



WELLNESS • RECOVERY • RESILIENCE

State of California

## MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting  
June 25, 2013

San Francisco Marriott Marquis  
780 Mission Street  
San Francisco, CA

866-817-6550; Code 3190377

### Members Participating

Richard Van Horn, Chairman  
David Pating, M.D., Vice Chairman  
Khatera Aslami-Tamplen  
John Boyd, Psy.D.  
Sheriff William Brown  
Victor Carrion, M.D.  
Paul Keith, M.D.  
Assemblymember Bonnie Lowenthal  
LeeAnne Mallel  
Ralph Nelson, Jr., M.D.  
Larry Poaster, Ph.D.  
Tina Wooton

### Members Absent

John Buck  
Senator Lou Correa  
David Gordon

### Staff Present

Sherri Gauger, Executive Director  
Aaron Carruthers, Chief Deputy Executive Director  
Filomena Yeroshek, Chief Counsel  
Jose Oseguera, Committee Operations Chief  
Kristal Carter, Staff Services Analyst  
Cody Scott, Office Technician

### 1. CALL TO ORDER/ROLL CALL

Chairman Richard Van Horn called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:10 a.m. and welcomed everyone. Committee Operations Chief Jose Oseguera called the roll and confirmed the presence of a quorum.

#### Chairperson's Remarks

Chairman Van Horn recognized former Commissioner Eduardo Vega, who was in the audience.

Chairman Van Horn stated that Gregory Wright passed away recently. Mr. Wright attended almost every Commission meeting, was an active consumer advocate, helped at the morning stakeholder trainings, was a member of MHSOAC Client and Family Leadership Committee (CFLC), and was active in the community forums.

Commissioner Wooton added her appreciation and admiration of Mr. Wright, and gave some remembrances of his friendliness, work, and dedication to the Commission during the time that

she knew him. Chairman Van Horn stated that Mr. Wright asked many detailed and important questions and will be missed.

Chairman Van Horn introduced new Commissioners Khatera Aslami-Tamplen, John Boyd, Psy.D, and John Buck.

## **2. WELCOME BY CITY AND COUNTY OF SAN FRANCISCO**

Chairman Van Horn introduced Jo Robinson, the director of the Department of Health of the City and County of San Francisco. Ms. Robinson welcomed the Commissioners to San Francisco. She stated that one of the principles of the Mental Health Services Act (MHSA) is transformation and shared a story of transformation and recovery that she called “Susan’s story.” She discussed how Susan’s life, and the community around her, changed, and stated that Susan’s full recovery was realized with the help of a social worker, a board-and-care home, MHSA, MHSA housing, and a Full Service Partnership (FSP). People with mental illness are assets to the community, educating us about strengths - their strengths as well as our own - and modeling wellness and recovery. Ms. Robinson stated that she is grateful to Susan and many others who teach the system to listen to them and to ask to partner together in the journey of transformation.

San Francisco has nine FSPs, serving about one thousand people, and has plans to develop additional FSPs. San Francisco’s data shows that FSPs work: arrests due to mental health and substance use disorders have dropped eighty percent, medical emergencies have dropped eighty-six percent for the older adult population, and school suspensions have dropped sixty-one percent for transition-age youth (TAY). San Francisco has gathered a group of people and begun discussions to figure out how to transition people from the intense FSP program to levels of higher recovery.

With the help of a cross-disciplinary team of administrators, evaluators, peers, and clinicians, San Francisco has developed and refined a tool called “the graduation checklist.” It was piloted in an FSP adult clinic, and they, along with behavioral health leadership in the city, joined a learning collaborative, put on by the California Institute of Mental Health (CiMH), called Advancing Recovery Practices. The collaborative realized good outcomes, but the consumers of the program helped them learn that they were not practicing wellness and recovery; therefore, they developed a recovery committee, started peer-led groups, and incorporated strength-based supervision.

MHSA funded a pilot project in a mental health clinic to enhance the participants’ quality of life by adopting existing protocols on nutrition and education. The program produced an unexpected peer leadership outcome.

In order to improve the availability and delivery of mental health services as they were renewed, San Francisco placed mental health practitioners in primary care clinics. MHSA funding helped to support this behavioral intervention, which provides help to approximately 650 individuals each month. San Francisco has used MHSA dollars to reduce the stigma of mental health and to encourage people to gain the care that they need.

Ms. Robinson expressed her gratitude to the voters of California, who have allowed this opportunity to help reform California’s mental health system and to charge the Commission with the task of preventing mental illness and providing early intervention through the lens of wellness and recovery.

**3. APPROVAL OF MAY 23, 2013, MHSOAC MEETING, and JUNE 25, 2013, and JULY 16, 2013, TELECONFERENCES MINUTES (ACTION)  
JULY – SEPTEMBER 2013 MHSOAC CALENDAR  
JULY 2013 MHSOAC DASHBOARD**

Commissioner Aslami-Tamplen stated that the May 23, 2013 meeting minutes needed the following changes: acronym API, on page 26, should be changed to Asian Pacific Islander, and acid test, on page 3, should be changed to asset test.

**Action:** Commissioner Poaster made a motion, seconded by Commissioner Mallel, that:

*The MHSOAC adopts the minutes of the May 23, 2013 MHSOAC Meeting as amended, June 25, 2013 MHSOAC Teleconference and July 16, 2013 MHSOAC Teleconference.*

- Motion carried, 12-0

**4. FISCAL YEAR (FY) 2013-14 BUDGET ACT UPDATE**

Executive Director Gauger presented an overview of the impact of the FY 2013-14 budget on the Commission and Assembly Bill (AB) 82 and Senate Bill (SB) 82, which were budget trailer bills. There are three budget items that impact the Commission this year:

- \$300,000 has been allocated for year one of the implementation of the Evaluation Master Plan, including six new staff positions, along with the continuous \$1 million appropriation to the Commission for support of the evaluation efforts.
- \$400,000 has been allocated for a one-time contract with California Institute for Mental Health (CiMH), which will be charged with developing consensus guidelines for involuntary commitment for mental health treatment and providing training and technical assistance for peace officers and the community.
- \$54 million has been allocated to fund at least 600 triage personnel in select regions, of which \$32 million will come from the Mental Health Services Fund, and \$22 million will come from federal reimbursement.

AB 82 was a budget trailer bill, which the governor signed on June 27<sup>th</sup>, that went into effect immediately and contains three provisions that impact the Commission:

- It codifies the current practice that the Commission is separate and apart, not only from the Department of Health Care Services (DHCS), but also from the California Health and Human Services Agency (CHHS).
- It requires the Commission, for the first time, to adopt regulations for Prevention and Early Intervention (PEI) programs and Innovation (INN) programs.
- It mandates that DHCS adopt regulations that are consistent with MHSOAC regulations. Staff has already begun putting together a workgroup, to be comprised of three members of each Committee, that will have its first meeting on August 12<sup>th</sup>.

SB 82 is a budget trailer bill that enacted the Investment in the Mental Health Wellness Act of 2013. This was the result of Senate President pro Tempore Steinberg's call for state action. It contains four provisions that impact the Commission:

- It makes findings and declarations regarding the need for a renewed investment in community-based mental health treatment options.

- It establishes the California Health Facilities Financing Authority (CHFFA) Grant Programs, which provides for the award of construction grants, to expand residential treatment and rehabilitative mental health services, and to support mobile crisis support teams throughout California.
- It establishes the Commission as the entity to design a competitive grant process to award funding to counties to hire triage personnel.
- It restores MHSA state administration cap from the reduced three point five percent back to five percent.

SB 82 specifies that the Commission is to administer a competitive selection process to award grants to counties, counties acting jointly, or city mental health departments for the purpose of hiring at least 600 triage personnel throughout the State.

The bill lists examples of the types of services to be provided by these triage personnel, such as making referrals, monitoring of service delivery to ensure the individual accesses and receives services, monitoring the individual's progress, and providing placement service assistance.

