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HMHS Cluster Transcript

March 18, 2026, 5:47PM

Kieu-Anh King started transcription

KK **Kieu-Anh King** 0:08
Testing, testing, testing.
Let me get out.
OK. Is it picking up?
Yeah. Can you talk?

GM **Gustavo Medrano** 0:25
Testing 1-2 three.

KK **Kieu-Anh King** 0:25
Fast the new one.

PT **Prity Thanki** 26:59
Today on National Vaccine Day, we're seeing a meaningful reaffiration of what public health stands for. A federal court decision has reinforced that vaccine guidance in this country must be grounded in science, transparency and established process, not politics and not ideology.
This matters because vaccines are one of our most power.

KK **Kieu-Anh King** 43:16
And transcription is also turned on.
Morning everyone.
I'll go ahead and call this meeting to order now.
Please note that the meeting will be moved.
Please app or by Thamar Sikka your following us for the meeting. As a reminder for my comment, we'll be limited to two minutes.
We'll start with introductions from board offices and then we'll go into first do I, Chris Conan, 4th district.
Thanks Chris.

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Tyler Cash from supervisor Barger Smith district Yolanda Vera from supervisor Mitchell's office.
Jasmine Garcia.
Javi, you first district, Jared Ertin third district.
I'm hilika yellow third district coach in your eyes, 4th District, 2nd district.
Do we have any representatives from the first district on the call?
Do we have any representatives from the 2nd district on the call?
Do we have any representatives from the third district on the call?
Do we have any representatives from the 4th district on the call?
And do we have any representatives from the 5th district on the call?
OK.
We'll move on to.
Representatives from the county.
Do we have any Co staff in the room?
Yuan King CEO Gustavo Medrano, CEO.
Budget CEO budget, alternative planning and CEO budgetary CEO. Budget Gray Young CEO, budget CEO, budget Cutter Chunk CEO budget Underper CEO budget Oliver Downs.
Sorry, I'm CEO budget.
Do you have any representative?
Randy Moore, County Council.
Do we have any representatives from public health in the room? Joshua, I'm asking.
Do we have represent mental health in the room?
Crystal, can you hear me?
Do we have represented some health services in the room?
Anna Gorman, DHS do we have any other county staff representatives in the room?
And we'll move on to county staff representatives on the call. Do we have any?
CEO staff on the call.
Who we have County Council on the call.

RK **Rachel Kleinberg** 45:56
Rachel Climb County Council.

KK **Kieu-Anh King** 45:57
Do we have?

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OK.
Thank you.
Do we have representatives from public health on the call?

Ben G. Phan 46:05
Ben Fan and team from DPH Finance.

David Cardenas 46:09
David Cardenas, Admin deputy for public health.

Kieu-Anh King 46:15
Great. Thank you.
Do we have representatives from mental health on the clock?
Do we have representatives from health services on the call?

Connie Salgado-Sanchez 46:27
Connie Salgado Sanchez, government relations.

Ferris Ling 46:28
Farrah, thanks for stopping DHS finance.

Kieu-Anh King 46:37
Great. Do we have any other county staff representatives on the call?
OK.
Great. We'll go ahead and we'll proceed with today's meeting.
As the agenda notes, we have one board motion, a presentation item, and a discussion item.
So we'll start with item 2A as each is motion.
My colleagues, good morning to you all.
We have just a couple of slides.
I know I love your office. No, this is good.
We all.
As you know, HR1 imposed a lot of imposed a lot of severe cuts.
To the county that are going to really hit our health departments. And so in February, the board approved 1/2 percent sales tax. Measure will go into June ballot to restore

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some of these important services and would raise, if approved, a billion a year.
There's a lot to get ready to implement it if the voters approve it, and in particular there is a portion that would go to recreating.
A clinic.
Program or creating a clinic program modeled after the My Health LA program that whereby it would be administered by DHS go out to qualifying providers to provide a range of primary care services to individuals who are otherwise impacted by HR one.
And so this is a motion that would get the county ready for that by just having them start the work.
Of preparing for it and then reporting back to the Board on Progress so that if the voters approve the measure.
We could be ready and ready to hit the ground running, so just a couple of slides please.
The next one.
This is a little bit of a context and we have Anna here from DHS.
We also have Community clinic association representation as well.
They gave a session last week to talk about the history of our contracting efforts with community clinics certain years, and it started with the public Private partnership program which?
Which is like 30 years ago. Hard to believe that that was done with the first waiver that the county received and then it transformed into healthy way LA. And then in 2014 it became the my Health LA program, which expanded and provided upwards of 100 and.
45,000 visits a year with 51 federally qualified health centers. And now we have the ballot, which the board approved.
I would actually, I think that number's wrong on the 45%.
So are the revenues being earmarked for a new no cost reduced healthcare program? So next slide please.
So what the directors would do is just direct DHS, in collaboration with the Community Clinic Association, to be ready to fully develop the program and to come up with suggestions to the board on what that would look like rolling out.
And they would.
The directive was to model the program.
After month is to model.
The program after my health LA, whereby the nonprofit at QHC's give no cost health

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care services to uninsured low income residents, and the network we're proposing could include partner pharmacies and specialists to expand the types of services. Because we all know from the lessons learned that the more primary care you provide and the more specialty care referrals you also have.
N DHS is to issue an initial report within 60 days with updates every 60 days. Thereafter, on everything from the proposed scope budget projections, how we maintain some kind of fiscal sustainability, performance measurements and accountability, patient care and eligibility requirements.
So I thank the departments for being here. If any of my colleagues have any questions on it.
But that is the motion.
Do you have any questions from board offices?
Yeah, I just have a quick question on so it's a report back from.
So 60 days from the whatever the 7th, right?
Correct, correct.
So we have time to tweak it in between, correct?
And we see what that is.
Well, so it is.
Well, see what?
What DHS comes back and I, and I think in terms of actually adopting it, the goal is to have them talk about what they're fighting in the proposal.
So it's to give the board plenty of time before they formally adopt it.
But I the assumption.
Would be there before anything is formally adopted.
It would have to be approved by the board and assume Randy raised your hand as well.
Yeah. And of course, we need the measure passed.
But no, of course I did.
When you first brought it up. Yeah, right.
That's, this is stuff that I wanted to make sure we hadn't. That's right.
We're not locking ourselves in what they bring back, it's just a let us fill in the specific the report back would come in. The board would have an opportunity to discuss it.

VG **Vanessa Gonzalez** 51:34
Actually.

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Kieu-Anh King 51:37

In add a public meeting if they wanted to.
They could then take those recommendations, either bring in a motion or the the department could come in with a board letter to create the program.
Yeah, I was just getting clarity to make sure that this is happening before June.
Before you know we we get locked in.
Yeah, that's just all that.
Yeah, I have a quick question.
How does this kind of fit in with the spending plan too?
Because I know there was a spending plan that the board considered and adopted, or at least approved at the last meeting.
But the spending plan itself, too, if the ballot measures passed, would also have to come back.
And then I'll imagine the report back information that Chris just just alluded to would maybe be included in what the proposed spending plan would be if the board or if we have to move in that direction. If it's approved. I I guess I'm just trying to see how. This will be connected and put that in, but I'll yeah, I mean this is the largest chunk of the money.
Yeah. And so it felt.
And also probably the more complicated in terms of rolling it out and getting it actuated because it would.
It involves so many other outside partners, you raise a good question, Tyler, on when the board approves the whole implementation, do they improve the whole kit and caboodle at one time, which is big or do we do it in in sections? Some might be readier to implement, right?
Now, and others might take a little bit more time, but this one in particular, since it seems the most directly related to.
Services available in the community.
And hopefully without disruption, this would seem like the one that we needed to elevate. But it's a good question. Maybe we can talk his group about it, but what makes sense for our bosses?
Yeah. So this this is only the cause.
And you said in in the motion, I remember there's like the 45% this is that this is the flesh up for that. But all the other percentages, OK.

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Yeah. Gotcha. Makes sense.
I have one question of course.
Thank you for this.
I see you have DHS DPSS and the Community Clinic association kind of taking a lead on this.
How are you ensuring that the voices of non if QHC you know specialties on and so forth are included in this the development of it, because especially as you're thinking about you know, requirements, qualifications, all of that you might have different, you know it's a it's a it.
A good question.
It's a tricky 1 because when I was talking to County Council about it, we wanted to make sure that we weren't inadvertently creating any conflicts of interest.
By naming entities that then might.
Compete for the money in in because the Community Clinic Association is the obvious Trade Organization that represents the majority of of who in the casinos has been involved in this. That's why we move.
There are other entities or other bodies.
Without inadvertently doing and running into conflicts for them later.
And this would be to talk about.
Yeah, I'd love to think about that and spec again for those non HC because they have different ways of operating.
Yeah, does does Community Clinic association represent non accuracies?
Yeah, not all of our members are affiliated.
I I will say the my health allay program.
It was a requirement of the program that the providers were federally qualified health centers to be participate in the program. I think we're still discussing what the requirements would be.
Under a new request for proposals or under new solicitation for for this program, with advice of County Council and to as part of the report back and also in terms of other organizations, they both CCLE.
An are thinking about ways to do some stakeholder engagement.
We worked in the past with a ton of community organizations representing.
Representing all the entire county.
And different sectors of the population and would want to hear from them again.
Also what worked?

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What didn't work?
What would you like to see out of a new program if this initiative passes?
So I'm hearing you correctly.
You, as part of this process you will do some type of stakeholder engagement and include those that may be are not.
We're not initially part of them, I thought.
We focus.
Correct. Again, we wanna make sure that anybody who is potentially may want to be part of the program that we don't create any conflicts of interest, but we also do want general input from the Community as we design this. Once it passes. I think that engagement will be.
Will step up that engagement for the purposes of the report back and during this planning process it'll be a little more.
Thank you.
The last directive is how prospectives of individuals with lived experience could be meaningfully incorporated as well too.
Gets exactly your point.
Yeah, but it's a little different, but.
Again, I just want to make sure I'm clear.
So you're saying the stakeholder engagement piece would happen after or during this initial development, so there will be some initial during this initial development and then if it passes, then we would do more comprehensive stakeholder engagement. Wonderful. Thank you.
We want, even for the purposes of planning, to make sure that we are incorporating some ideas and voices of those.
Organizations that we work closely involved with and partnered with.
In the past, wonderful. Thank you.
Then do you wanna add you in?
No, I I I believe that in the line of LA program, even there were a number of organizations that were not CCLA C Members.
So I was.
I'm here at the start, but there must've been a structural process for including them in conversations as that program was developed 'cause, we did not represent every single organization.
Any other questions from board doctor?

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Where's the state legislation?
Well, I think maybe we'll get an update of the next session.
Thank you everybody.
Do we have any public comment on this item?
Yes, thank you, Joanne Priest with the Community Clinic Association of Los Angeles County.
Jessa, thank you to the board for the motion.
I mean, we are excited about the prospect.
And look forward to the process.
To say leading up to and after it passes, I'll say optimistically in June.
We have a long history of partnering with the county to stand up these types of programs, so we are already talking with DHS and having those conversations. And so we definitely recognize and appreciate the need to move quickly in an open and really transparent way in the coming.
Months to pull all these, all of these pieces together and so we just want to assure the board.
That we are committed to doing that and the work is already underway and just express our gratitude to all of you and hopefully you know the the decoders will approve this in June and we can stand up a program, make sure unsure residents continue to have access to.
Care in the county?
Do we have any other public comments on this item?
Lucy, a hand from Karen Morris. Would you like to provide?

