

# HMHS Cluster Transcript

March 4, 2026, 7:51PM

□ **Atineh Sepanian** started transcription

**AS** **Atineh Sepanian** 0:10

Unmuted. So OK, get started. We'll get started. Great.

Hi, good morning, everyone. Thank you for your patience. We had some technical difficulties, which is why we're having a bit of a late start. I'll go ahead and call the meeting to order now. Please note that the meeting will be muted for all participants. You can unmute yourselves using the Teams app or by dialing \*6 if you're calling into the meeting.

As a reminder, public comment will be limited to two minutes. We will now start with introductions with the board offices in the room going first. Josie, can you kick us off? Oh, no, sorry, Allie.

Josie Escar, 5th District, Chris Coleman, 4th District, Yolanda Vera, 2nd District, Jasmine Garcia, 1st District, Victoria Donna, 2nd District, 8th District, Angelique Vanilla, 4th District, Box, 3rd District.

Great. Thank you. Do we have any board offices, board office representatives on the call?

**VN** **Vartanian, Natalie** 1:14

Hi, Natalie Vartanian, 5th District's on the call.

**AS** **Atineh Sepanian** 1:20

Great. Thank you. Um, do we have any CEO staff in the room? Antonis Efanía, Gustavo Medrana.

Do we have any County Council in the room?

Do we have any representatives from public health in the room?

Do we have any mental health representatives in the room? Can you introduce yourselves? Do we have any representatives from health services in the room?

Do we have any representatives from the Homeless Services and Housing department in the room?

Right.

Great. Thank you. Do we have any other county representatives in the room?

Great. We'll move on to folks on the call. Do we have any CEO staff on the call?

Any County Council staff on the call?

**RK Rachel Kleinberg** 2:29  
Rachel Kleinberg.

**AS Atineh Sepanian** 2:31  
Any representatives from public health on the call?

**JB Joshua Bobrowsky** 2:35  
Joshua Vobrowski with Government Affairs.

**AS Atineh Sepanian** 2:39  
Any representatives from mental health on the call?

**JB Jaclyn Baucum** 2:42  
Good morning, Jacqueline Baucom.

**AS Alejandro Silva** 2:45  
Good morning, Alex Silva, DMH.

**DT Donna Tang** 2:46  
Voliting.

**AS Atineh Sepanian** 2:46  
And.

**CW Cynthia Wheaton** 2:49  
Cynthia Wheaton, DMH.

**KP Karla Pawar** 2:53  
Carla Pawar, DMH.

**AS Atineh Sepanian** 2:57

Great. Do we have any representatives from the Homeless Services and Housing Department on the call?

Great. Any other county staff representatives we might have missed?

**CS** **Connie Salgado-Sanchez** 3:17

Connie Salgado Sanchez, DHS Office of Government Affairs.

**JA** **Julio Alvarado** 3:23

Good morning. We'll do Alvarado DHS contracts and grants.

**AG** **Allen Gomez** 3:28

Morning Helen Gomez, DHS gun relations.

**AS** **Atineh Sepanian** 3:43

We had one closed session item at 11:30 AM. We will start with public comment for the closed session item. CS1 conference with legal counsel, existing litigation E Arceniga, a minor by and through her guardian at Joel Arceniga versus County of LA Do we have any public comment on this item?

Great. Umm Do you have any public comment on this item?

Right. Thank you. And for the remainder of the agenda, we're going to flip the order a bit. We will start with the information item and then move to the SD2 motion and end with the SD3 motion. We'll now move on to item 3A.

This is an information item.

From DHS delegate authority to execute sole source amendments to various Proposition A and one non Proposition A agreement. Any questions from board offices on this item?

Do we have any public comment on this item?

Great. Next we have item 2B. This is the SD2 motion on improving the mental health of LA County youth. Hi, good afternoon everybody. I I think we have some slides. This is is a motion to support youth services. I don't know if.

Many of you are familiar with the alcove model, but as we know, many youth are experiencing a lot of stress. It's a hard time right now, and especially since COVID period where youth are experiencing more anxiety.

And so we had the privilege of going to a a center which is currently located in the Beach Cities, formerly was in the 4th district and now it's in the second district. And

it's such a wonderful, inspiring model and I really encourage everyone to go there because it's it's designed by the youth, it's for the youth.

I'm forgetting to go through the slides. So you know, this is this is just background on why we're doing it in the 1st place and some of the data which many of you are already familiar with in terms of rates of suicide and and some of the challenges. But let's go to the next slide. But I just want you to note the inside of the picture that was in the last one.

But this particular model of alcove and why it's exciting for us, especially as a mom who's had kids, it is we're still still growing. It's a one-stop shop and it's not a clinical based model and it really if you go in, you would never know it is a place where you can go for mental health.

Services or substance abuse services. It's a really welcoming setting. The furniture is chosen by the youth. The color scheme is chosen by the youth. They're always engaging them. Many of them are here and they can tell you about what their experience and what the model is. They have all these ways to engage, including mentoring and.

A place where people could just sit and listen to music or do nothing or do homework. But if they want to talk to somebody, they're safe places where they can go into a chat room, a private room. It's not a clinical room where they can go and get connected with experienced.

Professional help for whatever services they may need, and so it is stigma free. It really tries to just take them where they are and provide them the services they need to maintain and sustain themselves.

Next slide.

So we did this motion to try to sustain this particular model. And I know that Alcove, which was designed by Stanford, it was a model based in Stanford. It's had a lot of international presence. It's been in Canada. Kyla shared that she went to the Canadian version of it to take a visit, but in other countries as well.

Too and and throughout the county. And so it's two directives. One is to sustain the model and DMH is familiar with the model and has visited the site, but it's also to direct DMH to look at options to expand the model. It may mean it's not officially alcove.

But Alcove-like, which is where it's it's an approach where you're really letting the youth lead it and inform on how best to help them and to come back with a report on options to do that. So that's it. I don't know if there's any questions and we have

representatives from Alcove including some of the youth.

That go and lead the program and I know GMH is here as well too and is familiar with the program.

Any questions from board offices?

Thank you so much for this motion. Obviously we know Alcove well and we know we're very supportive of it. It's a phenomenal model. I just wanted to understand you mentioned alcove like, can you define that a little bit more and especially as we're thinking about as folks are seeing this, they might want to understand if they would qualify.

So who would qualify under that alcove like so alcove like you know and I'll be candid when we are looking at alcove in the model itself, Stanford design this this protocols of expectations in terms of how you design the space, what the inside looks like all the types.

Of facilities that should be inside the types of services. It even has incredible detail in terms of these youth advisory.

Alcove is, but it's still the the sense of the youth leading it, youth designing it. And I think even Stanford would acknowledge it is. It is a more expensive approach to to do this type of approach, but we're such we're so thrilled with it, but we didn't want to limit it to just.

Specific alcove as it's understood by Stanford. So that's why we use that language.

But I wonder if any of our speakers from alcove can say a little bit more on, I don't really know whether you really need more because it's really more on alcove like and they're they're running an alcove type program.

I only wonder because I know we've received questions, just wanna make sure that providers and others fully understand. Yeah, what that means. Yeah, and they're considering something like this. So I don't know if there's if that will come back and report back, but if there's a way to.

Yeah, yeah. I think that's a good thing that I'm hoping could come back and look at Mary in the report back for the motion in terms of what it might mean. So because, I mean, I think the hope is just to have the model out there, the approach out there, but then to figure out what that might look like in a different district.

OK. Thanks.

Thank you for this motion and I had a question on director one. Could you elaborate more on what you mean by sustained funding? I mean the existing funding that already exists within the department. So on the sustainability of the funding, my

understanding is that the state funding.

That Alcovetta received is expiring and so we've had numerous conversation for months with DMH about the potential of all their funds. They've confirmed it's consistent with the BHSA and the.

The early intervention services. And so that's, yeah, is that enough of any? Yeah. Any other questions from board offices?

Great. We'll move on to public comment on this item. Do we have anyone that would like to provide public comment?

We'll move the microphone to you there so folks and I can hear your comment. And just a reminder, probably comment is limited to 2 minutes.

OK.

Good afternoon. My name is Ali Stewart on behalf of Beach City's Health District, here in strong support of Supervisor Mitchell's motion, improving the mental health of Los Angeles County's youth. We are the lead agency for all Cove Beach Cities in Redondo Beach, and our youth drop-in center has seen more than 16,000 visits since opening in November 2022 by young people ages 12 to 25 across.

