MHSOAC
Mental Health Services Oversight and Accountability Commission
Meeting Minutes
March 22-23, 2012

Citizen Hotel
926 J Street
Sacramento, California 95814
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1. **Call to Order**

Chair Poaster called the March 22nd meeting to order at 9:15 a.m. He summarized the upcoming agenda topics.

2. **Roll Call**

Commissioners in attendance: Larry Poaster, Ph.D., Chair;
Richard Van Horn, Vice Chair; Sheriff William Brown; Victor Carrion, M.D.;
Assemblymember Mary Hayashi (March 23); Ralph Nelson, Jr., M.D.;
David Pating, M.D. (March 22); Andrew Poat; Eduardo Vega; and Tina Wooton.

A quorum was established.

3. **Changes at the Federal Level**

Commissioner Pating introduced the morning workshop presentations and stated they would help answer three questions:

- What is Health Care Reform (HCR)?
- What is happening in terms of preparation for HCR?
- What does this mean for this Commission and for mental health?

Commissioner Pating stated he would give a brief introduction on the outline of HCR; Sandra Naylor Goodwin, Ph.D., would speak on why mental health is involved in HCR; Alice Gleghorn, Ph.D., would speak on how San Francisco County and other counties are preparing for HCR; Robert Sugawara would speak on Medi-Cal; and Patricia Ryan would speak on the broader perspective at the county level.

A. Presentation: Overview of Mental Health Care Reform Under the Affordable Care Act

Commissioner Pating described the lack of consistency and organization in the national treatment system for mental health. In 2003, the New Freedom Commission on Mental Health was established to address this concern. They stated the need for continuous access to current treatments and services for all. In 2006, the Institute of Medicine issued a landmark report which states that there is no health without mental health and that health care must include the mind as well as the body.

Commissioner Pating stated that the key strategies of the National Health Care Reform of 2010 are (1) insurance reform and coverage expansion, which are

financing and funding services in a new way to pay for health care and (2) delivery system design and payment reform, which are efforts to try to build a more cohesive health care system. This means integrating mental health care with primary care.

He explained that one of the goals of HCR is to expand coverage. Approximately twenty percent of the people in California do not have health care insurance. Under the new HCR, four million previously uninsured people will receive insurance. This means the population that mental health provides care to will actually shrink, but the federal match dollars that come in through federal block grants will also shrink for this population.

HCR is built on an insurance model, whereas previous systems have been built on a federal block grant model in which counties receive money and deliver it into various services. Funding will now be following the patient in terms of health insurance. The model of health insurance goes into the Health Insurance Exchange, which is a web-based entity that mediates money coming in from employers, Medicare subsidies, and other federal subsidies up to four hundred percent. Products can be purchased at sixty to ninety percent copayment levels. The level of care that will be included in “essential health benefits” (EHB) is yet to be defined. Mental health has been designated as one of the ten EHB. The Health Insurance Exchange will adhere to the Mental Health Parity and Addiction Equity Act of 2008 where mental health care services will be offered with the same day or dollar limits as regular medical care.

Commissioner Pating summarized this portion of his presentation dealing with the issues of coverage expansion and payment of insurance reform as follows: (1) there will be more people coming online, (2) there will be a more standardized product, and (3) there will be a change in the way safety-net services are run.

The next portion of Commissioner Pating’s presentation dealt with the last two key strategies of the National Health Care Reform of 2010: delivery system redesign and payment reform. These strategies will answer the question: What does insurance pay for? He stated that the problem with current health care is that it is “top-heavy,” where acute care and specialty care are at the top and prevention is at the bottom. It was decided under the MHSA’s policies that this needs to be turned around. The Affordable Care Act (ACA) has taken this approach where prevention is emphasized so the higher expense of acute care can be reduced.

Insurance reforms are now building a system that will be more integrated: patients will receive care in medical homes, linked to specialty care and hospitals, but their total care will be part of mental health and medical care. Patient-centered care will allow personal physicians, whole-person orientation, and coordination and integration. It has to be done in a timely, integrated way, with good access. This is a model of care that has developed nationally.

This system has to involve good communication and expansion of electronic health records. The Mental Health Services Act (MHSA) can be used to correct the poor electronic records of the mental health system; some counties have been using MHSA monies under capital technology to establish this system, which will then be able to demonstrate the effectiveness of mental health care.

There is a very strong evaluation component under the ACA. This evaluation component has not been worked out for mental health, but should include research showing the improvements in local health systems. It would benefit the Commission to work with ACA to facilitate the evaluation of how patients are cared for.

In summary, HCR is insurance reform and coverage expansion, enabling more people to get insurance at a standardized level. Insurers will have to meet the HCR's standards in order to prove that they are adequately providing the level of care demanded under ACA, in exchange for small payment reform incentives. This will be rolled out sequentially through the Health Insurance Exchange. The Exchange will have eligibility and outreach issues; there are the issues of defining EHB and the term "parity," as there is no national parity standard at this time; there are clinical competency and capacity issues, because much of the mental health workforce is not reimbursable by insurance; there are health information exchange and outcomes issues; and there is the issue of overseeing insurers to ensure they are doing what they need to do. These are key steps that will be part of HCR and represent opportunities for the MHSOAC to get involved.

B. Presentation: The Business Case and Models for Health Care Integration

Sandra Naylor Goodwin, Ph.D., Executive Director of the California Institute for Mental Health (CiMH), stated that the crucial issue with the business case is how it affects health care costs, which will greatly impact mental health and substance use disorder (MH/SUD). CiMH has been collaborating with counties for five years to secure health care for people with serious mental illnesses.

People with serious mental illnesses have an average lifespan of fifty-three years, twenty-five years less than the rest of the population. If they also have a problem with substance abuse, they lose another five years. A little over fifty percent of these early deaths are by natural causes, treatable, or preventable health issues, which can be costly. People with MH/SUD also have a substantially higher prevalence of chronic health conditions and higher overall health care expenditure – two to three times greater than average. This directly affects the quality of health care.

Bi-directional integration is one solution to high cost: a person with a mild or moderate MH/SUD condition receives care in primary health care with support from behavioral health, while a person with a serious or severe MH/SUD condition receives care in a specialty MH/SUD or behavioral health service clinic with support from primary care.

The Four Quadrant Model is useful in planning for populations. The vertical line represents MH/SUD complexity, while the horizontal line represents the degree of physical health risk, allowing for a spectrum of physical health and MH/SUD issues. This model can be used to analyze the kinds of services necessary for each quadrant's population on a conceptual level. Most people in Quadrant One, with low risk for physical health and MH/SUD problems, will receive health care in a primary care setting, which should allow screening and specialty prescribing consultations. People in Quadrant Four, with high risk for physical health and MH/SUD problems, will have their care coordinated by an outstation medical nurse practitioner or nurse care manager, with intensity depending upon the type of problems exhibited. Many counties in California use the Four Quadrant Model to begin planning health care availability.

It is important to include MH/SUD in overall HCR because of the wide range of problems and treatments that fall into this category, resulting in higher medical costs for patients and their employers. The University of California (UC) San Diego examined nation-wide Medicaid data over the past five years, including pharmacy data. They found that fewer than five percent of the beneficiaries of Medicaid drive fifty percent of the cost; further, forty-five percent of Medicaid beneficiaries with disabilities have three or four chronic conditions, and roughly half of them have a psychiatric illness. California is currently developing dual-eligible pilot services for people with both Medicare and Medicaid. Fifty-two percent of this population have psychiatric illnesses. Three of the top five chronic illnesses that are the greatest drivers of cost are psychiatric illnesses and the highest driver of cost is a person with both psychiatric and cardiovascular illnesses.

Kaiser Permanente (Kaiser) did a local study of substance abuse of the employed population. They examined how costs were being driven by alcohol and drug problems. One of the findings was that if a person has a substance abuse disorder they had a much higher risk for certain illnesses, and those illnesses were much more expensive. Kaiser also found that family members of the individual with the substance abuse problem had higher health care costs. When Kaiser began offering integrated care, combining substance abuse disorder care with medical care, these higher-cost patients reduced their costs by more than half. When an individual with a substance abuse problem received help in becoming sober, their family members' medical costs were lowered to the average within a year.

Washington State studied the cost-effectiveness of investing money in substance abuse services. They invested fifty-one million dollars over four years in substance abuse treatment and saved one hundred seven million dollars, and concluded that for every dollar they invested they saved two.

Eleven percent of people being treated in the fee-for-service Medi-Cal system have a serious mental illness and the cost for them is 3.7 times greater than the rest of the Medi-Cal population. Milliman, an actuarial firm, was asked to study

the overall insurance costs in the employed population and determined that if a ten percent reduction were made in the costs of patients with comorbid psychiatric conditions through effective integrated care, for every one hundred thousand insured members, $5.4 million could be saved. The cost of doing nothing may exceed $300 billion per year in the United States.

At the county level, CiMH is developing a website that will share the integration progress in California based on county surveys. Thus far, seven counties exhibit basic collaboration, with separate systems at separate sites that coordinate care around their shared patients by telephone or letter. Four counties have basic collaboration on site, with separate systems sharing a site and communicating. Three counties exhibit close collaboration and a partly-integrated system, with mental health and primary care providers in the same facility with shared systems. Three counties exhibit close collaboration and a fully-integrated system, with all providers on site on the same team, giving patients mental health treatment as part of their regular primary care. All counties are working towards the ideal fully-integrated system; fourteen counties are using the Four Quadrant Model to help plan.

Commissioner Questions and Discussion

Commissioner Poat asked when will the counties and the Commission get to a level of evaluation that can determine what works and what does not work. Dr. Goodwin postulated that it may come out of the learning collaborative. She added that since all of the counties are structured differently, what works in one county may not work in another. Because of this, components of what works will have to be taken into consideration. These components will be integrated into the counties' systems accordingly. Part of the CiMH integration website will allow counties to work together as they develop their own methods of integration.