The bill mandates that the Commission take into account specific criteria and factors when selecting recipients and determining the amount of the grant awards, such as whether or not the county uses peer support or has a plan for seeking Medicaid reimbursement.

The bill states that the Commission can issue information letters or similar instructions to implement, interpret, or make specific the statute without regulatory action, and mandates the Commission to provide a status report to the Legislature no later than March 1, 2014.

Staff has completed an information-gathering phase for the triage personnel grants. They have contacted Senate President pro Tempore Steinberg's office, and met with CHFFA; Rusty Selix, the executive director of the Mental Health Association in California (MHAC); Patricia Ryan, the executive director of the California Mental Health Directors Association (CMHDA); and the Board of State and Community Corrections (BSCC).

Staff will be convening a group of subject matter experts on August 14<sup>th</sup> to help provide input to the Commission on the criteria required to be included in the grant. They have reached out into the community to understand the need and the types of services that should be made available. Invitations to be a part of this workgroup include the California Association of Social Rehabilitation Agencies (CASRA); the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO); Loaves and Fishes, a nonprofit organization in Sacramento; and representatives of a county, a probation officer, a provider, a hospital, a client, a veteran, a foster youth, an educator, and a patients' rights group.

Staff will bring the workgroup's initial criteria to the full Commission in September for approval, issue a Request for Application to the counties by September 30<sup>th</sup>, give counties October through December to write their Application for Proposal and submit it to the Commission, and bring the proposals before the Commission in January 2014 for approval of the recommended awards.

#### **Commissioner Questions and Discussion:**

Chairman Van Horn stated that the \$142 million is a promise that is thirty-five years old. In 1978, Assemblymember Bates established the Community Residential Treatment System, with an initial grant of approximately \$15 million, to build crisis houses across the State. That languished for lack of money for several years. The approval of this bill thirty-five years later is a tremendous opportunity for this Commission.

Vice Chairman Pating asked for clarification on whether the bill mentioned there would be a certificate process in the development of peers.

Executive Director Gauger stated that the bill calls for considering a county's use of peers and peer support as part of their plan, but it will be local discretion as to the types of individuals they request to hire. As part of the Workforce Education and Training (WET) program proposal, staff hopes to have the Office of Statewide Health Planning and Development (OSHDP) come to the Commission in early September, since they have been working on designing and obtaining approval of a peer certification process. That would be the process the counties would use when it goes into effect. Chairman Van Horn explained that the funds for the WET programs have been allocated to OSHDP.

Vice Chairman Pating suggested including someone who has worked as a peer in substance abuse services in the workgroup.

Commissioner Aslami-Tamplen asked if the bill specifies that the criteria that the Commission creates include the use of peer support and anticipated outcomes, and if it would make sense to specify the use of those criteria in selecting who is awarded.

Executive Director Gauger agreed. She recommended that the workgroup start with the law, which lays out specific criteria as a starting point. The workgroup may offer additional ideas that the law may not have included. Also, certain factors might be weighted.

Commissioner Poaster stated that the subject matter experts will be convening in August; the first time the Commission will see the criteria will be in September. The Requests for Proposal (RFPs) are to go out four days later. The criteria will be critical to ensure it raises the level in all counties.

Ideally, the local community planning process with regard to grants is consistent with the local community planning process that will already be occurring at the county level around the three-year plan. He stated that counties will be writing grants, doing the three-year plan, and implementing the Affordable Care Act (ACA) within the same timeframe. Commissioner Poaster encouraged the Commission to be aware of that and to ensure what the Commission asks counties to do will be done in a way that helps increase everyone's chances of being successful.

## **5. ROUND TABLE DISCUSSION OF MENTAL HEALTH CARE WITHIN A WHOLE HEALTH ENVIRONMENT**

### **A. Members of the Panel**

Stuart Buttlair, M.D., Regional Director of Inpatient Psychiatry and Continuing Care, Kaiser Permanente

Sandra Naylor Goodwin, Ph.D., President and CEO, California Institute of Mental Health

Jo Robinson, Director, Department of Health of the City and County of San Francisco

Louise Rogers, Deputy Chief, San Mateo County Health System

Chairman Van Horn asked the panel members to take their seats, which were distributed among MHSOAC Commissioners. He stated his disagreement that the panel came to testify before the Commission, as was reported in the Capitol Alert this morning. This is a discussion about what the Commission's role is in the whole health movement, how the whole health movement will impact the Commission, and how the Commission will impact the whole health movement. This is the first time the Commission has done this sort of roundtable discussion as part of a regular Commission meeting. Chairman Van Horn encouraged participants and Commissioners to "build their own box," to design what they think makes sense. He asked

Vice Chairman Pating, who chairs the Evaluation Committee, to conduct this part of the meeting and to introduce the tasks at hand.

Vice Chairman Pating stated that the Commission chose a panel discussion because of the monumental changes in health care and health reform. With health care reform, the ACA, a major expansion of essential health benefits, and an expansion of Medi-Cal benefits, California has the opportunity to provide the best mental health care in the country, both public and private, if it is ready to provide and integrate this care, and treat the whole person with the best resources available.

He stated that it is not a question of money anymore, but of how services are provided. The distinguished panel will brief Commissioners on the state of mental health, particularly the state of “whole health,” this integrated approach to reaching the whole person and the whole system, as is MHSOAC’s goal. These four exceptional, nationally-calibered speakers will speak on four issues.

Vice Chairman Pating stated that Dr. Goodwin will speak about the problems within mental health and about what marks this moment as historic. Dr. Buttlair will speak about how systems should integrate. Ms. Robinson will speak from a county perspective about what this means for county services. Ms. Rogers will speak about the financing of health plans and insurance.

Sandra Naylor Goodwin, Ph.D., President and CEO, California Institute of Mental Health

Dr. Goodwin stated that some of the reasons why CiMH does the kind of work it does now are the integration of mental health, substance use, and primary care. They are a major focus of CiMH and for the counties in California. Six years ago, national data indicated that people with serious mental illnesses die twenty-five years before the rest of the population. The primary reason for that loss of life is not their mental health condition. They are not receiving health care and, by the time they do receive health care, it is too late.

When this data came out, a county in Southern California decided to examine the specific population they were treating. They discovered that the people they were treating were dying, on average, at 41.8 years of age through lack of health care treatment. That county has been on a mission to change that situation, and they are doing an amazing job of developing integrated systems so their people get health care.

In a survey of employed populations by employers, the employers indicated the health reasons that they were losing money and having difficulties with production. Depression was in the top ten. Then, when they looked at what actually caused loss of productivity, depression was the number one cause. Not only were people absent due to depression, but also not working well. The cost to employers was about \$6,000 per year per depressed worker.

Medicaid is another driver of costs in the country. There is a study called Faces of Medicaid III, which looked at five years of Medicaid utilization and pharmacy data. They concluded that five percent of the Medicaid population drives fifty percent of the cost. This is all driven by chronic conditions. Drilling down to look at what pairs of chronic conditions are driving costs, in the top five pairs, three of them include a psychiatric condition, including the most costly and the second most costly.

Kaiser noted people with substance use conditions were driving the costs in their system. It was not the substance use conditions alone; because the individuals had substance use conditions, they were much more likely to have other chronic conditions that required treatment. Kaiser did a controlled study of the usual care versus integrated care - integrated addictions and health care treatment together. They determined that, with their usual care, the cost dropped only

marginally. When they did the integrated care, they dropped the cost of treating an individual by more than half - down to the average of their other clients in their system.

It was not just those individuals who had high costs; it was their families. The substance use condition impacts the whole family. But, the families' costs dropped with integrated care, and they had much better health outcomes.

In California's Medi-Cal system, eleven percent of people in the fee-for-service (FFS) Medi-Cal system have a diagnosed mental illness. The cost of people with a mental health condition is 3.7 times higher than the cost of the average individual without a mental health condition in the fee-for-service system.

