

DISCLAIMER: This is NOT a certified or verbatim transcript, but rather represents only the context of the class or meeting, subject to the inherent limitations of realtime captioning. The primary focus of realtime captioning is general communication access and as such this document is not suitable, acceptable, nor is it intended for use in any type of legal proceeding.

DISCLAIMER: This document is not an official certified transcript. This document is an unofficial transcript generated by a captioning service. This document may contain errors and should not be relied upon by the reader. The County of Los Angeles makes no representations or warranties of any kind, express or implied, about the completeness, accuracy, reliability, or suitability of the information contained herein; and assumes no responsibility for any errors or omissions in the content.

LACDMH-MHC-BHS

Thursday, May 8, 2025

12:15 p.m. – 1:30 p.m.

>> MICHAEL MOLINA: How are you getting us ready for the next round of BSHA funding that we approve and that's the stuff I would like to see. I find this all fascinating and we learn every single month about SAPC and I love that. But what are we responsible for as opposed to for information only type stuff. So I Louvre a slide at the end that says: "Why you, behavioral health commission" just so it plants a seed in our mind when BSHA comes back up.

>> GARY TSAI: Absolutely. Couple of things though. This commission actually will have some oversight responsibility for our system and that's one of the reasons why, you know, we want to spend some time diving deeper into these systems. I think it will be discussed today as well as in the future meetings. Part of BSHA is the integrative plan as well as the behavioral health oversight, accountability and transparency report. Both of those require both DMH and SAPC the funding stream and how we're funding it. The financing of our system and even BSHA, this is part of our work that's why we thought this topic was foundational to that. So I think your suggestion is a great one in terms of trying to make it after every presentation, how it's directly applicable to the work of the commission.

>> MICHAEL MOLINA: It takes us, well, me, years to understand everything relative to the Department of Mental Health. Right? It's taken me years to get used to the acronyms, to the various things that come up to this commission and the 7 plus years I've been on. And I guess I'm asking for a cheat sheet on each of your presentation to keep us mindful of what's coming to us. So I appreciate the future. Thank you very much, Dr. Tsai, it's great to have you with us. Can we now move to the DPH SAPC director update? We just did that one. DMH, or Kenia, should we go right into BSHA. Thank you, welcome.

>> Good afternoon, commissioners. Good afternoon. So in our last executive meeting there was an ask for report out on SALT and SALT expenditures and cap and so I'll talk about that and then dive into the BSHA report.

>> MICHAEL MOLINA: So you're doing A and C together on the agenda? Thank you.

>> Dr. Wong is not with us today. Remi was here for a short time but I'll be sharing. For the update, I have only 2 items. One I wanted to talk about the successful launch of amaze mental month. As you heard our Service Area 1 event Monday and Service Area 6 and event 5 have been in partnership with community colleges which has been really a fantastic partnership and it's brought out a lot of youth for sure and I think a lot of our partnering agencies have been there to provide resources. I heard the comment little bit earlier on food, so I want to share with folks that we provided some -- slow down? Sorry. I just want to make sure we provided food and snacks for all the events. Service Area 1 event, the college provided all that wonderful extra food, the hot food that was there, the tacos and all that and that was not provided by us. So I just want to do clarify that as well. In addition, we also had, we have our countywide event. I just want to say Gloria Molina park on Saturday, May 31, certainly, everybody is welcome to join us there. Now, any questions on case mental health month?

>> MICHAEL MOLINA: Keep going, please.

>> So 24, 25 expenditure. This is now specific to our stakeholder group and budget allocation. This is an interim report. So we don't have all of our receipts in. We're in April. By the end of the year, I expect we will be able to provide you a more detailed report with the types of expenditure by Service Area. So this is just kind of a high-level summary of what we have so far. So next slide. And I want to introduce Jamie Walker and she's been the lead for our planning outreach and engagement team and she works closely with the lead and Salt Lake City events and CAF. And I'll go through this report and she'll talk about process as well. This is Jamie Walker. I appreciate her joining us here. These are very, very warm seats. So I appreciate that. So we've got our budget allocation. Clergy engagement at 10,000, health neighborhoods, SALT 100,000 this year and community collaboration piece at 10,000, PRC at 24,000. If you go to the next slide, this analysis analyze data from July 1 to April 30.

So, again, we have a few more coming in. Requests coming in. Covering categories such as food, venue, auto visual, trainers, honorarium, we saw a very wide ray of events, expenditure and community engagement throughout the county. Data source from our own internal tracking logs requests. And we really want of the things we want to pay more attention to is assessing the effectiveness of outreach engagement for future strategies. Last year we did the work to revamp the process and this year we're trying to make some improvement and learn from that to make it easier. I believe that we are much more organized this year. Dr. Horn and her team has done a lot of work to try to strengthen the clarity, the training, and the process for folks. So then 23 and 24 served as that baseline year. To measure our efforts, identify trends, and areas requiring additional focus and support. 24-25 year, we wanted to focus on meaningful community interactions that effectively connected non-clients to the DMH services and raise awareness around well-being.

These funds, these are MHSA funds for planning outreach and engagement. They really need to be focused on pulling people into the system, really trying to involve people in planning, even if it's at the central level at the local SALT level, clergy level if trying to bring more folks into the community and process. And to engage community around mental health in general. But we want to make sure, too, we're mindful these are public dollars. So managing and kind of monitoring to making sure we're looking at expenditures that really are intentional and focused on that. Next slide. So these are our year-to-date expenditures by Service Area. And we expect some more like I said more expenditures through the month of May and June and I want us to say our requests are going to come in through May and we have a final deadline procurement, so anything requested for June, we should already be coming in the door this month.

>> REBA STEVENS: I want to ask a question. So my understanding is that if the cutoff was April 24th, so I would think that all of it is here today and not in June.

>> So we had an internal cut-off date to keep our people on track and organized and that was April 25. The PTS system, the county cut-off date is actually in May. And so what we want to do is we want to get as many spending plan in as possible so we can review them if we had any questions and revisions that needed to be made, that we had that time to do that before the cutoff date. So April 24 to 25 is not hard-and-fast. And we're still accepting them and reviewing them.