Commissioner Carrion asked if there is an institute or collaborative studying the level of integration as related to effectiveness and efficiency. Dr. Goodwin stated that CiMH is not doing so at this time, but she would like to see it happen eventually.

C. Presentation: Primary Care Integration and Health Reform Preparation

Alice Gleghorn, Ph.D., Alcohol and Drug Administrator of the San Francisco Department of Public Health, stated that her presentation would cover the broad objectives of HCR, the goals of waiver activities, and how this has been rolling out statewide across the counties. In addition, she would also describe San Francisco's preparation, and share a few ideas on the role of the Mental Health Services Act (MHSA).

HCR is intended to cover the uninsured. By 2014, millions of additional people will have access to Medicaid coverage. The vision in HCR is a shift to the model of primary health care homes, with a focus on prevention and wellness, routine care, and disease management. Ideally, this will lead to decreased reliance on

emergency care. It also focuses on integrated models of care. HCR redesigns business practices, moving toward electronic health records, electronic billing, and coordination of case management activities.

The goals of waiver activities are jump-starting HCR and increasing the federal funding through the implementation of the waivers. Dr. Gleghorn described the goals as beginning to enroll the uninsured, acclimating emergency room users to the primary care model, focusing on prevention, initiating electronic health records through federal incentives, and establishing operational aspects of the new system.

The Centers for Medicare and Medicaid Services (CMS) has the 1115 Waiver to reduce the number of uninsured. California participated with some counties in an earlier waiver in 2005. The new waiver began in 2010. In the first waiver, the Health Care Coverage Initiative (HCCI) covered up to 200 percent of the federal poverty level (FPL). HCCI is a term contained in the Low Income Health Plan (LIHP) under the second waiver. LIHP split into Medicaid Coverage Expansion (MCE) and HCCI.

California targeted 100,000 people from ten selected counties in the first waiver under HCCI. The plan went up to 200 percent of the FPL. In the second waiver under LIHP, California targeted 500,000 people from those ten counties, and allowed other counties the opportunity to volunteer to participate. The plan covers MCE and HCCI and is timed to end with the start of HCR coverage on January 1, 2014.

LIHP is an expansion of the original HCCI program but it is different in that it splits it into the two populations: MCE and HCCI. LIHP offers a range of benefits similar to what is currently being covered under Medi-Cal. It identifies two different enrollment levels, funding streams, and reimbursement potential for each of those populations; helps standardize some program aspects for participating counties, imposes managed care provider network requirements and clinical access standards, and imposes penalties if counties do not meet those provisions. Some counties do not choose to participate because of the increase in county costs to provide services to these populations.

LIHP covers individuals who are between the ages of 19 and 64, United States citizens or qualified immigrants, residents of the program county, and people who are not pregnant and not eligible for Medi-Cal or the State Children's Health Insurance Program (S-CHIP). They must have United States government identification and their incomes need to be between 0 percent and 200 percent of the FPL.

The benefits of the state plan are similar for MCI and HCCI, except HCCI does not necessarily include mental health benefits. LIHP does include medical home benefits in line with the focus of this model of having a medical care home as the primary contact for this system. The medical care home will conduct intake

assessment, make referrals as needed, provide care coordination across other systems, provide case management, and use clinical guidelines.

The mental health benefit for the MCE population is up to ten days per year of acute inpatient hospitalization, psychiatric medications, and up to twelve outpatient encounters per year. Counties may opt to provide mental health services through a carve-out as opposed to a carve-in system. Depending on resources, counties could provide resources and additional Medicaid services and receive federal funding for them if they are covered by Medicaid.

Counties are required to reimburse out-of-network hospitals for emergency room and post-stabilization services, including psychiatric services. This is another cost factor counties need to take into account. The counties have to determine what benefits they will be able to provide. The benefits are similar to Medi-Cal, but some counties elected to cover more mental health and to include substance abuse coverage. LIHP had tiered benefit options related to the difference between the MCE and the HCCI. Some counties chose to have a uniform benefit system. The counties bore the cost increases and had to adjust their benefits based on their cost projections. In addition, the Ryan White ruling came down as a requirement to move all Ryan White eligible individuals into the LIHP plan after many counties had already implemented their LIHP plan.

Counties must prioritize the lower income MCE group. They cannot do an HCCI unless they have an MCE, but they can do an MCE without an HCCI. Counties must consider what the highest percent of the FPL cap will be, given the estimated number of people it will be able to cover based on expenditure projections. The counties could grandfather enrollees from the earlier waiver into the LIHP plan if they continue to recertify, even if their income now exceeds the level the county sets for LIHP. In order to reduce the enrollment cap or lower the FPL, the county has to go through a public process including a county resolution and approval by the director of the Department of Health Care Services (DHCS). There is an incentive for counties to start modestly with the MCE population and expand up.

Concerning LIHP and Ryan White, after the plan was implemented, CMS and the Health Resources and Services Administration (HRSA) determined that all current Ryan White clients eligible for LIHP must be enrolled in the LIHP program. Under current law, the Ryan White funding must serve as the payer of last resort. The aftermath of this, specifically in San Francisco, was that LIHP had to assume financial responsibility for the Ryan White funded services and all their eligible clients. There was a direct cost shift from the federal government to counties. This displaced the uninsured from LIHP. There was also concern about the continuity of care for Ryan White clients.

LIHP funding is reimbursement for costs incurred delivering services at fifty percent of the Federal Medical Assistance Percentages (FMAP). The Federal Financial Participation (FFP) requires a match; the match for LIHP is county funds via certified public expenditures – no state funds. LIHP funding is in

two buckets. MCE is uncapped; however, HCCI is capped at a statewide maximum of $180 million. Counties have the option to either operate under an actuarial rate model or drawdown FFP using Certified Public Expenditures.

San Francisco's LIHP program, "San Francisco Provides Access to Health Care" (SF PATH), consists of individuals who started out in the HCCI and grandfathered in. They have incomes of 0 percent to 200 percent of the FPL. New enrollees started July 1, 2011, and went until the date of the Ryan White decision. They were individuals in the MCE with incomes of 0 percent to 133 percent of the FPL. After the Ryan White decision, SF PATH lowered the poverty level to 25 percent of FPL due to absorption of eligible Ryan White clients. SF PATH continued MH/SUD coverage for that population.

The provider network is the San Francisco Department of Public Health (SFDPH) primary care clinics. SF PATH was reviewed and approved by state DHCS and federal CMS and was implemented on July 1, 2011. SF PATH currently has over eleven thousand enrollees in LIHP.

SFDPH uses One-e-App to determine eligibility for SF PATH and other programs such as Medi-Cal and Healthy San Francisco. Uninsured adult residents do not have to apply to any specific program because One-e-App determines whether they are eligible for SF PATH, Medi-Cal, or universal health care under Healthy San Francisco. Enrollment into SF PATH is based on meeting federal eligibility criteria and applicant selection of a SFDPH primary care medical home.

There are fees involved for SF PATH, but with the majority of individuals enrolling into LIHP, there will not be any fees except for those who were grandfathered in. Clients who are eligible for LIHP services and have been identified through One-e-App are billed to LIHP. It is important to note that not all the behavioral health services provided are billed to or paid by LIHP.

Focusing briefly on the Mental Health Services Act (MHSA), the list of covered mental health benefits was short and most counties do not cover substance abuse benefits. Integration is not necessarily covered. MHSA could fill the gaps in services not covered in essential benefit plans, such as unlicensed staff, behavioral health homes or other novel settings, and targeted populations identified by counties that would not be covered under the federal plans. MHSA could also help fill the gaps with peer model programs such as System Navigators. David Mineta, Deputy Director of Demand Reduction at the White House Office of National Drug Control Policy, spoke to SFDPH about System Navigators, which are unlicensed individuals who help clients get to their appointments and link them with different aspects of care. Mr. Mineta said this is being considered at the federal level because research confirms improved care and health outcomes.

Other areas where MHSA could help fill the gaps are in pilot models of care such as workforce education on evidence-based practices, certain medications, integrated programs, and infrastructure not yet reimbursed.

Commissioner Questions and Discussion

Commissioner Carrion asked how SF PATH covers what LIHP does not cover. Dr. Gleghorn answered that San Francisco redesigned its primary care system seven years ago and offered universal health care coverage under a program called Healthy San Francisco. They took the indigent care funding and moved to a model of the primary care home. When San Francisco shifted to this model of primary care, it also conducted research to verify the projected outcomes. Healthy San Francisco has enrolled up to 100,000 people in the program since 2007 and has seen a decline in the use of emergency departments during this same period while California on a whole showed an increase.

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D. Presentation: The Changing Structure of Medi-Cal

Robert Sugawara, Acting Chief, Medi-Cal Eligibility Division, DHCS, stated that Medi-Cal eligibility today is very complex. Medi-Cal currently uses 257 aid codes to identify beneficiaries. Medi-Cal covers families, children, seniors, persons with disabilities, and pregnant women. There are categories that people fall into, combined with income-related criteria that establish whether or not an individual is eligible for Medi-Cal. Currently, there are twenty-eight mandatory pathways and twenty-one optional pathways mandated by the federal government that are to become eligible for Medi-Cal. Deprivation, such as an absent or unemployed parent, is also a major consideration for Medi-Cal eligibility. Other considerations include family income based on the FPL, family assets, and countable personal property.

The major proposed eligibility change is the ACA requirement to implement the income rule related to using the Modified Adjusted Gross Income (MAGI) for establishing eligibility. The formula for this calculation is currently being determined. Another eligibility change is the simplification of eligibility verifications by a federal electronic verification hub that will tie into the IRS and other federal data sources that identify income. The federal government has identified four categories of individuals who are subject to eligibility using the MAGI: parents and caretaker relatives, pregnant women, children up to nineteen years of age, and the LIHP population. In 2014, that entire population, approximately 327,000 people, will be switched over to Medi-Cal. It is estimated that a little over three million nonelderly Californians will be Medi-Cal eligible in 2014.