The greater South Bay, with more than 1900 enrolling in services, we provide free mental health and physical health services, substance use prevention, peer and family support, and education and employment. And that consists of the All Cove model, all six of those service streams. Importantly, All Cove centers are designed by and for youth, and you'll hear from some of our youth leaders today.

We first approached LA County about the innovative All Cove model in 2018 with the support of our then supervisor, Janice Hahn, who allowed us to secure a sign on from the Department of Mental Health to apply for and successfully receive an initial grant from the Mental Health Services Oversight and Accountability Commission in 2020.

The growing ALCO network across the state has five open centers, with another six centers expected to open in the next year with the support of Stanford Center for Youth, Mental Health and well-being. Across the network, 97% of youth reported that their ALCO visit helped them, and 30% said they would have not. They would not have sought help anywhere else.

This motion would help grow the network and create efficiency in scaling the model across the county. Since opening, All Cove Beach Cities has completed 170 suicide risk assessments. That's not just a number. That's 170 moments when a young person said I'm not OK and someone listened.

Those are 170 opportunities to prevent a crisis from becoming a tragedy. Continuing

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to fund and expand the Alcove Network is an investment in keeping families intact and communities whole. The cost of a timely assessment is far less traumatic than a psychiatric hospitalization or an emergency department visit. We thank you for your consideration of this motion.

Good afternoon. My name is Yash Jam, a high school senior at Mira Costa High School in the Second District. My first contact with the mental health care system happened when I was 12 years old. It was a police officer showing up at my door. It was 2020 and as a person of color, the gun in his holster was impossible for me to ignore.

What followed was an emergency room, then a psychiatric hospital, then to an intensive outpatient programs, an inpatient residential facility, and another hospitalization. At each step, I felt less like a kid asking for help and more like a problem being managed. Shouts surrounding me in the Uh, being told that I'm not safe enough to be alone.

learning that my life experience could be reduced to a treatment plan, a literal list of tasks I had to complete in order to exit a given center. It was horrifying, traumatizing, and deeply dehumanizing. All of that pain, fear, thousands of dollars, and hundreds of clinician hours could have been reduced if I had

Had access to support sooner if there had been a place in my community where I could simply walk in and talk to someone without navigating insurance, privacy law, referrals or long wait lists, all things that 12 year old me had to do in order for my parents to not figure out about my condition.

That's exactly why Alcove matters. Alcove represents something rare in mental health care prevention. It recognizes that young people don't suddenly wake up in crisis. Struggles build slowly in classrooms, at home, in silence and towering piles of homework, while expectations continue to grow heavier. A space where youth can. Walk in, find community, or speak to someone early can prevent emergencies before they happen. Investing in Alcove means choosing an early intervention over emergency response and community care over institutional care. It's trusting people. It's trusting young people when we say what we need.

I sit here because I believe we can build something better, a future where mental health care is approachable, local and humane, and where no young person's first interaction with support begins in fear. Thank you for your time.

Good morning. My name is Sophia Facchini. I am a senior at Mira Costa High School as well and I am also one of the co-chairs of the Alcove Youth Advisory Group. I

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started coming to Alcove as a volunteer. I was only 15 years old and I had a dream of getting a loved one mental health support that they needed.

Little did I know, I was beginning to create my second home, one that would help me grow into the woman I am today. The center is a truly special community. I've visited mental hospitals and residential centers, and the difference is night and day, not just in the quality and quantity of care, but in the community, whether it be interacting with clients, volunteers or staff. Alcove is the.

Place it is because the young people aren't just receiving the care, they're also a part of giving it. I may have started as a volunteer, but if you ask around, I practically live there now. Myself, I myself have utilized the services at Alco specifically for mental health and education and employment.

They were services that helped me better myself so that I could turn around and provide that same sense of safety and belonging to other teens who walk through our doors. I've gotten to meet so many amazing people as part of the Youth Advisory Group. The staff and the other group members play an enormous part in helping make youth feel safe.

But the most important people are the clients I've met as a trained buds, mentor, volunteer and peer intern at the front desk. I've had the pleasure of interacting with both newcomers and regulars. I've also some may open up right away, but others may also just never say a word. And it's my job to make sure that no matter what, I'm always there to smile.

Mile and be there for them and make them feel comfortable because I know what it's like to struggle invisibly. Memories of chatting by the pantry, giving tours of the facility, or playing board games in the Cove have helped me feel connected to each individual I come across. Those are moments that make those who need our resources come back.

A sense of community is what makes Alcove a one-of-a-kind place, and it is one I'm honored to be a part of and one I'm glad I can share a part of with you today.

Continuing to fund us means continuing to build support and empower young people across our county to lift up other youth. I look forward to seeing Alcove centers all around our community and working alongside them to guarantee that. My second home becomes that for so many others. Thank you.

Good afternoon. I'm Jaclyn Sun. I'm with Beach City's Health District. Thanks so much for the opportunity for our youth advisors to come and address you on this issue. Just some brief comments. While Alcove Beach Cities is in Supervisor Mitchell's

district, we serve young people across the South Bay and Service Planning Area 8 with about 26% of our clients coming from Supervisor.

District and what we're seeing is clear. Young people need support and they can't or don't want to access care through these traditional systems. That's why All Cove is designed as a no wrong door approach, meeting young people where they are without stigma and connecting them to early care.

And our work is truly grounded in partnership. Since we opened, we've engaged the region through more than 1800 touch points through Service Planning Area 8 and we work hand in hand really closely with our 13 partner school districts in the South Bay, not to not to supplant, but to supplement.

The mental health services that are being offered in school because we both understand that we're vital partners in this continuum of care. And just as important, we focus on priority populations. We are constantly hearing from young people, especially those experiencing homelessness, family instability or system involvement, that they may not feel comfortable seeking help in traditional settings. Alcove.

Provides a trusted low barrier space where young people are more willing to walk through the door. And we've developed a restorative justice diversion program to allow young people encountering juvenile justice system for the first time to get the early intervention support that they need. Instead of suspensions, young people are received supportive.

Services for mental health or substance use. They build leadership skills through volunteering and community projects. We've seen more than 200 young people go through our diversion program, helping them stay connected to the school, connected to their community, building these coping skills and avoiding deeper system involvement.

And so that's what it looks like to strengthen the system across the county by filling these gaps, partnering across these sectors and reaching young people who are often most missed. This motion is a critical step. I appreciate your support. It's a critical step in sustaining and expanding that approach across the county. And thanks for your leadership and your commitment to youth health.

Thanks.

Good afternoon, everyone. My name is Trevor Hall. I'm a junior at Mira Cosa High School and a youth leader on the Youth Advisor Group at Alco Beach Cities. Now, to all the parents in the room, I'm sure you know that teenagers don't always listen. So if they don't really listen to you, should we really expect them to listen to other

adults?

My brother was just that sort of rebellious kid. I admired him to my very core, but he, however, went down a different path. He wasn't the sort to respond to rehab centers or clinics led by groups of adults who didn't really understand him. It was on this path that his best friend was lost to overdose, remaining a forever 14 year old boy. His family never fully recovered, and my brother was never really the same again. What I've learned from this is that addiction rarely starts with addiction. It begins with untreated mental health conditions. We cannot wait until a child is wheeled away under a white cloth to act. It also taught me that most of those people that really need help won't just recover because an adult.

Tells them to That's why we need places like Alcove. It creates a community of youth to help guide the rest of their peers. By elevating youth voices and leadership, Alcove facilitates understanding and growth. Just in last month, for instance, Alcove has allowed me to plan and help lead at our annual South Bay Leadership and Wellness Conference, educating nearly 100 participants in our community on mental health and leadership.

Serve as a mentor for the youth created Youth Led Buds program where youth advisory group members mentor kids in our community ages 12 to 17, guiding them through their mental distress while also preparing to continue leading naloxone and overdose prevention trainings throughout our community. Now I share all this not for sympathy or to boost my ego.

I share it to give perspective. Prevention is measurable. Early support works.

Continuing funding for Alcove isn't just helping respond to crisis, it's reducing the likelihood altogether. I know what it looks like when support comes too late. I don't want to see it again. I would like to end my message by extending my gratitude for to everyone for offering their time and consideration.

Thank you.

Good afternoon. My name is Isabel Borock and I volunteered with Alcove Beach Cities for the past four years, and I'm currently serving on my second year as an Alcove Youth Advisory Group member. I'm here to share how Alcove Centers are not only spaces for mental health support, but also spaces where young people can grow into advocates and leaders and why continued funding.

Funding for these centers is so important. Through my involvement, I've helped connect thousands of students across the beach cities with mental health and Wellness resources. As a youth advisor, I've worked with other youth to help shape

programming and provide input on Wellness Center design and services.