Milliman, a national actuarial firm, did a study of the costs to insurers and insurance in this country from people with serious mental health conditions combined with other chronic conditions. They found that, if ten percent of the excess costs driven by untreated mental illness could be reduced, the result would be \$5.4 million in savings for every 100,000 people insured. The cost to the U.S., if nothing is done about untreated mental illness, is probably about \$300 billion per year.

One of the things that CiMH focused on, as a result of all of this information and the understanding that many people were not receiving both the mental health care and the health care they needed, is "bidirectional integration." People with mild and moderate mental health conditions and addictions should be treated in a primary health care system, but that system should also have behavioral health care available. People with serious or severe mental health conditions or addictions should be treated in a behavioral health care system, but that system should also have primary health care available. Currently, many counties with both primary health care physicians and nurse practitioners work in the behavioral health care system to assure that they understand when people have other health conditions, and make sure that they get treated.

As a result of all of this, CiMH has been working on "learning collaboratives," which are intense sessions where people come together for a couple of days to work on an issue, and then have conference calls with participants in between these learning sessions while they are running data, testing changes that they want to try to make, and deciding whether or not those changes are working. If they are working, they are spread to the whole system.

Out of the four learning collaboratives, three are finished. One has a focus on care coordination between mental health, substance use, and primary health care. In most instances, the health plan is present as well, so that it is a four-way team. Although it is not easy and takes creativity and work, care coordination is possible.

CiMH also has a learning collaborative with small counties, which is also based around integration. Then, there is one called "advancing recovery practices," which focuses on how the mental health system can retain its recovery focus and still do the kind of work it must do in order to be a participant in a future integrated system.

The last learning collaborative is centered in the health clinic itself, to help health clinics learn how to use their local community-based organizations to help people both stay out of services if they do not need them, and sustain their recovery so they do not keep coming back to the clinic.

The current opportunities are important to pay attention to. ACA, health care reform in California, requires parity: mental health and substance use services must be available without discrimination against people with mental health and addiction conditions. The Medicaid expansion that is taking place will bring in additional people who will need these kinds of services. The Medicaid expansion means that anyone who has an income level less than

134 percent of the federal poverty level is eligible for Medicaid. That has not been true in the past. Covered California has developed the Kaiser Small Group Plan as the benchmark plan, which will bring in many additional people. This will nearly double the number of people in the system.

It is important for the Commission to note that this will leave about 500,000 people who will not yet have access to mental health and addictions care. The 1915(b) waiver, which creates the carve-out to counties, has been approved for two more years. The ACA permits health home pilots; California has not yet chosen to do that. The CiMH will be proposing the creation of health home pilots in behavioral health care very shortly, and Dr. Goodwin hoped to present that to the Commission for support as it moves to the State.

Commissioner Lowenthal asked what a health home pilot is. Dr. Goodwin stated that a health home pilot is written up in the ACA, and most states are doing it. When people go to a clinic for services, that clinic is responsible for all of their care, and must coordinate everything that they need. Medical home is the other term for that.

Stuart Buttlair, M.D., Regional Director of Inpatient Psychiatry and Continuing Care, Kaiser Permanente

Dr. Buttlair's presentation answered several questions. The first question was what integrated care looked like in a health maintenance organization (HMO). He used Kaiser Permanente as a model. ACA and the Accountable Care Organization (ACO) that it created look much like Kaiser Permanente, because people pay a premium on a regular basis to a health plan, and then the health plan directly contracts with a hospital as well as a medical group. In a world of operationally, economically, and functionally fragmented systems, one of the things that Kaiser does, because it is a premium-based system rather than a fee-for-service, is to integrate its care across the board and do things in an economically parsimonious way, rather than having to bill for pieces of information and treatment. Kaiser provides a total package of care, and the ACA is asking for it.

Systems like the electronic medical record (EMR) help with integration. The EMR allows the physician to see when a patient has not only mental but physical health problems, and then the physician can be part of both treatments and can prescribe in a less dangerous way.

Kaiser clinicians have access to a clinical library, which enables them to practice in a best-practice way. Families can look up and ensure that their family members receive the care that they need. Clinicians can interact and integrate with patients through secure messaging.

Another question is how to integrate clinical models of care. It is important to have a continuum of care, to treat individuals at the levels of care that they need. Settings where care is provided are also important. Physicians have to be integrated into the system. The patient has to be a participant in the ongoing care and a true partner in treatment and mental health.

Physical health savings are the key to mental health engagement and involvement. Similarly, in other forms of treatment, the most expensive patients are those who have a physical health problem, a chemical dependency problem, and a mental health problem. The important thing is to provide medically integrated care in a system. Kaiser did a study of chemical dependency recovery programs, which provide physical health as well as mental health integration, and what the savings might be from this. Since the savings are in the emergency department and the hospital, upstream treatment and integration cut down on the cost for the system.

One of the challenges is everyone continuing to treat what now exists as "business as usual," by continuing to do what has been done before despite the fact that things are changing. Incremental changes and transformational changes need to be separated. There must be a

transformation in the way care is delivered. It will take vision and leadership; Dr. Buttlair stated that the Commission can provide leadership for real transformation of systems.

Commissioner Keith asked what Kaiser would like to present to other medical groups that will deliver care, for example, how to formulate an EMR.

Dr. Buttlair stated that many of the other ACOs are developing EMRs. New York does a great job of sharing information across the public and private sector about patients. The emergency rooms and health plans can access that information for Medicaid members in the state of New York. It is critical to start thinking about how to share information across platforms and across the system. There are enormous savings in that.

Vice Chairman Pating stated that there is capacity, within MSHA funds, to build this within counties, to build out the computer networks within county systems for enrollment into Medi-Cal and to adopt county-wide charting capacities. He brought up the issue of systemic competency, and encouraged the building of systems, not just programs.

Jo Robinson, Director, Department of Health of the City and County of San Francisco

Ms. Robinson stated that San Francisco has been working towards integration for well over ten years. Barbara Garcia, San Francisco's director of public health, has advanced this. About twelve years ago, San Francisco began to integrate mental health and substance use disorder treatment. It is an ongoing struggle, since providers from mental health and from substance use come from two different worlds and must learn to work together.

There is a whole host of competencies that people need to learn about the medical world. Primary care doctors need to be comfortable asking people about their mental health. They need to ask people about depression and substance use. San Francisco is learning, developing tools, importing approved tools, and figuring out how to do this, but the different groups of professionals have been trained very differently and even use different terms. For example, "consumers" or "clients" are called "patients" in the medical world. Ms. Robinson's hope is that graduate schools teach a new kind of medicine or care, one that looks after the whole person.

Sitting above one of San Francisco's primary care clinics is a behavioral health program; over five years, they have learned to work together. San Francisco received a Substance Abuse and Mental Health Services Administration (SAMHSA) grant two years ago, and only in the last six months have physical health and behavioral health providers begun working together as a team.

San Francisco County will not be ready by January 1<sup>st</sup>, but it will be steps ahead of other counties that have not yet begun to look at how to provide these services. San Francisco has hired a consulting group to help with Historical, Clinical, Risk (HCR). They are moving ahead with implementation of a behavioral health home. One of the biggest changes for behavioral health is providing team-based care. A team must be formed, consisting of licensed mental health clinicians, health workers, and peer specialists. Those teams, at each clinic, will have resources to pull from. Psychologists will take more of a leadership role, to be responsible for overseeing evidence-based practices. The core competencies and training will be a large part of moving forward with HCR.

The San Francisco Department of Public Health has over sixty-eight different types of Electronic Health Records (EHRs), none of which talk to each other. For an estimate of \$150 million, the Department could build a system that will allow sharing of a health record, but it is not built yet.

Commissioner Lowenthal was eager for more information from New York about the computer system.