ACA eligibility requirements are simplified. There is no asset test for the MAGI population and the verifications are streamlined. The groups are collapsed into those four major groups for the MAGI. There is an online portal using a single, streamlined application for all modalities (online, by mail, in person, or by phone) for applying to Medi-Cal, healthy families, Exchange health plans, or tax subsidies.

There has been some discussion about “horizontal integration,” which will allow this application to be used for public assistance programs as well. DHCS does not see this happening until after 2014.

DHCS has been working with the Health Insurance Exchange and the Managed Risk Medical Insurance Board (MRMIB) on the procurement of the California Health Care Eligibility, Enrollment and Retention System (CalHEERS) vendor, which is the eligibility enrollment system that will process the applications sent through the single portal. The goals are that it will be consumer-friendly, seamless, and state-of-the-art. DHCS is working with advocates and stakeholders in leveraging and modernizing state and county eligibility legacy systems.

Mr. Sugawara stated that he was asked to do an overview of the ACA Essential Health Benefits (EHB). ACA requires the Secretary of Health and Human Services to define EHB. Health plans that must offer the EHB are non-grandfathered plans in the individual and small group markets, Medicaid benchmark and benchmark equivalent plans, and basic health programs. Health plans not required to cover EHB are self-insured group health plans, large group market health plans, and grandfathered health plans.

There are ten benefit categories of EHB, including MH/SUD. The ACA also requires that the scope of benefits must equal those under a “typical” employer plan. One of the challenges is that the statute does not define “typical.” Other ACA requirements are that the secretary must establish an appropriate balance among the ten benefit categories; benefit design cannot discriminate on the basis of age, disability, or expected length of life; benefits required by state law not included in the EHB are paid for by states; and plans are to be assigned an “actuarial value” reflecting the percentage of benefits covered by the health plan versus cost-sharing of the individual.

The states are to define EHB by selecting a “benchmark” plan reflecting a typical employer plan in the state. The benchmark plan needs to equal the standard for qualified health plans in the Exchange and all plans in the individual and small group markets in the state. States must choose, during the third quarter of 2012, for the first coverage year in 2014. If no benchmark plan is chosen, then the default is the largest plan by enrollment in the largest product in the state’s small group market.

Mental health services is one of the ten categories required by the ACA, for individual and small group markets, to be included in the EHB. Substance abuse services and behavioral health are also included. The understanding is that the federal government is proposing that mental health parity applies to EHB.

One of the challenges is timing because September 2012 is the deadline to choose the EHB package. It must represent a typical employer plan and cover the ten defined categories. If the EHB package is missing any category the State will have to identify other plans or programs that can supplement that package.

Commissioner Questions and Discussion

Commissioner Brown asked for an overview of benefit eligibility under the ACA of people who are either incarcerated, on parole, on probation, or are under the hybrid version of parole and probation. Mr. Sugawara stated incarcerated individuals are not eligible for Medi-Cal with one exception called the "inmate exception," whereby an inmate needs to receive inpatient services off the grounds of the correctional facility. There have been a number of bills related to expanding coverage of Medi-Cal for incarcerated individuals. Parolees are eligible for Medi-Cal. CMS will likely issue some sub-regulatory guidance via state Medicaid director's letters if the current policy is changed.

E. Presentation: County Perspective

Patricia Ryan, Executive Director, California Mental Health Directors Association (CMHDA), stated that it is important to preserve the established structure in California because it maintains the array and location of services that county mental health and their contractors provide to individuals in the community with serious mental illnesses. CMHDA has been working hard over the past few years to ensure, wherever possible, that the community mental health system maximizes federal participation and maintains a service structure that focuses on recovery and resiliency.

The system in California, with the rehabilitation option and targeted case management state plan amendments, is not typical of most states. Although there will be many new enrollees in 2014, not everyone will be enrolled in the new system. California will still have a system that serves the disabled, SSI recipients, and AFDC-eligible beneficiaries at the fifty percent matching rate. It is important to understand that the specialty mental health system counties, not the State, are the entities that provide state matching funds for the community behavioral health services provided under the specialty mental health system. Therefore, it will be necessary to preserve the flexible use of resources to be able to provide services to this specialty population, which has serious mental health needs outside of the overall system.

Over the last twenty years, CMHDA and counties are the reason for the rehabilitation option and the targeted case management option in California. Counties were previously limited as providers of community mental health services by the clinic option, as inpatient care, psychiatry, and some psychology visits were all that were covered. Under the expanded rehabilitation model, there is a much broader array of services. Counties pursued this with the understanding that their money would be used to obtain additional federal funds.

Recently, CMHDA worked with DHCS to better align the coverage requirements with the recovery and resiliency focus of the MHSA in the State plans, which will allow counties to provide services that focus not just on deficits, but on recovery and resiliency supports for treatment planning purposes, and to maximize federal reimbursements using MHSA dollars as appropriate.

Last year, CMHDA sponsored a bill that allowed counties to pull down additional federal money based on actual costs rather than a statewide maximum allowance, which artificially capped the reimbursement that counties received. Counties will now be able to bring in more dollars through federal financial participation without costing the county or the state any additional money.

CMHDA advocated for mental health services in the 1115 Waiver, which was implemented in San Francisco. When it came to the details of how minimum mental health benefits would be implemented and the choices counties would have in providing billing for services with those benefits, CMHDA advocated for DHCS and CMS to support a broader definition of outpatient benefits. This enabled more than clinic-based benefits and allowed the specialty mental health system to bill for those benefits as well as provide services under the rehabilitation option. CMHDA also helped counties that had the money-as-match to see the benefit of providing services beyond the minimum benefit by utilizing county funds along with federal financial participation.

Finally, CMHDA provides an opportunity for parolees to be targeted by counties for enrollment in the LIHP. Counties are receiving additional funds in order to care for parolees; the counties can use some of these funds to provide the match and to pull down additional federal financial participation, which essentially doubles the amount of money that could be available for serving parolees.

Public Comment

- Delphine Brody, MHSA and Public Policy Director, California Network of Mental Health Clients (CNMHC), agreed with Dr. Gleghorn's presentation on how MHSA could "fill the gaps" not covered in essential benefit plans, and stressed the importance of unlicensed staff, including peers, in the expansion and integration of person-centered health care homes to include MH/SUD clients. As System Navigators also include peers, she emphasized the importance of increasing and expanding System Navigators. Ms. Brody also recommended complementing workforce education on EHB with workforce education on community-defined practices, including culturally-specific programs that serve communities based on their definitions of what is effective rather than on empirical studies.

  Ms. Brody asked if the LIHP mental health minimum benefits reflected the federal requirement or San Francisco's decision on how to use those benefits. Dr. Gleghorn responded that minimum benefits were not set by San Francisco. San Francisco provides a range of benefits for all its mental health programs with access to all behavioral health services. Patients can call a behavioral health access center, then be screened and placed in a variety of services. Ms. Brody also expressed concern that the federal minimum seems to value crisis management over prevention and wellness-focused programs.

  Ms. Ryan added that the minimum benefits are in the terms and conditions of the CMS-approved waiver; all counties that implement a LIHP must provide at

least that minimum benefit. The ten outpatient benefits can be a variety of outpatient visits including crisis intervention, targeted case management, etc., that are not typical clinic visits. Each county is able to go beyond that minimum, as San Francisco does.

Summary of Commissioner Discussion on Morning Presentations

Potential Role in Health Care Reform for MHSOAC

- Influencing policy in the following areas:
  - Essential health benefits
  - Medical home
  - Eligibility and outreach
  - Workforce development
  - Evaluation
  - Inmate/parolee eligibility for Medi-Cal
  - Other public policy
- Oversight in larger health care system
- Public relations

Comments and Concerns on Health Care Reform

- Policy positions should be based on the Act.
- Should the Commission lead the discussion forward for California and the U.S. by advancing the MHSA values and integration?
- Will we lose the gains made in MHSA values and services under health care reform?
- Health care reform may be the vehicle for integration.

Next Steps on Health Care Reform

- Seek to have mental health adequately represented in discussions.
- Collaborate or coordinate evaluation with larger health care evaluations.

4. Changes at the State Level

A. Overview of Governor's Proposed MHSA Trailer Bill Language

Kiyomi Burchill, Assistant Secretary of the Health and Human Services Agency (CHHS), stated that she would recap last year's changes to community mental health under Assembly Bill (AB) 100. After which she would outline how the governor's Trailer Bill Language (TBL), publicly available at the Department of Finance website, clarifies the MHSA and proposes to consolidate the functions of the Department of Mental Health (DMH).

Since MHSA was enacted eight years ago its implementation has evolved by including DMH and its interpretation of the Act, the establishment of the MHSOAC, and the local level community planning engagement process. After

AB 100 was enacted last year as part of the budget process, counties became responsible for determining the MHSA services they deliver, consistent with the statutory requirements of the MHSA.

There are two key changes on the policy and fiscal levels. First, the enacted changes in MHSA significantly reduced the State's administrative role by eliminating State approval of county MHSA plans by both DMH and MHSOAC. As a result, to reflect that change in the responsibility shift to the counties, DMH eliminated 123 positions. Second, a new funding distribution system will be starting July 1, 2012: on a monthly basis, all unexpended and unreserved funds in the Mental Health Services Fund go to the counties.