>> REBA STEVENS: I'm going to interrupt once again because there was a request based on Federal Government and what's happening and how it's affecting young families and diapers and formulas and that sort of thing. And I brought to the attention of Service Area 6. And I was told it was too late. And so I think there's a mix match in how we are addressing needs. And the other is, I understand this is just an overview, but we deserve to have the fullness of how every single dollar and to whom it was spent.

>> MICHAEL MOLINA: Thank you, Commissioner. Go ahead.

>> So I'm going to then move on to -- as a total, by the way, that's not on the slide. But altogether to date, we spent \$682,317 across all of these groups. And so we have some expenditure comparisons on the next slide. So we can look at last year to this year. And so in some areas, we see Service Area that really picked up their planning and their ability spend and we have some where we see changes. Major outlier, I know Service Area 3 we kind of looked into what was happening there, and they did last year put on a number of large, not large but moderate size events that there were not as many, it looks like requested this year. And in general, we see an increase in expenditures and service areas 1, 2, and 8. And again, we want to continue to work with the POE leads on requests and expenditures, and I think fine-tuning that process. Next. Just folks to see a breakout who is spending those dollars. The SALTs of course have the majority of the budget and majority of the expenditures here. Followed by our Service Area community collaboration.

Our health neighborhoods and our peer resources and then our clergy engagement. And how this is just a large one time, again, next slide, we'll be providing a full detailed report with all of the expenditures when we hit end of the year and have our full total. But already we see a good chunk, the majority of the funding was spent on catering and promotional items and services. And that promotional items and services is the thing we need to look more closely at and that will be prone out more because on the service side is kind of things we're encouraging our SALT funds for which are things like cultural events and projects really pulling the community in and their activities or learning opportunities and enhancement opportunities. Some of the smaller promotional items and things that go out maybe not have that much of that value. And our next slide. So as we move into 24/25, hosting more impactful events and working with the POE folks and competent to talk with them about what worked well and with a didn't and how we can once again, start early in the next year to make sure we can help folks get their plans in and support them doing that early.

>> MICHAEL MOLINA: Any questions on the expenditure plan?

>> I appreciate your presentation. For the consults [Off mic] .

>> So we do have spending parameters on honor remain and it's based on if it's recognized and considered an expert or not. Honorarium have been paid up to 1499 and up to 250 depending on who the speaker was. And people come with lived experience and come and speak from expert perspective on their experience. But then it's also trainers that include like our maternal yoga trainers, and some of our art trainers and stuff like that. So the honorarium do range but they're basically trainers and some folks with lived experience.

>> [Off mic]

>> Our consults also fall into that category as well. So sometimes we have folks that come in and speak with our DMH liaisons regarding event they're throwing and is it going to be useful to the community? And things of that nature.

>> MICHAEL MOLINA: Thank you, Commissioner. Anyone else? Commissioner Thomas Roache.

>> THOMAS ROACHE: Just out of curiosity. Take on why Service Area 4 and Service Area 5 generally tend to spend less and Service Area 7 spends more. What's your read on why that's the case?

>> So our Service Area 4 and 5, they actually collaborate a lot together on their events. And they put together stuff that's meaningful. So you'll see events that are going across both service areas. I think service areas each have a different need. We see Service Area 1 and they have a different need than Service Area 5. A lot of that depends on the landscape, a lot of it depends on who are coming out to the event and the population and who they're servicing. So it really does depend across service areas as to why spending happens in the way that it does. I know in Service Area 5; they do a lot of outreach to our older adult communities. And so a lot of that is partnering with

other community organizations. And kind of piggybacking on events that are already happening. And so our department doesn't have to spend a whole lot of money to table at that event. Some of the promotional items and some of the speakers and stuff, they're already on staff or it's already in stock and we show up with what we have.

>> MICHAEL MOLINA: Thank you, Commissioner. Commissioner Lawrence Schallert.

>> LAWRENCE SCHALLERT: Does this always go through the SALT? I'm seeing some events in the City Council person, Imelda Padilla-Frausto, and Santa Clarita is just a community event and not a SALT event. Is it always going to go. In order to access the money, does the SALT have to make the request? Or can the city make the request? Can it go through a counsel person or city?

>> The SALT budget belongs to the SALT. So anything that's suspended under the SALT should go through a decision process with the SALTs. So if there's an expenditure, I would be curious to know more about this particular event and who offended it. SALTs aren't the only entity with this funding. So clergy folks and health neighborhoods, as do, we also have our UsCCs with their own budget and different kinds of projects. If you can give me little bit more example, we can look into what that was and how it was.

>> LAWRENCE SCHALLERT: Sure.

>> MICHAEL MOLINA: Anybody on this issue?

>> REBA STEVENS: So I would hope that we could be informed and clear about how the dollars can be spent. You know, what is it that you can't spend it on? How can it be spent? I think it's not clear to the community about how those dollars can be spent. The other is around, you acknowledged when you first said about the public comment around Service Area 6. And the food, and then you acknowledged that it was Service Area 1 who provided those, that refreshment.

>> MICHAEL MOLINA: No, the college did.

>> REBA STEVENS: The college. But the flyers all said food. And so I think that it's really important to uplift the fact that there is some messaging that's happening that it could be disappointing to the broader community that is showing up on how something is messaged. I think we just need to be clear about that so that folks that are representing us are going somewhere else and having a different experience, and even as the co-Chair, he should have been aware somehow or another that there were opportunities for food to be had, even if it was by way of the college. So I think we need to really, we can improve in that area around how we are messaging and ensure that we're messaging clear and accurate to the community.

>> MICHAEL MOLINA: Thanks, Commissioner.

>> I agree. That's a good feedback.

>> MICHAEL MOLINA: I completely agree with Commissioner Stevens. This is the third time I've agreed with you. [Laughter] let the minutes show that that

Commissioner Stevens and I are in agreement 3 times so far. I look at this Service Area 8 is the after area I follow the closest and I think they're all terrific people. I can't tell you how they spent \$72,000 this year, but I'm sure they did and I'm not questioning that. But I would love to see in the end of the year report that we get a pie chart identifying where the money was spent within each Service Area. That way, just kind of remind me, oh, yeah, we did that event for catering. Oh, yeah, we brought in that consultant. Just a pie chart. I don't need to see every line item where the dollar went but I'd rather see a categorized chart rather than a bar.