Commissioner Aslami-Tamplen asked if San Francisco, when collaborating with the primary care settings, provided trainings on how to address and reduce stigma and discrimination. Ms. Robinson stated that the primary care doctors have quarterly training meetings, and certain videos are required for any provider to watch. However, this needs further development.

Commissioner Mallel asked who chooses evidence-based practices in order to allow for diversity. Ms. Robinson stated that one of the practices that San Francisco tries to embrace is involving consumers in the process of choosing, but is looking at things such as motivational interviewing and ensuring that people truly understand how to do that. San Francisco has a multisystemic therapy (MST) program with a focus group of psychologists, psychiatrists, clinicians, peers, and family members to help choose what needs to be done.

Louise Rogers, Deputy Chief, San Mateo County Health System

Ms. Rogers stated that San Mateo County's health system, Behavioral Health and Recovery Services provides both mental health and substance use service. San Mateo County has embraced the direction that Dr. Goodwin described earlier for bidirectional care. San Mateo County set the stage for that several decades ago. Like other counties, San Mateo County believes it is essential to identify and provide mental health and substance use services within primary care. The largest single group of clients that San Mateo County serves in the system is in primary care.

San Mateo County has responded to the issue of people with mental illness dying twenty-five years earlier by expanding the primary care services that are available within the behavioral health settings, by bringing in nurse practitioners and, with the help of MHSA, expanding that model to include health education, smoking cessation groups, peer-led well-body groups, peer wellness coaching, physical activity and nutrition groups, and other supports for consumers' chronic disease self-management. This direction is challenging and not yet fully integrated, but Ms. Rogers stated that it was a great effort in a direction that has a long way to go.

Many counties have embarked on the bidirectional integrated care effort; San Mateo County has been doing it for years and has been challenged. The integration efforts San Mateo County tries to advance at the provider level in the system do not always succeed, even if they are generating great outcomes, partly because of how they attempt to fund them. They have taken a siloed approach, historically. There were experimental programs implemented without looking at who ultimately had the risk and who ultimately had the reward; there was no way to sustain those experiments, because the insurance companies and the payers had not been engaged in the dialogue. In this HCR landscape, this is more important than ever before.

San Mateo County is one of a number of county-organized health systems in California. The county-organized health systems had, for a long time, single health plans that were responsible for covering all of the publicly-insured people in those counties. In San Mateo County, the Health Plan of San Mateo (HPSM) has responsibility of the health plan for the medical coverage for everyone on Medi-Cal. It is more than ten percent of the population and, after HCR, it will be much greater. This plan has public governments and members of the board of supervisors who sit on the plan board, and is publicly accountable; therefore, HPSM is very concerned about the public interests, the county's interests, and the safety net of San Mateo County.

This is a great opportunity for the health system, because its interests and HPSM's interests are aligned. HPSM has chosen to contract with the county Behavioral Health and Recovery Services to deliver the mental health and substance use services for all of their members. This has been a great integration opportunity for San Mateo County, and has allowed the county to demonstrate its worth, how it affects the business case for integration, its impacts on health outcomes and health care costs, and its improvements to the health of the population.

Clients that receive an integrated approach have improved client outcomes, decreased psychological distress, greater social connectivity, and improved health outcomes; they remain in school and are employed in greater numbers. In terms of costs, for the total wellness effort over a two-year period, there was a twenty-five percent decrease in in-patient costs, a forty-seven percent increase in outpatient costs, decreases of thirty-two percent in psychiatric in-patient and Psychiatric Emergency Services (PES) costs, and a significant decrease in long-term care costs. There was also a sixty percent increase in primary care utilization.

Ms. Rogers has been encouraged by the direction in the Medi-Cal/Medicare planning process for highly orchestrated partnerships between counties and plans. There are many opportunities for the Commission and the state to support partnerships between plans and counties that will demonstrate the efficacy of integrated care for improving client outcomes. San Mateo County has the ability to target people who are complex and falling through the cracks in an integrated view of the data.

With regard to the integration issue with health plans, health plans are focused on predicting and managing the medical risk, both clinically and from a cost perspective. They have advanced technology for doing predictive modeling and care management, but, for the most part, public behavioral health is not connected to those care coordination strategies. This is something that San Mateo County is quite focused on improving.

#### **Commissioner Questions and Discussion:**

Chairman Van Horn asked the Commission to examine its role in the future. It may not be in statute at the moment. The challenge that came from the four speakers is interesting. ACA had no public option, which prevents its integration. The Commission needs a clearly-defined role to bring clarity to the total health system.

Dr. Goodwin stated that all of the work being done around integration is driven by people who want to improve care. Although the savings is difficult to pinpoint, there are no incentives to do this kind of integration work. Some good incentives or statutory requirements to help people do this kind of work would drive it even faster. Dr. Goodwin encouraged DHCS to talk more about what they are doing around integration and what their vision is for behavioral health in the future.

Vice Chairman Pating stated that the Commission will look at the integration paper this afternoon. One of the first requests is that the state would ask DHCS or a state entity to take up the role of coordination.

Ms. Rogers encouraged the Commission to be on the lookout for the idea of the medical home, as the opportunities around that tend to be defined medically. The person-centered health care home can be anchored in a behavior health specialty type of setting. It is an important concept for the Commission to remain focused on, because, for the most complicated consumers, the starting point for access to health care will not be in a waiting room of a standard ambulatory care setting.

Commissioner Carrion stated that conversations about integration are important. Clients, behavioral health people, medical people, and peers all have their own languages. One of the things the Commission can do is to promote and identify methods for this conversation; learning collaboratives could be part of this. Commissioner Carrion asked if there is a specific model that needs to be followed for the collaborative group to come together, and if there are rules to be followed.

Dr. Goodwin stated that there is a specific model, which came out of the Institute for Healthcare Improvement (IHI). It is a very structured process, takes a fair amount of work, and is an intensive process that the participants go through.

Commissioner Carrion stated that something like that will be needed to bring everyone to the table for these discussions.

Dr. Buttlair stated that he is part of a nonprofit organization called the Institute for Behavioral Healthcare Improvement (IBHI), which is an offshoot of IHI. He has been working with systems around learning collaboratives and changes; he stated that it is a workable process and CiMH has done a good job in developing those programs.

Dr. Buttlair stated that California has a fragmented system of care. This Commission could start with a gap analysis and bring together key stakeholders, building on these concepts. There are payment, benefit, and model issues. If the Commission did some kind of analysis, legislation could flow from this.

Chairman Van Horn stated that the Commission has one year left with Senator Steinberg as pro Tempore. If the Commission wants to be the convener of this major conversation set that encompasses housing, substance use, mental health, and primary care, the Commission needs to ask. No other Commission or advisory body in the State has current statutory authority regarding integration; this Commission may need to “build its own box.”

Vice Chairman Pating stated that the design of the Commission includes a sheriff, a superintendent of schools, consumers, families, substance abuse, and large group providers. Vice Chairman Pating stated that his belief that the Commission is supposed to be that integration convener. He hoped the Commission could leverage its strengths to make a difference.

Chairman Van Horn asked for Commissioners who have felt impacted by the system to comment. Vice Chairman Pating asked Commissioner Brown to discuss his role as a sheriff, on both the Commission and MHS, and his involvement in health reform conversations in his county.

Commissioner Brown stated that Santa Barbara is in a transitional process, but is involved with both the public health department and the Alcohol, Drug, and Mental Health Services (ADMHS), which are working together in certain areas. For example, a jail discharge planner works with released inmates who have mental illness or are homeless. He has worked with the ADMHS to develop a restorative policing-type program that operates to help people who are homeless in the community. It involves the sheriff’s deputy as well as the health practitioners. They have been impacted by six years of continuing staffing cuts. The challenge is to provide even the most basic level of law enforcement and correction service. As the economy starts to recover, additional partnerships will come about, because law enforcement leaders recognize the importance of integration and work with the mental health and medical communities in partnership to address some of the challenges and problems in the community.