I've also had opportunities to represent the youth perspective at major conferences and collaborate with peers across California through statewide leadership initiatives and more. These experiences show how Alcove gives young people real responsibility, leadership skills, and a voice in the in the decisions that affect our well-being.

Alcove empowers youth to take on an active role in improving our communities. Through youth advisory groups, students guide programming decisions and lead outreach efforts. Recently, youth leaders from across the South Bay participated in a youth-led youth advocacy conference in partnership with Ted Lew's Youth Advisory Group.

Young people there learned about policy making, practiced advocacy skills and discussed solutions to to the issues impacting our generation. These opportunities exist because Alco Centers provide the foundation, mentorship and resources to make youth leadership possible.

Investing in the continued operation of existing alcove centers means investing in prevention, early support, and youth leadership development. Sustained funding ensures that these spaces remain accessible, programs remain consistent, and young people from across Los Angeles County can continue to receive the the support they rely on.

I respectfully urge you to prioritize funding to sustain existing Alco centers so they can continue strengthening youth well-being and developing the next generation of community leaders. Thank you for your time and consideration.

Good afternoon. My name is Cindy Carcamo and I serve as a Youth Engagement Coordinator at Alcove Beach Cities. I'm here in strong support of this motion to sustain existing alcove centers and explore expanding the model across the county. I have had the honor of supporting the young people who walk through our doors, especially our youth advisors, some of them who are.

Today.

To just share their voices at Alcoa Beach Cities, we provide a safe, welcoming space where young people can access a variety of different services at no cost. But beyond services, we offer something just as critical belonging. Youth help shape our space and our programming. They are not just participants, they are our partners. I often think about how different.

My own upbringing might have been if a place like Alcove had existed while I was

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growing up. Many of the youth we serve are navigating anxiety, depression, stress, family stress, academic stress, and just different systemic barriers. Early access to caring, youth centered environment truly changes lives. Sustaining these centers ensures continuity and stability.

For the young people who really rely on them, expanding this model thoughtfully will help reach communities with the greatest need. And so I respectfully urge you to support this motion, continue and continue investing in the well-being of our future youth. Thank you for your time.

Good afternoon and thank you for the opportunity to speak. My name is John Hooper and I'm a peer specialist at All Cove Beach Cities. We've heard from any youth advisors today and a few years ago I was a youth advisor as well. I was part of the very first youth advisory group cohort when All Cove Beach Cities was just an idea and before the doors ever opened.

Before I ever worked at all COVID cities, I was a young person in crisis myself. I struggled with addiction, I struggled with grief, and I struggled with with identity and purpose. I know what it feels like to look like everything is fine on the outside, while internally you're falling apart, and I know how terrifying it is.

To not know where to go for help today, not only do I have 5 1/2 years of sobriety, but I've used my journey, my story and my experiences and turned it into a career of helping others. At All Code Beach Cities, one of my main job duties is meeting one-on-one with young people. Every week I'm sitting across and working with individuals who are carrying that same weight I once did.

What makes my role as a peer specialist unique is I don't just support them with training, I support them with lived experience. When a young person tells me they feel ashamed, stuck, or hopeless, I don't just empathize. I understand. And when they ask, sometimes without words, does this get better? I can look them in the eye and say yes, it can. I'm pretty.

That moment of connection changes everything. I've seen young people come into Alcove, guarded, anxious, barely making eye contact, and weeks later begin to open up and advocate for themselves, reconnect with family, return to school, choose sobriety, or simply believe that their life has value. Those shifts may sound small in a. Ort but they are life changing in real time.

Allcove is often the 1st place a young person feels safe enough to tell the truth about what they're going through. It's a it's a space without stigma, without cost barriers, without labels, to support community and belonging. I often think about

how different my own path might have been if a place like this had existed when I was younger.

But what matters more to me is that it exists now for the young people walking through our doors today. We're not just providing services, we're interpreting, interrupting cycles, we are restoring hope and we're changing trajectories. And it's all already happening at Alcove.

I am deeply honored to be part of this work. I believe it's one of the biggest blessings of my life is knowing I've impacted others in such a positive way. I've seen the change. I am the change. Thank you for your time and consideration.

And if there's folks online. Wanted to thank the speakers for taking time out of your days and for your courage in coming. I really appreciate it. And to my colleagues, I can't say enough about how available Stanford has been as a thought advisor on this and on the model and what it means and how to set it up. So if you want any contacts, I'm happy to share them with you.

So thank you.

Thank you. We'll move on to item 2A. This is the SD3 motion on reforming and integrating mental health care within the county's homeless services system, and I'll hand it over to SD3.

Speak up.

Yes.

All right. Well, first and foremost, I want to start by thanking DMH for the partnership on this motion. It was a long time in the making, so we're excited that we're at this point. So I know I don't need to remind my colleagues and everyone present that we definitely have a homeless crisis on our hands.

So this is really an attempt to to try to to tackle that. We know that the corresponding field mental health response system has not really kept track or kept up with the level of need and a lot of that is due to limited funding, restrictive funding and then also workforce shortages.

So we need to really get creative and start thinking about how to best leverage services and dollars to be able to provide these services to our individuals in our streets. With the new Department of Homelessness, there's definitely an opportunity to do that. Now we know historically the housing system and the service system have not.

Not always been connected, so we really need to figure out how to make that happen. Now the other thing is we know that with FSP programs, over 50% of

enrollees are currently experiencing homelessness and immediate need of prevention. Additionally, we we know that existing FSP slots, um we need to, we have existing FSP slots and we need to increase capacity as we transition to BHSA.

Currently, DMH has about 10,

400 adult FSP slots and 3000 or so of those slots are currently vacant, and that's in large part due to workforce shortages. So this is there's a lot in this motion. I'm not going to read all of the directives verbatim, but I do want to summarize some of them so you'll.

Have context and understanding of what the motion does. The first two directives direct EM agent consultation with CEO and the new homeless department to one designated team of staff to work with homeless service that the new homeless department to ensure SMI people experiencing homelessness get the appropriate services they need.

for and qualify for. The team will have experience working with the homeless population. They will work with homeless service agencies to address problems, perform case review meetings, implement changes as roadblocks arise, and the team will report to the DMHS Deputy Director of Community Engagement.

Active here is to establish a dotted line report from the DMH DMH's Deputy Director of Community Engagement to the Director of DMH and will be responsible for facilitating collaboration with the homeless department and find solutions to systemic barriers.

They will also work closely with providers, local jurisdictions to improve data sharing, to sign programs and improve access to housing and behavioral health services.

Further, there are a set of directives towards DMH. I'll quickly go through these.

One, ensure the homeless department has referral pathways to DMH services. This includes ECRC to work with the homeless department to continue identifying care and treatment gaps for people experiencing homelessness with SMI, including maximizing CalAIM, ECM and community supports funding.

3 Invite the Homeless Department to educate stakeholders on regional homeless alignment, including the Behavioral Health Commission and other programs.

Similarly, the Homeless Department will ensure DMH stakeholders are informed about Measure 8 goals and standards of care.

4 Collaborate with the Homeless Department leadership to inform advocacy on

BHSA and other state and federal funding and policy to support people experiencing homelessness. 5 In partnership with the Homeless Department, engage with local

managed care plans. This is to clearly outline responsibilities for people experiencing homelessness.

Six continue to identify opportunities to better better leverage funding internally and collaboration with the homeless department and other county departments. And this as an example, more training on better coding and billing. 7 provide additional training to all DMH directly operated and contracted staff on how to engage.

Engage and work with people experiencing homelessness and again with the focus on enrollment and billing. 8 DMH public facing staff be appropriately trained to effectively refer to the full continuum of DMH and homeless department services.

With the homeless department and homeless service providers explore how to train staff and multidisciplinary teams to better connect people experiencing homelessness to services across DMH managed care plans and the homeless department 10 with County Council revise protocols to streamline the sharing of client.

Information across departmental teams and also train DMH staff, contractor providers and stakeholders on HIPAA. We ultimately need to ensure that we're all aligned. We've heard for many years the how we define HIPAA has a lot of flexibility, so we need to make sure that we're using it in the most appropriate ways.

Across our system of care #11 develop a system to monitor FSP and HSSP providers to ensure contract compliance. This includes field-based delivery of services.

Compliance should include producing site visits, file reviews, and ongoing performance management and provide technical assistance to providers as needed.

Needed 12 Support the Homeless Department to become a DMHFSP provider. 13

Explore opportunities for field medicine providers to become FSP providers. 14

Continue to expand the IHOP and continue to monitor. 15 Continue to analyze and improve contracting processes and compliance.

