, and mentoring – to ensure efficacy."

Additionally, Dr. Scorza explained that UJM workgroups and other stakeholders, including non-County partners, will focus on development and implementation of a cross departmental strategy for outreach, engagement, and access to program issues. These strategies may include developing a website, resource portal, and operationalizing a "fast pass" for DCFS and Probation populations. The Directives and/or Gap/Barrier identified is to achieve "…outreach successes and opportunities for improvement, including review of language inclusivity and cultural competency." Member Dr. Scorza noted that this function was born out of the need for more models/approaches that see and hear youth and offer authentic co creation. Reported youth concerns are centered on the difficulty to navigate the system. This will address the need for a comprehensive "no wrong door" approach to get youth access to programs. Dr. Hunter informed the group that because the data indicates disconnected youth are primarily ages 23 and 24, strategies must reach minors when they are in school and identify young adults before they disconnect. This will allow the group to address difficulty in navigating the system and find services available to these populations. "Low hanging fruit" objectives could include a centralized website, information, and referral systems (closed loop), and social media development.

Member Pleitéz Howell stated the need for young people to lead the charge in this area, specifically to identify, support connection, facilitate connection, and reengage young, disconnected youth. A discussion ensued whereby member Dr. Ferrer noted that most of the work is coming from disconnected youth and suggested that resources be focused on youth before they are disconnected, in other words 'at risk'. She shared that there are external models to emulate their trajectory, and that applying them to this population would be a matter of moving them from a pilot to a system. Vice Chair Nichols questioned if they would be able to bridge the data between a 15-year-old living alone, experimenting with drugs, and not attending school and a homeless 24 year old. Addressing such dissimilar trajectories may require two different strategies and the TAY Table would need to orient the difference between the two subcategories. Member Dr. Ferrer suggested the PPSGC focus on known vulnerable populations and used the example of LGBTQ+ youth and the data identified risk and high vulnerability in this population. Vice Chair Nichols added that new healthcare reform provides funding for housing support as healthcare. He asked members how the County could connect kids to new housing support to prevent them from becoming homeless with housing assistance programs. Member Dr. Ferrer posited a systems fix could be the best way to implement a global screening tool. If improved, all departments can embrace it for screening and implementing strategies to engage this population with assistance programs.

Dr. Hunter stated that the TAY Table would be ideal for better cross departmental alignment to leverage benefits through Medi-Cal. She noted that departments must establish Memorandums of Understanding (MOUs) with managed care plans for their respective populations. If someone is the holder for all funding, the table could be a place to collaborate as a County and maximize what is available, allowing an entire community to access these services. She is unsure whether the TAY Table will think broadly about CalAIM, and that department leaders will be on this group and how the County aligns with individual MOUs.

Member Dr. Ferrer asserted that departments will be getting access to payment for services, and insurance will now be required to pay for some housing support, with some limitations. She agreed that County negotiating, through a proxy, for a managed care plan, after action plans are developed, for what we need outside CalAIM could be effective to avoid paying individuals on a case-by-case basis. She shared that then service providers would be reimbursed for community service, not individual care because insurance pays less for healthy people. Furthermore, that once the County has a concrete action plan, it can be used as leverage during negotiations. Additionally, DPH will have data on 10 communities that

have dismal outcomes. Since March teams have gone door to door asking thousands of households what they need, generally. She stressed the importance of including in the UJM, responses reflecting real time opinions, regarding service and support offerings. She also stressed the importance of having access to predictor variables to be common across groups such as food insecurity and danger in community,

Member Dr. Scorza noted Qualtrics software can gather feedback from communities. Wherever the screening location might be, it will allow them to speak to concerns and needs for that individual and location. The Qualtrics database not only structures questions for community feedback but provides tools to help analyze and code for meta-analysis. He suggested that one way to utilize the software could be to find the variables that create barriers to digital access, such as broken links. Member Dr. Ferrer stated that it also has a utility to bring up red flags/predictor variables that can identify what features are the most problematic for populations. Member Pleitéz Howell asked if the UJM can incorporate mentorship and relationship building elements. Vice Chair Nichols commented that there is a strong opportunity to collect predictive data. Member Dr. Ferrer stated that it would be optimal for the TAY Table to cover engagement gaps that occur when a subsidy program ends to bridge engagement. All subsidy programs are based on paying 30%. Medi-Cal has 100%. If someone is transitioning from Medi-Cal to another subsidy program, the difference in subsidy size will create a "cliff" effect for affected individuals. Vice Chair Nichols asked if this table would incorporate these discussions on subsidy changes across County departments and if that the TAY Table must be able to account for population overlaps. He suggested finding a common point from which to start and to recognize where the connections exist. Member Pleitéz Howell noted that mentorship and relationship cultivating are the most important factors to maintaining youth engagement and asked if the Table will capture them. Member Dr. Scorza noted that although data from schools can be inaccurate, there could exist systems that enable them to report on outcomes, while also dependent on purpose and district. He shared that school districts can gather a list of students who are coming into their district can connect directly with families. There is now a new student identifier, that follows them district to district, a way to get data. Cal State and other systems can share data and should be explored. Vice Chair Nichols noted there are opportunities with machine learning and predictive analytics to identify people who are at risk and these variables could be used to determine vulnerability based on data patterns. Qualtrics can take transcripts and manage and organize data in real time. Member Dr. Ferrer noted there is a big intersection in populations and specific issues. Variables such as economic stability, discrimination, and connection to needed services are common across all disengaged populations.