KM **Karen Morris** 59:02
Hi, good.
Good morning.
Yeah, just thank you so much for the motion and appreciate the effort to get working on this early.
As you know, SEIU has been supportive of the half cent sales measure.
We would just ask for very inclusive stakeholder input, including clinic workers and labor. Certainly our Members who work in the system will be impacted.
Regardless, and the other thing is.
Brandi had mentioned if the county chooses to have this calendared or or or

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discussed at the board, I would ask that the report back and the calendaring be in the interest of transparency in open forum. Thank you.

Kieu-Anh King 59:52
Thank you.
And I see Jennifer has their hand up as well.
Jennifer, would you like to provide public comment?

Jennifer Chou 1:00:00
Yes, hi there.
My name is Jennifer Chao.
I am the new health policy director at the Los Angeles LGBT Center and I just want to affirm the center strong support for this ballot measure.
Along with our partners at CCA Lac. Thank you.

Kieu-Anh King 1:00:22
Thank you.
Would anyone else like to provide public comment on this item?
Great. Thank you.
Next up we have item 3A.
This is the fiscal year 2627 recommended budget recommendations for health services, mental health and public health.
Good morning, deputy as well. My staff taking their seats and I get the presentation from I meet up very slowly to get the value you might want to come forward on this side. You might want to come around this side for CEO to be able to.
Schedule.
Great. Good morning, deputies.
Kiwan King with CEO budget.
Today we have the CEO's budget recommendations for fiscal year 2627, which starts on July 1st of 2026. For these three active health and mental health services cluster departments.
A bit of background, this is the first of three phases of the annual budget for those who are familiar.
Those who aren't feel free to reach out after the meeting, and I'm happy to sit down with you or anybody in your office.

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To give you an update or a primer, April 14 is the date of the CEOs recommended budget presentation to the board members.
That's on a regular Tuesday meeting.
At that meeting, the CEO will give a presentation on the larger budget in 2627 as well as major highlights in the key departments, including the HMHS departments we briefed on this information to the budget deputies last week.
And if you're interested in following any of the other clusters and their information, I believe they are starting today and tomorrow and then concluding next Wednesday and next Thursday.
I'm happy to give you the links to their meetings as well.
The second phase of the budget is June. Final changes.
That's usually the last Monday in June and then we conclude and set the final adopted budget for the county generally in late September or early October with the supplemental changes budget.
This year that is on September the 29th.
It's the last Tuesday in September and that will be our final budget for fiscal year 2627.
For today's presentation for health and mental health services, you'll see that we have DHS followed by DPH, followed by DMH.
We in the budget we will have.
In the budget, we will have a budget presentation for the Alliance for Health integration.
Ahi, as it's known, has not been active since 2023 and we are working to figure out the best path forward to sunset, both to retire AHI. But for now, there is still a department. There will be a page in the official budget book as a recom.
Budget. But because there are no changes and the department's not active, you will not hear a presentation on AHI today.
As as you may know from the set items on the budget that the CEO has been presenting.
Here in Boston's, the county is facing some major headwinds, to put it lightly, in many of the departments in our departments in particular on the public health, health services and mental health side, all of our departments are are very strongly affected by what's happening both the state.
And federal levels. Each department, I think has a very unique circumstances to face in 2627.

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Some are already known.
Some we know are coming in in the future and I think as as my team's discuss their recommended budgets, you'll see a little more granularity in terms of the specific circumstances that each department is facing.
At next week's health cluster, we will have a more in depth discussion on the DHS physical outlook and so some of that information will be coming in seven days.
And with that, let's go ahead and kick it off.
With health services and an upper morning deputies, the team and I walk you through the DHS budget recommendations for the space. As you're aware, Doctor Galley and the DHS team has communicated the physical situation that DHS is facing, including Medicaid cuts and remedy losses.
So that's putting us straight on their existing operations, so.
As a result, you will not see any program expansion.
In this phase, some of the resulting changes will be reflected in what we're gonna discuss today.
And we would like to field questions at the end of the presentation. With that being said, I would like to commence the presentation with Eva Kecki.
So item number one for DHS, housing for health budgetary transfer reflects the transfer of the housing for health programs and staff from DHS to the new homeless services and housing department.
This is in line with the board letter and BA that was approved by the board on December 9th of last year.
And for the second item, I'll pass it to Frederick. This adjustment reflects the removal of one time funding items from $172 million in appropriation from the 2526 final adopted budget. The funding reversals are primarily for housing, for health and ODR program.
And removing funding from our AB, one O 9 and other grants.
And the next section is gonna be presented by Oliver. Item number three reflects salary, employee benefits.
This reflects projected increases in various employee benefits and item number four is capital projects and deferred maintenance.
This reflects a net decrease primarily due to the completion of several capital projects. Item number 5 will turn to GESTALTEN. So with #5, this is the Los Angeles network for enhanced services.
So like last year, we have a $2,000,000 appropriation.

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For lanes, the funding is to support their operations and basically continue helping the electronic patient information to be given to participate in hospitals in the LA County.
Moving to item number six, this is ministerial changes, so this item includes a lot of minor and technical adjustments.
So for example, there are some appropriations for cost and purchase order increases for existing contracts that were board approved.
Or some equipment maintenance services for hospitals and other minor adjustments.
You also see that there's a deletion of 102 vacant positions.
This is a procedural action from the Department of Health Services Department, cleans up their records for when there are long term vacancies, and for that I'll turn it over to for item number 8.
All right.
#7 reflects revenue changes and this reflects a decrease in revenue to align the budget of revenue with the revenue levels projected in the fiscal outlook presented in October of 2025.
The productions are primarily primarily tied to changes anticipated with HR One and is related to enhanced payment program. The global payment program and the quality incentive programs.
The net result is about a revenue loss of $662,000,000.
The next adjustment is the fund balance and operating subsidies.
This reflects the use of fund balance.
And operating subsidy allocations to the hospital Enterprise Enterprise Fund.
The use of fund balance here is also in line with the levels proposed in the October 2025 fiscal outlook.
Additionally, the adjustments also include an increase to DHS's contribution to the IHS SMOE and a 1% increase in the AP85 Moe, and that completes our presentation.
And if you have any questions, we open the floor for any questions.
Questions from work.
I'll go first.
So you mentioned the deletion of 102 vacant positions.
You mentioned that those were long term and how do you define long term so with the ranges from like four years, that's the longest position that was there and then three months. So it's between four years and three months there was an outlier of eight days but that.

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Was the only one that we saw from the vacant list, but generally we would put it between four years and three months.
Can we get a list of those?
Three months to four years or four years and three months.
So starting from February 13, 2026, so starting from that date, four years, OK, going back, that's the vacant and then also going back three months.
But we can share the list also like January. Oh, so it was so it could include if it was just Vegas and January.
Yeah as well.
OK. And you'll include the the time that it's gonna be vacant given that a fixed, yeah, we'll include the date.
We can include the date's vacant and then yeah.
For each budget unit as well, that would be great.
Thank you.
And location.
Yeah, we can provide that too, yeah.
And then also for ihss the health benefit, what was that amount?
That's 1.3 million.
And for eighty 80585, that's 3.67.
OK.
Thank you.
I had a department have any renewed estimates of how I know it's taken a lot of steps to try to improve on efficiencies and save money in that way.
Are there any updated numbers on how much it's been able to save?
I don't know who to ask.
I'm just looking through the efficiencies that it's an effort so far.
Yeah, I can speak a little bit to that.
I think you will see some more detail in the DHS physical outlook, which is going to be presented here next Wednesday, OK. And I I don't want to speak on DHS's behalf, but I've seen a draft and I know there is specific language on the efficiencies and.
The projects that DHS has undertaken.
And were there any another question I guess is is for the department and the CEO?
Are there any requested changes from the 2526 budget that were requested by DHS but were denied?
Yes, there's there's a there's requested changes that were denied and we could share

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that with you.
Can I ask for the revenue changes?
Are these changes that have materialized or expected expected at this certain point?
And then it'll change with the next fiscal outlook and then we'll update the budget accordingly, OK.
Any other questions or comments?
Thank you.
And Next up is the Department of Mental Health and Wellness.
So this budget phase DMH is proposed, a very modest request. As Doctor Wong mentioned in her public budget presentation, they're still busy preparing for the transition from Nhsa to Bhsa, including finalizing their staffing models and other expenditures needed to bring up their programs to speed.
And the VHS at corns? On top of that, you know, they still need to finalize their projections relate to HR1, which will have a negative impact on their Medicaid program.
So that leaves this budget, which includes a net addition of 81 positions, offset by revenue in the coalition of 81 big positions.
These positions are the result primarily of the they're longstanding efforts to bite, size and fix certain areas.
As well as an expansion of reentry services for their juvenile halls and camps. So aside from these models increases the rest of the budget is mostly comprised of the lesion of one time budget.
And with that, I'd like pass the time to my partner. Anisa. Yeah. Hello everyone.
So the first adjustments reflects 5.3 million in the additional 41 positions.
To provide direct services to address critical workforce shortages across the department.
The second adjustment reflects 2.2 million and 11 program support positions across the image to provide support and strengthen various programs.
This is primarily for child well-being and reinforced services and requirements.
The third adjustment reflects 4.2 million in 29 positions to address workload issues.
This is primarily for their accounts payable section.
Hi item 4.
Replace the deletion of various one time funding the vast majority of which is mhsa, and lastly item 5.
This reflects various adjustments to their general operations and this page. The

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majority of this is related to the reduction of their nhsa prevention funding and that's it for DMH.
We're happy to answer any questions.
OK, so similarly check out.
Can we get a list of all of the positions for the Drax Services program, support Central Admin and also the 81 long term vacancies of course. Thank you.
And then also the changes in services Tron from county departments under operating costs, understanding that these are nhsa, can we get a listing of what those are to what department and the dollar amounts?
Yeah. Thank you.
And as an FYII think this committee asked a similar question back in November or December at one of the quarterly updates from DMH, and the department did send a preliminary list in late December with the detail on the projects for prevention that we're not going to be fund.
After July 1st, but I believe we might have an updated list with dollar figures attached.
So we'll provide that.
Thank you.
Yeah, yeah. But we do have that list, but we don't. The dollar amounts that we don't do that.
Thank you. I this might be a question for the department, but just wondering if for the the first item listed here, the expansion in forensic and juvenile settings, I'm curious if we can get some details on on what that is if that additional clinicians in one specific FAC.
Or multiple.
And then I was also wondering about the news Psych nurse Practitioner residency program.
Kind of what the Nexus is with kind of like workforce expansion within the department.
Is there a pathway or pipeline from the Nurse Practitioner program directly to DMH to help with our workforce shortages?
I think the department may have to answer that.
So who can maybe get back once we check with the department for the second one?
For the first question you had about the.
Other positions for the juvenile halls, those are going to be medical case workers that