The governor's budget proposal includes changes to the new automatic monthly distribution system. Among the clarifications made are the roles of the State and counties, particularly in light of this automatic monthly distribution system. Some of the key clarifications are the approval of county plans, submittal of county plans to the MHSOAC, and the repeal of the performance contract provisions, which have never been implemented. With the automatic monthly distribution funding, a contract cannot be enforceable by the counties or the State. Additionally, the proposal removes authorization for the State to issue guidelines, as plans will be approved at the county level. The budget proposal also preserves all five Prevention and Early Intervention (PEI) statewide projects, and contains provisions to transfer them to the appropriate entity for administration.

In terms of State partners, the MHSOAC historically has worked with the DMH. As a part of the governor's new organization of behavioral health, DMH will be eliminated along with the Department of Alcohol and Drug Programs (ADP). Those functions will be consolidated into departments that will be well equipped, given their missions and core competencies, to lead those areas. With regard specifically to MHSA, like the overall community mental health reorganization, the bulk of those responsibilities are going to the DHCS. There will also be a deputy director appointed by the governor for MH/SUD disorders.

Not all of the MHSA functions at the State administrative level are going to DHCS. For instance, the Workforce Education and Training (WET) program will go the Office of Statewide Health Planning and Development (OSHPD), which already administers a number of workforce programs for mental health. OSHPD will have responsibility for the five-year workforce plan in conjunction with the Mental Health Planning Council as is the case under current law. Additionally, the MHSOAC will receive the family and consumer contracts that DMH currently administers. Those contracts are referenced in the governor's budget as the training and technical assistance contract. The MHSOAC will continue its role in evaluation of the MHSA.

The governor's budget proposes a new Office of Health Equity within the Department of Public Health (DPH) which will receive the California Reducing Disparities Project (CRDP) and will be looking at a comprehensive and

integrative approach to the social determinants of health, both physical and mental.

In summary, the State's role in administering the MHSA will be limited. The MHSOAC will receive county MHSA plans and evaluate the programs. The MHSA data systems will be shifted from DMH to DHCS, along with the bulk of community mental health. The departments within the CHHS will see through all of the MHSA statewide projects for which they have responsibility. The CHHS will work with the Commission in securing quality, cost-effective services for children and adults with mental health needs.

Commissioner Questions and Discussion

Vice Chair Van Horn asked how the TBL varied from the Steinberg bill regarding the Senate's approval of the deputy director of MH/SUD. He also asked if the salary for the Deputy Director position has any adjustment potential. Ms. Burchill responded that the TBL proposes that the deputy director will be appointed by the governor and confirmed by the Senate. She added that the salary falls under the constraints of California's salary structure and therefore has no adjustment potential.

Commissioner Vega asked if there is a defined role for mental health boards and commissions at the county level in that process, and if there is a plan for the California Mental Health Planning Council (CMHPC) to provide assistance or training for mental health boards to review their county plans. Ms. Burchill answered that AB 100 does not specify who would approve the plans. She suggested that counties consider utilizing their local mental health boards. The CMHPC will have the same relationship it now has with the local mental health boards. Commissioner Vega recommended that, if there is no forum at the State level, the county boards and commissions be made available for consumers to have a part in the process of county planning.

Commissioner Vega requested clarification regarding where contracts for training and technical assistance, such as those currently held by CiMH, will be transferred. He also asked, on behalf of the consumer advocacy community, how DHCS will receive clients' feedback. Ms. Burchill answered that both the CMHPC and the training contracts, including the CiMH training contract, will be associated with DHCS. DHCS will receive feedback through this Commission's stakeholder input.

Commissioner Poat asked for clarification regarding whether or not the performance contracts between DMH and the counties will be required. Ms. Burchill clarified, that the MHSA requirement for the State and counties to have a performance contract was never operational. Last year's changes prevent either party from enforcing the terms of such a contract, so that language will be removed from the statute.

Commissioner Pating asked who would provide checks and balances to the counties' integrated plans. Ms. Burchill stated that since counties are responsible for determining the MHSA services they deliver, the County Board of Supervisors will be a consistent overseer.

Commissioner Wooton recommended that CHHS gather a taskforce of consumers and family members who can influence the development of the mental health system, as it is difficult in some counties for these parties to contact the Board of Supervisors in order to participate.

Commissioner Poat asked what the administration expects regarding funding allocations. He also asked if there was any sort of vision for what the MHSOAC's role will be in regards to evaluation and the results that will come in from the counties. Ms. Burchill stated that once the funding distribution system is active, the State Controller's Office will send out counties' allocations each month. The counties will calculate how much of the funding should go into Prevention and Early Intervention (PEI), Community Services and Supports (CSS), etc., using the percentages in the statute.

Chair Poaster stated that county plan submission to the MHSOAC will be a source of data and information that the MHSOAC can use for evaluation. He asked if there will be standardization regarding the number of plans. Ms. Burchill answered that counties currently exhibit a great deal of variation in their approaches and investments. Chair Poaster clarified that the County Board of Supervisors of each county will develop the content of the county's plan consistent with the statute.

Commissioner Nelson asked who would be responsible for the issue resolution process. Ms. Burchill stated that the issue resolution process will be transferred to the DHCS.

Commissioner Vega asked if the State will ensure that stakeholder input will be possible at the county level, in order to involve stakeholders in the planning and review of MHSA plans. Ms. Burchill answered that the statute requires counties to allow stakeholder engagement.

Commissioner Wooten added that it is the law for the counties to consider the stakeholder process.

Chair Poaster clarified that there are regulations in the law about what needs to be done with outcomes. Ms. Burchill stated that CHHS is examining current regulations in light of the changes AB 100 made in order to ensure the regulations are in compliance with the law.

B. Highlights of Recent Legislative Hearing and Senate Bill 1136 (Steinberg) Compare Proposals with MHSOAC'S Prior Adopted Principles and with AB 100 Workgroup Agreements

Sherri Gauger, Executive Director, stated that she would share highlights from the recent joint legislative hearing between the Assembly and Senate's Budget Committees and Health Committees that was held February 21, 2012 and highlights from Senate Bill (SB) 1136 (Steinberg). She would also compare those proposals and the administration's TBL with previous Commission-adopted actions, including the AB 100 Workgroup recommendations, the adopted principles regarding evaluation, last year's Governor's Budget, and the Commission's role in a changing mental health services environment.

Executive Director Gauger stated that the Commission participated in the February 21st joint legislative hearing and gave a brief overview of the Commission and its responsibilities, and also discussed the impact of the governor's proposed TBL on the Commission.

During the hearing, the administration presented the governor's vision for reorganizing behavioral health. Stakeholders responded to those proposals and then legislators offered their perspectives.

Some of the themes that emerged from the joint legislative hearing were:

- Will there be cost savings from what is being proposed?
- Will this ultimately improve care for clients?
- How will stakeholders continue to be involved in a meaningful way?
- What is the role of oversight going forward?
- How much of these changes should be made through the TBL versus the policy process, which provides much more opportunity for public comment.

Executive Director Gauger stated that SB 1136 signals the intent to amend Proposition 63 and other mental health statutes. It touches on almost all of the same sections as the TBL and contains a proposal to amend the Community Mental Health Services division of the Welfare and Institution Code in technical ways as well as in policy ways. Executive Director Gauger then gave a brief overview of the principles and AB 100 Workgroup recommendations that have been previously adopted by the Commission.

Executive Director Gauger stated that Chief Deputy Executive Director Aaron Carruthers would discuss the proposed TBL and where it might conflict with the actions this Commission has taken to date.

Chief Deputy Executive Director Carruthers gave an overview of the TBL and compared the governor's proposal with the Commission's principles and the AB 100 Workgroup recommendations.

The first issue is how the funds are proposed to be used. The budget and the TBL propose that MHSA funds should be used for MHSA purposes. This keeps with the MHSOAC budget principles which state that MHSA funds must further the purpose and intent of the Act. The staff does not recommend any next steps on this item since it is consistent with Commission's desire on how funds are used.

The second issue is the allocation of funds. Per AB 100, effective July 1, 2012, the State Controller's Office releases MHSA funds on a monthly basis directly to counties. The governor's proposal eliminates the MHSA sections used for the process of determining what proportion goes to each county, erasing a state process and the Commission's role in that process. The governor does not describe a new process for determining the proportion of funds. This is contrary to the AB 100 Workgroup Priority 2 and this Commission's expenditures principles. A possible next step is to consider if the Commission should seek a process for determining the proportion of funds.

The third issue is reserved MHSA funds. The governor legislatively allocates and sets aside $60 million to administer the CRDP. Reserving the funds is in alignment with the recommendations within the AB 100 Workgroup Priority 2, which looks at reserving funding for the CRDP. The Commission may want to support WET program funds being reserved as well per the AB 100 Workgroup Priority 6, which is to determine how to ensure WET funds are protected.

The fourth issue is the State administrative fund. The TBL adds "any other state agency" to organizations that may be funded by the MHSA. This competes with current statute, which currently names only three State organizations for funding. A possible next step is to consider if the Commission should seek funding for evaluation and Commission activities before other State departments not named by voters are funded.

The fifth issue is plan approval. The County Board of Supervisors must approve CSS, PEI, and Innovation (INN) plans. The AB 100 Workgroup and Commission principles have not addressed this issue. The staff does not recommend any next steps on this item.

The sixth issue is plan submission. After adoption, counties will be required to submit their plans to the Commission for evaluation purposes. AB 100 Workgroup and this Commission's principles have not addressed this issue. A possible next step is to consider if the counties should also be required to submit annual updates to the plans to support the Commission's evaluation efforts.

The seventh issue is PEI design. Under the TBL, counties, not the State, will establish a program designed to prevent mental illness from becoming severe and disabling. The AB 100 Workgroup and Commission principles have not addressed this issue. A possible next step is to consider if continuous quality improvement should be accomplished by ensuring program design is based on outcomes obtained from evaluations.