>> REBA STEVENS: Can I add one that I believe we can also support is to, when we are hearing from, and I think it's important for you to be aware that there were only 3 SALTs that showed up. No UsCCs. It's really important that we understand that the by-laws do say that this is a requirement. So you were present to see that requirement, not each online. I think it would be helpful for us to be able to start collecting that information on a monthly basis by way from our chairs that are coming to present to us about what they've done financially. And that every single Service Area group should have, because Service Area 6 does not, have a written report that is issued to the broader community at every meeting and it's about holding us accountable. There's nothing written that says how money has been spent. So that we as a community and co-Chair can follow dollars.

>> Yes, shir.

>> We talked about this a lot and this comes up all the time, this idea how we interface SALT teams and how they're accessing teams. And I think everyone here has a lot of different anecdote or this person and that problem. So I want to hear from you, is this a problem? Is SALT having difficulty accessing funds and going through that process. Do they have a problem? Did they misunderstand fundamental process and is there opportunity for education or is this just a series of anecdote?

>> And I'll let Jamie speak to her interaction. Again, each lead is different, right? So I would say overall it not, you can see some service areas are spending quite successfully. We trade to create a clear process. And right now our next step is to provide clear guidelines and we always provide technical assistance and support. And we could be more aggressive with that where there are Service Area struggling.

>> Also we make a move towards more intentional spending and hosting events that are meaningful to the community, we have had some TA provided for the Service Area team to support them. I do a lot of that to support them in their spending. My team and I are also working on spending parameters and creating infographics so people can clearly identify what funds can be spent on what. So people have a clear idea of how they can move forward and access these funds. There really isn't an issue with the workflow to access funds as you can see Service Area 1, all the service areas have been successful in accessing funds and spending down their dollars. So it's not an issue with the workflow or the staff not knowing how to access funds. That's very clear. But

we are working with them around consulting with them about different events and stuff they can't spend their money on and items they can purchase for that.

>> I'm getting a report back too that broader engagement strategies.

>> MICHAEL MOLINA: As an observer, one or two years ago, this was a hot item on this commission. We had Service Area showing up and all this money and we didn't know how to spend it or what to do with it. The department is being unhelpful. I commend the department for making it easier. We hosted together some Town Hall or meeting about 6 months ago where we explained a lot of, we try to explain the confusions at times. I think a lot of that confusion is gone. We don't hear that as much but I'm not saying it's perfect. It doesn't seem to be the overwhelming concern by a lot of Service Area, not necessarily the chiefs, but the co-chairs, the volunteers on how to tap into this money. So at a surface, you've done a great job in the past year, improving the system. I think there's always room for improvement. But I think overall, as an observer, this hasn't come up with the commission for about a year and I thank you for the Town Hall we had a year ago because it was helpful.

>> REBA STEVENS: I think another area where we could address is where our - - where these dollars have been spent. For instance, it's in my community and so we should know how those dollars are spent particularly for Service Area 6, because if you look at your annual plan, you're going to see Service Area 6 is Service Area of poverty. So I think it's really important that we really Zoom in on what is already, what the data is showing.

>> MICHAEL MOLINA: Let's see how we can maybe report that out. That's little bit more of a challenge but I like that idea a lot. All right, let's move on. That was the easy presentation. So let's move to your next item, Kalene and that's the BSHA update.

>> KALENE GILBERT: I have one more quick one and we were asked for the CAF. And that's a verbal report out unless you like me to save that.

>> MICHAEL MOLINA: It's not on the agenda, so I don't know -- we can hear it but we can't ask questions about it because it's not on the agenda.

>> KALENE GILBERT: We can present it next time.

>> MICHAEL MOLINA: I'm getting hands behind you.

>> It is part of the director's update. It's what was requested by your commission. The director's update.

>> MICHAEL MOLINA: Sorry about that. Okay. Go right ahead.

>> KALENE GILBERT: And we'll make this one pretty quick. So just for CAF is our client activity fund. This is stipend for incidental we share with community members as an incentive to join our planning meeting SALT meetings and all of the above. This year we had 29 active CAF participants and 27 active co-chairs for total of 56 participants. The allotted budget was \$102,000. And the expenditures collectively between the two to this year have been \$55,000. We are expanding. This has been part of working with SAPC. And we're inviting new community members and CAF is open to

them as well. And so we have some trainings that just occurred. Some that are coming soon and we're opening it up for more. And that is also --

>> Could you send that in a written form? Just a paragraph of how much or how many?

>> KALENE GILBERT: How many coming in?

>> How many people are utilizing it now. Because I'm not visual. I'm a reader.

>> REBA STEVENS: I think what would be helpful is to understand what the requirements are. What is the timeline and when new participants can come on. If I'm not mistaken, you said 59 people are participating? 29?

>> KALENE GILBERT: 56. Sorry.

>> REBA STEVENS: 56 people. And that includes your Service Area chairs. So let's really -- let's sit with that for just a moment, y'all. Because that says, this is a county of 10,000 people. Let's sit with that. I'm serious. To me, that is just sad. Because recently, there was -- I don't know if it's a recertification that you facilitated. And you were very clear that there was no new CAF members. But there were people who were trying to get in. So if you could tell us when that new timeline is, how do we increase it and how do we also explore how it can be used? Because at one point in time, it wasn't just about attending a meeting and it was about outreach and engaging in the community. It was about speaking at an event and being able to capitalize. It was much more than what you're offering now.

>> MICHAEL MOLINA: Thank you, Commissioner. Can I recommend that we table this for now and bring it next month with a written report we can digest and we can talk more. Because obviously it's an important issue for couple of Commissioners. So let's take it into next month. Thank you.

>> KALENE GILBERT: Thank you, Jamie, for joining.

>> MICHAEL MOLINA: Thank you. So now we'll move to BSHA.