Ins.

Policies Meet with providers to provide guidance, incentives and consequences to improve service delivery. 16 DMH executive staff to participate in a ride along with home or other DMH field based teams. 17 Provide all necessary data on referral services and outcomes that are necessary for.

The ongoing Measure 8 process to the homeless department 18 report to the board in 90 days and biannually thereafter on the status of implementing all of the above.

And lastly, I do want to point out we have received amazing feedback and we do plan on adding.

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One directive regarding, I'm sorry, moving the directive regarding data sharing that was initially assigned to the position that's being reported to the director of DMH. That's going to be its standalone just because it is a massive undertaking and should and requires other key partners. So that will be its own standalone directive.

And the second is we also want to add a directive regarding support for FSP contracted providers to receive additional support as it relates to hiring staff and I will open it up to questions.

I was wondering specifically about the like the current ride alongs with the home team. Is that something that DMH currently engages in? Is that part of also their their training or ongoing training to kind of have that?

You know, direct service experience for so that we should continue. Yeah, yeah, that's just. Is that OK? Yes. Did we? Yeah, we should pass this along. There we go. You know, how about.

Hi everyone. I think you all know me. I'm Kyla. I have been on the executive team at DMH now for five weeks. And so five weeks, been a busy five weeks. And to answer your question, we all have done ride alongs. And actually I'm very happy to say that it was my second week with DMH that I did the home ride along. The next week I did an IHOP ride along.

Veterans Military and Family Services, FSP ride along in a couple weeks. I'm going to Hollywood 2.0. So we take it very seriously. It was literally as soon as it was announced that I was taking this position. I got an e-mail right away saying, hey, no, you haven't started yet, but I want to set up these ride alongs. So all executive staff at DMH have already been on home ride along.

And we take that very seriously. And so does that answer your question? So it's an ongoing expectation as well. Absolutely. Yeah, I'm the newest executive member. And like I said, before I even started, it was an expectation that was put out there very publicly to me.

Is it OK if I ask another question as well in terms of the FSP for street medicine providers or is that currently something that they are not eligible for and how does that directive, I believe it's directive 13.

On the same field medicine providers, what would are there state mandated requirements or is there flexibility on onboarding St. medicine providers to become that rescue?

So my understanding is that right now field medicine providers are not this was referring to contracted field medicine providers, right? And they are not FSP

providers. And so we have been exploring this with them already and we are in the process of talking to them.

To figure out if they can become new FSP providers under the new transition to BHSN.

They can hear you all. Oh, wow. So we either need to eject or move this around. Yeah.

This is Josie from SD5. My question is, do you have any performance metrics that you expect to be included in the report back? How can we evaluate the direct different directives?

Yeah, that's an excellent question. That's definitely something we can consider to formalize a little bit more. We do anticipate that via the report back 90 days and by annually thereafter, we expect to see improvements as those reports come through. But we can explore actual performance metrics more applicable. While I have the mic, I have another question as well. I think it's directive 2 that talks about presumptive eligibility.

I'm not sure who to direct this question to, but I was wondering if there could be elaboration on what that term means and what criteria is involved under presumptive eligibility. I'm Amy Tipson for C3 on housing and homelessness.

So this motion, I'd love to hear more from y'all because it it was in some of the feedback sessions that we did with the different SDS that this this topic came up. The reason we put it here is partially because we heard at the Emergency Centralized Response Center that DMH so at the ECR.

RC, you'll hear from outreach workers who are engaging with someone who may be presenting or even saying I'm enrolled with DMH, I have no problem. And So what happened historically is you're you sort of fill out an application or like a referral. To see if you could potentially be eligible for a DMH bed. And let's say this is the person standing there saying I want to bed tonight, I'll take anything. And maybe this outreach worker thinks, oh, I've not ever heard you say yes, so I want to be able to find you a bed today. What's happened at the ECRC a couple of times is there'll be no other beds necessarily available.

But maybe a clinician is saying no, I I think this person has mental illness or I've written a diagnosis or and DMH is looking at IBIS and they haven't been able to find it. We have heard on a couple of occasions that they have allowed that person to access what may be the only available interim housing bed in a portfolio and it could be a DMH fund or the IHP bed.

And so that's how we're using the term presumptive eligibility because they are presuming that they will be eligible. They will do more assessments maybe the next day, connect with the clinician, figure things out. Maybe there's even a hiccup in the Ibis system where the person say no, I go to DMH and at that moment in the field, they can't identify that. And DMH has been incredibly flexible to say, let's put you in an IHP.

We know how important it is for you to get inside when you're saying yes. So we've used the term presumptive eligibility. We understand that they have implications with medical. So if we need to change that wording, we definitely can. Yeah, thank you, Amy. That's actually very helpful of an explanation because we were confused about what that term meant because my understanding is that presumptive eligibility isn't.

Official term in Medi-cal, right. But when someone shows up to an Uh, there's the you need presumptive eligibility assumed that they are going to have Medicare or sorry, Medi-cal and you can treat them in the Uh, right. Which is not what we're referring to here. So that was a very helpful idea. So we can check if we wanna, we could maybe change that work on clarifying what it is. Yeah, we know what you're referring to. Yeah, we don't.

Because it is a medical term of heart, right. It has an official legal definition. OK, so that's helpful. So we can work on it. So you'll see that amended before it comes for the. OK, great. Thank you for that. And I do want to just address, I think also I talked to our team and they said that they've been working very closely on it.

I have come and quickly assess people right away so that they can then go into the community bed. So that and that I think is a new development. Yeah. So we'll definitely work back. OK, great. That's good. Thank you. My other question is I was wondering if there you anticipate there being a fiscal impact.

for many of the direction directives of the motion.

Oh.

We.

Week 5, I mean and then there's always a potential fiscal impact, right. And I think that's what we would report back on out of you know right now what I might think is the one about expanding, actually expanding IHOP, right. Anytime you talk about the expansion of an existing program could have a fiscal impact and I think there were quite a few, I think there were.

Number of directives that said, you know, work with CEO to see if additional staff are

needed. So there's one about data collection or sharing data and did mention like potential additional staff. So I think for those we would have to look to see if there's a fiscal impact. Mm-hmm. Those are the ones I'm thinking of right now from.

I read this. Yeah, that's that's right. Where there potentially can be, it says if funding is available and if it's staff, it says when you see you as funding available. So it's not not a whole lot of them and I'm sure we'll see that. OK. And what's interesting on that too is I think if you can expand FSP.

I think you create more capacity within IHOP, so hopefully there'd be an offset in that cost because IHOP sometimes has to keep people longer because they can't transition them to an FSP. So they can be transitioned, then they can open up more space within the IHOP existing.

Thank you, because I have just for the record.

**JB** **Jaclyn Baucum** 45:06

Great. Sorry to interrupt. May I? This is Jacqueline. I just want to add something else and I'm sorry, I can't see you or hear you very well. So hopefully you can hear me. So also for fiscal impact, anytime we expand services, the department experience experiences A fiscal impact. That doesn't mean.

**AS** **Atineh Sepanian** 45:18

Yeah.

**JB** **Jaclyn Baucum** 45:26

That we can't pay for it, it doesn't mean it's going to be a county cost, but expansion of any services will have a local match requirement. So that's still a fiscal impact, just to clarify.

**AS** **Atineh Sepanian** 45:36

Thanks, Jacqueline.

**JB** **Jaclyn Baucum** 45:39

Sure.

**AS** **Atineh Sepanian** 45:42

Go ahead. Yeah. Thank you. Sorry. Oh, crossing the mic. OK. Read them. Yeah. OK,

you're good. OK, great. Thank you. Just a couple questions. I was happy to hear that you're moving the data sharing to a separate directive.

I was wondering if there are or maybe Kyla, you can speak to any data sharing challenges currently between DMH and HSH that would potentially require state and federal advocacy. I'm just wondering like what we can envision might be helpful to improve data sharing between the departments.

Oh, sorry. No, it's OK. Or I don't know if I have the computer. I don't know. Maybe HSH could talk about what's if you want to. Yeah, I do know that IHOP is the 1st and it's an innovative program that's between a partnership between DMH.

HSH and SAPC and it's the first one that has a shared system where everyone inputs into the same system and it's called. I have it written down in my notes in there, but you probably know Care Manager, right? And it's been very successful and my understanding is that's the first of its kind. And so that's an example of like a shared platform that everyone's using in the IHOP.

Program. Hi everyone. Lidhi Shamkara.