The eighth issue is performance contracts. The governor proposes to delete performance contracts. This is contrary to AB 100 Workgroup Priorities 3, 8, 10, and 11, and MHSOAC's county performance principles. A possible next step is to consider if there should be a mechanism to ensure that the MHSA is implemented and maintained in accordance with the Act.

The ninth issue is compliance. The governor proposes to delete the State's ability to request a corrective plan from a county that is not in compliance with its performance contract. This is contrary to AB 100 Workgroup Priorities 3, 8, 10, and 11, and MHSOAC's county performance principles. A possible next step is to consider if there should be a mechanism to address noncompliance with the Act.

The tenth issue is guidelines. The governor proposes to delete authority to write guidelines, including the Commission's ability to write guidelines for PEI and INN, including the CRDP. This is not consistent with the AB 100 Workgroup's Priority 9, which states the Commission has a stronger role in policy through the regulation process. A possible next step is to identify a role the Commission should take in policy making and to consider if the Commission should continue to develop reducing disparities guidelines.

There are other issues outside the TBL. The MHSA named three compliance tools: plan review, performance contracts, and the Commission itself. Plan review is eliminated by AB 100, performance contracts are proposed for elimination, and the Commission relied on the other two as tools for its own oversight. AB 100 intended that the State, in consultation with this Commission, establish a more effective means of ensuring that county performance complies with the Act. The governor does not specify how this will be done. AB 100 was signed into law in March of 2011. Chief Deputy Executive Director Carruthers asked if this Commission should seek to advance this issue.

Another issue outside the TBL is evaluation. AB 100 Workgroup Priority 4 reinforces the Commission's role in evaluation. The governor restated the Commission's role in its budget and in the TBL. Welfare and Institution Code 5845(d)(6) states the Commission may obtain data and information from state or local entities that receive MHSA funds for use in its oversight, review, and evaluation capacity. However, there are no consequences for an entity that does not provide the needed data or information. Chief Deputy Executive Director Carruthers asked if this Commission should seek to address this issue.

C. Stakeholder Perspective Panel

- Jane Adcock, Executive Officer, CMHPC, stated that since the TBL came out between CMHPC meetings, they have not had a chance to discuss it in full Council session. CMHPC is looking into certain areas, many of which this Commission already discussed, such as the placement of the licensing and certification function, the placement of the Office of Multicultural Services, the performance contracts, the transfer of the workforce functions over to OSHPD,

the placement of the Planning Council, and the stakeholder contracts. CMHPC will discuss these areas at the next Council meeting in April.

- Kathleen Derby, MHSA Policy Coordinator, National Alliance on Mental Illness (NAMI), stated NAMI California is a statewide organization of 71 local affiliates and represents over 19,000 individuals with mental illness and their family members. She stated that the current scale of change brings both opportunity and danger, but she wanted to focus on the positive. The opportunities of reorganization and a proactive adjustment can further the mission of the MHSA. The success of the new realignment depends on strengthened client and family member involvement in the local communities. Many of these changes are aimed at integrating the systems into the whole health perspective, which can be done in accordance with MHSA values. The plan to integrate mental health services regardless of funding stream can help spread recovery orientation to services that do not already contain them.

  Ms. Derby stated that there is a danger when the State acts in haste to propose changes to the system, with lessened accountability, without first consulting those who it will affect the most – clients and family members. She pointed out the danger in such rapid changes as the dismantling of DMH and state approval of MHSA plans, and the deletion of annual performance contracts as the centerpiece of accountability. There is concern about interagency interaction and fragmented venues for client and family member stakeholder participation. As functions are dispersed to five different state departments, funding to counties needs to be attached to a mechanism for accountability to MHSA at the state level, protections for the interests of client and family stakeholders in plan approval, and the accountability mechanism of outcome reporting.

- Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated that REMHDCO supports the administration's proposal to place $60 million with the DPH. REMHDCO also supports involvement of all stakeholders representing both community and government entities. REMHDCO strongly opposes removal of county mental health performance contracts from statute, as oversight and accountability must not be limited to the local level. REMHDCO supports the language added to the statutes that clarifies which State entity will review the counties' MHSA plans. At this time, REMHDCO has taken a neutral position on the proposal to divide the functions of the Office of Multicultural Services (OMS). If the administration is willing to clarify that the functions of OMS will continue to be accomplished, then REMHDCO does not mind if they are split. There is nothing in the proposed chart or description of the Office of Health Equity that assures the OMS will continue to perform their duties.

- Commissioner Poat asked for clarification regarding REMHDCO's stance on the OMS administrating CRDPs. He asked if REMHDCO was in opposition to the MHSOAC administrating the CRDPs. Ms. Hiramoto answered that REMHDCO was not aware that the MHSOAC wanted to do it. She stated that since the OMS

has the expertise and the experience, it makes sense that they would "get down to the nitty gritty" and administer the Request for Proposals themselves.

- Ms. Ryan gave an overview of how counties view the governor's proposal. It is important for counties to recognize that California's community mental health financing and administration are undergoing significant changes. Required data reporting, research, evaluation, and quality assurance activities are not currently integrated or fully occurring. CMHDA supports the administration's proposal to clarify and streamline the requirements in the MHSA, but opposes the elimination of the performance contract. CMHDA also opposes the $60,000 grant to the DPH for the CRDP. While they do not disagree with the statewide project, they support a sustainable approach. CMHDA is concerned about the precedent this would create in amending the Act to set aside local funds for a state level project of any kind.

  CMHDA supports the streamlined funding distribution process because the new continuous monthly appropriation process will allow communities to more effectively plan for services by providing a consistent funding stream. Regarding oversight, CMHDA supports the governor's proposal that requires counties' plans be adopted by the County Board of Supervisors and submitted to the MHSOAC. Local stakeholder engagement and community planning requirements were not impacted by AB 100. Regarding evaluation, accountability, data collection, and reporting, CMHDA strongly believes the MHSOAC has the primary role in outcomes and evaluation, but believes an integrated approach is imperative in order to ensure high quality and cost effectiveness in the community mental health system. Ms. Ryan implored this Commission to fully engage counties in a meaningful way in finding a solution to how oversight and evaluation can best be accomplished.

- Commissioner Vega asked for clarification regarding county oversight. He asked what the process would be for ensuring that the local oversight would happen for the counties. Has there been discussion regarding this issue? Ms. Ryan answered that there has been discussion, but there needs to be meaningful conversations about what needs to be overseen. Chair Poaster suggested that this subject could be brought up at a later time, as there is much discussion.

- Rusty Selix, Executive Director, Mental Health Association in California (MHAC), emphasized that AB 100 called on the state to replace the approval of county plans with something to provide comparable oversight. The administration's proposal seems to consider AB 100 as the starting point, rather than the original Act. Mr. Selix recommended that the Legislature put in place some requirements for the State to take action. He commended the AB 100 Workgroup, which the Commission staff held, for identifying five objectives regarding AB 100.

  - Ensure the ability to collect outcome and cost information reported and analyzed to identify the best programs.
  - Develop a local stakeholder process.

- Develop a mechanism to ensure that all county expenditures are in accordance with the law.
- Make the Commission's guidelines on plans binding, similar to the transportation Commission law.
- Clarify the ability to set aside money for the undertaking and continuation of statewide projects.

Mr. Selix stated the greatest area of frustration following the Act is the loss of regularly-collected outcomes reports. He suggested the Commission develop something comparable for children, building on the child system of care requirements. He stated MHSA can be used to fill the gaps left by the transfer of mental health for special education students to schools, if the Commission develops a role with the Department of Education to track outcomes for that program. Regarding the PEI area, Mr. Selix suggested the Commission track the number of people receiving mental health care, as an increase in both private insurance and public funding will show that PEI is working. Regarding local stakeholder process, he recommended an annual comprehensive process to include all the funding a county intends to cover, with a requirement that they do outreach to the community and respond to comments, and to ensure compliance. There should also be a corrective action plan that will withhold funds until compliance is reached. Mr. Selix asked the Commission to ensure their guidelines cover the new requirements of integration and HCR.

- Commissioner Poat asked Mr. Selix's opinion on what he thinks is the base for policy regarding mental health, adding that AB 100 is not necessarily so. Mr. Selix answered that the base for mental health policy is written very clearly in the Act.

- Diane Shinstock, United Advocates for Children and Families (UACF), stated UACF does not have an official position because the Board has not yet met. However, UACF wants to ensure that the stakeholder process is qualitative and that family members in particular have influence at both state and local levels. UACF is concerned about the deletion of the performance contracts. Ms. Shinstock recommended that any action be clear to the public to assist them in navigating the system to resolve their issues.

- Ms. Brody, Representative of the California Network of Mental Health Clients (CNMHC) stated that the Board of Directors of the CNMHC has not taken a position. However, her comments are based on prior CNMHC positions. CNMHC feels cultural competency plan requirements need to be integrated and protected and would like the MHSOAC to have a role in reviewing county plans. CNMHC also wants to ensure that the MHSOAC will maintain its oversight and policy voice in regulations.

Public Comment

- Beatrice Lee, Executive Director, Community Health for Asian Americans and President of REMHDCO, stated her organizations are very supportive of the

CDPH to administer the $60 million and for the OMS to fully administer the rest of the project in designing it, releasing the funds, and administering the contracts.