>> KALENE GILBERT: Okay. So just some things we wanted to share. I'll start with the community planning process. As I get going, I want to reconfirm some of and reiterate what Dr. Tsai said BSHA being about the full spectrum of services and funding programming across both mental health and substance use. So I will try to make it a point to differentiate between BSHA, the Act, which covers everything and BSHA the funding source talking about the BSHA funding components. So we'll start with our executive, or management team. This is made up of Michelle, Kathryn, and myself and some of my managers working with our consults for the planning process. We're meeting weekly and actually in some cases, for logistics, twice weekly to plan and implement the community planning process which is going to inform that integrated plan. So we met with stakeholders and we're continuing to build up. We talked before about the different seats and we're coordinating to build that group. And we are continuing to outreach to new folks throughout the year. The meetings in the months of May and June are going to focus on gathering community input needs and present

various types of behavioral health data to prepare for further discussions between the months and July and September or where we can do deeper dives into housing and continuum of care. So some other updates. So the final BSHA models, policy modules outlined in the BSHA program regulations were released in April. When I have been saying or come up here and say we're waiting for guidance from the state, this is the guidance we have been waiting for so it is incredibly helpful for us to not only that, but they released the template which Kathryn is going to talk about which helps us understand what their vision is. And help direct our planning and even our analysis around funding, because there were even some small rules that make big differences on how we can fund different pieces. Only thing I want to say about that is there was one really great win in that policy module. There's a lot of advocacy around expanding that definition of early intervention. In the original version, we could only serve individuals who already display signs and symptoms of mental health. We think early intervention should also, we should be able to reach out to community that have known risk factors. And so we did get that language changed and we were happy with that. Ultimately, we look at our programming and that means some of our prevention programming potentially be early intervention funded. And where that's the analysis that's happening now. Ultimately it's going to come down to prioritizing what we can and can't do but we always want the flexibility, right? It also outlines our Full Service Partnership program. Only thing that's missing right now is the high fidelity wrap around for children and that's the only thing not clear yet and we're hoping to clear that in the next few months. Housing guideline, and that's a whole topic and what's coming with housing is incredibly complicated and a lot of collaboration expected with managed care. And so we're doing the work of digging into the policy modules and impacting the program going forward.

>> I'm going to introduce myself very briefly again. I'm Katherine Li from SAPC. And I'll talk about the integrative plan you heard us speak about a few times. Reason why we speak about this, this is basically a perspective spending plan for 3 years that covers all of our behavioral system with mental health and SUD. And funding sources inclusive of BSHA. So what recently happened is, they just released their draft module for guidance for integrative plan which we provided comments on. They've also released two other documents one of which is a very, very detailed template that includes all the narrative and questions around the integrative plan around our different programs and services and funding sources and challenges and all those different things. And as well as a budget template that we have that is a much less complicated, but, you know, Excel sheet that includes all of our funding sources as well. And asked us to split our funding in BSHA into different funding categories. This is a lot of details so I'm going to try to break this down as much as possible. So we are currently reviewing this template to see what we can convey as well as to our CPT members and we're trying to make it digestible as much as possible. The template is extremely

prescriptive. It asks for a lot of data. This has been a point of advocacy, because it's quite a lot of work for both departments to handle all that? Then get CPT input. And the other thing that's really important is we have been provided statewide behavioral health goals. Which there are 12 total. We are going to report on 6 of those. And we have an additional 7 that we need to look at. Fortunately, the data has been provided for us already for all those different statewide behavioral health goals. And we're basically going to be looking at disparities between the countywide performance and the statewide performance and what types of programs and funding we will be implementing to address those disparities. And this is going to also be a starting point for the community discussions we're going to be having in the coming months. Finally, we are still waiting for state guidance on number of items. One big item you may have heard us speak about is the behavioral health outcomes accountability and transparency report also known as BHOCTR for short. And we currently have about 100 pages worth of information. So we're still waiting for the guidance around this. This is really important because we need to understand what metrics will be held accountable and what outcomes they're going to be looking for. And the first year we need to start tracking is 2026. So, obviously, this doesn't leave us a lot of times to set up those mechanisms. So that will be due in 2029. Excuse me. And then finally, one portion of the BSHA funding source that is going to stay is on the prevention side of things. So we are still waiting for CPH guidance on what that looks like.

>> MICHAEL MOLINA: Thank you very much. Any questions on that? Sounds like a lot coming from the state. So we'll have hearing updates in the months to come.

>> REBA STEVENS: So on a serious note, we take things for granted, that shift and changes easy and it isn't. And it's an adjustment. And even in the adjustment, it doesn't mean we're adjusting, right? Because it's still the unknown and that sort of thing. So the question clearly is: How are you doing?

>> MICHAEL MOLINA: That's a valid question. Is it overwhelming? Is it something you expected?

>> KALENE GILBERT: I'll be honest, it's a lot. And one of the things my team heard me say a lot is, you know, I think it's all kinds of ambiguity that's exhausting. And that has been the more challenging piece of last couple of months to know we have these very big changes coming but not having all the details click into place so we can say here's our destination and here's what we're going to do and now we can figure out how to get there. I think the past month or so, even though we have some reactions to what the state is asking for has been very helpful for me. Because I think now, too, we can start to understand what they're looking for, what we agree with, what we want to advocate for. And how can we digest this in a way that we can share it with the community, commission, and help people understand? So it's a lot. I'm tired. I'm going on vacation by the end of the month by the way.

>> MICHAEL MOLINA: You deserve it.

>> KALENE GILBERT: I definitely need that break. But the other team is working very hard. It definitely feels like there's little bit of a turning point here where we're not spinning our wheels quite as much. But thank you for that.

>> MICHAEL MOLINA: Anything to add?

>> That's a very, very kind question, not that you haven't been kind throughout the entirety of the today's meeting. At times, it felt like fly the plane while where our building it. So we were concerned about all the changes and CPT and community planning process was transparent as possible and it's kind of hard to give direction, and be transparent when you don't have all the pieces and sometimes it might look like we change course, and it's not really us changing course. It's us reacting to your guidance that Macon inflict or not conflict and how do we communicate that's helpful for the commission and all the stakeholders in the community. But certainly a lot to process.

>> MICHAEL MOLINA: Thank you, Commissioner Stevens for grounding us there. We'll see you next month. One more question?