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are just going to be.
Gathering information and providing targeted case management and referrals.
OK. And do you know if that's like across all the facilities or is that one season?
Yes, across. OK, thank you. Sure.
I just had a follow up question for you pioneer. Our offices particularly concerned on the impact that the behavioral Health Service Act makes to the prevention programs and and just finding out about the extent that in an excellent library parks and incubation Academy programs overlap with the justice.
Populations. So this report you're going to be giving, it'll have that detail in terms of county wide. What particular programs are being hit and eliminated as a result?
I.
I believe we've already had them. If we don't have the exact detail, we DH together.
OK, great. We. Yeah, we did ask for a schedule of the impacts to departments and programs as part of budget review. OK. Thank you.
And then the other thing would be helpful to know is the timing of it and when the hit happens because some of these are grass roots organizations that get the funding and just trying to understand a little bit and it needs a separate conversation with DMH where it.
Yeah, and and we'll have the detail and follow up.
I believe the impact is July 1st of almost all program and DMH has been proactive in reaching out to the affected departments to let them know that the funding cannot continue after July 1st under BHSA guidelines.
Can I in that presentation as well?
Is there any update on state guidance on how municipal counties can?
Can reach those dollars, those prevention dollars.
I don't know if there's been an update since.
We will defer to DMH unless my team knows today.
I will now.
I don't know that there has been.
We don't know how those dollars are going to be spread out.
Yeah, but we'll we'll follow up with the department to be sure that if there is an update, it's included in what we send out. Thank you.
Sorry, just one more question.
All these 81 long term vacancies, are they all related to transition permits you say?
No, those are just long term vacancies that the department had that they were just

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going through and kind of.
So are there any positions being eliminated due to the transition?
I understand they're hiring up in other areas, but as of now, not that I know of, right?
Now 81 are related if there are any positions being eliminated.
Transition. No. They're 81 or.
Thank you.
Thank you.
OK. And next off is the Department of Public Health and Ray Young will be meeting on the scene.
Good afternoon and I will be presenting recommended budget for public health.
For public health data, bosaline formed of the fiscal challenges they're facing due to significant funding reduction from their federal and state sources.
They've had to realign their budget with existing resources and accordingly was this budget paid.
The request is rather straightforward and on the conservative side, so beginning with the first adjustment.
Gender impact assessment is directed through a board motion and we are recommending 125,000 in one time, NCC funding for year three of this study.
I seek to advance gender equity goals, kind of like.
Item number 2 GRANT funding.
This is an stereo adjustment that aligns the department's budget with available funding from various grants. The overall adjustment here is a net decrease of approximately 6.8 million in funding.
Item number three is adjustments supporting departments, maternal child and adolescent health program and asked one time NCC funding from the Office of Child Protection at 750,000 for Project Hope and 600,000 for to help me grow program.
And item number four is a ministerial adjustment, and it's it's also routine that it removes one time NCC funding received in the prior year.
A total of 15.6 million in funding is being removed for this program. For all the programs listed there.
And.
Hello everyone.
Good afternoon.
I've just been 5 reflects deletion of nine positions and a decrease of about 6.9 million in funding to align with the available measure A&H funding per the spending plan

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approved by the board on February 3rd, 2026.
Adjustment 6 reflects a decrease of about 19,000,000 in ministerial adjustments to meet TPH's operational needs.
This includes removal of a one time funding from special funds services provided by other county departments and various other adjustments.
Items 7-8 and nine are all finance targets.
And with that, we'll take any questions.
Thank you for the number two item number two, all the programs that are going to be moving are any of these reliant on CBO providers?
Like I'm assuming the this is through DPH and DPH like contracts with with with providers contractors.
Do we know?
We don't think so, but I'll have to get back to you on that.
Can we?
Yeah. Can we confirm?
Because I'm curious, given the decrease how that's gonna impact, if any?
Any of our community providers and kind of let the communication plan is gonna be if they also then need to, umm acclimate to that.
And then.
My colleagues had a question.
Let's see. DPH was requesting one time. NCC for the Care Connect pilot with the DD providers.
It's not, it reflected in this budget.
Do we know if this pilot is gonna continue or what? What the status then?
Is care connect right?
Yes, the DPH was requesting one time MPC of 462,000 for the continuation of the Connect pilot with the domestic violence providers. And I also had a similar question.
Yeah. OK.
Yeah, we'll, we'll, we'll re looks up the detail. If, yeah, if y'all can follow up with us 'cause again, that's obviously something that we'll consider.
Yeah, I believe it was deferred to a future phase.
Yeah, it was a request for $460,000 of one time funding to support stipends to help additional.
Domestic violence Cpos get trained on how to use the new Care Connect platform that I believe launched in February.

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Don't quote me on that and I believe that was deferred to a future phase and we don't know how future we're talking about.
Well, the next phase would be on June, OK.
Yeah. And and.
The net effect of a deferral.
Is actually zero, because if something's approved on in the budget on April 14, it doesn't take effect until July 1st. And so the next phase is the end of June.
So if something is approved in June, not sign of, this will be approved in June. But if something's approved in June, it still takes effect July 1st, OK.
So there's there's no.
There's no effect to defer something in April to June. OK. Thank you for that.
Is this the same with the dual have two then?
The dual hub.
I believe was deferred. It is.
Thank good. And can you define what deferral mean is, does that mean it will be funded or will be considered defer means it is deferred to consideration in the subsequent budget phase?
So consideration, yeah, in in many instances, if departments are requesting one time funding.
When when they submit their budgets in January, we generally only done a 5 month budget status report.
And so at the five month mark saying N30, we ask departments to tell us how much have you spent, how much have you encumbered, how much do you think they'll have leftover?
And so when they make one time requests like for the $460,000 for the Care Connect funding.
If if we don't yet have a good enough gauge of where departments are going to be at year end with their available fund balance, we will frequently defer the request to to subsequent phase where we have better financial data on how much funding the department has left over.
At the end of the year that can support those needs. And so in in general, if a department is requesting.
One time general fund or one time NCC, we would prefer to wait till later in the year and later in the budget to see if they have their own savings generated that can support that need as opposed to bringing bringing over money from other counties

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that could go.
To other necessary uses.
And I'm sorry questions. OK. Can the department provide or more of a break out of what the ministerial changes are?
Yeah, absolutely.
I could have been and can I ask for the programs?
Will these be these services be provided county wide or are they concentrated in specific areas?
Which one again?
I'm sorry, the maternal childhood and adult and health programs.
Any question again, sorry. Will these services be provided county wide or will they be concentrated in certain areas?
I'll pick it back to you on that one, OK?
Yeah, that's OK.
Just on #5.
Are those the the mobile units?
Yes, that's part of it.
So there's more than the mobile units, yes. Can you get that's a breakdown of that.
Yeah, I could.
So for the positions, particularly or just the general, I could give you both actually.
So it's about 888,000 for encampment and assessments that involves.
Five EH positions, sorry, environmental health positions.
And then there is 2,000,000 for mobile clinics and that includes 4. Sorry, four public health nurses.
And then there is 3.6 million for client engagement and navigation services related.
What are those Dev contracted services? Those are contracted.
Yes, yes, the SAP C is contracted services and then the other two involved positions.
And some contracts. OK. Thank you.
The questions on DPH.
If not, why don't I recap the questions and then if I miss anything, tell me you can get it taken care of.
So in DHS, we wanted a detailed list of the one time funding that we are backing out.
We also wanted Yolanda asked for a list for all departments on budget requests that were either deferred or denied.
We also wanted a list of the hundreds.

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Two positions.
By how stale they were, and what facilities or departments they were with.
Move on to DMH.
And Hiloka asked for detail on all of the position changes, both the the pluses and the minuses, 81 new and 81 deleted.
And helika.
Let's see.
We also had a follow up on the nurse Practitioner residency program and the kind of Nexus to workforce programs and hiring within DMA.
And the full detail on the services of our county departments, changes related to the elimination of prevention funding under BHSA.
And Elizabeth had a question on whether or not there's any updated guidance from the state on prevention funding under BHSA. And then for DPH, we had some additional follow-ups. We wanted the detail on the grant funding changes, whether or not there were CB OS impacted in what?
Sort of communication plan DPH has undertaken.
Detail on the services provided under maternal child and adolescent health.
And whether or not their distributor around the county or in specific areas, the full detail on on ministerial changes or DPH and I think that's it.
Can I add to that on the grant funding? And I don't. Also this was Esther your ASK, but is there a consolidated list that makes up the six 6.8 million that can be shared out?
Oh, sure.
Yeah, we, we will add that to the list. Thank you.
Great. And so we will follow up with the questions. And as as we get the detail either internally or from department, we will send it out as quickly as possible since we know that the budget's coming up on your support team. Thank you.
Thank you. Thank you. Thank you. Thank you.
Do we have any public comment on this item?

KM **Karen Morris** 1:30:19
Yes, good morning.
Good afternoon, Kara, Morris.
Just want to thank the departments for the presentation as you're sharing that information.

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CEO budget staff with the respective board offices at just ask if you kindly could include myself, Karen Morris at SEIU. With that detail. We always have questions about deleted.
Positions and at times what I really welcome is is the questions.
From the board office and the scrutiny and and understanding the fiscal challenges that you are all placed with sometimes a stale vacant position could simply be a position that they're running registry on and cannot recruit because of compensation or other issues.
So it's very difficult to get those positions re budgeted.
It would be wonderful to see if any of those positions they're running registry on, or if it's difficult to recruit. Thank you.

KK **Kieu-Anh King** 1:31:26
Thank you.
Do we have any other public comment on this item we do?
Christopher Egan.

CU **Christopher Ige UAPD** 1:31:34
Yeah, Christopher, you get from the Union American positions in Dennis. And we also would request the same information to of the deleted positions. Thanks.

KK **Kieu-Anh King** 1:31:49
Any other public comment?
OK.
Thank you.
We'll move on to item 4A. This is a discussion on the street mining of LA County mental health and SUV beds.
OK.
Well, good afternoon everyone.
You should have received the report and the slides, so we're not going to go through the cover report today, but just focus on the slide deck and I'll get us started with DMH and then I'll pass it to DPH and DHS.
Katherine, can you introduce yourself for the record, I'm not.
I'm Jacqueline Bacon, senior deputy Ed, Department of Mental Health.
Paula, I'm deputy director of managed care operations for mental health.

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I'm hungry, director of community programs for Department of services. Gary side, director of the Substitute program.
Control with part of public out.
Alright, so since it's been six months, just as a quick reminder, the board had directed at the three departments to work together and consolidate all of our relevant treatment bed reports. And I think in the report there's actually an appendix that shows you all the different reports that.
Kind of came into this consolidated effort so that we can have sort of a streamlined conversation on treatment beds.
So.
Just, you know, kind of preface the conversation with something that's in the report but not in the slide deck.
Is, you know, since 2023 when we first started doing kind of bed recording, there have been a lot of shifts that have occurred within the system that impact the network.
So things like our jail closure effort and increase in jail referrals into community treatment.
DMHS has reduced its reliance on county hospitals and tried to prioritize use in other hospitals.
Decrease in access to state hospital beds.
So whereas previously you were over 400 at one point, we now have 213 allocated beds within the state hospital system.
And then we also had success in expanding programs like home and IHOP that do a great job of reaching people on the streets or In interim housing. And as a result of increased engagement and success there, it also drives up demand in an uptake in services some of.
Which occur at the treatment bed level.
Of course, there's also state initiatives like the HSA, SB43. The H connects tell you all of the initiatives that come down, but all of this can contribute to fluctuations that you might see, you know, period over period.
So this report builds on the 1st Fed Report, which was first period of January to June 2025. And so this presentation reflects the second time period which was from July to December of 2025.
So just looking back six months, so the first slide you have in front of you, just to reorient you, this is the format for everybody slides to try and keep it.