- Jamila Guerrero-Cantor, California MHSA Multi-Cultural Coalition (CMMC), stated the $60 million set aside for statewide projects, ultimately meant to reduce disparities in the State, is an important opportunity. The OMS is unique in its ability to oversee and administer the funds to projects to reduce disparities for un/under/inappropriately-served communities.
- Jim Gilmer, CMMC, REMHDCO, and the African American Strategic Plan Workgroup, stated that from the perspective of a PEI evaluator of over thirty plans, he has noticed four important points in his evaluation of plans since 2008: real stakeholder involvement, focus on reducing racial and ethnic disparities, focus on community-defined evidence, and focus on community participatory evaluation. He urged the MHSOAC to consider these areas in their ongoing decision making.
- Emma Oshagan, Ph.D., CMMC and Director of the Armenian Program Development at Pacific Clinics, commended the Commission's efforts to reduce disparities among communities. Dr. Oshagan is in favor of the distribution of the $60 million to DPH, and would like OMS to stay together if possible.
- Marbella Sala, Latino Reducing Disparities Project, stated that the MHSOAC's ability to provide guidelines and regulations is of critical importance in the RDP project. Ms. Sala also expressed concern that counties, like statewide forums in which she has participated, will not be engaged in the PEI process as they develop plans in conjunction with the Board of Supervisors and local planning councils, and will not receive PEI monies or participate in hearings and mental health planning councils at the local level. She recommended having a different process to ensure that plans are reflective of and monies will be utilized for un/under/inappropriately served communities.
- Russell B. Vergara, CMMC and Adjunct Faculty at the University of Southern California School of Social Work, expressed concern that counties may make decisions of policy and funding that exclude communities that have historically been underserved, unless principle exists of valuing the human detail. CMMC believes that policy-making decisions are able to be meaningful and responsive to the needs of the community when the communities' wisdom is recognized and valued. CMMC appreciates the commitment of the MHSOAC and the comments and concerns members have expressed regarding future changes.
- Steve Leoni, an advocate and consumer, stated the elimination of performance contracts gives even more latitude than was envisioned in the original 1991 realignment. Over a decade ago, the DMH's compliance unit was looking at compliance with realignment, checking if each county had a functional mental health board; this effort is not under consideration in the transfer. Clarity in the law is essential in order to prevent lawsuits. Mr. Leoni pointed out that cutback of state-level funding through AB 100 has actually hobbled some of the statewide

leadership, even at CiMH, where they are currently underfunded for many of their training projects since they no longer receive funding through the MHSA.

- Viviana Criado, CMMC and Executive Director of the California Elder Mental Health and Aging Coalition (CEMHAC), supports maintaining the OMS. She emphasized the need for available resources in order to effectively implement the plan for reducing disparities, and for the development of a stakeholder process that incorporates the necessary principles for inclusion of special populations.
- Sandra Marley, advocate and consumer, emphasized the need for client and family-driven oversight. She believes the responsibility may be too great for the Board of Supervisors and may be better suited for the State.

Summary of Commissioner Discussion on Afternoon Presentations

Chair Poaster stated SB 1136 appears to be this Commission's vehicle to negotiate with the administration. It is time for the Commission to sharpen its focus.

Executive Director Gauger facilitated the Commission discussion and summarized the afternoon presentations: Assistant Secretary Burchill provided an overview of the administration's TBL; staff presented a refresher of how that might impact some of the prior decisions this Commission has made; and stakeholder panelists and members of the public shared their perspectives. Executive Director Gauger asked Commissioners to discuss the potential impact of these changes on the Commission, centered on three areas:

- Possible future roles for the Commission
- Comments and concerns
- Emerging themes or possible consensus

Summary of Possible Future State-Level Roles for MHSOAC

- Is there a role for the Commission in the inputs, as well as the outputs?
- Developing standards for local plans that support Commission evaluation and having the evaluation results inform those standards – a continuous quality improvement cycle. This would include issuing the RDP guidelines.
- Continue to uphold the vision of the MHSA.

Summary of Comments and Concerns on State Level Changes

- The MHSOAC should maintain or enhance its ability to carry out local oversight.
- What must be in place to make sure that the stakeholder process is vibrant?
- Currently, there is no process in motion to ensure meaningful stakeholder participation in the planning process.
- Too much local flexibility may lead to a system that cannot be evaluated effectively, as evidenced by Proposition 36.

- It is difficult to do outreach to un/under/inappropriately served communities. With this in mind, what is the most effective way to build on what has already been built?
- The Board of Supervisors as the ultimate approving body creates problems and challenges and may result in consumers and family members finding themselves unable to attend their lengthy meetings or approach the board itself.
- Consequences are needed for noncompliance with mandates contained in the MHSA.
- The RDP Project legislative set-aside may create a dangerous precedent.
- There is support for statewide projects.
- There is support for continued funding of WET.

Summary of Emerging Themes or Possible Consensus on State Level Changes

- Performance contracts are needed.
- State oversight is still needed.
- Evaluation continues to be a critical role for the Commission.
- A strong local stakeholder process is needed.
- The State and its counties, rather than being in opposition, should be in a partnership working toward a common goal.
- Drive vision at the state level and implement at the local level.

5. Recess

Chair Poaster recessed the March 22nd meeting at 5:02 p.m. The meeting will reconvene tomorrow at 9:00 AM.

Friday, March 23, 2012

6. Call to Order

Chair Poaster called meeting back to order at 9:10 a.m. on March 23rd and summarized the upcoming agenda.

7. Adopt Minutes of the January 26, 2012, MHSOAC Meeting

Commissioner Vega stated that there were a couple of technical wording changes he would like. He will give the specifics to staff.

Motion: *Upon motion by Commissioner Brown, seconded by Commissioner Wooton, the Commission voted unanimously to adopt the January 26, 2012, Meeting Minutes.*

8. Staff Summary of March 22, 2012, Commissioners' Afternoon Discussion

Executive Director Sherri Gauger presented a PowerPoint presentation summarizing the Commissioner discussions from the prior day's meeting on health care reform and state level role of the MHSOAC

See pages 13, 24 and 25 for staff summary that was presented.

9. Final Commissioner Comments Regarding March 22, 2012, Agenda

Commissioner Poat made a comment regarding the potential role of the MHSOAC. He gave his support in adopting a framework similar to the one depicted on the slide entitled "MHSOAC Potential Roles in Influencing Policy in the Following Areas" and using it as a way to move forward.

Commissioner Wooton voiced her support of statewide projects and the continued funding for the WET projects that are not listed in the summary. Executive Director Gauger agreed to add those points to the staff summary.

Vice Chair Van Horn clarified that the MHSA is on its way to becoming fully integrated. He stated that the RDP needs clarification; either in the TBL or elsewhere, and that there has to be consequences for non-compliance with the mandates contained within the Welfare and Institutions Code. He echoed Ms. Ryan's concern that this could set a precedent for the Legislature taking money out of the MHSA fund, and emphasized the need for a clear sense of what will best protect the MHSA fund.

Commissioner Brown referenced a statement made in the previous session that the MHSOAC should not be the only entity responsible for mental health program accountability in California. He stated the Commission is not structured for that, and emphasized the importance of MHSOAC retaining its titular mission in continuing to oversee county plans in the designated areas set forth in the Act. The Commission's accountability and oversight, including plan evaluation and comparison to identify the best results, is necessary. He recommended that the Commission take a larger part in policy development, for example asking the federal Congressional delegation to change the law regarding Medicaid and Medi-Cal and restriction of mental health funds for people who are in custody. Chair Poaster added that this would be a great opportunity for the Commission and the Sheriffs' Association to collaborate.

Commissioner Carrion postulated that there is a need to define what "oversight" means.

Commissioner Vega requested mapping the logic model adopted by the Commission in the past with today's discussion. He requested an overview from staff about performance contracts and what those entail. He appreciated the guidance structure of the presentations that laid out the distinctions between the AB 100 Workgroup and the governor's proposal, and requested a follow-up. He also suggested discussion regarding practical action on RDP relating to the administration's proposal. Chair Poaster agreed to add this to the agenda.

Commissioner Poat emphasized that evaluation focuses not on MHSA expenditures but on mental health system outcomes in order to see progress with the Legislature. He recommended bringing to the Legislature the goal of updating the Commission's structure to handle the task of mental health system accountability. Vice Chair Van Horn echoed Commissioner Poat's concern regarding the proposal of an evaluation framework. Chair Poaster stated that it would be helpful to have a discussion on the Commission's role in relation to other agencies.

Commissioner Nelson suggested that the Commission create evaluation guidelines to send out to the counties as soon as possible.

Chair Poaster stated that the Commission has some tremendous opportunities for innovation regarding what will ultimately be adopted by the Legislature. He suggested focusing on local stakeholder processes and challenging the Commission to put resources into the system to ensure strong local stakeholder process.

Commissioner Poat stated that the next generation should prioritize a process driven by consumer and community data. Vice Chair Van Horn added that data systems do not currently deal with outcomes, which makes it difficult to measure the positive effects on consumers' lives.

Commissioner Brown recommended the Commission expand in the local approach to mental health services. He expressed concern about the Commission jumping straight into an oversight role for the entire mental health system. He believes it may make the Commission less effective. Commissioner Poat agreed that the Commission's current structure is not up to the task, but added its vision of its role within mental health funding has changed; he recommended forming a list of two or three key issues to work on at this time.

Commissioner Hayashi offered to work with the Legislature to clarify the role of the Commission, ensuring its authority in accountability and oversight of the Proposition 63 funds. She stated that the Commission has a critical evaluation and oversight role that must be maintained. This is an important opportunity to have input in the latest budget trailer bill.

10. Mental Health Planning Council (CMHPC) Update on Activities and Priorities

Gail Nickerson, the past Chair of the CMHPC, discussed the national perspective on the CMHPC. The Substance Abuse and Mental Health Services Administration (SAMHSA) of the Federal Government block grants are administered by the Center for Mental Health Services (CMHS) at the federal level. California gets a $56 million grant on an annual basis. If a state wants SAMHSA funding, they have to have a mental health planning or advisory council.