>> I just want to get you know what you're hearing from state and what you're thinking about. Behavioral health goals, you know? Because in my mind, I'm looking at number of suicides, different demographic of suicides, and we heard Dr. Tsai say one of his goal is to keep people and retaining care, longer care. And I know coming from long time with working community health. Sometimes we were asked to get people out of care. And somehow that was a goal. And those of us who worked in those clinics. Now, you really want to keep them in. So there's this tension all the time. And so, in prevention, it's really hard to know if you're actually making any progress. You just know it should be progress because it's in theory. So in general, what are they saying they're looking for in terms of behavioral goals and behavioral health goals?

>> I think they're quite broad. There are some, for example, I do believe that suicide one of the areas of behavioral health goals. They will one related to education, something around truancy and they have something around overdoses. They have a very broad array of areas. There's also quality of life, I believe, access to care. So they cover a lot of different areas. Some of which are obviously, we can influence more than others and that's why I think we have some optionality of the remainder of like the 4 so we're not required to report on them and we can choose which ones we can report on. For example, one of those is, I think untreated behavioral health conditions or something like that? So some of them are more related to the work we do and some of them are very broadly oriented around societal broader population-based goals.

>> So with suicide, sorry, would you be working with local law enforcement, crime analysts, public health to actually track suicides and demographics to suicides in order to gather that?

>> So these are the -- there's a working group at the state level that identify these 12 population states, health goals. And so they look for existing data sources. And so they've ARDI find what those goals are and they do access to care, child access

removal, homelessness, and state has identified some data source and providing counties with their data compared to state level data. There are 5 already which relate to poor populations, homelessness, childcare and suicide is one of them. And school, I think as Kathryn mentioned. So the state is providing us with data, but when it comes to suicide prevention data that's something we work with public health and they're the core of that information.

>> Thank you, Mr. Chairman. I just wanted to acknowledge the staff. I know it's been acknowledged a few times already today. And building off what Commissioner Stevens was saying that you know, I'm just finishing my second year on this commission. And first couple of meetings I was here, we were confronted with this big bad monster of BSHA that was we all knew was going to happen. But we're hoping it wasn't going to happen. And it was a pretty tense, I mean, it was pretty tense for me starting off as a Commissioner walking into that context. But I want to acknowledge the fact that, how transitions, not always easy, but I really want to thank you for kind of coming in and really, what teams to me is just embracing the process and what's happening, and knowing that whatever happened was beyond our control. But this is kind of what we have in front of us. And we all still have this job that we have to do, our various roles that we have. So it really is, I really see it as a very positive and optimistic feeling that I have over the last few months than I did when I started. And I think a lot of it has to do with how you're kind of handling this transition, working together, bringing on teams to kind of support this process. So I really appreciate that. Thank you so much.

>> Just building little bit what Commissioner Schallert was saying. Just taking a step back, the real fears of making this transition was now we have the added layer of bureaucracy and centralized state level imposing, you know, edicts and directive and might actually distance the work from the local target and effectiveness. What's your impression vis-a-vis of the general question. Is it doing out of direction that's relative healthy or is it going to be okay or battle for the next few years?

>> I think I might ask you to rephrase the question how you're describing where we're headed?

>> Couple of years ago, things originated from the office, gathering our own data and doing our work and deploying at that level. Now we have a state that's coming in, no, this is how you have to do things. Are they -- I'm trying to think of an adjective that isn't a swear word. [Laughter] do you know what I'm talking about? Giving you directives or giving you hundred pages of direction and looking at this like this is out of touch and this isn't happening in the way it's flexible enough. And you can cater it to the reality of what's happening in the county?

>> KALENE GILBERT: I think that's a huge question. I think anything that is this prescriptive is always going to be a challenge from the State of California, because L.A. is unique. And so that level of prescriptive is loss for us, and certainly area of advocacy wherever we can do more defining here. So I would identify that as actually one of our

major challenges and frustration with that process. And I've been saying to a lot of our stakeholders overtime, those who have been with us for 19 years have very different experience in the planning process. State is very much what we're doing going forward and helping them understand and conversation about what this system looks like and how and where we concentrate those resources as opposed to a lot of defining we've been able to do together before.

>> MICHAEL MOLINA: Thank you, Commissioner. Thank you ladies.

Colleagues, just awareness it's 1 o'clock and we're halfway done. So next we're going to move into legislative updates from both Department of Mental Health and DPH SAPC and Elon and Michelle is going to join us. Statewide federal.

>> Thank you. Good to be here.

>> MICHAEL MOLINA: Hi, Michelle. Welcome.

>> I appreciate the questions that you were all just asking about the BSHA process. I'll just note that we've had a lot of comments that we sent back to the state about what they're asking us to do. And I'll just add on that as our colleagues just spoke about the boater and state behavioral health goals. One of the main comments our department submitted to the state and last round of comment is that state needs to have realistic expectations what we at the county level need to produce and gather in terms of data. So for example, some of the data that's being requested is well outside control of county. And I'm not just talking about DMH and DPH and I'm talking about the whole county. So some questions that asked the county to reply is really actually better answered by the state administration itself. So for example, they asked how many of our contracted providers. So that would be our legal entities have contracts with the managed care plans in the county? We are happy to ask our legal entities that question. They have no legal obligation to answer or tell us. And in fact, the state which oversees the managed care plans is in a much better position to answer that question. And as we discussed earlier, some of the behavioral health goals are not -- you know, when it comes to education and other elements, those are well beyond the scope of the behavioral health departments. So we have shared some concerns that some of the things the state is asking us to do, data they're collecting, things they may hold us accountable for are actually not within our scope of responsibility or authority. So we do have concerns adding on, because that's some of the things you were asking about. And on that note, I'll jump into the Leg updates. I'm going to -- Ms. Stevens, you asked how we're doing?

>> REBA STEVENS: How are you doing, baby?