We'll throw our Chief Medical Officer up. Should we bring out the chair?

Hi, I'm Lidhi Shamkhata. I'm the interim Chief Program Officer at HSH. I'm Heidi Bepruz. I'm the Chief Medical Officer at HSH. So in terms of we're talking about case conferencing, we do need a shared platform and that would help us really be able to make sure that we are all able to talk to each other. Right now we already do a lot of work together.

Through DMH and through HSH. Now we have shared clients. We do a lot of integrated services with the HSSP program. Also anytime we can leverage FSP, but we do not have a shared platform. The one place we do is with IHOP and is what Doctor Heidi has been able to launch for us.

We we need it. We need to be able to get into data systems to be able to see what kind of services people are accessing and also what types of housing they're going to need in the future, something that has been sorely lacking for all of us. And we're, you know, and then you start talking about the contracted providers.

We'll then have to enter into four and five different data systems. And so there will always be sort of this, you know, our our director calls it tech debt, right. We don't have the tech that we need to be able to appropriately service and to be able to assess and to do those case conferencing things that we need to do for people to stay stable in their housing.

And then talking to Lanes, yeah. So we're working at HSH with our own contract with

Lanes, which is a health information exchange system that probably is the most robust in the county right now.

And one of the things we've explored with DMH is how could we use Lane's data to help with case finding. So both in terms of potential identification of clients who are. Demonstrating certain type of high risk diagnosis or utilization patterns or risk events with medications to help sort of make sure that we're going to the right person at the right time. We also can use lanes for.

What we call ADT for admission, discharge, transfer opportunities. So if we're following a certain cohort collectively, we can run a profile and say who's in the hospital? Do we need to go and see and try to stabilize to help with the discharge to make sure that that's OK?

Lanes has also assured us that they can run data reports for us so that if we wanted to track certain type of outcomes over time, we could again feeding like a collective cohort. So there's a lot of use case for lanes. I think we're also exploring right now between DMA.

And the new HSH Data Science Department about data use agreements where we could access data in Infohub that typically is de identified, but is there also a way to access those data to get as much as we can with 42 CFR rules and those kinds of things information on?

Whether or not we're having impact that we want to have. So there's a lot of collaboration in this space. I'm really excited about it. For the first time we're having the right conversations and I think we can really move things forward. Can I just add a little more too? I think just it's so important to know and part of the reason behind this motion, so you have the homeless service system, many of whom are not.

Medi-cal providers. These are not DMH providers, which I think sometimes they are. We have some very large homeless service agencies who are FSP providers, for example, but we have our really, really large ones. So I'm sure many of you are familiar. Ellie Family Housing path topics. They're not Medi-cal providers. So they have their, they have their beds. They may have hundreds and hundreds of beds. Of course they do PSH as well, but and they have a lot of people with serious mental illness that they wouldn't necessarily even know how to connect and they're they're trying to figure all of that out. But I think it's just important to note, so I'm a homeless, I'm an outreach person and I meet a person, I have access to HMIS. I don't know anything else about this person. They could be fully enrolled in FSP.

They could be in the process of conservatorship. I mean, there could be a million

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things. I have no idea that. And I'm trying to and I'm held accountable to metrics to help this person. Plus I want to help this person. So I think it's important so that the systems don't talk yet. So we have, I mean you're you work in homelessness.

You have funded beds, you're in champ. I'm a medical, you know, maybe I'm in Ibis or I don't know is Orchid. I hear about Orchid. I don't actually know what Orchid does, but so there's another. And then of course we have Info Hub, which at this point is pretty much de-identified data. So it's not actually helping the person on the ground who's trying to help an individual in front of them.

So, and I think a lot of this also and why we want to also tweak this language on data is it's going to be attorneys. So attorneys stand in the way of the execution of MO use that allow these data systems to talk to one another, that allow the individual to talk to. Well, I'll have our experience and I have been working for a very long time with this.

Just let me give you one last example. We have an outreach, we have an access center that is funded for in Spa 5 funded by the homeless service system. And in a room there sits 2 individuals, one is a homeless case manager and one works on CVEST. So they connect.

People, the services, their computers, their desks essentially touch. This person can see all kinds of enrollments because they are funded by DPSS. So let's even say they can get the benefits documentation that's needed for this client to move into interim to permanent housing.

The person sitting next to them is not allowed to say, can you print that out for me because the state won't allow them access to that information. So this is the kind of challenge that we're facing. It is so big, it is so impactful on the work that we do and I would venture to say if we could only execute more data exchange.

Um, we could change nothing else about the system, and we would see a reduction in house.

Super important.

You want the mic back? Oh, wait, I'm sorry. But that's the other great thing the board did, though, which is at the Emergency Centralized Response Center. All of these data systems are in the room. So DMH can say, oh wait, oh, Tom says he's with DMH. He went to bed. Hold on.

Oh yeah, Tom's in. Let's get Tom a bed. I have a bed in spa seven. Take them there right now. So it is like a manual workaround to this lack of ability to share. So that's been incredibly successful and DMHS participation at the ECRC and integration in the

homeless service system there.

It's it's a game changer. CIO is ultimately responsible because it can't be live by DMH because it's clearly it's complicated. I'm sorry. The direct one that I'm looking at it would be CIO, OK, everyone has clarification.

And then Chloe, did you? Yeah, just one more question. OK, so the first set of directives, thank you. No, yes, the first set of directives to E just.

Improving and expediting access to housing is is this. I don't know if DMH wants to respond, but housing I believe is a different is in a different shop than the countywide engagement division. Is that correct Kyla that this like does that does it make sense to have that fall under?

Yeah, sorry. Yeah, sorry. I thought you were done. No, it's OK. I'm sorry. No, it's OK. I think. I think Kyla knows what I'm asking. I I I just wanted to make sure that this fits under the deputy director of countywide engagement division and if not, if there's maybe a need to amend that directive.

OK.

Thank you. Yeah. So in DMH, right, we have our org chart and so the I'm the Senior Deputy Director of reentry and so under the reentry division is countywide engagement and then the housing division and so the housing division is.

Maria Funk, who I know you all know countywide engagement is Latina and so the interim housing and permanent supportive housing is run by the housing division. So, yeah, just wanted to so, so one of the reasons that we need the Deputy Director of Countywide invitation to report to Doctor Wang is because we need a person to be able to look at everything.

And be able to solve for issues as they develop again data like this, they can have a bright-eyed view at like all the different services because homeless touches CMH across the system, it's not just within that shop. So we need somebody to be able to kind of manage that and then also work with directly with the homeless department to navigate.

A lot of these issues, so that's why that's part of their the directive.

Yeah, I don't know. I don't know. I'm curious cause that actually comes here. No, I mean it just it feels like because we're including some directives that involve Maria and Kyla's over both of them and it seems like the started line is kind of skipping over Kyla, not including Maria.

I'm just wanting to make sure that there's communication for all of the correct people who are over these various systems. So I I don't know if if you have, yeah, it

obviously makes sense that the director of DMH should be involved in these conversations, but I just want to make sure the the right people under them are involved so.

Just something to think about. I don't know if Kayla, if you have anything to say to that or or Anhelika, if you have anything further, but no, I think that's very valid. And yes, that's OK that there's definitely needs to be communication across. Yeah, yeah, it's a big task. You're not over MSP.

No, but neither is Latina. Correct. Correct. Why the dotted line? Because the integration of privacy, what is what is some disparate components within DMH are all critical to the homeless service response.

This is This is why the dotted line because there can be all kinds of planning for FSP. It needs to be integrated with the work that Latina does, particularly as the subject matter expert that she is on homelessness, particularly unsheltered homelessness. And so that's why the dotted line and that and that was well workshopped with DMH as the idea of.

Kind of instead of saying we want a new staff person that's high level that can integrate all these different disparate components to better integrate to have a response to homelessness, the the work around was this dotted line. So is the idea that Lisa Wong will be community like you mentioned FSP and you mentioned housing.

So it's the idea that Latina will be able to communicate what's under her shop to Doctor Wong. Doctor Wong will be able to communicate around the LSP. That's exactly because we can't expect Latina, like you said, or Kyla to go and give direction to another piece of the department.

That maybe as as they're trying to, as maybe Latina and and Kyla, like maybe they're thinking about things specific to homelessness because many of their programs are, well, two of their programs are dedicated to homelessness, but their programs are greatly utilized by people who are homeless. So as they're trying to create this system.

To more intentionally integrate with HSH, they can't do their, they don't. They can't direct FSP to do a certain thing. So that's hence the involvement of the director.