The CMHPC's federal duties related to the SAMHSA grant are to review the state mental health plan that is required by Public Law 106-310; to submit modification recommendations to the state; to review the annual mental health implementation plan, which includes implementation of MHSA; to advocate for individuals with serious mental illness and to advocate on the federal and state legislations that

affect consumers, family member empowerment, and planning and policy development. There are also duties to annually review, monitor, and evaluate the allocation and adequacy of mental health services in the State and to evaluate the mental health system through policy outcome measures or oversight of the managed care system that the state has set up.

The federal Council composition requirements are: consumers who have or are receiving mental health services, family members of adults and children, providers, and consumer-related advocates. More than fifty percent of the planning council must be individuals who are not state employees or providers and who do not have connections to other state departments.

Walter Shwe, past Chair of the CMHPC, spoke about the SAMHSA block grant reviews that the CMHPC is responsible for each year. Three times a year, the CMHPC conducts reviews on behalf of DMH. They ensure that the programs are effective and are meeting the federal and state requirements for funding. The CMHPC has performed these functions for years and hopes to work with MHSOAC on State activities, which include advocating for effective quality mental health programs and making recommendations regarding California's mental health system. The CMHPC is charged with evaluating services from funding streams including realignment, Medi-Cal, and the MHSA. They are also charged with reviewing program performance and the delivery of services by reviewing performance outcome data, reviewing and approving performance outcome measures, and reporting the findings and recommendations of program performance to the Legislature, DMH, and local mental health boards. They advise the Legislature, DMH, and county boards on mental health issues; recommend rules, regulations, and standards for the administration of services; annually conduct a public hearing for the SAMHSA block grant; and participate in the recruitment of candidates for the director of the DMH. In conjunction with other statewide and local mental health organizations, they assist in training and delivering information to mental health boards and commissions to ensure that they are able to carry out their duties effectively. They have been advising DMH by having CMHPC members serve on State committees and taskforces, meeting regularly with department staff, and advising the mental health boards and commissions on key mental health issues. CMHPC members are appointed by the director of DMH. The CMHPC meets quarterly in various locations around the State.

Ms. Nickerson also discussed the major areas of focus that the CMHPC has had recently. They have "functional" committees that cover quality improvement, human resources, legislation, regulations, funding, policy and system development, and cultural competence. The system of care is for children and youth, transitional age youth, adults, and older adults. The CMHPC is focused on the realignment, AB 109, AB 114, the federal HCR, participating in national whole health and state whole health coalitions, advocating for mental health parity, integrated services, monitoring the health benefits exchange for California, best practices, human resources, the WET program, a five-year plan for cultural competency, and the transition to the DHCS.

11. California Mental Health Services Authority Semiannual Update

Wayne Clark, Ph.D., President, California Mental Health Services Authority (CalMHSA), introduced John Chaquica, Executive Director; Stephanie Welch, Program Manager; and Ann Collentine, Program Director. He talked about CalMHSA's accomplishments over the year since they last reported to this Commission. At that time, they presented a plan to implement statewide prevention programs to prevent suicides, reduce stigma and discrimination, and improve student mental health.

Ms. Collentine stated CalMHSA has executed twenty-five contracts with "program partners" since July 2011, when they last reported to the Commission. The contracts contain more than 5,600 deliverables. CalMHSA has forty-four county members of the Joint Powers Agreement (JPA). CalMHSA is serious about accountability and has implemented CalMatrix, a database system, for contract monitoring and for tracking outcomes on the 5,600 deliverables. CalMHSA values stakeholder input and believes in transparency with all projects (contact information is on their website). They believe in evaluation and have selected the RAND Corporation as the organization to perform PEI evaluations. They launched all three of their initiatives at the same time. Ms. Collentine listed the highlights for the last quarter of 2011 for each of the four initiatives.

Dr. Clark spoke about the RAND Corporation, a company contracted to conduct PEI evaluations with outcomes at the end of the initiative. CalMHSA has invested up to $10 million to implement a complex and comprehensive multi-phase evaluation of all programs/initiatives. He explained how the strategies work and discussed the key objectives of PEI evaluation. He noted RAND's three components: goal, process, and outcomes-based evaluations, all conducted at three levels. RAND put together an evaluation logic framework with structure, process, and outcomes. The preliminary works-in-progress for the evaluation design are descriptive studies of capacities developed by each program, population level, and broad statewide monitoring.

Dr. Clark talked about the Statewide Evaluation Expert (SEE) Team, a team of twenty researchers and evaluators who provide expert advice to the RAND Corporation. Dr. Clark stated that CalMHSA's next steps are to collaborate with staff to develop program partner technical assistance, the draft of the statewide evaluation strategic plan, available in April 2012, and the final strategic plan adopted by CalMHSA's board in June 2012.

Ms. Collentine stated that there are thirteen new counties that have become members and that the original plan did not project this. Referring to the First Amendment to the CalMHSA Work Plan, the new participation has resulted in an additional $8.1 million of statewide project funds assigned to the JPA. This amendment seeks to use these funds as expeditiously as possible to expand the

scope of regional projects to include those additional geographic areas and the underserved population. In addition, this amendment seeks to strengthen racial, ethnic, and cultural competency within existing projects.

Ms. Collentine identified the primary principles for developing this funding allocation as being to work fast in order to ensure new counties are part of the whole CalMHSA statewide project, to maintain the overall consistency that was in the original guidelines, and to consider the unique characteristics of communities who are participating. She discussed CalMHSA's proposal for each of the four initiatives.

Ms. Collentine stated that one of the amendments to the Implementation Work Plan is a new $300,000 deliverable in PEI in the contract with RAND, which will include a PEI evaluation framework. This framework is being developed and will be presented for Commission approval in the summer of 2012. This framework is the development of a comprehensive statewide evaluation framework, which consists of identifying a consolidated list of overall goals across PEI programs, identifying data sources, developing a conceptual PEI state evaluation framework and an analytical approach that logically links programs and strategies with outcome measures, and indentifying ways to link PEI evaluation with the overall MHSA evaluation.

Ms. Collentine showed a graph of the funding allocations. She stated CalMHSA posted the draft plan for thirty days and comments were incorporated into the plan. CalMHSA is seeking MHSOAC's approval of the First Amendment to the Implementation Work Plan.

Commissioner Questions and Discussion

Commissioner Poat voiced his appreciation for the timelines on the Student Mental Health Initiative. He requested that Ms. Collentine coordinate with staff to insert the outcomes in the Committee's hearing schedule, if only a description of what was adopted in each of the five levels.

Commissioner Carrion said yes and asked if there were opportunities for all of these programs to overlap. Dr. Clark said "yes" and gave one example. He stated that there is a study out of Australia which shows that eighty percent of youth use electronic media to talk about suicide, rather than the telephone. Using this same logic when program partners sit down together, they share their electronic and Internet knowledge such as navigation of Twitter and Facebook.

Commissioner Carrion recommended structure between the people running the programs so they can communicate on their own plans. Ms. Collentine stated, with CalMHSA's portal, CalMatrix, all contractors have the ability to use message boards to ask for additional information from other program partners. There are also monthly calls, which have a high participation because they are looking for opportunities to enhance each other's program experience. This is CalMHSA's statewide coordinating workgroup and is built into the portal.

Commissioner Carrion asked what mechanism there is to identify projects, which may not necessarily be a part of any current programs, and which may be more effective than the ones RAND is evaluating. Dr. Clark stated that RAND put together a 120-page bibliography on the literature on suicide, stigma, and student mental health to assist in locating literature on specific needs. Part of the RAND program evaluation allows them to replicate efforts with additional resources if they work well, and to reevaluate and take a different course if they do not work well.

Commissioner Nelson asked for the timeframe on CalMHSA's key outcomes. Dr. Clark stated that the goal is to have those outcomes in place and ongoing by the end of the evaluation, so that five or ten years from now there will be an ongoing, sustainable ability to measure those key outcomes. Commissioner Nelson asked when to expect the first report on the key outcomes. Dr. Clark stated, although there are many variables, CalMHSA is working to put some policies in place to get a measurable baseline. He will speak to RAND about this.

Commissioner Vega commented on Commissioner Carrion's question stating that these programs are very exciting in that they are all integrated. Having these projects is going to make a huge impact on California in terms of suicide prevention and stigma reduction. He raised concern about the tremendous workload that comes with these projects and wanted to make sure that CalMHSA has everything necessary on the administration side in order to accomplish these tasks. He cited the $400 thousand set aside for staff infrastructure and observed that CalMHSA was using very little administrative resources. Dr. Clark clarified that the $400 thousand is actually for planning. The administrative funds are from a separate funding source and are for the management of contracts. The allotments are different in terms of the shift; they are directly allocated to suicide prevention and student mental health initiative. Commissioner Vega asked for clarification regarding whether the funds were being held. Ms. Collentine made the clarification stating that CalMHSA will identify which programs will be augmented in the future, but now is not the time to augment stigma and discrimination reduction contracts because the full initiative has not yet been rolled out. The $2.9 million will be added to whatever is done with the second Plan Amendment and then that will be the time to identify where those dollars might go and the initiative will have been implemented.

Commissioner Hayashi asked a question about the California Community Colleges Student Mental Health Initiative. The four key activities outlined under this initiative sound great and she agrees that training faculty and staff members would be a worthwhile effort, but asked if some of funds can be used for hiring licensed professionals to help students. She stated her concern that faculty and staff, if they are not licensed and trained health professionals, would be unable to take steps to further identify students with mental health issues.

Ms. Collentine responded that the key activities are part of CalMHSA's approved plan, and that changes to the plan would have to go back to the Commission for

approval. She assured the Commission that CalMHSA has always been concerned about sustainability. Working with the Community Colleges Foundation allows them to serve more students and to build up resources. The challenge in this whole project has been the loss of staff due to the loss of school funding.