>> It's these first couple of slides that are really bothering me. So I'll get into the state bills too, but when you're asking what we really nervous about it's really what Congress is going to do about Medicaid. And I don't want to speak for Michelle, but it's true for our 3 county health departments. We do not know how this is going to play out. We're getting constant updates about Republicans are saying. How far and deep will the

cuts go? Are we going to see Republicans that represent purple districts? Maybe come back and defend Medicaid? We'll see. This is going to happen pretty soon. Just as a reminder, DMH in our own department, we get \$1.2 billion a year in federal Medicaid revenue. So our total Medicaid spend is \$2 billion. But actually, the majority, 60% of it comes from the Feds. That's how much is at-risk for us. We have no idea what's going to happen. Are they going to have work requirements? Are they going to put in per capita caps? We don't know. Because we don't know, we can't give you the estimate of potential impact. Somebody has to make a decision in D.C. and so then it goes to Sacramento and then we can tell you the impact. But at this point, we can give you better information. But we expect things to change within the next few days, maybe even this week. Next slide is about the President's budget proposal as you may have heard, the President is proposing to make major changes to the federal org chart as we think of it major changes to HHS and possibly folding SAMHSA into a new administration for Make America Healthy Again. MAHA. Right now, this is what has been put on paper, but in addition to the potential cuts to SAMHSA, there isn't a whole lot of detail. So this is something we're tracking carefully but we don't have much information on yet.

The next slide, we have just been saying that we're monitoring, I've gotten 4 emails just since this meeting started about updates from what are federal lobbyists in Washington, D.C. have heard. There's some letters bouncing back and forth between members of Congress and in administration asking point blank what's happening with SAMHSA? Congresswoman Baragan asking this letter and there's not whole lot of information coming from the administration. In addition, there's no slide on this but I want to note governors may revise and that's expects to do come out next Wednesday on the 14th that will have impacts to the world of behavioral health but we're not sure how. As we heard, there's a significant budget expected at the state level. We do not yet know how the governor is going to hold it to address it in his budget. And then one other question which we have been asking and not heard any information about, which is what does this administration in Sacramento, what does the governor administration expected to in the face of Medicaid cuts?

They're keeping it very close to the vest. I don't blame them for it. But at this point, we don't like know how the state may respond. So I expect to have more updates in all these areas in the next report. I'm going to stop right there. That's all budget stuff, federal state. And then shift right now into legislation. One of our -- this is one of our key bills was SB16. This was introduced by Senator Blakespear coming out of the San Diego area. Although if you read this text here, you won't get a clear sense what was happening behind-the-scenes. But I do want to know an early version of this bill was very concerning, because it had counties who were applying for HAP funding which is homeless state grant accountable for 50% of ongoing cost of city homeless shelters. So it was essentially a huge cost shift from cities to counties. Right now, if cities operate

their own homeless shelters, they have to figure out how to pay for it. This would have shifted it on to the county's budget as well. Thankfully, that element was amended out of the bill that county and partners in CBHDA was affected. So this was a high priority bill and you heard us express concerns earlier in the ledge cycle. Another is a stern bill. This is SBA23. The county should be adopting a position on this soon. So as of right now, all you've got is no position taken yet by DMH or the county. But I do want to note we expect the Board and CEO to take action on this soon. This bill would expand the eligibility for CARES Act for clients who have bipolar disorder 1. So the original CARES Act criteria which was basically schizoaffective disorder. This would add a new group of eligible clients. As we have all heard, you know, there's a lot of focus on CARE Court. There has been for years in Sacramento and call to expand eligibility because the numbers of clients was much lower than many people across the state expected. So this is one bill. It's a pretty simple bill. It's short in terms of the actual language to expand and add bipolar disorder for one client. We expect to get an update where the county is in the future. But I can tell you there are many people across the state, including members of CBHDA believe adding bipolar disorder one clients could be beneficial to the clients. So we'll see. Another bill that's generating a lot of interest is DB367. This is Ben Allen. On the Westside. This bill, I would not have been able to explain to you couple of weeks ago. It made so many technical changes nobody other than Connie Draxler or James Quan could have explained it to you. Bill was amended extensively so a lot of the original components were removed. The bill, as it reads now. Is streamlined and simpler, although we don't have a position yet we expect it to be drafted for the future. For you guys it's not helpful, I'm not tell you where we are. All I'm saying is this is a priority bill because it makes a lot of changes to LPS and we're taking a close look at it.

>> Can we have a copy of the bill?

>> Of course. When you read it, I urge you to take a look at the tab on the ledge info website what the bill reads now. Because if you look at previous amended, it will give you a headache. Another bill that we are examining and I think some people may be surprised where the department is on this is AB348 by assembly member Krell. As you'll see we're expressing concerns and CBHDA has opposed unless amended to the bill. One of the concerns is this bill will put into state code FSP eligibility criteria. We do not have concerns about the substance of the bill. In other words, the current version and the presumptive eligibility it puts forth, we have theoretical concern about putting programmatic eligibility criteria into state code. Right now, FSP regulation is up to the state and counties through regulations. Through BHIN and through letters the state sends to counties, and final discretion about FSP eligibility is up to the counties. We are concerned that putting this into state code would reduce flexibility for state and counties in running the FSP program. So we're not supportive of the idea of putting this in state code.

>> Flexibility isn't good?

>> That's exactly what we're saying. We believe that flicks built should be maintained. If these eligibility are put into state code, we lose that flexibility because we have to go back to the legislature to get changes.

>> There's a lot of stuff in there. Not even relevant anymore.

>> Yeah. So that's our marriage concern with it. We're discussing it now with the board. The CEO and the Board have not yet taken a position but that may change in the near future too. But I wanted to highlight this bill for you, because many people who read it the first time oh thought, presumptive eligibility especially for people coming out of jail or prison and people who have been held on 5150 multiple times is a great thing and our response is yes, we agree, and that's why we accept them into the program. But our issue is processing the bill uses and not the actual substance of the bill. Last one I want to talk to you about today, actually, second to last is AB416 which is another Krell bill about involuntary commitment. And we had a caller in the public comment section who mentioned this bill. This bill would add ER docs, essentially, or ER physicians to the list of clinicians who could be authorized to put somebody in an involuntary hold. We do not position on this yet. Our analysis of the bill as currently drafted, we don't have concerns. We don't actually think it will make much of a difference here in L.A. County at all. We have a pilot project where we have added and designated ER docs in some of the hospitals to do this because we understand the issues. We have too many people ending up in medical ER facilities. And it takes too long to get PMRT, MCOTs or take them into a medical facility to the psyche ER. So we understand the need for it and we don't think it will make a huge difference in L.A. County so at the moment we don't have a position. But it's generating a lot of focus and attention which is why we put it here.