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It disappeared.
It's done having some technical difficulties. Oh OK.
Is not being shared OK.
One moment it's not.
No problem. Ryan's.
Yes. Yeah.
OK.
All right, we'll try again.
So the slide, so the slide you see on the screen for people that are dialed in matches the slide deck that's printed.
We start with kind of our crisis part of the continuum for DMH.
So crisis stabilization units, which you all know is, you know, urgent care chairs also go by another name which is empath or those are crisis stabilization units within emergency departments.
So DHS PES, for instance, is licenses.
CSU as well as a couple other that are popping up around the county within certain hospitals.
So the top right is the growth.
Kind of charting that the board asks for. Everything on here was in response to different metrics that the board provided input on before we finalize the report, format. The green box shows some metrics, specifically that the board wanted to track over time.
The top left is just the chart flex the blue top right numbers.
And then the bottom really talks about on the left, what is the forecasted need for the fiscal year that we're in and basically like the progress that we've made right now, does that fully satisfy that projected need or where are we in relation to that given all of?
The different initiatives and so the orange boxes to the right of that are about the in development or pipeline of you know even if we have satisfactory network from our perspective and forecasting, we're still looking to.
Continue to enhance the network should something fall off.
Contract and or if the need should expand because we contract and only you know pay when the service is delivered.
So it's OK for us to have more than our projected need because it just means it's available at the time that the demand exists. So looking at this slide, you can see that

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it's been pretty steady since the last report period, although we do have some kind of.
Urgent care projects in development, which you can track on the bottom.
And the phases correlate with how close to development.
And you know, is this project we we try to track all of the BH Sip awarded projects?
Those aren't county projects necessarily, but we still wanna know as our community based partners and providers are getting, you know, building up capacity and expect to come back to serve the.
Medical population. They will have to contract with DMH, so we want to understand where that is kind of in the queue.
So we're doing pretty good with urgent cares.
I would say you know the one area geographically that we're still prioritizing.
Is in service area 7 at this time, so that's pretty much it for this slide and I don't know if you want to do questions slide by slide or if you want to do all DMH slides.
There's quite a bit, so let me know what you prefer.
Yes, I think we can.
I had a question on how this relates to because I know in the above center.
We've been trying to open up these crisis stabilization beds for use, and I know there's other sites as well too, right?
So how does that relate to this?
And what's the plan for opening up those chairs so specifically for those I know I've had a chance to meet with Elizabeth on this as well.
Those are those were solicited.
There was no response to the solicitations.
And so right now we're working with the grant was funded to build them by both CHACA as well as PBH step dollars for that particular project.
And so we're looking at basically, do we need to use it for alternate setting at this point?
So those are not projected.
Actually, I can't, Lauren.
Are those still in the orange?
The CSU for adolescent OK.
Those are still in the queue, but if we should decide to go another direction, we would pull them out of the development here and add it into the other level of care that we're considering.

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Are they in the back in the concept phase then? Or they no, they should be.
Well, I can have Lauren check exactly which Phase I don't have the list in front of me.
So we can we can find exactly which phase they're in for you.
Yeah, I have another question.
You mentioned having some beds in the state that state hospitals.
I know that earlier in the year there was a little bit of a scare regarding the States ruling on like the staff ratios for some of the the state psychiatric hospitals.
And you know, there was this mandate that people were gonna have to comply before he was into January.
They got extended to June.
Are we still like tracking that and are we concerned that there may be impacts some of our people that are in in these state hospitals?
If you know the facilities themselves are not able to meet that staffing ratio and then they have to discharge patients so that wasn't specific to the state hospitals that was specific for acute psych hospital, OK.
And so yes, we are tracking the emergency regulations pertaining to acute psych hospitals within their staff ratio. Yep. Thank you.
There was an extension on the implementation time frame. It's the middle.
It's summer, right?
Yes, so that the hospitals have adequate time to you know.
Hire.
I just had a quick question. Someone to Yolanda.
It's just you mentioned that service Area 7 is the one that it doesn't have as many BCCC we have any beds in service area 7.
No, right?
There's no urgent care.
There are any of the conceptual projects or defined projects?
I think we let me check on that for sure.
Should have brought my full list.
No worries getting into weeds there.
No, that's OK.
And I have a clarifying question. You said just to make sure I heard correctly, the license chairs in LA County, that difference is like.
Basically, chairs that are in the queue to be oh, I'm sorry. In the top there, you're looking at the blue.

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Yeah. No, that was those.
Yeah. So this one looks very similar, but you'll see when we get to inpatient, those numbers are very different.
Licensed chairs in LA County, in this case, for each of them, it actually was an attempt for us to show you how many are there.
Total not just specific to DMHS network because I think it was Supervisor Barger specifically that asked us in one of the board meetings she her question was around well, how many are there total?
Because if your needs projected exceed the total even available license, then one would you know presume that you can't actually meet your goal is I think where she was going with that.
So we we tried to put it in there.
But we we technically contract for virtually all of the urgent cares because it's very much a sponsored.
DMH project, but as some hospitals build out like what are called empath units, which essentially nearer what DHS operates in their, they call them PE s s that Collins can talk about. But those models that are kind of like ACS, it's like an urgent care that flows from the.
Emergency room so that those that are experiencing the psychiatric emergency don't have to stay and crowd the emergency department. They would flow them into.
Specific different licensed section and went once it moves into that area. They have to contract with DMH because the managed care plan is the payer in the emergency room and then the mental health plan is the payer in the crisis stabilization unit.
OK.
OK.
I just want to question so this is total beds.
Do you have a breakdown?
And I know we don't have a lot of apps that have a lot send chairs, but.
Do you have a breakdown of dollars that I don't have it on here, but I can get it for you, OK.
Thanks. Yeah.
OK.
So let's go to the next slide.
Acute inpatient.
OK.

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So, acute NPO, maybe.
Sorry I don't have the clickers so I can't answer. I was just hoping the powers would be would like to move it over.
Change the change the sharing option.
Yeah, lots of PowerPoint issues today. I apologize.
Is that also one issue I know.
So I'll just share from here.
For you to work around.
There you go.
Ice cream is perfect.
There's an empty one next door. That one is still working.
I'm going to share it from my laptop and see if that works better. OK.
My team's dies.
We are back online.
We're back online, OK.
I'll keep going.
And then keep on can tell me if we need to stop. OK, so acute inpatient again. Time period July through December 2025. There's a little bit of a unique situation.
In in acute inpatient, that's OK we have our standard contracts with hospitals.
E for service or short doil hospitals so that when people are hospitalized they can, you know, basically claim medical.
We also have what we call specialized contracts with some of our some not all of our hospitals because we have specialized populations like those that are, you know, going through the conservatorship process that where it doesn't align perfectly with the medical payment structure.
So an example of that is if someone is going to take over 45 days to be conserved an aph for instance, is not eligible for admin day payments because their IME excluded.
Well, that is a very difficult business decision for a hospital to make.
If they wanna put someone start the conservativeship process, but there's no revenue, and so DMH has entered into certain agreements with hospitals to help keep people through that process and slow payments that are not through medical but other mechanisms, so that we can ensure people are supported and.
That we don't have a cycling, you know, of hospitalizations that can occur as a result of kind of the statute differences.
And so we call them specialized inpatient beds for that reason, so.

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When we're trying to kind of mesh the two networks together to show you the overall picture, it gets a little tricky because they're used in very different ways.
And So what we show here and what our projections are for when we do network forecasting is more around how we need the specialized inpatient, because we have enough general inpatient beds.
We're not worried about that, but when we talk about needing to use hospital beds in a certain way, that's what we're specifically speaking to.
So we do not only have, you know, 156 inpatient beds. The average acute census for this report period, it was about 1380 across the different hospitals and that's a combination of those that just kind of end up hospitalized and we process what are.
Called Tars so that they can get paid. And we do like a concurrent review and also those that are in our census for specialized in patient beds.
So there are many, many license beds as you can see that number is much, much larger than our slice of the pie because we're not the only payer right for acute psych.
Hospitalization is a covered benefit for anyone with health insurance.
So anyone all of us who have county insurance, regardless of whether it's Anton Kaiser, if it, God forbid, someone ended up in an inpatient psych bed?
Your insurance is going to pay and so they contract with hospitals to so it's a much bigger number.
And then something else we added here was a median length of stay.
So I have our tech and math guru next to me, Doctor Arun, who can who used to run our informatics within the department and moved over to manage their operations.
About 7-8 months ago.
Yeah. And so he's been a great partner on this report as we look for like ways to continue to refine and present the data that is more accurate.
And precise. And so a couple of revisions occurred during this report back period.
As a result of his involvement, so one was adding in the median length of stay, which is not always the same. As you can see for mean which is the average and then it also we did some refinements for a couple of the levels of care which were.
Significant enough and we wanted to make sure we were comparing apples to apples.
So in your report we actually added appendix that supersedes the previous report so that when you're comparing them time period over time period, you would be looking at the same comparison.

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Of data. And so we wanna make sure that it stays current.
Is there anything you wanna add to that?
No, I I'd say the biggest impact you'll see is with the specialized beds.
Originally we we had to just say this hospital has both specialized and other beds, but we couldn't segregate them.
But we combined a couple of sewer systems and were able to separate the clients in that way.
The state how much is this reflective of? Like best practices, or at least what we're trying for.
Well, I think it varies.
You can weigh in too.
What I what we've seen is that so sometimes it's very short, right?
The general acute inpatient you can see that it's it's quick. When we look at the specialized inpatient, it's because we are intentionally.
Trying to ensure that that person is connected, whether it's through the full conservatorship process.
This and then getting into subacute level of care that someone's not getting prematurely discharged, so we don't see hospitals. You know in this space. It's not like they're misbehaving.
It's it's more that these are really complex cases and sometimes it could be as a result of they were accepted into like a subacute facility and they're just waiting for that next bed to become available.
Yeah. Any other questions here? Yeah.
Acute inpatient patrol admissions is 20,000 and the unique is 13.
But just I wanna make sure I'm leaving this right. Almost half of them are.
Half of the people are returning to. Well, yeah, go ahead.
It's it's more that you have a few people that come in multiple times, yes.
Most people, yes.
Yeah, it is a little misleading when you just look at it from that perspective.
So yeah, we have some, which is one of the reasons that we started designing specialized contracts because we're watching some people cycle. And one of our goals is, you know to reduce.
The readmission rate.
You're welcome.
It's OK.