And Amy, just, I hope, and I know I'm super new, so I think you need first after this. I wasn't even here. So I don't think your intention is to take me out of the process. No, heck no. And we're still here. I didn't take offense from this, but I want to make sure I don't need to, right. So like, I don't think you're saying you need to take me out of.

We're so happy you're here, Kyla and.

I'm very committed to this work and I've already been working really closely with Latina and Maria and Jacqueline and honestly everyone. So that should, if it needs to be said, should 1000% be said, could not be happier that it is you in that role and have incredible confidence in what we will see moving forward as a result. Thank you so much. A lot of pressure.

Yes, I know you are.

Coordinate all of this right while also ensuring that like Latina has like adequate like lines of communication with Doctor Wong. Like I'm just still like like I'm trying to understand like sort of like how the way this directive is written will achieve what you just described and I'm wondering if there's like a more.

Effective way of doing it because it still seems like it would be complicated given that FSP is not, you know, like I I just don't know how this addresses the challenge that you just described. I agree we would potentially have a different idea for it. This is where we got the DMH, but 1000% can go back to DMH if they want to see it.

Definitely. We also very, very strongly believe that homelessness requires a subject matter expertise that not everyone who works in DMH will have, that not administrative people in any entity will have.

So that is, that is some of the thinking behind where this is 1000%. If we feel like it may not achieve that goal, Kyla is now here, which happened after the writing of this motion. We can revisit it. We wrote this with DMH and we want them to feel comfortable. That's right. So we could say, yeah, but we can also make some changes. This is the point of cluster.

We've already made changes based on other offices. We want this to be workable for everyone. So if that is the feedback and Kyla, you have some thoughts, let's change it.

100%.

Get the mic, please. Get the mic. Thank you. Fantastic.

Like I, you know, a lot of like the times what we hear from like cities and like constituents is like really just concerned with people that are on the streets like going through crisis. So I'm wondering how will HSH becoming an FSP provider address that?

OK.

You know, as you know, we're, we're I think maybe about 60 days old and so we're just trying to get our infrastructure together, trying to get everything set up. And so

one of the things we are considering is how to become an FSP provider. We know that there will.

Be some of the same challenges that DMH has, even, you know, having FSP providers. We know there's workforce challenges. We know that a lot of these positions don't get filled, but that's not to say we wouldn't head down that road. We have quite a few other things we want to put in place before we start thinking about that. We're still trying to launch our enhanced care management.

Trying to get our infrastructure together. So I think we will be an added support, but again, there will still be challenges and I don't know that we'll be here just to fix everything. We'll be an added sort of resource to be able to bring on more providers and to be able to do the work in conjunction with DMH.

But you know, it is. It is a limiting factor just knowing that these jobs actually don't get filled very quickly.

Thank you.

And I feel like the one thing that the homeless department will bring is subject matter expertise. They they they know how to work with this population. They want to work with this population. So that's the critical piece here, subject matter expertise.

OK. And how, how long will it take to become an ESP provider?

What is DMA to support? Yeah, I think we have probably that maybe about two years. This year we're launching, we're gonna get our infrastructure together. Next year we'll start to be able to put those pieces together and understand what it even means to. I don't know. I'm assuming we'd have to get licenses and.

State and you know, I think we will want to work on all of that directly with them to understand what else, what we have to do so that we can bring it online fairly quickly. I mean, I think you know we would look at it this year anyway, but understanding exactly what we have to do would be.

I I just wanted to add that also in two years like things are going to evolve and and one of the things I'm thinking about and I've talked to Kyla about is that IHOP is proving to be a really phenomenal anchor for work in the unsheltered space.

So one of the things that we might think about is how do we tend roll out FSP through IHOP because in essence DMHS service in IHOP is like a field based FSP program. So you know it could be that we think about and and if we are able to get someone asked the question.

Field medicine becoming FSP providers, the landscape is going to change and it's

really about coordinating that evolution to make sure that it's meeting the needs that we seek. And so I think we're really excited to work with DMH and community based providers and field medicine providers to think about how we.

Create that patchwork quilt because I think to your point, like just adding other FSP teams isn't necessarily going to solve the problem that we have of somebody calling outside of, you know, a restaurant saying he's here, what do I do? We have to address all of the steps in the continuum.

Error. I think that's something we're really starting to understand better now.

Miss Cola, are you thinking about the expansion of IHOP for insurance for people?

Well, I think that's one of the things we're thinking about is could it be an anchor space? Because one of the issues that we we have often is oftentimes FSPS because of the way they're regulated or anchored in clinic.

How could we anchor FSPS in the shelter and in the community? And that's something we've been talking about with Kyla and Latina. So I think this is something that we would work on in our report back about what the vision might be and.

I think there are opportunities to think about how we can continue to learn and evolve because I think both home and IHOP and field based FSP create a continuum of care opportunity.

Take advantage of. I also think like we we do have regulatory challenges, right? Some of the stuff is really dictated by the state and no matter what we did and add services, sometimes hands are tied regardless. And so I think gives us an opportunity to really think about what as a county do we really need here locally and what state. Changes there might be in the next two to three years. We will hopefully also have federal changes hopefully in the right direction. And so I think these are all opportunities for us to really put in place right now as we work closely and learn. But yeah, I mean I think you know going field based is probably one of the things that we really.

Or if we want to see true change on the streets.

And then, you know, just kind of like thinking about how you know this may take two years. We like just discussed the the data piece, which is also challenging and there are a lot of like complex things like in the motion. So it's more of a question for like SD3, but I'm wondering how you.

What like define success right in relation to this emotion like what is success, what is the outcome right that you're hoping to achieve and what does that success look like? Well, so the way the continuum sort of works right now when you think about

how we're addressing people, particularly unsheltered people is you have you have multidisciplinary teams on the bottom. So those.

And like managed care plans responsible for low to moderate, you have the home teams at the top for people who you know are the the most vulnerable, the most seriously mentally ill. Many of them are regularly and voluntarily held, potentially on a conservatorship route. Incredibly successful program. There's the huge gap in the middle of people with serious mental illness who should be cared for.

When eligible by DMH. And so they're this this big band of people with serious mental illness. And So what you find a lot of times is these people are still here, whether they are under the care of.

DMH or not, they're in our shelters, they're on our streets, and they are being helped by homeless service providers, many of whom have no clinical experience, aren't paid to be clinicians, would very much appreciate support from the department for people that they have identified like.

We cannot keep these people, but we don't want to exit them, and the homeless service providers really don't exit them, but often cannot connect to DMH, don't have the access, or when they get connected, it's a team that requires a person maybe to go to a brick and mortar site.

And so we get calls regularly from, again, homeless service providers who are not connected or DMH providers saying we sure think, I mean, we live with these people, we sure think they're eligible. We cannot seem to get help from DMH. So this is really about expanding the FSP program to better connect with all.

The people who are there waiting to be helped, who are being elevated by our interim housing providers, by our outreach workers, saying can someone please help these people? So that's the goal is better mental health support for those who should be under the care of DNA.

And and given that like so much of the motion is focused like on FSP right and and supporting HSH becoming an FSP provider, is there a reason why there is no directive directing HSH to become an FS an FSP provider given that so much of the motion?

Centers on that, right?

Well, the the reason that the motion focuses primarily on DMH is that what DMH has said to us and and what other offices have said is we want DMH to be able to do this, this kind of care. We've heard from DMH our contracts require field based care. So the goal is at this time we do think it's going to take a long time for HSH.

They have to get their capacity even if they went at record speed. I think it's 12 months, right? Like that's from DMA from the like from the regular from the regulatory licensing standpoint, yes. And that doesn't take into account all we have to do. I don't want. So this is saying how can we get FSP now because if.

Is owned by DMH, not HSH, to give a more robust care to people who are homeless today, multiple, you know, many of whom are dying every day on our streets, seven people. So this is about, yes, HSH. If if HSH had FSP, now we would make this about HSH.

HSH doesn't have FSP, they'll get FSP. If you think there should be a motion directing them on a timeline to become a provider, we can talk about that. Certainly. No, I think it's more related to the directive, right, that it says it directs CNH to support HSH in becoming FSP provider. And to your point, like they're not at that stage yet. So like, I'm just wondering like.

Would it not make more sense to include HSH in that directive as well, just for accountability purposes, right? Because sure, we're asking DMH to do this work, but then there is no accountability. I'm not saying that HSH won't do it, but I'm just saying right, like there's accountability on one side but not on the other. So it would just.

Be better aligned if 1000%. Yeah, there was something that also right directed and I'm not saying it has to say direct HSH, you know, but like something that also includes accountability on HSH's part. Yeah, yes, we will look at that for sure. I think we can explore it and we are in earnest exploring.