>> MICHAEL MOLINA: Can we comment on these legislations? Only because my son is an ER doctor. And I really like not being able to -- I don't have the power to do it. Bring an LPS person that's designated to that, because if I can do it, then I have less trust for my patients. They know I can make that thing. This is totally anecdotal, but I think that was the consensus with his team at his hospital.

>> I appreciate you sharing that. And I'll just note that the bill right now does not mandate counties to designate ER doctors. It's permissive but not mandatory. So right now in L.A. County, we have a pilot. We have not expanded that pilot beyond the number of hospitals and providers that we've had in that system. So at the moment, I don't think L.A. County has any plans to expand it if this bill passes. But we already have the authority. So we don't think the bill will impact us this much. But if it moves through the legislative process, the bill changes and all of a sudden it goes from permissive to mandatory, then both your son and the county would have a different take on it if that makes sense.

>> MICHAEL MOLINA: Sure. It would be nice to have, do some kind of survey VR doctors who have this power now and those that don't, what they -- because I just did my own little survey.

>> So the sponsor of this bill --

>> Survey of 1.

>> The survey is association of ER docs. It's ACEP is the acronym. This is not an L.A. County issue. They view this as an issue in bigger challenge in other counties that do not have as many LPS facilities.

>> MICHAEL MOLINA: Yeah, I can see they don't have somebody to go to.

>> Last bill is AB1032 which is by another local L.A. County delegate that is heading to assembly floor. This one actually does not impact DMH directly but we do or we're weighing in here because it impacts county residents. This bill would -- is directly related to the fires. And basically require plans that are in the private sector, it would require them to authorize and pay for a certain number of mental health visits. I believe the number is 12, although I don't remember specifically. [AB1032] And this bill is highlighted by the county, and I know supervisor barber has mentioned this because it will help address emerging mental health needs. This is not impacting the Medi-Cal system or DMH, but it would impact those with private market insurance. So we're watching it for the moment and seeing how it moves. I realize that was a lot of bills but if you have questions, I'm happy to answer them.

>> MICHAEL MOLINA: Let's do Michelle first and then take questions. Good afternoon, Michelle.

>> Good afternoon. Michelle Gibson, the Deputy Director of Department of Public Health. We have slides we're going to pulled up. We're going to start with bit of a budget discussion too. I think we were asked that at the last session well. Some of it will overlap with Elan was saying. And first slide, if you could move to the next one, just briefly is just kind of the structure of how Medicaid is structured, the federal, state, and local level and of course the Federal Government establishing that state level and interpreting that and county level implementing in short kind of short of time. So next slide. So we look at the federal budget concerns. I think the one area that we wanted to flag for us, which is likely applicable for the develop of mental health 2 is looking at federal share in the contribution that we get for each Medi-Cal service we provide. And so you'll see kind of from the images there that for individuals who are Medi-Cal eligible before the Affordable Care Act, we get 50% from the Federal Government, 50% is county contribution. Those who are eligible after the Affordable Care Act, the Federal Government pays 90% and we pay 10%. So much better deal for those, at least county perspective. For those that are eligible after the Affordable Care Act. And so when we look at the types of proposals and discussions that are going on at the federal level and of course this is very fluid and changing regularly, some of the areas that they're looking to address are possibly decreasing the federal spending. So one of that is reducing

FMAP. And limiting coverage so those who get services and adding contingency such as work requirements. So these are kinds of discussions going on at the federal level.

>> [Off mic]

>> I am concerned. Absolutely. And this slide will talk about that, right? So we're trying to kind of game out the scenarios but it is very much bit of a guessing game as we try to figure out how they're going to make changes to the Medicaid program. And so the FMAP which is the federal match is if that decreases and it's most likely to decrease on the newly eligible which is 90% from the federal 10% contributed by the county, if that decreases, essentially what that would do is have a commiserate increase in cost. The cost we have for our services and the rates we pay will be the same but we won't get the same federal match to support that. That will definitely impact our budget and our ability to deliver services. If they take a look at coverage, and decreasing those who are eligible for the Medicaid program likely the adult population because that's where we expanded drug Medi-Cal organized delivery system, that would shrink the people who receive the medical services and our provider network have built up because of the delivery medical system. And that would impact provider viability because of the potential changes and volume they have from those who are eligible. If we add contingencies most likely which is work requirements, that would also be a significant impact on the substance use disorder population because it would impact the time and participation of treatment. And so these are areas that the Federal Government is looking at potential changes for Medicaid, each of which would have an impact on publicly funded Medicaid services. Next slide. The other piece that's impactful and this seems to be less of a focus at the current moment is how the Federal Government is looking at Medicaid waivers. And so the directing Medi-Cal substance use disorder side is under 2 specific waivers. 1115 waiver is specifically what is able to deliver Medicaid reimbursable services for beds that are over 16. This is a concern to us, because the vast majority of our residential providers are over 16 beds. So that would make them ineligible if this were to change. The 1915b waiver is where we have all of our expansion of levels of care.

So prior to DMC-ODS, outpatient limited portion of residential was billable to Medicaid. With the 1915B waiver and DMC-ODS, that expanded to all those eligible including residential withdraw management outpatient for all those who are eligible for Medicaid. So you'll notice on there each of these Medicaid waivers are looking to be expired in 2026. So we are hopeful that the waivers continue throughout the term of the agreements thus far. And that these are also essential components that would be wonderful to continue even beyond the 2026 because that's what enabled SUD system to be able to expand and serve more individuals.