Member Dr. Scorza stated they will provide copies of assessment/screening tools and case planning templates used to assess strengths, needs, and eligibility. Additionally, they will create case plans related to education, workforce, and associated wraparound supports for youth and young adults ages 16-24, including but not limited to child welfare and justice impacted people. Furthermore, the team will provide contextual information on who is completing the assessment/scan and case plan, how often the assessment/scan and case plan will be completed, milestone triggered updates, whether the assessment/scan and/or case plan is required by a formal regulation, law, or funder, how the information will be collected and used, and include recommendations regarding opportunities for integrated assessment and case planning.

Member Dr. Scorza went over next steps and explained that the PPCIT/SOC will brief and engage additional stakeholders on proposed structure and process. Additionally, the SOC/PPCIT will identify and assign subject matter experts to relevant workgroups, with a target completion date set for October 7, 2024. Finally, the PPCIT will collect information on existing assessments/tools and case planning templates with a target completion date of October 15, 2024. Dr. Hunter explained that the TAY Table Analysis was developed to meet the Board's request for a statistical analysis of assessment and screening, with a goal to move to a universal evaluation tool.

Concerning the inventories overview, Member Dr. Scorza explained that prevention inventories (program/funding, contracts, and housing/homelessness) were due by COB at the September 30, meeting. Furthermore, CEO HI and prevention data requests were combined into a single, integrated request, and templates were prefilled with existing CEO HI data. Finally, departments were asked to update the CEO HI data, provide prevention data, and to collaborate on funding.

Member Dr. Scorza stated nearly 130 programs (addressing all domains) have been submitted by 9 out of 24 PPCIT member departments. Data from 340 contracts have been captured (totaling ~ $1.7 Billion), with the Top 5 Funding resources as the state (2011 State Realignment), federal (Ryan White Grant), and County (Net County Cost, Measure H, and DPH NCC). Additionally, 9 PPCIT departments are finalizing data internally and are expected to submit inventories by next week. The number of submitting programs is expected to grow to over 200. Furthermore, 6 PPCIT members are not direct service providers, and thus will not submit inventories. Dr. Scorza noted that this well help identify gaps and enable backtracking work, to be completed by the fiscal year end. Some groups were not able to provide data but will be able to submit an update.

Concerning the resource mapping timeline/role of funding workgroups, he explained that inventory data is being analyzed by a team to map opportunities to leverage, braid, blend, and sequence funding in support of the PPSGC plans (program, Spending, and Staffing). The timeframe overview for this work is:

a. **Early October – Initial review of budget data by CEO BOMB (on a rolling basis)**
b. **Mid /Late October – Inventory data review (on a rolling basis, following BOMB's review)**
c. **October December – CEO/consultants meet with departments to clarify/confirm data and answer questions.**
d. **December '24 – January '25 – Conduct analyses/develop initial findings for County Team's review.**
e. **January 25 – Initial results available for discussion.**

The role of the PPCIT's Funding Workgroup is to coordinate department team participation and attend meetings with the CEO and consultant team. Additionally, the team will coordinate timely submission of data requested by the CEO/consultant team and will discuss what worked with the PPSGC. The PPCIT will consult with departments and bring on a consultant to facilitate co creation of a joint policy agenda across all departments. Legislative affairs will submit to the board and petition enaction. And UJM will have a parallel function.

There was no in person, virtual or in person public comment.

Attachments: PUBLIC COMMENT/CORRESPONDENCE

4. Updates on Proposition 1's Implications for Prevention and Promotion in Los Angeles County. (24-4298)

- Dr. Lisa Wong, PPSGC Member and Director of the Los Angeles County Department of Mental Health (DMH)

Member Dr. Wong provided an overview of Prop 1, legislation proposed by the California State legislature to support the Governor's mission for monitoring behavioral health. The state needed more flexibility and found that local needs could not be met due to spending constraints. It is inclusive of Senate Bill 326 (Behavioral Health Modernization) and 531 (bond measure), which was approved by a small margin and proposes a significant shift to create a NEW housing category, reducing funding from core mental services. It does not add new funds but does add a new population. Further, it proposes $6.3 billion in bonds to build residential, community housing and locked facilities, with two types of funding

for treatment and housing.