I don't think we know exactly what we're gonna be faced with and you know with with any regulatory challenges or any licensure challenges. So I think just for HSH we would appreciate maybe you know talk about exploring it so that we can come back to you and let you know what we found because if there is a timeline and we've realized.

We just can't do this. Yeah. I mean, I just want to make sure that there's a flexible way to be able to have a, you know, a dialogue. Yeah, I know. And I understand we can do that maybe then for direct HSH to report back to, yeah, or like add like flexibility even to like the director write that.

Indicates like D and make sure it's like maybe HSH in partnership with DMU to explore opportunities for HSH to become an ethic free provider. Sure, just to make it a little bit more balanced. We're happy to be told to explore. No, we're we're we understand you're you're going through a lot. I'm not trying to, but it's just like, yeah.

It's just making sure we're accomplishing what you know it's intended. I had a couple more and so I wanted to follow up a little bit on questions that have already been asked.

One was there was reference to the mental health workforce labor shortage and I'm wondering because obviously we want this to be successful. We want people who have SMI's and who are willing to accept services, which is a big if.

Get the services, but I can I guess this is a DMH question, but if new housing department has a response to on how does the labor workforce shortage?

Into our county's ability to close this perceived gap between people who need or someone who needs services and getting services. Well, our biggest challenge is the field base nature of these services, which is exactly the point of this motion, right, is we need to bring those to the people where they are.

Or at, which we agree with. But hiring for those positions is very challenging. And I know this is something that in my old position I used to talk about in the alternative crisis response world all the time, right? It's the reason we can't get our response times quicker is because we can't hire for those teams. And so same for, you know, FSP, you read off the numbers.

Earlier about the vacancies, not the vacancies, the MD slots. Yeah, yes. And that's because of the vacant because we can't hire enough for FSP. So people want it, they have no choices and they want to go someplace else. It's two things. It's because supply and demand, right? We post COVID, we have a.

Small supply of mental health professionals and we have a huge demand for them.

And so people are given their opportunities and they're being paid more to sit in a clinic sometimes or to go to Kaiser and work in telehealth and we're asking for them to go in the field. And so that's why we implemented field based bonuses, which this board had something to do with.

A couple of years ago and we've implemented overnight bonuses and after hour shift differentials and the recruitment is amping up. But it is hard to recruit for those positions because there isn't enough supply and the competition is fierce right now. And it's not just an LA County problem, right? This is a statewide problem right now with mental health professionals.

And I think the reality too, just working in the field with the psychiatrists that are incredible, the MHSI who are in the field is takes a special person to do this work, right? It's not just, you know, someone is going to sign up for this because of the pay.

This is often extremely challenging work and so and I think that's one of the things psychiatrists will tell you is we need pipeline, we need to build that sense of.

Ownership and like the sense of like we are here as as custodians and stewards of care and how do you sort of build that population of providers. I think it's something that DMH is exploring and I think what's happening now is that the the psychiatrist. Who are able to do and willing to do this work because they're being stretched so thinly, their ability to respond to field crises is limited because they're wearing so many other hats. We hear that a lot from our homeless service providers.

Who do have mental health staff is just like I have to have this person also manage PSH and IAH and run a clinic and go out to see Johnny at Johnny's Pastrami and it's like.

Wow. Right. And so, so I think it's a, it's a huge issue and and and I think that's why we have to think about efficiencies and how do we create that field based efficiency is something that we're going to explore together and it does spill over into the homeless service sector, right. I mean we see the shortage of case managers and program.

Managers. And then when you don't have the support of the specialty mental health in, say, a permanent supportive housing building or an interim housing site, everybody's then sort of, you know, at their wits and burned out. So you know, there are some workforce development things happening on the homeless services sector side. There are things I'm sure that you know that are going to happen on.

Workforce side for mental health professionals. But again, like Kyla said, this isn't even just a county issue. This is state. It's a national issue. We just don't have the workforce right now. I do think there's opportunities as well. I would say the third thing in talking to psychiatrist is that.

The reason the work is so far is because it's a revolving door because of our issues. You know, we value the right self-determination. You can put a hold on someone who requires 5 to 6 people. You get them into a hospital and then three days later they're out.

And and that's not something that any number of psychiatrists are going to be fixed. And I think one of the reasons home team has been so successful is that they have developed incredibly strong working relationships with the hospitals to be like, dude, this person needs to stay and let me tell you how and I'm going to connect them to housing.

So that continuum again is really critical to make them effective so they don't burn

out in the field. And I think those are also trainings that DMH realizes they have to give to their service providers because otherwise the burnout is real and you can't. So that's another piece that we have to think about where I do think there's room to think about.

Regulatory changes and other things that we can do to help that flow. We're trying with Carecore and stuff, but it remains to be seen if it's going to solve the revolving door. I wanted to reference this challenge. I know the question on metrics, but before I get to that last question on metrics.

Um.

I always wonder about everything else. I mean, I wish we had an infinite amount of resources, but with the workforce shortage, I know DMH is also focusing on populations leaving the jail. And as we just heard, youth populations, there's people with moderate illnesses.

I'm and maybe it's just a reflection from whoever on DMH still on the line.

How any thoughts, concerns on how this focus on FSP may or may not impact other FSP efforts just given the overall shortage? And I know that's always that's always the challenge with the county, but I just wondered.

You have any comments on it in your five weeks? Yeah, I know, I I don't know if I see right. So it's Jacqueline. I think Jacqueline's on the line. Jacqueline, did you hear that question?

**JB** **Jaclyn Baucum** 1:18:57

It was a little choppy, but I think I got the gist of it. So Yolanda, correct me if I'm not answering it correctly. So I heard you ask about like competing priorities essentially and you know, how do we ensure that the the focus of this motion on FSP doesn't sort of bump something else out?

So if that's the right question, then I'll answer it. I just want to make sure I heard it.

OK. OK. So I think the good news is, is that as we explore, you know, FSP, the goal for DMH, you know, as it operates the health plan is to have FSP services available for anyone who's entitled to them, qualifies and needs them, right.

**AS** **Atineh Sepanian** 1:19:18

Yes, yes, yes, that's right.

**JB** **Jaclyn Baucum** 1:19:35

So nothing in here actually expands beyond the scope of what we're already planning to do to have an adequate network for all of our members and for uninsured. So I think where we have to focus on is the question that you're bringing up is really more directed towards the use of county directly operated staff. Relying more heavily on contracted network staff where they do their own recruitment, they can apply their own bonuses and they have their own mechanisms for recruiting staff. So I do think that we should be cautious of it sort of on that directly operated side so that we don't.

If we sort of gobble up the whole workforce within the county because we have stronger incentives for instance, then we could end up competing with our own provider network that ensures our network adequacy for from a managed care perspective. So it is something that we have to watch.

But just at face value of making sure there's quote enough FSP, that's already, that's already underway. You know, that's part of our network advocacy anyways.

**AS** **Atineh Sepanian** 1:20:37

Then I think my last question is and I and I want to like really applaud the goal of how do we, I mean, because when we think of homelessness in the county, we often think of people who are SMI's and it's the hardest thing, but also we know.

So then you put like 6 months of effort a year on the effort and Yolanda is still there and and and so the hard question on how do we know that it's working and that DMH is helping enough and.

And you sort of talking a little bit about it, about the subjectivity of people feeling like they're getting TMH to help. But I I'm, I'm wondering if the authors could think about what does that actually look like? Is it?

It may be with DMHS guidance and the housing present, what does that actually look like in terms of numbers with the knowledge that it's so hard and you may be doing everything you can and it's not bumping a number up and someone's still experiencing a lot of still in the street, you know. So anyway, I don't know if thoughts. Looking for an outcome though. So there's no we're not looking for a housing placement. We're literally just looking for at this point just enrollment. So, so increased. So that's an outcome with increased enrollment that would be of people who are experiencing homelessness into DMH programs, particularly FSP because the truth is when FSP is connected and you have.

I hired a worker who wants to be field based. It's incredible. It is an incredible

program. It helps. Help means you're in my interim housing. I don't want to kick you out, but you're screaming every night and you're there are five people in your room. If you have a good FSB worker that has that before, they'll come out the next day. They'll engage with you.

And it's it's a game changer. Then that person may leave and go to go back to the street. They're they're homeless in the shelter, obviously, but then they go back to unsheltered. You call the FSP worker. Hey, we can't find them. OK, I got it. That kind of partnership is the results are unbelievable and we just want to see more of that. I see. I see you nodding your head, and I don't know that Jacqueline's nodding her head, but it seems like that's that's a specific, concrete, measurable thing that you can track.