So these are the pieces that we are -- next slide. Elan covered this a little bit but part of this is Medicaid areas we're concerned about that's our treatment system. There's also a lot of changes he mentioned around consolidation of SAMHSA,

eliminating certain programs as you'll see here up on the slide. Pregnant and parenting women. Overdose prevention. Screening and brief intervention, et cetera are also things looked at right now. So this would be another component that would be impactful related to our block grant which is similar to what mental health gets as well. Next slide. I think it goes without saying that when we look at key priorities as it comes to Medicaid for our behavioral health system, the first is to protect Medicaid coverage and the benefit package to ensure our safety net populations continue to get care as well as to continue to support the waiver program that have enable and expansion on the substance use disorder side. And we'll talk all the pieces we talked about today. We have done some projections and simply we don't know what's going to happen and it's difficult to estimate and project the impact it will have on the system. So I'll pivot here to do some brief updates on the legislative report. I'll skip the federal one because Elan did a great job covering that and go to the next slide.

First piece is one we wanted to highlight. It's AB1037, substance use disorder care Modernization Act. This is an L.A. County sponsored regulation and so we are doing that with SAPC and Department of Public Health and we support this. Really what this is going to do is modernize the language that we use in state statute to be appropriate to how we deliver care now, kind of as the conversation was earlier and how our language helps define how we support those that we serve. And so some key areas that this legislation would include is allowing risk reduction language. So this affects our harm reduction services. It looks at barriers residential treatment programs, the regulations or the law says you cannot enter into services if you have used within the 24 hours. And so that is certainly a challenge because those who are needing residential services are the ones who are needing the highest level or most of the highest level of care for us so we want to have opportunities to serve them when it's medically appropriate in our residential programs and not have to turn them away so they've been sober for 24 hours. The other piece is looking at some legacy pieces around the time it takes to license and certify as it relates the visibility to provide immediate medical services as well as update to Naloxone and it is an over-the-counter medication and no longer requires a standing order.

So we hope this is a bill that will have broad support. I think it really is trying to look at how do we continue to support the substance use disorder clients in the way we speak and the way we deliver services. That's the first piece of legislation. Next is AB309. Hypodermic needle and syringes. And this extends current law that enables licenses or -- I'm sorry, to obtain hypodermic needle without prescription. So this is as you know with our harm reduction services, this is important piece of our ability to help support and sustain public health and reduce the spread of communicable diseases through clean needle exchange and this would extend state law on that. The next piece is 8396, needle and syringe ex-services. And I think the concern we have with this legislation is that the overly punitive nature of that, the concern being if we require

individuals to be able to -- one for one exchange for the syringes that we may not be able to have the community impact that we do as well as increasing the burden and penalties for providers and particularly, suspending of operations if they were found to be out of complain.

>> REBA STEVENS: Does that mean they don't have something to exchange? If I don't have nothing you ain't giving me nothing?

>> I think they're really trying to track. I have to look at. This is one we got so we know there aren't any syringes in isn't community that was not turned in. And last one, if you can switch the slide. AB255. This is supportive recovery residence program and this provides funding to provide recovery residents in alignment with the National Alliance for recovery residents. Currently, DPH does not have permanent supportive housing but something we certainly are encouraging and wanting to see growth on is additional recovery housing options for individuals that are seeking an environment that is supportive of their abstinence. We certainly want to keep reminding Department of Public Health is support of housing first option but we also know many of our clients are interested in recovery-oriented environment. So we want to have opportunities to have the full continuum of services. And this would potentially provide an opportunity to expand that through funding as well. And with that, that is my last slide.

>> MICHAEL MOLINA: Any questions? Commissioners?

>> Just out of curiosity, do you know if there's sponsoring organizations or group of individuals behind Ben Allen LPS bill?

>> Yeah, there may be multiple, but I know main one is CSAP, the California Society -- or psychiatrist? I'm sorry, I know the acronym is correct. But I'm not remembering the extended name. But it's CSAP. It's a group of psychiatrists, California society of psychiatrists or something like that, that has sponsored a number of bills that are often trying to expand avenues into LPS conservatorship and into CARE Court and other avenues to get more people into involuntary treatment. And in this case, one of the things that the original introduction -- introduced version of the bill really raised a lot of eyebrows and they were actually taking sections of the probate code in regards to probate conservatorship and folding them into LPS conservatorship. And so that was what raised our eyes in the original version. A lot of that has been amended out but there's still concerns we're working through with the bill.

>> MICHAEL MOLINA: Any other questions, colleagues?

>> REBA STEVENS: I have a comment. First, I want to say thank you. It's nice to get to know you. And I think that's a key piece is the nice to get you know you. So that we're not, I mean, this went too fast. I really want to understand bills. I want to understand when I need to call in, how do I support and gathering the troops to call in, something which I do. So I think moving forward, we need to be more mindful of this new BSHA and having the time to really not only hear from you, but I mean, you were going like, you were flying. And to me, it's just not fair. So I just want to acknowledge

that and I look forward to getting to know you better and supporting you and not having to move so fast.

>> MICHAEL MOLINA: Again, this is the 4th time I'm agreeing with Commissioner Stevens. It's important that we spend time on legislation. Thank you very much. Colleagues, just so you know, amidst in this presentation we lost quorum so we cannot continue with the agenda as printed today. So we'll dispense with the updates and we'll do that next month. We can adjourn the meeting, but constitutional say and have Mr. Franklin's presentation if you like to do that. I agree with Commissioner Steven saying, something we can offer to you, if you like to return next month when the full commission is here, we would be happy to put you on the agenda next month so we can do that.

>> If I may, this is Kenia. As a kind reminder, you did add 30 minutes to meeting for SAPC. So if you remember the last meeting, there was a discussion May, June, July meetings were going to allocate additional 30 minutes.

>> MICHAEL MOLINA: Thank you for the kind reminder but that still does not excuse the Commissioner.

>> KENIA FUENTES: I'm not saying it's not time because of quorum.

>> MICHAEL MOLINA: So if I can have order, it's up to you Mr. Franklin. We love you to come back next month and present to the fuller commission. If that doesn't work for you, we can take it now and listen to your presentation. However, we can't engage in any dialogue with you. That's just rules of the way we operate. And I apologize for that. That we've lost quorum and we have to look at a Plan B. Are you willing to come back next month with our apologies with what happened today? Thank you, Mr. Franklin.

>> REBA STEVENS: Can I ask for one thing and that's Mr. Franklin is at the top of the agenda.

>> MICHAEL MOLINA: Colleagues, we'll adjourn and we'll continue next month. Thank you.

[Meeting adjourned at 4:36 P.M.]