Chairman Van Horn asked Commissioner Keith, who represents an insurer, what he saw as the challenge for this Commission and where it might move with regard to integration.

Commissioner Keith stated that what needs to be addressed is how to accomplish integration. The key is the technology to gather the information and the manpower to do the integration that is being described. With multiple systems, this is difficult. The health care delivery system in the state of California is very diverse. WellPoint, his company, like other major carriers, does not have good information or capital to allow that kind of integration to happen.

Behavioral health is often of low importance to insurance companies, because the costs associated with mental health are considered to be relatively small. Also, the administrators of health insurance companies do not understand behavioral health or substance abuse. Commissioner Keith has a conference call at least once a week with medical counterparts to discuss medical cases with significant behavioral health implications.

Commissioner Keith stated that working with the Legislature is an important avenue, because they can mandate certain things to happen. He emphasized the importance of a concrete proposal; a series of steps to be taken that will operationalize the plan of making integration occur with a timeline.

Chairman Van Horn stated that this Commission has the authority, but asked if it should garner more resources to do a better grade of public education on the impact of behavioral health issues on the total system.

Commissioner Keith stated that medical costs drop dramatically when patients with high utilization of those costs receive mental health care. What will get the job done is pressure from an authority to do this, providing some funding and a timeline.

Commissioner Poaster stated that the role of the Commission is to provide oversight and accountability for the Mental Health Services Act. By policy, a major portion of that will be done by evaluation. The Commission is being audited and the audit will be coming out in a couple of weeks. The Governor and the Legislature appointed DHCS to be the administrative spokesperson for the state of California as it relates to the delivery of health care services and the implementation of the ACA. There has been some significant pilot work done with regard to these integration collaboratives, involving a whole variety of people. Commissioner Poaster asked what it would take to expand that to involve more people in the discussion, including creating incentives to involve DHCS in that process.

Dr. Goodwin stated that the pilots are the basis for a broader discussion with more organizations involved. However, it is costly to do this with no incentive for participants.

Commissioner Poaster asked what incentives could be provided to influence participation. Dr. Goodwin stated that Dignity Health put out some grants for participating health clinics. Money is one good incentive, but Dr. Goodwin encouraged Commissioners to think of others.

Commissioner Poaster stated that involving the Department of Managed Health Care (DMHC) would also be important in trying to put together these incentives. That is a way to help the Commission put a package together that would make sense, and that might be a product to sell. He encouraged staff not to become overwhelmed by the future, but to focus on one step at a time.

Commissioner Carrion stated that, if integration is not only a key factor but where the Commission is headed, there has not been any conversation on staff positions that would do this work. He asked who will conduct the collaboratives and give structure to integration, since it seemed like the work of a separate office.

Vice Chairman Pating agreed that staff resources are limited. This panel was intended to be an education and awareness of what is happening in health care. Within the programs, there are opportunities to be active. The counties have unspent Capital Facilities and Technological Needs (CFTN) funds. With regard to community services and supports (CSS) and PEI, he asked that the Commission be a constant window, even through evaluation, in order to build a system with a collective impact. He stated that the Commission will need to examine the integration of low income health plans with MHSA. He hoped that the Commission would call for a state conversation to ensure that they are on board with the effort.

Commissioner Poaster stated that counties have been providing the money for information technology. The Commission's responsibility is to provide oversight over that and find out how that money is being spent, and make comment with regard to it.

Commissioner Lowenthal asked all of the speakers how she could help at the state level with legislation.

**Public Comment:**

Becky Perelli, an advanced practice nurse in community and mental health nursing, the director of Health Service at West Valley College, representing the California Community College Chancellor's Office Advisory Group on Student Mental Health, complemented the Commission and thanked the leaders on the panel. She stated that she believes integrated care is the best way to leverage resources. She requested the Commission look at the California Community College system as a partner for these issues, because the WET programs are not available in every community college. Also, the health services in community colleges are there to support students; there is a learning collaborative on the national level that has shown that increases in Grade Point Average (GPA) decrease depression in students. In terms of incentives, she suggested public information and marketing, to focus on the positive results of these pilots.

Delphine Brody, the Public Policy Director for the California Network of Mental Health Clients (CNMHC), thanked the panelists for this important discussion on whole health. She stated that she would like to see more leadership from the mental health community as well as substance use and primary care. The conversation is not complete, and she asked that mental health and substance use clients across the lifespan and the un-served and underserved populations be included. She cautioned against disregarding the social, cultural, and pharmacological factors involved in mental illness when discussing the purported hidden costs of untreated mental illness.

Vickie Mendoza, the Director of Parent Empowerment for United Advocates for Children and Families (UACF), also thanked the Commissioners and panel. She stated that Kaiser is reducing the numbers of mothers whose babies are born with drugs in their system, and also are identifying those with mental health issues. Fifty-two percent had substance abuse issues, and, of those, thirty-six percent had mental illness. She stated that they are identified and moved to another system, but there is little data on what happens next. Sometimes mothers have additional children besides those who are identified within the hospital system. She requested that the Commission address those families that are identified with drug and mental health issues.

**6. GENERAL PUBLIC COMMENT**

Eduardo Vega, the President of the California Association of Mental Health Peer Run Organization (CAMHPRO), stated that he was excited about the Commission's role in SB 82. He supports the Commission for contracting with peers and partnering with the CAMHPRO to advance client-stakeholder evaluation and the support of clients throughout the State. MHSA has pushed the funding of consumer-run programs across the State. There is still more to be done. These programs across the State need support to continue their transformative work. He hoped the Commission would continue in partnership with CAMHPRO.

Yafta Alter, representing Peers Envisioning and Engaging in Recovery Services (PEERS), a consumer-run organization that focuses on ending stigma and discrimination in the community, and a consumer, stated that consumers' diagnoses are only a part of who they are. She stressed the importance of focusing on overall health, balancing mind, body, and soul. This will allow people with mental health issues to be more self-determined and empowered. They can be and are productive and constructive people in society.

Martin Fox, the former Chief Legal Officer of the Special Court-Martial Convening Authority at Fort Ord, California, from 1973 to 1975, stated that, veterans with post-traumatic stress disorder (PTSD), which is the natural result of exposure to traumatic events and is not a disorder, have not been able to access the treatment they need. Veterans living with mental illness made up twenty percent of the state prison inmate population before October 1, 2011, which has increased to thirty percent. The Lanterman-Petris-Short (LPS) Act and MHSA promises were broken. He stated that state mental health organizations have abdicated their public safety responsibilities by establishing policies and procedures that limit treatment for persons living with mental illness who understand their need to seek it voluntarily, and deny treatment to those who do not believe they are sick. He exhorted the Commission to return responsibility for helping persons living with mental illness that do not believe they are sick to the civil justice system by adopting assisted outpatient treatment, known as Laura's Law, throughout the State. Assisted outpatient treatment was certified as an effective, economical recidivism-reduction program in March 2012 by the United States Department of Justice (DOJ). The consensus throughout the United States supports the implementation of Laura's Law statewide.

Helena Liber, of the Alameda County Pool of Consumer Champions (POCC), stated her concern about how Alameda County requests MHSA funds for programs that do not always follow what they intend. MHSA requires that consumers be involved, that the program have a recovery and wellness vision, and that the treatments not be forced or coerced. Also, the programs that already exist for basic mental health treatments are supplanted with MHSA funds, which is against what the Act requires. It is the duty of the Commission to not only look at the language and the plans set out by counties for their programs when requesting and receiving MHSA funds, but also their implementation. She requested that the Commission look more closely at programs and what they are supplanting, how they are cutting other programs that were funded by the mental health budget, and taking MHSA funds to run those programs without increasing the recovery and wellness vision that MHSA was meant for.