Commissioner Hayashi acknowledged that the same challenges are present with school nurses. There is an ongoing resource issue. She asked if the community college system is establishing an infrastructure for referrals for treatment, and if there is follow-up care to the faculty and staff's screening, or if they are diagnosing as they have been trained. Ms. Collentine stated that most community colleges have a counseling center and protocols for referrals. Dr. Clark added that training counselors in new and better ways to deal with contemporary issues will help students and will also be sustainable.

Commissioner Vega asked if any of CalMHSA programs teach about suicide warning signs in K-12 classrooms. Ms. Welch answered that through their social marketing contract CalMHSA has a ground-up campaign building on existing local efforts, which focuses on using radio, social networking, and recent collaborations with school partners to teach about suicide warning signs. She recommended a website, www.yourvoicecounts.org, which gathers stakeholder input from around the state to develop the suicide prevention social marketing campaign.

Commissioner Poat asked for clarification regarding whether there was a per-student allocation. Dr. Clark answered that funding was divided proportionately between the three university systems. It became apparent, as CalMHSA went into implementation and gathered additional resources, that community colleges have six to eleven times the number of students as other colleges. This is the reason for the direction they have taken. Dr. Clark added that the policy being established today is only for this funding. There will be another proposal in the fall regarding additionally assigned funds.

Commissioner Poat suggested a presentation on the rationale behind this vote for the total allocation of the funds between the institutions of higher education.

Public Comment

- Betsy Sheldon, California Community Colleges Chancellor's Office, voiced her approval of the amendment. The Chancellor's Office is one of the contractors of CalMHSA. She addressed Commissioner Hayashi's question about the faculty and staff training component of the project and stated the Chancellor's Office is aware of the balance between raising awareness and providing resources. She stated, with this approved amendment, the Chancellor's Office will address the issue of returning student veterans as brought up by Commissioner Vega and Dr. Clark.

- Ms. Hiramoto stated she does not oppose the adoption of the amendment and urges support of community colleges. Community colleges have always been concerned with cultural competence and diversity and have worked closely with REMHDCO. She encouraged the Commission to continue to seek other ways to ensure culture competence and reducing disparities in all of its projects.
- Ms. Marley asked the Commission where she could find out which counties joined CalMHSA, how much those counties allocated to CalMHSA, the purposes for the allocations, and where the allocations came from. Dr. Clark answered that she could find that information on CalMHSA's website and would get back to her to help her.

Motion: *Upon motion by Vice Chair Van Horn, seconded by Commissioner Nelson, the MHSOAC approves CalMHSA's amendment to the Implementation Work Plan and the corresponding increase of expenditures.*

12. Evaluation Committee

Status Update on Current Evaluation Deliverables and Future Contracts to Implement the Evaluation Expenditures Approved by the MHSOAC on November 17, 2011

Kevin Hoffman, Deputy Director, MHSOAC, stated that he would provide an update on the current evaluation deliverables that UC Los Angeles (UCLA), with its subcontractor Evaluation Management Training Association (EMT), and California State University, Sacramento (CSUS) are working on. He would also provide the status of the evaluation priorities for use of the $875,000 the Commission approved in evaluation funds at the November 17, 2011, meeting.

Mr. Hoffman stated that UCLA and EMT have current contracts, known as Phase 2 and 3 Evaluation, to provide deliverables regarding statewide impact of the MHSA. He stated that one of the deliverables, due November 30, 2012, is an analysis and summary of expenditures of all MHSA components from Fiscal Year (FY) 2006/07 through FY 2009/10, including a cost analysis regarding full service partnership (FSP) indicator variables.

Another Phase 2 deliverable is the County Profiles for Priority Indicator Reports. They will provide a state-level draft report for stakeholder input on priority indicators for the most recent one-year period, to be provided by June 30, 2012. Thereafter, a draft state-level report, including stakeholder input on the same priority indicators for the same reporting period, will be provided by September 30, 2012. They will also provide the first of two county-level reports on priority indicators for the most recent year period by September 30, 2012. A second county-level and state-level reports on priority indicators for the recent one-year period will be provided March 31, 2013.

Part of the Phase 3 deliverables is an FSP cost/cost offset. There will be a draft report for stakeholder input on per-person FSP costs and cost/cost offset analysis on

the impact of outcomes achieved, in comparison with expenditures for FSP, to be provided by June 30, 2012. The final report that includes stakeholder input is to be provided by September 30, 2012.

To ensure quality data is available to support the Commission's evaluation efforts, current contracts with CSUS will provide user support for the Data Collection and Reporting (DCR) system that collects individual outcomes on FSPs. To date, the following deliverables have been completed by CSUS: a revised data dictionary in October 2011; Data Quality Reports provided to each county based on data reported to the DCR since its inception in January 2012; a DCR User Manual in February 2012; and a partner-level data template to allow counties to view summaries of clients' historical data in the DCR in February 2012. The upcoming deliverables that are to be provided by CSUS are the following: detailed technical instructions to help counties create their own reports, available in April 2012; regional trainings on use of the overall DCR system, available in May 2012; and a digital video of those trainings, available in June 2012.

Mr. Hoffman reported on the status of priorities for the use of the $875,000 in evaluation funds. On November 17, 2011, the Commission adopted the Evaluation Committee recommendations of the Priority Proposals C (Early Intervention), G (Reducing Disparities), and H (Data Quality), to expend the fiscal year 2011/12 funds for evaluation.

The purpose of the Reducing Disparity Evaluation is to measure the impact of the MHSA, as well as state and local policies and practices, on disparities. This consists of two deliverables, one using existing data and the other using primary data collected at the community level.

The purpose of the Early Intervention Evaluation is to conduct an initial evaluation of similar MHSA early intervention programs which will provide information to policy makers and the public in order to improve intervention services.

The Data Quality Interagency Agreement is based on the Commission's priority to dedicate funding to data quality in order to assist with evaluation efforts. The existing interagency agreement with CSUS will be expanded to add statewide webinars, regional trainings on how to analyze FSP outcomes, increasing data quality reports, and correcting data in an effort to ensure the quality of data at the state level.

Mr. Hoffman stated that the next steps are to issue Requests for Proposals and execute two contract awards (Reducing Disparities in Access and Early Intervention Evaluation) before June 30, 2012, to encumber the funds. The recommendations will be presented at the Commission's next meeting. Also at the next Commission meeting, the Commission will be asked to approve an amendment to the CSUS interagency agreement for data quality improvement.

Commissioner Questions and Discussion

Commissioner Poat stated, as part of the Chair's goal of a focused evaluation workshop, it would be helpful to hear the staff's perspective on the issues,

timeframes, and policies necessary to help the integration of services. Mr. Hoffman stated that the MHSOAC is meeting with CalMHSA and other groups to determine what everybody is doing and also to see if there is any overlap. Executive Director Gauger added that staff is working to develop a statewide master plan for evaluation, which looks at what is happening in all levels of government.

Commissioner Nelson asked if the Commission needs to determine what the External Quality Review Organization and the Medical audits are doing. He added that they are including MHSA projects in their evaluations. Mr. Hoffman answered by referring to Executive Director Sherri Gauger's earlier statement about developing a statewide master plan for evaluation in the near future. He stated that these are the types of issues due to be examined at that time.

Chair Poaster pointed out that the CalMHSA project was a $130 million project when it was approved, and an appropriate amount of money was dedicated to evaluation. The Commission has the responsibility of MHSA dollars of over one billion dollars a year, but the budget is $875,000 this year, which is less than 0.1 percent.

Commissioner Poat reiterated the intention of developing a statewide master plan adding his belief that it is probably the most important policy question for the Commission moving forward.

Public Comment

- Ms. Derby gave her support in prioritizing the local stakeholder processes and emphasized that evaluation and stakeholder processes go hand in hand. She stressed the importance of clients' and family members' active participation in the ongoing evaluations. A key component of the MHSA evaluation master plan includes evaluation of local stakeholder processes, both internally by community members and externally in relation to statewide standards, and exploring the correlation between involvement and community outcomes.
- Eva Nunez stated a client can come up here and talk for thirty years and still be in the mental health system. Clients in the public merely want adequate service. The contracts the Commission makes today will affect generations to come and make a difference in the lives of mental health clients. Things can change for the better when the law represents clients and families more.
- Sandra Pool, Assistant Director, REMHDCO, introduced herself to the Commission and stated that her primary responsibilities are working on stigma and discrimination reduction. She added that she looks forward to working with the Commission in the future.

13. <u>Client and Family Leadership Committee</u>

A. Adopt Recommendations on Accessibility

This item was moved to the May 24, 2012 Commission meeting agenda.

14. Commissioner Comments – Future Commission Business

Commissioner Hayashi stated that she likes the location of the meeting. Chair Poaster agreed with Commissioner Hayashi's statement and added that most people in attendance had expressed the same thing. Commissioner Vega added that the building addresses almost all of the accessibility issues.

Vice Chair Van Horn suggested a workshop-style agenda for the July meeting. The next two Evaluation Committee meetings are in April and June. He would like to see the Evaluation Committee draft a proposal in the June meeting for the Commission so that an extended discussion on evaluation for the July Commission meeting can be held.

Chair Poaster stated the Commission's next regular meeting is in May, with a special teleconference call in early May if necessary. He recommended further discussions on evaluation and local stakeholder processes be put on the next agenda.

Commissioner Wooton suggested that the Client and Family Member Leadership Committee as well as the Evaluation Committee hear consumer and family member perspectives on those processes.

Commissioner Brown requested working with the Executive and Chief Deputy Executive Directors in crafting a letter to be sent to the Congressional delegation about the issue of Medicaid services to those who are in custody.

Commissioner Nelson stated there is a pilot program for federally funded hospitalization Institution for Mental Diseases (IMDs), which he would like more information about and would like to discuss with Commissioner Brown regarding how this may help people in custody.

15. General Public Comment

No public comment.

16. Adjournment

Chair Poaster adjourned the meeting at 12:27 p.m. on March 23, 2012