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It's great to see the numbers going up, so kudos to the departments for that.
The forecasted mean is that.
Assume that the jail is still open, not really the forecasted need.
We what we try to do so currently what happens is that most of the folks that are going to be medically eligible.
Able to go into this level of care from a jail setting are put on a 5150 or they're conserved or put on a temporary servership. Once that process starts, they're out within 24 hours of the jail right now.
So it's not contributing to census build up.
So this is consistent then the forecast we need is consistent with the yes, yeah. And we may tweak that. Again, when we look at fiscal year 2627 because we've seen a rise in the number of tcons coming out of the jail.
So where it used to be, you know, like three to five a day, I think we're closer to 50 to 70 a month, which may still be the per day.
I think it was Monday through Friday before, but it's it's ticking up a little bit. And so we're digging into that with public guardian, with Regional Health services trying to take a look at what's, what's going on is it that because the PAT works better, more people are?
Getting identified earlier? Or is it because there's truly a rise in the number of people within the jail that are eligible for that need pre disability standards?
Yeah.
OK.
All right, we can go to the next slide, subacute.
And so subacute has been one of our, you know, primary areas that we've been targeting for several years.
And so we have, you know, continued to climb there, which is great.
Just realized we put fiscal year 25 to six four, which is not a year that we're in. So we'll fix that.
But yes, so we're currently up to 1554 and our overall.
All goal is closer to 1700.
So we have some in the queue. There's quite a few that were awarded in most of these, you know in the projects phase two are mostly BHS awarded projects or county projects that are getting closer, like for instance LA general and then you know some of those project.
That are going to help add to this number, which is very exciting.

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So you know, we're we're climbing and we're getting close.
Again, we'll continue to refine the estimates so that as other things realize, like you know, it's like legislative season.
So I keep reviewing bills and I'm seeing the state wanna do.
More diversion from prison state hospital and I'm watching that like, OK, this is gonna have a local impact. If this goes forward.
So we would need to reevaluate.
What is that local impact and how does it shift our numbers for instance? So we are kind of watching that those legislative impacts and you know hopefully the legislative changes won't exceed the investment that the state made in the local infrastructure.
Through the HSA. So nothing.
Is there anything you want to point out? Subacute? I think it's we've spent a lot of time on sub acute in previous reports, so we're OK. OK, so long, space.
That's a long. Oh, yeah.
Yeah, this is and so and also I'll just take a minute to clarify. 'cause, I think one of the things when I came into the Department of Mental health three years ago.
I was incorrectly thinking that subacute was like a step down for a lot of people who stayed in the hospital, and it's not.
It's actually, you know, it's those that are conserved and that are highly impaired. And so it's, you know, when folks go into that level of care, it is very, very complex.
And so this is something though that we work on with our providers as well, like in all of our you know our team that's under Doctor Arns. We have a whole team that goes into these.
These facilities meets with the discharge planners, monitors treatment reports and you know, anytime there is an opportunity where we as the health plan feel like someone's ready for discharge, we initiate conversation with the facilities if they haven't already initiated it with us. And also we have to.
Often bring in conservators into that conversation, because they're all almost all conserved. Yeah.
A quick clarifying question for the defined projects or beds in development, could you say that those do include?
Potentially contracted beds that for privacy, they do include some of those.
But we this is only through December, so anything that was awarded just announced we'll we'll put in the next one that will go in.

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Yeah, this is just through December.
Yeah. Thanks for asking that.
So there were several like St.
Vincents that received. You know there's a lot of MHRC beds that they had put in there.
I think it was like 156 or something. So yeah, that's not in here.
OK.
Next slide please.
OK.
So this is crisis residential treatment, which is CRTP is what we call it.
And so this had a difference.
Here is that CRTP is an open residential setting like ERS.
So I'm going to talk now about these two kind of extended residential levels of care, CRTP and ERS.
And so there's more of a mix in CRTP between voluntary and involuntary.
So it stayed pretty static since the last time we currently.
We do have, you know, not 100% utilization across our different CRTPS. And so we still have capacity there for new utilization and so, but even still there, just like the urgent cares, there are some projects that are still coming through the pipeline which will you know.
Continue to ensure that it remains an adequate number for us and so you know, we like, we feel more comfortable when we have more than you know what's the projected need because we don't want people waiting.
So.
So that's CRTP.
And then ERS is the final kind of slide here.
And this one we had in that this time period brought on a particular facility where Rex reported in the beds added is 75.
But the capacity will go up to 150, but we only reported half because we had just begun to use the facility and we didn't want to report the yet to utilize part of the facility.
So in the next report, we'll have the other half represented there.
As well as which is development, we left those down in phase three and then there are, you know this is an area where I would say actually not very many providers in the Community applied for ERS levels here because these are licensed as like adult

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residential facilities or.
What's the other word?
I'm looking for social rehab facilities.
Thank you.
I don't know why it just jogged my memory looking at you.
I don't know.
We spent a lot of time working on this together, so I think so as certain providers, that's not really like a license type or if they have an ARF, they might also be focused more on the housing side and they might be contracted more under the ERC which. Is doctor Funk overseas that side and so some providers the same, you know, type of facilities and licensure could be flexed into two kind of levels.
Of care is where one is residential treatment and one is housing plus services.
So that's how they're differentiated.
So this is an area of focus for us still because as we get more movement in the upper, you know kind of the network we want to make sure that it continues to be a good option for anyone who matches.
That's ers, yeah.
Have you?
Did you have the median length of stays for the previous years and have you seen kind of patterns in the SKU?
Or along the spectrum.
Therefore we we haven't looked at that, but we could and that's where we'll probably get idea to to look at the longer trajectory and change. Mm-hmm. Cause the the crisis treatment programs, the meetings a lot closer to. Yeah. I mean, once, once you have in terms of that.
You're talking about the distance between the mean and the median, and for both subacute and DRS.
Yeah, a few people who are there for five years and that I was really close to me, which is why we added the meeting 'cause. It's more representative of a typical state.
Yeah.
Great question.
OK.
So almost time to pass it over to my colleagues.
We just have a couple more sections and then they can go through their slides.
So there is one slide in the deck.

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I don't spend a lot of time on this, but it's on the settlements.
This was a specific part that was requested.
Stay in the motion.
So obviously the board receives updates through other mechanisms as well. For both Lyons and DOJ. But these are the consolidated numbers from the health departments. So for the alliance, this is a shared commitment between.
DMH and SAPC.
And then for DOJ, it's between DMH and DHS ODR. And so the good news is we are very much on track and we will, you know, be we're going to beat our goal and then also the alliance and in DOJ, the DOJ for Rutherford initial.
Target. I think it was 284 but let me make sure I say that right one.
Thank you.
256 was the actual commitment in the settlement agreement and then the board offices did a follow up motion for, you know, P3P4 which I think was a 14 combo and that was to kind of raise that number to 500 and so.
The progress that we're charting is to the 500 number, even though we've met the obligations for DOJ.
So I don't know if you guys have anything on that, Gary, that you wanna add to this one, I'm sorry. Now, OK.
Yes, good news.
I know our Councils are breathing easy on that one.
All right.
And then last just last we just there was a request to kind of put in some charts that show.
Oh, sorry.
You can go to the next slide, put in charts relative to like, OK.
Well, when someone leaves this level care, where do they tend to go next?
Yeah. And so last time they were getting pie charts and our pie chart was so tiny.
You guys can't do it.
I'm sorry. So we tried to.
I mean, it's still kinda hard to read, but we tried to.
Make it a little more legible and so mostly you'll see here not surprising when someone's in that specialized invasion setting because they're conserved or getting conserved. They're almost always going to suffocate. OK.
So that's like the the primary discharge there. If we go to the next slide, subacute.

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Umm.
They go most often to residential with supportive services, so this could be ERS. This could be sometimes. It's CRTP not as often.
Or it could be housing with services like one of our enhanced residential care settings.
So continuing on kind of that residential care and then some when it says that the queue that's a queue.
Yeah. So that's sometimes because within subacute we also have our medical sniffs and we do patch payments within the medical sniffs.
So someone develops a medical condition like cancer or like they need a feeding tube or something like that where we can't serve that person in an NHRC who doesn't handle those complex physical we might need to transfer them so they get discharge.
It's not fully a discharge from subacute level of care, but it's reported as a discharge from 1 subacute and then in addition to the other surprise of the whole number to General Hospital is that is that RLA General Hospital.
That that would be typically for physical health care.
We have a a serious physical emergency that needs attention.
Yeah. So the hospital level attention.
I think they make they make go back. But then yeah, there are bad holes.
That we, you know, pay the providers the seven days or whatever the standard is for medical to hold the bed and then if it exceeds that they can, you know request.
There's like a process for requesting exceptions, and if it otherwise it counts as a full discharge and then we have to of course get someone into that bed because there's a need and then we would need to, like, get them back into the next available bed depending on.
The person you know their medical conditions, Co occurring, yeah.
OK.
Let's see.
We have a couple more CRTP the next slide, and predominantly CRTP again being open residential. This is mostly a lot of folks come in and they stabilize and then they go back home because there are direct admissions, people can refer themselves as their family members in the C.
Unlike the other levels of care, so it operates more in that crisis side.
And so we have a lot of folks that are able to go back to.

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Community with linkage to treatment as part of their discharge plan.
How many just leave?
Oh yeah, so about 36%, just walk out.
So they're probably reflected in the black.
Actually no.
I'm sorry, that's not considered a discharge location, so it's in the footnote.
So what we did was we took.
We wanted you to see all the places where they go and then the footnote tells you for people who didn't have a discharge destination, IE they were AWOL or against medical advice, that it's it's represented in the footnotes for us. You can see what percent that represents.
So yeah, it's pretty high for CRTP and ERS is the next one and it's about 23%.
So the again, the common denominator between those two is that they're open settings, meaning not locked. OK.
So when people, if they're there voluntarily, we can't keep them there.
So that does come into play when we consider diversion or when we consider options as alternatives to incarceration because.
Because we can't physically restrain someone in those settings.
We need to be careful about, you know, what type of treatment opportunities may exist for individuals in lieu of jail.
And then ERS is really similar picture to CRTP.
You know there's some fluctuation, but the end numbers need overall numbers of discharges during the six month period is not super high because as you saw previously, the length of stay exceeds the six month window.
So that's why you're not seeing an exceptionally high number.
Of you know, 172 or crisis residential was higher because the length of stay is a lot shorter. So and I think.
Oh, no, I lied. There's more.
There's more bed distribution by level of care.
This one was also a request just to be able to see how it all plots out, so sorry.
Next slide, really leading with you behind, I'm sorry, Q1.
So in this slide you should be able to see kind of like the bottom left is is the the levels of care there urgent care acute and patient substitute CRTP and ERS and then across the different service areas. OOC is out of county.
We do contract with facilities outside of LA County for a variety of reasons, and so

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you can peruse that and then if you have, you know questions later on, let us know.
And this is one is by service.
Planning area and one is by the next slide is by Subur District because sometimes it's easier to see them separately.
And then bars are in the order that's listed.
Because I'm yes.
OK, because it's not color coordinated.
Good call.
We'll change that next time we'll match the bed type font color to the bar color.
Can I ask on the southern beds?
Do you know how how many of those are the medicals of the cube as opposed to just oh, like within subacute?
How many are in the medical sniff versus MHRC?
We have that.
I don't have it today, but yeah, the vast majority looking on medical but but we can get you exact.
I feel like it's increasing though with, you know, because the comorbidities that a lot of our individuals, especially the aging population were seeing you know, us coming out of jail, a lot of complex physical health cases and it does create some placement challenges because we have to find.
A facility that can do both.
There is currently about we have actually a good number of medical Staffs. We partner with the health plan, the managed care plans because they pay for like the custodial day rate like the room and board essentially of the SIT well they pay for skilled nursing needs if those.
Should exist. If it's not a skilled nursing, paying for kind of this, stay at the skilled nursing facility under medical and then we're patching that with behavioral health.
So that they can hire staff specifically to add that on.
So it's kind of a dual, it's two plans, yeah.
OK.
I think it's now time, finally.
I don't think you have as many so faster sideshow now.
Alright, so Jeremy, before you start Jasmine, we are not going to lose the room at 1:30 PM because the next cluster has been cancelled.
So just just FYI.