Roland Angle, representing Families for the Ethical Psychiatric Treatment of Patients and Prisoners (FEPTOPP) stated that he had three matters to present to the Commission concerning the administration of state mental hospitals. The first matter is the failure of the state hospitals to commit to the recovery model of treatment for mental disorders that came from the people's movement, composed of people and their families who had first-hand experience with the mental health system, emphasizing family support and relationships, empowerment, and coping strategies using an open dialogue model. In the Department of Mental Health and the Department of State Hospitals, the reference to the recovery model has been dropped and the new mantra is evidence-based medicine, which relies heavily on randomized control trials, which have been shown to be dominated by the pharmaceutical industry and, as such, fundamentally flawed. He asked the Commission to take steps to implement the recovery model of treatment program at the clinical and community level.

The second matter is the administration of the mentally disordered offenders law. The second demand is that the state hospital enforce Penal Code 2968.

The third matter is that the state officials in law enforcement need to have a statewide grand jury to investigate and report on the extent of the crimes that are being carried out in the cover-up of these laws not being followed.

James Lockett stated that he was glad to see more people of color in the audience, but sad that there were no African Americans on the Commission. He stated that the funding and misappropriation, misdirection, and misuse of funding for Alameda County must be corrected or else there will be more atrocities. He stated that he had a complaint to submit to the Commission. He stated that he would like to see the \$340 million that is directed to Alameda

County Behavioral Health Care Services go to the people that it is designated for, not to the people who are paid, employed, stipended, or contracted.

Cardum Harmon, the Campaign Manager for the Alameda County's 10x10 Wellness Campaign and a person with lived experience, stated that the 10x10 Wellness Campaign is committed to providing services, activities, and policies that incorporate the eight dimensions of wellness that were cited by SAMHSA's research. The goal is to increase the life expectancy by ten years over the next ten years. For FY 2012-13, the goal of the 10x10 Steering Committee and Subcommittee was to see how the capacity of these service teams can provide integrated mental and primary health services from a holistic perspective. First, they identify the ways Alameda County mental health service providers address mental wellness from this perspective. Next, based on provider responses, they do outreach to corresponding service team clients to determine how current services are helping them to attain their desired health goals. Finally, they find out what clients are interested in doing and what keeps them healthy. Based on survey results, they would like to support service teams and introduce holistic wellness activities. Eighty-five percent of the service team staff indicated a need for more support services to be offered to their clients. Providers expressed the most significant needs in holistic services. Service team clients greatly benefited from services that offered a physical and emotional support connection, so the holistic approach is a valid part of integration for primary care and behavioral health care services.

Rosa Quinonez, consumer and advocate, thanked the panel for answering her questions. She had heard funding was going to be spent on mental health, but did not know where the money went besides going to a clinic. The clinic that takes care of her prescribes medication. She stated that POCC is one group for mental health people, but she asked where the millions of dollars has gone.

Bernice Black, of POCC, stated that she is a consumer that is trying to get back into the working field, the chair of Consumer Employment Task Form, and a member of PEERS. She is a recovering drug addict of twenty-three years. Over the years, she neglected her health and, as a result, needs dental work. She asked that the services funded include dentures.

## **7. CLOSED SESSION - GOVERNMENT CODE SECTION 11126 (a) RELATED TO PERSONNEL**

Chairman Van Horn excused all guests for lunch and moved Commissioners into a Closed Session.

## **8. SECOND READ: INTEGRATION POLICY PAPER: A VISION FOR TRANSFORMING THE MENTAL HEALTH SYSTEM THROUGH SERVICES INTEGRATION (ACTION)**

Vice Chairman Pating stated that the goal of this paper is to capture the essence of the earlier workshop. The Act requires that MHSAC promote integrated service experience for clients, in addition to the other values of the involvement of consumers and family, recovery and wellness, and the whole person approach. It is hard to integrate services without systems coming together. This paper states MHSOAC will look to integration as one of its transformation lenses. It was meant to stand alongside the two other transformation policy papers: to transform the system by developing a competent and strong evaluation of the mental health system, and to transform the system by ensuring that there is consumer and client participation in all Commission activities. This third transformation policy paper is to transform the system through promoting integration.

At the last Commission meeting, there was a general consensus that this was a valuable thing to do. Revisions included adding "family" to make "client and family"; changing "adults, older adults, TAY, middle age, beyond middle age, children" to the term "across the lifespan"; emphasizing the cultural and ethnic focus and competency that was required and pulling out the

whole person; and clarifying what is meant by the word “integration,” through the term “bi-directional integration,” which is not just mental health being folded into primary care, but it is primary care moving into mental health, and other services, such as foster care, being brought into mental health.

On May 23, 2013, the Commission looked at the first read of this report and offered comments. This presentation is a summary of changes that were made.

The vision and introductory narratives on pages 1 and 2 were expanded by clarifying that behavioral health services resulted in integrated or coordinated care for persons with co-occurring mental illness and substance use; also, the need for continued attention to integrating behavioral health services was identified, and the term “bi-directional integration” was added.

The vision statement on page 2 was modified with an emphasis on integrated services being available to persons of all ages across the lifespan and on persons from various racial, ethnic, and cultural populations. It identified that this whole process was to ensure an integrated service experience that served the whole person.

In the recommendation section, there were small modifications. In the second recommendation, the term “in addition to” was added. The first two recommendations suggested that there be a state conversation to promote this integration. This is occurring not only in the State but nationally, so the first recommendation is focused on that. The second recommendation states that there be some state entity that might hold a workgroup so that these conversations can come together, and that this workgroup should not only look at various levels of integration and associated outcomes and begin to collect data, but look at ways that information could be shared in compliance with the Health Insurance Portability and Accountability Act (HIPAA). There was also concern that this needs to fit in with federal confidentiality for substance use services.

Lastly, the conclusion includes that there be integration across the lifespan and that integration efforts at all levels include peers and families in order to promote and transform the mental health system.

#### **Commissioner Questions and Discussion:**

Commissioner Poaster stated his appreciation for the work done, especially the emphasis on bi-directional integration. That is an issue that is a little stronger than the previous draft. He asked if the mention of DHCS on page 4 but not in the recommendations was intentional.

Vice Chairman Pating stated that this was intentional. The logical entity is DHCS, but he did not know whether they would agree to it.

Commissioner Poaster asked if DHCS is the Commission's recommendation.

Vice Chairman Pating stated that this is his wish. He asked if it is Commissioner Poaster's recommendation to ask. Commission Poaster agreed, to be consistent with the report.

Executive Director Gauger stated that she is comfortable with modifying Recommendation 2 to specify DHCS.

Vice Chairman Pating stated that the adjustment to Recommendation 2 on page 7 will be changed from “MHSOAC recommends that the appropriate state entity develop a unified mental health care delivery framework...” to “MHSOAC recommends that DHCS develop a unified mental health care delivery framework....”

#### **Public Comment:**

Lillian Turner, POCC member and consumer, thanked the Commission for the services she has been provided over the last twelve years by the mental health department. She received support from the PEERs program and is now working with POCC. Twelve years ago, she began with an eighth grade testing score in community college, and now she has a master's degree and is an organizational practitioner and consultant, and has a bachelor's degree in sociology with an minor in social work. She stated that the social inclusion program is very important. She stated that she still has problems getting a permanent job, but has been working part time in social work and advocacy for homeless people. It is important that homeless people that have mental health issues be afforded free housing and that the Commission support shelters and provide free and low income housing.

Jim Gilmer, of the California MHS Multi-Cultural Coalition (CMMC), REMHDCO, and the African American Workgroup, stated that he was part of some of the groups and activities and feedback for the paper, and submitted that the bi-directional vision be expanded to multi-directional. The report does not have enough community-defining practices emphasis. He stated that he would like to see more community portals and linkages to nontraditional services where people can be served. Ventura County and the Central Coast are faced with a lack of housing. Nontraditional, faith-based organizations are not even on the radar of the system. There are many small congregations with recognized recovery homes that should be a part of systems integration. He asked that faith-based community-defined practices be part of this systems integration plan, because it is very institutional as it stands now.