Sorry, OK. Can I come back? Yeah, absolutely on that. OK, I wrote it down though. I'm I'm.

JB

**Jaclyn Baucum** 1:23:02

So Yolanda is sorry, just a clarifying question so that Kyla and I can noodle on that and get back to you. Is the outcome that you identified related to increased enrollment? I think maybe it was Amy who said increased enrollment into DMH programs and then there was.

Specific conversation around having an engaged FSP provider. So I think we would need to train if if there's going to be accountability to a certain metric, we would need to absolutely work with SD3 to generate that metric just to make sure it doesn't conflict with what we're required to track by contract elsewhere.

I don't think it would, but yeah.

AS

**Atineh Sepanian** 1:23:35

Oh, great. OK. And I do know that right now we are working on across all DMH services and all supports tracking, right. That's been something that's been challenging 'cause it's like in each different part of DMH. And so I think that this could be trackable, measurable, but let us talk to our data.

OK.

I have one last one, but I'm wondering if you've given any thought to including DPH SAPC in the motion. Just, you know, this is intended to support, you know, the in-house and I think we're all in alignment, right? That is a need and just given the number of people with co-occurring, right, mental health, SUDS and.

**GT** Gary Tsai 1:24:13  
OK.

**AS** Atineh Sepanian 1:24:18

That they're also part of the HSA implementation. I think it would be great to see them in this motion as well. We had them. It just was the scope of it got so large and we also workshopped it for a very long time with D&H many, many, many phone calls and exchanges of versions. It looks very differently than it did, I think 6.

Months ago when we started this, so we just decided we couldn't. But I think that would be the next iteration. We would have loved to do both. That just wasn't an option since we don't have a behavioral health department next iteration in terms of like before the motion is finalized or no.

Yeah, it would have to be a separate motion. Yeah. They also don't have the level of funding. I mean things, it'll be a very different looking motion and there's also there's it will look differently, but yes, we would workshop that. I don't think it's really like, I don't think DPH has to have like their own directives, right. But like as we're like naming DMH, it could be, you know.

So DMH could still be like the first in many of these with, you know, DPH stop yet second, you know, like it doesn't have to be specific directives, right? And I understand you want to do something broader, but I think we intend to soon create better coordination.

I think it makes sense, but we can keep discussing. I mean, I think we would like that, but like you could make the same argument that we should, as we've heard from many people, this shouldn't just include FSP. There are a lot of other resources that are really important for people who are homeless. So I think part of the reason we started and got to this.

Scope was because it was already so complicated. So I don't, I mean, I don't, I don't want to say that we would amend the motion in that way because I think it would take a lot more time. Honestly, I don't think we could just say them as second because they do very different things.

Yeah, for instance, DPH does not have FSP. They have their own contracting, they have their own. So there it's it is very, very different and and believe us, we really attempted to include them because we wanted to focus on behavioral health, but they are just so different. So ultimately we decided let's move forward with this and.

Separately, we'll do something next on as it relates to DPH and yes, it all does need to be integrated. So maybe we could think about how we do that here. So we'll we'll take that back.

One last question, considering all this discussion about adjusting the metric and the performance of these directives, does DMH think that the I think it's 6090 days to report back is an appropriate time to get all this together? It's what we're gonna ask. Ask me. We would love more time. Um, we would appreciate 120 days.

We can take that back. We have, we have a.

Very. Yes, we'll take that back. And if you break stuff out into other, no, if there's some portions that are broken out into other directives, maybe it could be, oh, let's talk about that, right? Like if there's one that's just the data, like the data one that's alone, that's 90 days. But this is very OK, let's talk about that.

Any other questions?

Great. Any public comment on this item?

Great. Thank you all. We have Christopher. Please go ahead, Christopher.

**CU Christopher Ige UAPD** 1:27:46

Yes, Christopher, you get from the Union of American Physicians and Dentists who represent the psychiatrist. You know, we we do have some concerns about what's been talked about in the metrics and stuff. We would like to be part of the conversation on that part.

If there are going to be metrics that are that are going to be set on our members, especially with FSP and also the home teams, you know we do have, we're pretty good at with helping with recruitment on that part, but you know we want to.

We are concerned that a lot of decisions are being made and the providers are putting feedback into this. So you know, we hope to be part of the conversation.

Thank you.

**AS Atineh Sepanian** 1:28:32

Thank you. Do we have any other public comment on this item?

Great. Thank you all. We don't have any items that are continued from previous meetings or any emergency or urgency items. So we'll move on to item 6, public comment. Again, quick reminder that general public comment is limited to two minutes. Do we have any general public on today's agenda?

Oh, please go ahead.

**This document was generated by AI and is not an official meeting record. It may contain errors.**

Good afternoon, everyone. Joe Green, former co-chair of the LA Community Commission on HIV. Yesterday, several former commissioners spoke to the Board of Supervisors that the cohort was told to address why that happened, I think and again speaking as a former commissioner.

The Commission made a few missteps when we when we notified the commissioners that they weren't going to be seated, we notified them less than 12 hours before they were seated. When we went on the day of the Commission meeting, we went, when we went to present, I asked if the data regarding reflectivity was that was available.

And it was not. So yesterday when Jada went before the Board of Supervisors and said I don't see myself as an African American woman with a child represented, it's because she was never presented with the data, the fact that when you look at at at the unintended consequences.

Six of the 8 commissioners that were not chosen were members of the California Planning Group. Those individuals were intentionally chosen by the State of California to partner with the Los Angeles Commission. They're not there anymore. That's that. So that was not either intended or unintended. Those issues, along with the fact that in looking at the interview process, we had, we had people from all over the country participating in the interview process, unfortunately, and it wasn't until after the fact, it was brought to my attention.

That every single, almost every single person in the room in that selection committee was conflicted, either personally through their interactions with the people that were being interviewed or because they were contracted under DHSP. So those are the primary issues.

That are before you that the Commission's been disbanded. It's not there's. I asked Don if we could be reconstituted to address these issues. I don't think that's going to happen. She's checking with County Council, so it may be up to you all along with the.

Uh, the County Council and DHSP to figure out how to proceed from here. Thank you. There are concerns. Thank you very much for your time.

And then, Brandon, you said we had someone. Yeah, Beth Nishida. Beth, would you like to provide public comment?

Beth, you can unmute yourself.

Hi, Beth, would you like to unmute yourself to provide public comment?

Beth, if you're there, unmute yourself and you can go ahead.

8.

Technical difficulties are solved, I guess.

**BN** **Beth Nishida** 1:32:12

OK. I think I got it. Sorry about that. I'm here. OK, good. My name's Beth Nishida and as you know, I'm the co-chair of the long covid Community Advisory Board at CAC and I'm also a patient there and I've been struggling with a chronic illness that is known as long covid for almost four years.

**AS** **Atineh Sepanian** 1:32:14

Yeah, we can hear you. Thank you, Beth. Please go ahead.

**BN** **Beth Nishida** 1:32:30

I've appreciated meetings with each of you and the support that you've provided the residents in this county. Our job has not ended though. The meetings were only the first step. The data from LA County shows that there are thousands of people throughout the county struggling with a chronic illness that is little understood, life altering and devastating.

long covid affects every part of life. Even those who are considered mild may be left unable to work. Some struggle with or are no longer able to pay bills because of their inability to work, and many have issues with inconsistent housing. Patients struggle with basic daily living skills. Like other chronic illnesses, long covid disproportionately affects women.

Those with higher economic instability and those with lower education levels. As I'm sure you know, last week the LA City Council voted to officially proclaim March 15th as International long covid Awareness Day. This is a historic day for the City of Los Angeles. It is important, though, to have the same commitment from the County of Los Angeles for each resident.

Who is struggling with long covid? We have followed up with your asks. We've met with DPH. We've met with DHS. We've met with all of you. We've met with Doctor Ferrer. Again, I ask that you invite Doctor Ferrer to speak with you about long covid. She's an expert and has met with us. Again, I ask that the Board of Supervisors appoint a task force to study long covid in LA County.

And again, I ask that the county address the needs of so many of its residents. Thank you.

**AS** **Atineh Sepanian** 1:33:48

Thank you. Would anyone else like to provide general public comment?

Great. Thank you. We'll go ahead and adjourn this meeting.

I think that's abandoning me for the next. I don't have the trailer going too. I'm gonna. I think in a different room. It's crazy. It's an issue. Sorry, it's OK.

□ stopped transcription