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They're like, but we want to get out.
All right, so next slide.
So we'll start off with where the clients are going. These slides are gonna look similar in terms of the general content presented.
So this is similar to what Jackman had presented.
This is across our residential residential withdrawal management as well as recovery oriented housing environments.
And so you'll see here that if you look at the 1st 4 bars to the left, about 65% of the people that we're serving in these beds.
Do go to some kind of housed setting.
About 36 or so in some kind of stable and permanent housing setting, about 15% are admitted to residential.
About 7% are admitted to one of our recovery oriented housing options and then another 5% are added to or discharged to dependent supervised settings and then to the right.
Bars are varying forms of essentially homelessness or unhoused status, similar to what Jaclyn had mentioned 19% of.
Individuals do leave treatment before completing their their treatment episode, and so that's not included here.
But that is sizable given that either also unlocked settings by the nature of substitutes.
Next slide, if you have a question.
Is there a reason why not to include the AWOL in the chart for both departments?
I mean, we could create it as a bar mainly because we were talking about where people go and.
AWOL isn't really where where someone's going, but we could include a bar.
Kind of separate from that.
That was the main rationale for why I think we didn't include a separate BARC.
It wasn't a destination.
I see just in the next chart that DHS awdr I think notes numbers, but I think we're just a bit further.
Improved. Yeah, I think we could professionally assume were many of them, unfortunately.
Yeah, yeah, we can add up. I mean, it's not a problem for us to add another bar.
No, it's it's pretty harder to read, so we'll put.

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Yeah, we can add it.
Any other questions from the board?
This just shows our bed distribution across supervisorial districts on the top.
Spas.
On the bottom and then on the left are our bed numbers. The green pie chart is our residential fence, so.
2500 or so.
A little more than 2500 and then the blue is our recovery. Orange and housing beds.
And so if you add that up and add the other components of that pie, which is our inpatient which is hospital level withdrawal management beds as well as our.
Out of county residential beds.
Because we do contract with some entities that are usually around the border.
Where you know, sometimes LA County residents can better access those sites than some of the sites that they have county. When you add that up, it's about 47160 total beds across salsa network.
You have 68 listed out of county on the residential 68 residential beds out of county.
Do you know out of county where they are or usually it's the bordering counties with LA?
Because it's, you know, usually people who live in LA with the right of border.
So there might be more severe Dino or. Yeah, exactly.
All right, moving forward.
This is our residential adventures.
On the top right.
Graph or chart rather you can see across the past four fiscal years what have been added.
What are beds?
Lost numbers generally look like we've been fairly stable on the residential side.
We do anticipate some increases with some of the BH SIB awards once those are actually realized. The behavioral health continue infrastructure program that the various rounds.
Associated there were a number of SUV residential sites and beds, including withdraw management beds that were awarded to that process.
You can see our average length of stay members a little bit over 15 days.
And then on the charts or the graphs on the bottom left is essentially the beds that are in pipelines.

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So we do have 232 beds or so in phase two, which is where we scoped out the beds. It's beyond concept, but not quite. During the contracting process.
So there are some beds that are in the pipeline and then similar on the.
Bottom table you can see that across LA County, the state does license about 72180 residential substance use beds.
We contract for about 2600 or so and so that gap is essentially, you know, private beds, other other beds that are funded through other payers.
Why are we losing so many beds, especially 2526 and even lesser?
Yeah, we did have one.
Facility these are usually related to facility closures.
Yeah.
They're individualized circumstances. I wouldn't view this as a trend.
You know, when we implemented DMCODS back in 2017, it was a pretty significant jump in terms of what the requirements were.
And staffing, for example, and the hour requirements.
And so there were a number of agencies that.
Most agencies did well, but the number of agencies that struggled, and I think that as we move forward, a number of those agencies are still continuing to struggle. And as new changes come online, I I think we'll probably start seeing some of those beds lost while we're also.
Gaining additional beds because we are getting a lot of interest in terms of entities that are interested in contracting.
So it's just a it's a fluid add in and subtract of the beds. I would say that.
The state is implementing the 4th edition of ASAM in 27/20/27 and that is a very significant change and we imagine there being some fluctuations as a result of that as well.
And these beds that we're losing is that statewide or is it unique to all of?
I can't say that I have visibility on, you know, this statewide trends.
I can say that from 2017 to.
Now our residential beds have increased by over 200% and so we have been increasing.
I suspect that that's.
A different trend than across the state, where we've increased more.
But again, I I can't see.
As when you said that's on file appeared that mostly like managed care plans or are

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there others, so commercial plans do pay for beds.
They're usually shorter lengths of stay, but they do paper beds, and then there's just private sector, you know, some of them don't even deal with insurance. Yeah, yeah.
Next slide is our withdrawal management beds.
These are more consistent.
We don't have nearly as many 186 beds total across the network.
And you can see the average length of stays relatively free because this may mean just stabilization in terms of withdrawal management and then usually placement in residential or nonresidential settings depending on clinical need.
Do we just go back?
Do we need more?
Because that makes 186 for the last leg of several years.
Is there a need for more or like we're good?
When you look at the projected needs, we are meeting projected needs.
I I think what the projected needs don't factor in is geographic considerations, right.
Because we're looking at how many beds we contract for and what the projected need across the county is, it doesn't mean that everyone everywhere in the county could get a bed at exactly the right. They can see that they're preferring, right?
Just means that.
On any given day, typically we have about 20% of our vets that are that we contract for that are not filled. And so from that vantage point, I think Sam C still thinks that we need to continue to grow.
We certainly need to grow withdrawal management. I think one of the huge changes with the Acam 4th edition implementation that I mentioned is that.
Residential settings will all be expected to be able to offer withdrawal management and so basically it converts our residential capacity to all residential plus with dual management.
So that will change.
In 2027.
Thank you.
And next slide and I think this is my last slide.
This is our recovery launch and housing vent.
This is where we've grown most significantly.
You can see on the top right just in terms of.
Almost a doubling from fiscal year 2223 to fiscal year 2526.

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I think this reflects some additional funding opportunities through the state. For example, the behavioral health bridge, housing funding.
We also fund some beds with hope through a settlement dollars.
And cfci so you know there's different funding opportunities which are contributing to this growth average like to stay a little bit over 100 days. We do have some beds as you can see the 26 on the bottom.
Table that are in the contracting process.
So we have a little over 2000 beds in total for Keri. These slides also don't reflect the latest we ship.
Yeah, of course.
Yeah, yeah, we don't.
I mean we we will probably in the next year end .2, we'll start seeing those numbers.
We're starting to hit.
All right.
And then, unless there's any other questions, anything I'm passing back at home.
So since I just one question on BH trip and Triple department.
The projected in scope have we already identified funding for those?
For the for the other agencies.
So.
I can see for DMH what we've so directly operated, yes. Or those budgets go in early on. I mean what we do is we have to adjust with the appropriation adjustment, but we don't ask for NCC.
So it's more about.
You know, getting the money from ourselves each year as the expansion occurs.
The you know, one of the biggest priorities we had with the county projects was to try and build them so they were not, IMD excluded.
So we could leverage medical. And so that's been a key strategy for us because otherwise with the IED exclusion, then we have to use all realignment dollars, which is a finite resource.
So that like for the behavioral Health Center was one of the, you know, landmark achievements was getting medical certification.
But it's three MHR CS 'cause they were basically the first one to ever bring in H that were not ID excluded.
So that was that's been our pattern across the different restorative care village projects of the county campuses.

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The other in terms of the CD OS, then what we're trying to do now, because they don't have any obligation to be keeping us in the loop necessarily. But we are reaching out to them early kind of each quarter to say what's the progress of your how do.
You build it because some providers have dropped out like they're.
Not able to complete their their bills because something happens.
So we are staying in touch with Ahps, staying in touch with the providers saying what's the status and watching them kinda come to completion and telling them and now is the time for you to go feel you need to go hit the solicitation you know now and start.
Applying because the getting the BHS funds does not exempt them from the competitive county solicitation process, and we were very clear about that with them.
So they still have to go through all those steps and we encourage them to do it as early as possible.
So we kind of keep, you know after them.
And once that process starts is when we have to then identify funding, so to speak, with services. So it expands the service budget for the health plan in each of those levels of care. Again taking it from ourselves, moving it over, appropriating the right funds to to keep.
Billing. We went through a big adjustment or or we're currently going through a big adjustment in Word, OK.
So you guys are we're working on the final changes we're always.
A few at at one at least one ahead.
And so when we put forward an appropriation adjustment, it's to be able to catch us up for expansion for 2526 that we could have partial mid year for. But then also looking ahead at fiscal year 2627, which does take into account project.
Projects in the pipeline. So yes, we are going ahead and.
Not everything syncs up with our budget cycles, so we have to look as far out as we can.
Reasonably, yeah.
And Saab's very confident that we'll be able to financially support the new.
Beds from the music process. I think one of the big reasons why we we are exempt from the IMD exclusion, right?
So we can pay for residential beds, IMDb beds with them, especially nice system with Medicaid dollars. So that that makes a big difference.

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Hey. So can we go to the next slide?
So these are the ODR key threads. ODR did not add a keypad since the last report back. We have 45 acute beds online.
There were 20 that were targeted to be up in February, March, though it was a construction sort of development delay there and we're expecting them up before July. So that lasted seen us in Pasadena.
You can see there that the average length of stay presses around 82 days serve 125 individuals.
We have 3 providers working in this space.
Question for the next slide.
So our subacute pads so Odr added 42 pads in Long Beach. For the odr housing program.
This was the 50 beds in the P3.
V4 portfol that we're supposed to be added for to our housing.
So we're really starting the process of ports and utilizing this level of care, which we have not had access to before. The courts have been very amenable to sort of working with us to move people out.
So it's exciting. The 20 beds that are pending on the acute side will allow us to move people out in that acute level.
So essentially, it'll help us.
Get people out who are sicker sooner and have them not stay in jail to be treated down.
So we're really excited about this.
As we've stated before, we don't know how many of these beds are readily depends on our success with the courts. And those are the things that it's our need to test this out.
There was a glitch.
So the 5th event facility in Long Beach that was initially planned due to something related to zoning became a 42 bed facility.
So it left US 8 short of what we were supposed to do.
So the eight beds were not stood up and currently we're looking for a site to adds.
So there's there was a kind of a glitch that happened just based on the site development plans being sort of not going according to the original.
Sort of targets.
And so that does leave us a bit short, but.