1. **Behavioral Health Continuum Infrastructure program (BHCIP)**
   a. **State decided each county should send a letter petitioning for funding.**
2. **Home Key focuses on the creation of permanent housing.**

Member Dr. Wong explained that both sections of the measure are decided at the State level, with the County not able to make any decisions, pertaining to capital. Member Dr. Ferrer noted that with expansion of health insurance in California, most people now have health insurance. Although rates for reimbursements are scarce, the State made a big investment to ensure that covered services would be reimbursed. Also, match funding is no longer available. It also expands target populations and changes programming to a full-service partnership. It focuses on early intervention and creates a new funding category only available for housing services. The State will look at a cross continuum of services provided for mental health based on need, total capital, and specific spending plans. The Department of Health Care Services (DHCS) will take revenue to be administered by the State Department of Public Health (CDPH), will likely generate behavioral health services. While they are considering how the PPSGC could provide a transitional service for highly successful intervention programs, they will hire a consultant to assist. Early intervention categories include outreach, engagement, and linkages across services. Targeted services must include direct engagement with a priority on those services reimbursable by Medi Cal. She explained that prevention is no longer a funded BHSA category. Additionally, DHCS will absorb 4% of all Mental Health Service Act (MHSA) revenues prior to distributing to Counties for universal prevention programs to be administered by the CDPH. Furthermore, the Department of Mental Health (DMH) will be able to administer early intervention Programs that address:

1. **Early clinical intervention services.**
2. **Outreach, engagement, and services linkages.**
3. **Targeted and selective prevention services to at risk populations.**

Furthermore, this will impact outpatient services. Last year, 32% was spent on this only. Post BHCA, that is 17.5% shared with crises linkage, capital facilities, and workforce education and training. Although the outpatient and client run services in the County are currently funded with MHSA Outpatient Care Services (OCS) funds, reducing funds from 37% to 17%. Under BHSA, mental health services that are not part of a Family Service Plan (FSP) or Early Intervention will be funded with Behavioral Health Services and Supports (BHSS) flexible funds or non BHSS funds. Analysis is in progress to review OCS services and what will be funded.

Concerning the impacts of programming changes on current programming and direct services, Member Dr. Wong explained that an increased number of outpatient services will first be provided and categorized as a lower level FSP. Additionally, there will be increased access to FSP for adults, youth, and children, with fewer BHSA funds available for general outpatient youth, adults, and children services. There will be increased access to housing resources and rental assistance. Furthermore, no BHSA funds will be available for Universal Prevention Programs. Finally, there will be a priority placed on referrals to managed care for individuals with mild to moderate needs.

In preparation, DMH is engaging with DHCS and statewide advocates for BHSA guidelines to advocate for the diverse population needs. Analysis is underway of existing programs to determine future funding availability. DMH is also working with DHCS for specific guidance on how BHSA funds can be spent and what programs are eligible. Finally, providers and stakeholders will be solicited for feedback. She concluded that the formal BHSA planning phase will begin early 2025. $37 million is currently allocated to programs conducting efficient work for Perinatal Equity Initiative (PEI).

Member Dr. Ferrer stated that although it is not optimal, outside providers have been looking for opportunities on substance abuse and prevention work and that DPH now redistributes to the County. The State will not provide direct services but will instead come up with a distribution strategy. There will be an opportunity to reclaim control and maintain access to dollars. Additionally, DMH will lose local control, along with a sense of what the community needs. Lastly, competition of entities applying for dollars will result in insufficient allocation. Member Dr. Ferrer explained that this proposition was born out of frustration with unevenness on behavior health and substance abuse funding that the state wants to create opportunities for community-based organizations (CBOs). A reality of this is that health care systems will not see money directed to the County, and will need to thread the needle, in favor of strengthening community partners. But to do it at the expense of the County leaves a void in a centralized plan. If the State gives to organizations that do not meet County codes, it will be an empty investment. Joint advocacy is necessary for opportunities to return. The policy agenda is to build flexibility for Counties to have control or ability to plan service delivery in a unified fashion. To mitigate negative impacts would be to leverage relationships with CBOs and philanthropic organizations. The biggest effort will be a system wide analysis for what kinds of work they are doing, and how that work can be translated to fit into a different category.

not clarified what they plan to do with MHSA, and if anything allocated will be honored. However, a bulk of services are funded at low cost and may not be impacted. Chair Dr. Jackie Contreras stated that despite changes to CalAIM the State's expectation is that if there is an upfront need it will not be needed later and that it will be helpful to understand how to access resources. Member Dr. Wong informed that the State has stricter compliance standards and the County funds better when populations are 95% compliant. Finally, there will be ancillary impacts which effect communities, parents, and all things needed to surround other efforts.

There were no in person, virtual, or written public comments.

Attachments: SUPPORTING DOCUMENT
PUBLIC COMMENT/CORRESPONDENCE

III. MISCELLANEOUS

Public Comment

5. Opportunity for members of the public to address the PPSGC on items of interest that are within the jurisdiction of the PPSGC. (24-4299)

The following members of the public provided virtual public comment.

Tina Rios

There were no in-person or written public comments.

Attachments: PUBLIC COMMENT/CORRESPONDENCE

Adjournment

6. Closing Remarks and Adjournment. (24-4300)

Chair Dr. Jackie Contreras announced that the next PPSGC meeting is on November 20, 2024. And for more information to visit ppsgc.lacounty.gov. She then adjourned the meeting of October 2, 2024 at 11:53 a.m.