Steve Leoni, a consumer and advocate, stated that his hope that this will be a living document. The next step to integration is with social services. Then, the ultimate system owner would be CHHS, not DHCS. The focus has been in integration on primary care - specialists and clinicians in urgent care settings. They need to understand mental health issues, as well. Outside of FSP, connecting a hospital discharge with community services needs work. He recommended offering cultural toolkits to organizations like DHCS as well as to service providers. He cautioned that some people do not trust mental health services. They may stay away from primary care when it becomes integrated, and that could mean unintended consequences. He exhorted the Commission to think carefully about how to implement this.

Vice Chairman Pating responded that integration is a process. It began with mental health and substance abuse, and now includes primary care. He stated that he could envision it much larger at some point in the future. He related Commissioner Carrion's suggestion that, perhaps in next year's annual charter, each Committee might consider one integration activity, work with another Committee, or some project that focuses on this. There are ways to operationalize this in the future.

Commissioner Brown agreed with Mr. Gilmer's suggestion to recognize and acknowledge the importance of nontraditional and faith-based resources and services, which are part of the overall system.

**Action:** Vice Chairman Pating made a motion (second not necessary as it came directly from the Committee) that:

*The Commission adopts the report entitled, "A Vision for Transforming the Mental Health System Through Services Integration" as presented by the Services Committee on July 25, 2013 with the following amendment: Replace "the appropriate state entity" with "the Department of Health Care Services" in Recommendation Number Two on page seven.*

- Motion carried, 11-0

## 9. FIRST READ: FY 2014-15 THROUGH FY 2016-17 MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN INSTRUCTIONS

**Action:** Commissioner Poaster made a motion, seconded by Commissioner Wooton, that:

*The Commission waive the Second Read of the FY 2014-15 Through FY 2016-17 MHSA Three-Year Program and Expenditure Plan Instructions.*

- Motion carried, 11-0

### Presentation

Executive Director Gauger stated that MHSA instructs counties to prepare a three-year program and expenditure plan, and to submit annual updates. After being adopted by the county board of supervisors, counties must submit these plans to the Commission. Currently, in law, the Commission is the only entity that is receiving these plans and updates. The instructions staff is presenting for approval are for FYs 2014-15 through 2016-17. This is the third public meeting held to review these instructions. A workgroup that was comprised of two members from each Committee met on May 9<sup>th</sup> to review and comment on the staff's draft instructions. Their work product was then referred to the Services Committee for review and comment on June 19<sup>th</sup>. In addition, the Financial Oversight Committee met on June 28<sup>th</sup> to review and comment on the instructions and the fiscal worksheets that will accompany these instructions when they are sent to the counties.

The purpose of the instructions is to assist counties and their stakeholders in developing the FYs 2014-15 through 2016-17 program and three-year expenditure plan to include all the necessary elements as required by law and regulations. This will provide the essential elements necessary by law in preparing a plan for a county board of supervisors' approval. Staff has been told by the counties that they found the annual update instructions helpful.

The three-year plan instructions provide the Commission the information it needs for oversight to track, evaluate, and communicate the state-wide impact of MHSA, and to approve new or amended INN program plans.

The principles that staff, the workgroups, and Committees used when they were developing the three-year instructions are aligned closely with the law and what is in current regulations.

Chief Deputy Executive Director Carruthers stated that the three-year program and expenditure plan incorporates all of MHSA components into one document. In the past, different program components rolled out at different times. Now, counties will put all elements into one plan, which will include the elements of CSS, CFTN, WET, INN, and PEI.

Per statute, each plan shall be developed with local stakeholders. The instructions specify who these stakeholders are, including clients, families, providers, education representatives, and local law enforcement. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful involvement on mental health policy, program planning, monitoring, and budget allocations.

The instructions specify a thirty-day review by stakeholders and local mental health boards/commissions will hold public hearings on the draft. Plans shall describe the services for children, TAY, foster youth, adults, and seniors, including the number of persons served and cost per person. In asking counties to describe their PEI programs, for the first time, the instructions ask counties to describe their prevention programs, differentiated from their early

intervention programs. Also, the instructions ask counties to include a sufficient amount of information on their INN programs, to ensure the Commission has what it needs to determine if the plan meets the approval requirements. If an INN project is already rolled out and demonstrated to be successful and the county wants to continue it, the project should be transitioned into another funding category - possibly PEI or CSS. The instructions also ask counties to describe their programs for CFTN, to identify shortages in personnel, and to keep track of the local prudent reserve.

In addition to program elements, the instructions ask counties to provide a description of the number of persons served and the cost per person in CSS, PEI, and INN programs. Statute states that counties shall also include reports on the achievement of performance outcomes for these programs, with performance separated from early intervention. By law, MHSA County Compliance Certification, MHSA County Fiscal Certification, and the board of supervisors' date of adoption are required to be submitted with the plan.

The Financial Oversight Committee worked on a series of worksheets to accompany the instructions for proposed expenditures over the course of the three years. It includes a separate worksheet for each component for each fiscal year. Counties have agreed to provide additional information about the proposed expenditures, and to show the Commission how MHSA funds will be leveraged from other sources of funding.

Staff is working with DHCS to ensure they incorporate the information in these worksheets into the annual expenditure report to show what is planned and what has actually been spent, as noted in the expenditure reports.

#### **Commissioner Questions:**

Commissioner Nelson asked what to do if a successful INN project's program funds have already been spent.

Chief Deputy Executive Director Carruthers stated that, if counties choose to continue an INN program after it has been proved successful, then they can make decisions based on their own priorities as to how to fund it, but it will need to be funded from a different source.

Commissioner Nelson asked if the program would be discontinued if alternate sources of funding had already been used.

Chairman Van Horn stated that growth dollars could be used. If the INN program proves valuable and is better than something else that is being done, it can be substituted in. Counties cannot use INN dollars past the grant period, because the purpose of the INN fund was to ensure that there would be a continuing process of INN over generations.

Vice Chairman Pating asked who finally approves the CSS portion, and who approves the PEI and INN programs.

Chief Deputy Executive Director Carruthers stated that the county board of supervisors is the statutory agency to approve the plan. The only exception to that is the INN component, which comes to the Commission for approval; counties cannot expend funds until receiving the Commission's approval.

Vice Chairman Pating asked, in terms of the robustness of the process, if the stakeholder process and the adequacy of the planning of the programs involved are now determined at the board of supervisor's level of the counties.

Chief Deputy Executive Director Carruthers stated that this is correct, although the instructions do ask counties to describe their stakeholder process. It is up to the county to decide if their process was or was not enough.

Vice Chairman Pating asked if copies will be distributed to Commissioners or any other entities in the State.

Executive Director Gauger stated that it is not the Commission's practice to distribute those plans, but they are on the MHSOAC website.

**Public Comment:**

Mr. Gilmer stated that he was one of the members of the workgroup. He wanted to draw attention to the additional considerations that the workgroup submitted to the Commission. The workgroup spent a lot of time discussing the issue of meaningful stakeholder engagement. As a former PEI evaluator and having evaluated approximately forty-five counties, he went into the process thinking of continuous quality improvement for communities of color. The California Reducing Disparities Project (CRDP) funding is one spoke in the wheel, but there is opportunity with this three-year plan and the integration and funding tied to it to launch into something that will move closer to truly reducing racial and ethnic disparities, particularly as counties can be held accountable for stakeholder involvement of communities of color. He asked Commissioners to take the time to look at the recommendations the workgroup submitted.

Stacie Hiramoto, the Director of REMHDCO, agreed with Mr. Gilmer's comments. She attended the Services Committee where the three-year plan was last heard, and it was very discouraging, because un-served and underserved communities, families, consumers, and even providers have expressed dissatisfaction and disappointment with the stakeholder process at the local level. She felt everyone is doing their best, and understands counties have much to do, as does this Commission. But it seems, whatever is in the law, only the bare minimum is being done. She encouraged the Commission to not lose ground on the transformational aspects and public communication with the counties at the local stakeholder process, and to work with the new California Stakeholder Process Coalition. The stakeholder process is so important.