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We have way too fast when we get started on this work set.
Excited about that in this subject space? Also there is a little gap here. So because we're reporting in March and this is December data, we actually stood up a 68 bed facility in February in Claremont. And so that is not reflected in either the beds, added Col.
Or in the in the phase because they were, they're done.
So I don't know.
Probably before we sort of take this before, we should sort of put that somewhere so that those beds are up and so.
There's not going to be a bend active.
They're often active, yeah.
Another build I don't actually know how, but they've been active, they've been active since.
So I think that site came up.
In.
February, January, February. So it's pineapple.
Yeah, but we've been.
Yeah, I'm curious about associate that and then the the.
50 just getting 42 beds is that active?
And yeah, the 42 beds are active.
OK. And we have, is it full?
Do you know capacity?
I don't know.
I'll have to check in terms of the link, I'd be curious about both the Claremont and the beach. OK.
I'll follow up will be important to on Helica's question. So one thing I forgot to mention in the beginning that's in your written report is so for DMH and for SAP C, This is under our health plan obligations. And for odr it is not a health plan.
So.
Work that they build is funded differently.
It is not a, you know, it's a commitment by the county, but it's not a like a requirement. And so when we talk about funding, anyone who's medically who has medical and is eligible for what are actually called adult residential treatment services, which is what you claim for.
In a sub AQ setting, those are all mandated covered services entitlements under

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Medicaid.
So we will, we have the budget and we always will find it. And as long as that.
And it's different for odr because they're not meeting a mandate in terms of like a staff story requirement, so they don't. The budget does cap the capacity, so it's different for us than it is for odr in terms of that.
So I just wanted to clarify that.
We, the other presentations they have are projected, need and I I don't, I don't see like a parallel number in odr for projected meeting.
So I don't.
I don't know.
Maybe that's something we can sort of take up in the next one.
I'm not sure specifically why.
I think one reason on the.
On the IC solution side is we have a fixed budget, right?
So we contracted that with the state that even if the need were higher on on the, we don't have a mechanism to bring on more beds.
Feel like that's like it's it's like a separate question, but it's still good to know. Like what?
So what's the need now and whether we have funding for it or not? There's if there's a way to measure that. Yeah, I think we're relatively close on the fifth side in terms of that piece.
And then as I mentioned just before on the audio housing side is brand.
You don't actually know what the need is.
In terms of the appetite for the courts to meet people through acute and sub acute symptom programs and and what will we sort of get people out 'cause that's really it's a closed system.
It's really about getting people out sooner into those settings and then and then treating them down to the lowest level.
So, but we can try to think about how to include that so that we're we're doing that in parallel.
Yeah, I think it was excluded mostly because since they're not operating in a health plan function, the forecasted need.
That it informs our slides is about, you know, medical forecasting, which you can use.
Both what's happening?
Your claims, but also like what are the expected?

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Like, what's your saturation point from a population measure that you're expecting?
And this is like an open-ended hypothetical conversation for them.
So I mean, yeah, you guys can think about how you would.
Yeah, that's part of the bigger system too, right?
Because if we if we address the need, it might reduce the and so there's a there's some complexities in terms of modeling that.
Sort of thing, right?
So I I I have to stay as is 257 days which is a little bit longer.
We served 84 individuals.
We've done a lot of work in the last year and really trying to improve our length of stay both at the acute and sub acute levels.
Obviously, having enough beds to start playing now that we have more beds, we're really actively trying to reduce our length of stay on the acute side.
One of the things Odr has as you guys are aware, is the interim housing plus beds.
That's been often the outlet for a lot of people coming out of our acutes and subocutes, and we can step people down straight from acute to IH plus meds.
So it's a really sort of valuable sort of a little bit more resource interim housing sort of tool that is out there and the fist houses operate like chocolate. Yes, gracially about is there a way that we could get that output more smoothly from odr beds to avail?
Acute beds.
To our subcube edit, if it's more appropriate.
It's so I guess the question for both departments is that working in terms of an active identification for people who may not need odr, but they could safely be transitioned over to unavailable mental health bit you mean as a transition from an odr bed into the normal, yeah.
Network because I think given given the funding challenges of ODR, like the really that when the funding.
Do we deal with the by just making sure that we're not keeping people in an odr bed?
From a long time, they really need to be when they could be transitioned somewhere else. Yeah, but I think it depends if they need medical necessity truly.
Versus a court order treatment. So you know, we'd have to look and see like how many other folks that are actually in sub Q beds need their criteria for the health plans.

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Level of care it tends it.
It's not always perfectly aligned.
Yeah, I do think there are examples, for instance with miss, but we do admit to the DMA system.
We sort of leverage the system to move people through, especially 'cause. We don't have the acute and sub acute levels of care, OK, if this operates a little bit differently and now we have some beds coming online for our, for your housing program.
I think the medical necessity piece is important and I think you know we're working within the system and the structure is the piece that we do, do a little bit of it I think.
It's probably worth the conversation again.
It hasn't been something that we visited a long time.
We've tackled it with regards to the Obn C beds, which we're always.
Pretty much short on budget so, but in those business and challenges addressed, but maybe it's something worth revisiting, just to see what there's an opportunity there.
Particularly as we bring on these acute and housing sites, we'll take that back.
OK.
And the last slide shows sort of where individuals wanna exit from our queued and sub acute beds. You can see that most.
Stepped down for interim housing sites, both regular stabilization interim housing and our interim housing plus type beds, which include both the fist houses and you know housing fest that's under the housing side. We do have some that move from Subicute to subicute for the sub acute destinations and.
Then a group that moves that kind of in rent residential care level, which for us is sort of like those that needed supports of their activities of daily living.
Kind of. The RCFP residential care for the elders without residential care facility and a construct on the acute side that we have not actually. Ryan just told me today we had our first two awols from our sub Q, but it wouldn't be reflected in the.
Data because we haven't seen them in this quarter. So but this quarter we'll see some in the next one reflected and then the low.
The awall ones like, are they just out and about?
Do we know if like AWOL is like jail?
Like back to jail? Or do we know?
Yeah. So once they're past their mandated rate 5150, their holds, they can't walk up the facilities voluntarily.
We have at all of our facilities.

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We have a protocol because they're under, particularly for the fist sites, really heavily protocols where we try to get a hearing date right away and they've got to keep them there and then get the court hearing date and the court, the judge can sort of, you know have.
Macrobe effect or whatever we wanna call it, to try to keep them at the facility, but we do.
Some people that voluntarily leave and then at that point, there's a warrant right issued for the rest of the building to your quote UN quote, period.
And then they would be picked up.
But we do try to keep them there and have the courts try to do it or actually directly demand them into custody. If there are few to continue.
And if for TMH it's different subacute level because almost everyone who's there is conserved, right?
So people are under different legal authorities for being in the facilities or the procedures are different.
And then the last slide is just the DHS distribution. This is just where we're at with the contact with.
You can see it there.
Yeah, there's up in spot one.
Yeah, spot.
Yeah, I think this also reflects not mistaken our DHS hospital beds, which we didn't report on this report as part of the DMH data, but it's reported that of a facility based transfer site.
Thank you.
Have a great question.
Esther's like.
I'm just going back to the need.
Can you outline how you identified the need? And are you saying that if you meet that, then anyone and everyone that needs access reserve bag will be able to get it immediately and there will be no bottleneck?
So that is a complex question.
So for the first part, how do we project the need?
So for us, if you recall, that was one of the big endeavors that we took on with working with HMA to create more in depth forecasting tools for the treatment that networks specifically.

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And that was all I want to say was like started three years ago that was.
And then there was a subsequent IC5 board motion that implemented kind of the next wave of governance recommendations, which comes through a different report back to you guys. I think the next one's in April.
So anyways, so that.
Was done through like a high level like high level view and then like a more detailed claim space.
So Doctor Arns, before he came over?
I won't say to the dark side because I think it's great over here, but he came over from our, you know, as our Chief Informatics officer in DMH.
So he and I were working together on that forecasting tool and developing that.
So it was everything as detailed as the actuarial level of view of what's happening with all the claims utilization, lots of things he had to do to smooth the data. So it can feed into this machine. And then the high levels will be more of that population like.
Expected for this type of population with these dynamics, what would be expected?
These levels of care more like a saturation expectation and then the truth is probably somewhere in between.
And so when we're doing our estimates, we're actually using a more conservative approach to take a high level view so that we're overestimating most likely.
And then even with that in some areas where we were anticipating either legislative changes or?
Or jail closure work.
We actually bumped it up even more based on like like the stay and things like that to create more of a runway and not create a bottleneck to answer the second part of your question, I think that even if we had thousands of beds more than you know.
How many get utilized every day?
I think there's always gonna be a challenge sometimes with certain clients getting into treatment and that's because of a variety of factors.
So it could be, as we accelerate work in the divers space, there is high criminogenic behaviors. That is not a medical condition that is a like Co occurring situation and only certain people are gonna be trained, you know, and have the, you know quite frankly the will to.
Work with certain populations.
And so there, there is some industry limitation.

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Just how many available providers are there?
How many available resources are there of what type?
Registered sex offenders is another category that can be very difficult to find matches for.
Arsonist. So you know, that's that will continue.
I believe you know, despite the argument effort that's been put into date, and even as we continue to expand, I think we'll never free ourselves of some of those peculiarities.
But I do think it will get better.
So I I think our approach is is gonna be similar to DMH, but I can walk you through kind of how we start off thinking through what the community needs are.
So nationally, there's a national survey on drug use and health and Suh.
And they actually have state specific prevalence estimates, right?
So we take the state to California specific prevalence estimate.
So that's at a population level.
So, you know, let's let's just say 17 percent is the number right at a population level, 17% of the population have an SUV. Then we take that and determine.
What the medical population of that group would be then we think about what the utilization would be because just because someone has an SUV doesn't mean that 100%.
Kind of them acting services. So we consider the utilization piece and then that gets us to kind of what we think the specific needs would be. And we do that for different levels of care. And then we look at how many beds this is on the supply side.
We contract for kind of where they're located. I think similar. What what Jacqueline said and what I was referencing earlier.
The The X Factor in my mind is also on the on Ross contract with CBO side. They work with. Some of them work with different payers.
And so they'll have a set number of beds and there actually isn't a great way for any of those pairs to absolutely guarantee, even though it's in our contract that like, hey, we contracted with you for 100 and then anthem contracts with them for 50, but they.
Only have 120 beds, right? And at any given time, if they just happen to have more Anthem people or happen to have more staff see people, they'll probably fill that bed, right?
And so that's what creates some of the variability in terms of just because we have

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enough.
On paper contract capacity.
It doesn't mean that anytime someone shows up anywhere, they're gonna be able to get the placement that on paper, like we should be able to provide.
Thank you. And is this something that you will revise as we move forward the forecasting?
Yeah, yeah, absolutely.
That's we are constantly doing that, yeah.
So those numbers, have it changed from the initial. So when we started reporting in this manner just we've only done one other report in this manner. And so it hasn't changed because it was just kind of that's why we say fiscal year 2526 projected need.
Because we will revise it for fiscal year 2627.
And we'll see if there's any. I mean, you can point out if there are any notable changes I kind of forecasted a few things where it depends on which way some of these legislative efforts fall. And also, you know, obviously there's things happening in the as you heard.
From the board motion, you know, in the uninsured space that sits outside of medical, but still is, you know, kind of an obligation that DMH, you know, that we serve a lot of uninsured folks as well.
So there's different rules around it, but there's still a commitment. And so there's, you know.
That affects things differently too. So as we're watching that, it's like our total denominator of medical eligible population might decrease.
So in our projections for medical, that might fluctuate, but then we have uninsured projections that have to sit side by side if we're going to continue to serve them in the same way.
It's just that right now, because virtually everyone that we serve is medic on Medicare or Medicaid eligible.
Those numbers almost converged right?
That's why the my health LA program was sunsetted was because the coverage existed.
And then now we're looking at how that out again as a result.
So yeah.
Do you have any other questions from board offices on this item?

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Thank you.
Is it related to the better part? I think.
Can they?
Can they be allowed to stay in public comment?
Sure. If it's related to that report, sure.
Please, please go ahead.
Well, I think that he's asking if they can stay for general public comment.
Oh, you have general public comment, yeah.
Oh, that. That'll be after. And then. Also regarding the agenda.
So I don't get to. It's like on the general agenda. We'll do it after, but this is regarding the bad report.
A better one.
Mm-hmm. Yeah. Regarding the job report? Yeah. With mental health, right.
I mean, I mean part of it closure, but yeah, well, it's odr.
You want me to include general public comment or do that based on prior conversations?
I don't think that his comment is related to the Fed report.
I think it's a general public comment.
We'll move on to you shortly.
We'll just do we have any public comment on the VET report?
OK.
Great. Thank you.
One more.
Question.
Do I have to book? I'm leaving this policy 2 minutes.
It's also regarding the agenda regarding there is that the part of my message, so that will be it.
It's still 2 minutes, yeah, but if you have additional like so.
Thank you.
On the agenda, how long that would have been?
It's it's two minutes in general, OK.
So it would been two and two two separate 'cause. I'm doing general public comment also you know coming on the agenda to support.
What? What do you mean you're commenting on the agenda?
Which agenda item are you?

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The one that they just spoke on the bed report the bed report because I was affected by that.
So he wants to comment on the report, they have to say, also wants the general.
I no, I understand. They understand.
It's fine.
This is a long meeting and I go ahead.
So it's 22 minutes, right?
OK. Who's the chair here? Who's the chair?
From the chair. OK. Can. Are you the one that make the decisions or they? Well, it's also it could be council related. OK.
So we we have a collective, we have a collection decision making process.
But thank you.
Thankfully, that's collected. Mm-hmm. So I'm back here again because the pre, the, the panel who did the presentations since October of 2024 when I was placed at La County Jail, I came in from USC hospital with a dis bulge in my back with medical records.
And I'll give that to be passed around and for the chair at the end. And when I went to LA County jail, October 24th with medical documents stating from USC hospital have a disposal, I should be housed in a hospital area. I was told that it's our.
House as the sheriff deputy house. We don't care about that.
Then they place me in an area where it's not supposed to be because I just came from the hospital with the dislo. When I ask for a Lieutenant or a supervisor, which is on the document.
They said that they're gonna call their team to put me in a cold room.
So this is a thing that's going on.
So someone from the mental division came out.
They labeled me as schizophrenic and they were doing this in conjunction with the Sheriff Jeffrey's, and it was a nurse at the time.
So when I hear people speak about betting, that's why I wanted to come on the issue because my betting going to have been used for someone else that probably needed that type of assistance.
So they took me in their room, stripped me from my clothing, put me in a blue gown.
Everything is on the documents and they told me that I'm schizophrenic.
The nurse should not have been in position to do that to me.
He should not.

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I don't feel nurtured in a position to label someone.
After three days later, another Doctor Who I had to weigh down, nice female, finally came over and she gave me an evaluation in her report.
Her report is in here.
I am not schizophrenic.
I should not have been there.
My parents is fine.
Everything is fine and I was at a D class since October 24th.
I've contacted mental service director, each one of them has sitting here all their offices.
I went downtown towards Figaro St.
You can't even go upstairs, so the way they have these divisions blocked off, you can't even notify people have left message at their office since October of 2024.
Not one of these directors that I spoke to for this kind of all these suggestions embedding have contacted me and the nurse is still working at La County jail.
So how are the? How is it that the panel allows these people to continue to be appointed and paid when they're not even doing what they're supposed to be doing, and the employee is still working there and they're asking for more allotments and more things when they're not?
Even doing that job in in an accurate manner, and they're they're ignoring their job of service. Since October of 2024.
I've been ignored about this.
So when I hear them come speak or the panel not not listening to people that come speak or not looking into these matters, this is a very, very serious issue that a nurse is still working there and label me as schizophrenic and I'm not so the same att.
Or the same notion that people should be concerned about people mindframe the panel and also the appointed people should also be concerned when people minds are played with like it's happening to, it happens to a lot of people.
There's no protocol. If you call to the mental division right now.
Today, if you have a family member in LA County Hospital.
You won't get through to anybody.
There's no number to call, and if you do call, they will hang up the telephone.
There is no number.
There should be a number from 9:00 to 5:00 or or hotline that someone can call to check on a unit or a family member. For these type of services if people care so much

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and you cannot since October. I'm just not understanding the Glaxo outside of complaining about.
I filed a claim and my claim goes I have still federal grounds to file the claims.
Gonna be violent against them. I'm gonna list the departments.
I have telephone records.
I have emails that should contact each one of their departments.
And I've been down here several times.
I'm not understanding why this panel is not reporting this to the Board of Supervisors.
Why is it that this panel is in compliance with these people who are appointed and all these titles and all these divisions, to give all these PowerPoints?
They're just talking Burbage as not equating to anything because in order to move forward they would have to address issues like this and it's not being addressed.
These are more abandoned here, more more that when all this is still going on and they cannot identify the person who's working there or not.
And I can't.
I just think that this is horrific, that the panel itself.
Has not taken action since I've been here the last time Diana did ask me to e-mail her, but I chose to come down and bring the documents so she I'm not going to be by her. She did tell me to e-mail.
I did not e-mail it the last time, Brandy, but I did. I did.
I wanted to bring the documents, so I wanted to say that part that she did, she did offer me her e-mail, but aside from that, I just feel that something should be put on the agenda regarding my matter.
I think something should be put on the agenda to to to find out, is the nurse still working there or if this is not important to the panel, I would like to know why is it that these they're they, it might matter before I even got they should.
Have been homeless and they did not. So I have another copy. They can have a copy for themselves.
I don't want it seem like I'm being compared to them, so I want to go over there.
But this is for their the directors whatever, and I love ones like the chair.
I don't.
I don't know.
Copies thanks to my favorite pocket.
Ahead and then which chair office do I come back to get a follow up? Or do I just

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come back to another meeting because I understand public comments are kinda short and might might or may not be on the agenda.
So do I a matter regarding your private matter is not going to be on this.
This is the the health cluster meeting. A personal matter would not be put on the agenda for this cluster.
I don't think for this past year, employment matter will never be discussed in a public setting like I'm not speaking about employment, I'm speaking about. I'm well, you were talking about the nurse you're speaking about the mental division.
There was the thing that you can speak about regarding mental health.
I'm not speaking about things that someone's Social Security number.
I'm speaking about my mental being on the agenda regarding these appointed directors and panels refusing to address my matter that have nothing to do with someone's personal information being.
In public.
I can talk to you again after.
Well, I would like to present to the board now.
I want to put it on the record that I would like the panel to if it's not. If it's the term not to be put on the agenda, whatever form of investment, the type of matter that is not appropriate for this agenda. If you'd like to submit a.
Claim, which you said you have for this past this cluster. This cluster does not hear private matters.
This cluster here this this meeting.
Is the health deputy cluster does not hear private matters.
You know, I came to discuss their neglect, but I understand that.
But that's your private matter and your private allegation.
This cluster here is board letters and matters for the for the Board's consideration.
OK.
So you're the chair for the mental health for for this meeting? Yes. For this meeting.
Who?
The chair for menswear.
Who chair the director.
Yeah. Who's the director of mental health? That would be Doctor Wong.
So that's the person.
That's ignoring my matter.
So who would I speak to regarding doctor, don't ignore my matter?

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We can connect it to DMH.
DMH isn't in the jails.
DMH is not in the jails and and I'm aware that correctional health is already addressed. The gentleman several times.
No, I understand DMH is not in the jail, but they're using the resources.
No, you are incorrect.
It's not a matter we thank you for your comment.
You left your materials.
I can contact you again if you'd like, but the matter will not be brought to this.
Not being on agenda.
You're saying that mental health have nothing to do with the jails?
Mental health.
No mental.
They don't actually Department of Mental health their resources conducts the mental health treatment within the jails, which division, Health Services, Department of Health Services, Department of Health Services.
Correctional health Services, the Department of Mental Health, does not provide the Department of Health Services in the jail.
Department of Health services.
So we were picking and choosing Department of Health services, the one that did not respond to me. They did respond to you. You know what? I don't want to argue with you directly.
There are other people waiting to speak and.
So, ma'am, I never just thought you.
I never got any response from what she saying.
I got I so I would like a response from the chair to give me a copy of that for you.
Do I need to give you my information?
So, she said.
I received it.
I've never received it.
Believe you shared it with Brandy, right?
And this is their interest.
See how they left this here.
That's their interest.
This is what I'm talking about.

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It's thank you.
Thank you.
Do we have any other general public comments today?

Beth Nishida 2:49:43
Hello, can you hear me?

Kieu-Anh King 2:49:45
Yes.

Beth Nishida 2:49:46
Hello. Good afternoon.
My name is Beth Nishida.
I'm the Co chair of the Lunkova Advisory Board at CEC and I'm a patient there as well.
And it's chronic illness that affects many, many, many people within Los Angeles City and Los Angeles County, the city of Los Angeles recognized long COVID Awareness Day on Sunday.
It's critical to recognize hundreds of thousands of residents living with this disease and this chronic illness throughout the county, recognition that people suffering with the chronic illness of long COVID is the first step, but not the last one.
We're grateful for the recognition.
The next question is how are we going to meet the needs of the hundreds of thousands of sufferers within Los Angeles County?
What will LA County do to ensure that the needs of people who have been sick with this chronic illness for months or even years are met? Medical care with medical personnel who understand long COVID housing food resources?
We followed up with your asks. We've met with DPH and DHS.
We've met with all of you. We've met with Doctor Ferrer.
We've met with DPH multiple times and we're now meeting with them on a regular basis again.
I ask that you invite Doctor Ferrar to speak with you a lot about long COVID.
She's an expert and has met with us as as her staff. We've met with the LA Times and I emailed the article that was on the front page of The Sunday Times to you on Monday. Channel 4 ran a segment about those of us suffering with long COV.
And includes the ASK for the task force. If you haven't seen that, I can e-mail that link

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to you as well.
There will also be a segment on KANEK.
Should be.
That should be airing within the next couple of days.
I'll send that to you when it becomes available again, I will ask.
But again, the the for the board of that the Board of Supervisors appoint a task force to study long COVID in LA County to bring recommendations back to the Board of Supervisors so that the county can address the needs of so many of its residents.
Thank you.
You.

KK **Kieu-Anh King** 2:51:35
Thank you.
Do we have any other public comment on today meeting?
Great. Thank you.
We'll go ahead and adjourn.

Kieu-Anh King stopped transcription