Suzanna Tavano, of CHMDA, stated that her appreciation for the Commission's efforts to move the instructions forward at this pace. Regarding the expenditure plan, the more detailed the required information is, there might be a tendency to be less accurate because of working with estimates. Also, since these will be estimated budgets, the actual figures will vary over the course of the year, certainly from year to year. With that in mind, the plans and particularly the expenditure plans will be able to provide a broad understanding to the public, but probably should not be used for policy decisions because they will change over time. Counties generally do not budget three years in advance, particularly not with Medi-Cal and realignment. Again, the expenditure plans will be developed, but it is to be expected that, by the second and third year, changes will occur. She stated that it will be difficult for counties to forecast MHSA distributions three years in advance without guidance from the State. There is a possibility that all counties are developing their own forecasting methodology, and that they will derive different numbers based on those different formulas.

Ms. Brody applauded the Commission for putting the plan together. It is essential to include each of the elements listed, in terms of who should be included in the stakeholder process and what standard should be used. The public review closely reflects the statutes and regulations. She stated her concern that the "what to include" section in the plan about the stakeholder process is not adequate to what precedes it. It does not provide enough information to a reviewer to hold a county accountable to any standard that is presented previously in the document. At a minimum, it should contain the same standards that are in the statutes and regulations cited. It should also be up to stakeholders, not to counties, to decide to what degree stakeholders will be meaningfully involved in the process. Stakeholders need to be able to develop state-level accountability mechanisms. These are needed to ensure that the level of the implementation rises to the standards and expectations of stakeholders statewide. The

California Stakeholder Process Coalition is holding an in-person meeting on July 29<sup>th</sup> in Sacramento; she invited Commissioners to attend.

Marlo Simmons, MHSA Coordinator for the Community Behavioral Health Services (CBHS) in San Francisco, stated that it will be challenging for San Francisco to separate prevention activities from early intervention activities for some of their PEI programs, because some programs are mixed. She cited Welfare and Institutions Code Section 5848, which has a “where possible” descriptor. She suggested adding “where possible” in places for more meaningful information collection.

### **Commissioner Discussion:**

Vice Chairman Pating gave recommendations of things to do in order to ensure robust stakeholder input, robust integrative plans, and the capacity for robust evaluation:

He agreed to a strong stakeholder process, since there may be local disagreement. He asked staff to encourage the state to move forward with issue resolution, particularly as it becomes more local. It can be anticipated that there will be some disagreements that need to be resolved; the State needs to set up an issue resolution process.

With regards to planning, he encouraged counties to think about the roundtable discussion earlier today on the value of integration - to build a system and not just separate programs. This is the first time all of the component programs will be brought together: CSS, PEI, and INN. He stated that his hope that the county mission will be, as the Commission looks to the second phase of planning, to consider how all the parts that were initially put together separately can now come together into an integrated plan.

He asked staff to ensure the Commission gets what it needs to do a robust evaluation. Staff needs to be looking forward on whether legislation needs to be strengthened on what the Commission wants the regulations to say.

**Action:** Vice Chairman Pating made a motion, seconded by Commissioner Brown, that:

*The Commission adopt the Fiscal Year 2014-2015 through FY 2016-2017 Three-Year Program and Expenditure Plan Instructions and the “FY 2014-2015 Three-Year Program and Expenditure Plan Funding Instructions.”*

- Motion carried, 11-0

### POCC Member Recognition

Commissioner Aslami-Tamplen acknowledged the twenty POCC members present in the audience. Chairman Van Horn asked POCC members to stand and be recognized. Commissioner Aslami-Tamplen added that POCC was funded by MHSA and is made up of over 700 ethnically-diverse consumers from Alameda County committed to transforming the mental health system. She thanked them for their hard work.

### **10. REPORT FROM JUNE 13, 2013, MHSOAC COMMUNITY FORUM HELD IN THE COMMUNITY OF ROHNERT PART (SONOMA COUNTY)**

Raja Mitri and Jo Ann Johnson participated on the Community Forum Workgroup and had the opportunity to watch the forums evolve into vibrant community events attended by hundreds of mental health stakeholders. Ms. Johnson thanked everyone who worked to make these events successful.

Ms. Johnson reviewed the five goals of MHSA Community Forums. She stated that the forums have benefited from Commissioner participation since their inception, and she invited and encouraged Commissioners to continue attending the forums. In 2011, the format for the forums was changed so that participants could offer input in separate discussion groups. By 2013, the discussion groups had expanded into seven categories.

Over 1,385 individuals have participated in the last eight forums. The date and location of each forum is identified three months in advance. Finding adequate facilities has been challenging and sometimes requires location changes and short notice. Even with these difficulties, the forums are well-attended, with many counties represented.

Seventy percent of the participants of the Rohnert Park forum in June voluntarily chose to fill out questionnaires. Twenty-nine percent of the participants who chose to answer indicated on their questionnaires that, before the forum, they had not heard of Proposition 63 or MHSA; forty-four percent indicated that they were not aware of programs and services in their communities funded with Proposition 63 MHSA dollars; and sixty percent indicated that they had learned something about MHSA and the Commission at the forum.

There was positive input received from discussion groups and questionnaires about strategies and services that have changed or been expanded since implementation of MHSA. Some, identified as most effective, were peer providers, peer programs, support groups, and mobile crisis teams. Many of the services and strategies identified as improved or expanded since implementation of MHSA were also identified as areas that require further improvement or expansion. Some of the most significant service challenges identified were access to services, improvement and expansion of services, and education about services and mental health issues.

MHSA Community Forums have generated interest and enthusiasm, with participation increasing over time, and have provided education and information about MHSA and the Commission. The workgroup has continued to seek ways to improve participation, particularly from un-served and underserved communities. Given the number of individuals participating, the forums represent a meaningful opportunity for the Commission to ensure that the perspective and participation of clients and family members is heard, and is a significant factor in the Commission's decisions and recommendations. It is expected that the reports from the forums may impact future policy direction

#### **Commissioner Questions and Discussion:**

Commissioner Mallel stated that she attended the last forum. She applauded the workgroup's organization and stated that the forum was very valuable. Everyone's voice was heard, and a good deal of information was passed back and forth between providers and consumers.

Chairman Van Horn stated that it has been proven that the community forums are a good way to meet constituents and give people a voice, rather than having them as guests at Commission meetings where they have three minutes to speak. He stated that the need for the Commission to consider, as they put together a work plan for 2014, how to strengthen the community forums, and perhaps adjust the focus of Commission meetings to incorporate more of a roundtable approach to longer-range problem solving.

Vice Chairman Pating asked what is being done with the information gathered at the forums, how is it being collated, and if there will be a summary at the end of the year, since it is difficult to make an assessment when Commissioners only see a report on one forum at a time.

Executive Director Gauger stated that one of the things included in the 2013 Work Plan and in the Committee Charters for CFLC and the Cultural Linguistic Competency Committee (CLCC)

was that they provide a report immediately following the forums. Staff will gather the information, make recommendations as to policy implications, and submit a final report to the Commission at the end of the year.

Commissioner Nelson suggested that staff provide a summary report in September before putting together the Work Plan. Chairman Van Horn agreed.

Commissioner Nelson emphasized the need, in the future, to look at how many of the participants are actually getting funded by MHSA.

**Public Comment:**

Mr. Fox stated that thousands of service members are returning from Iraq and Afghanistan, of which many will be mentally ill. Soldiers who suffer from “shell shock” are never knowingly prosecuted. He reviewed the report of this Community Forum meeting and specifically looked for family member discussion, and noted he did not see any mention of an incident that took place after the CIT discussion when someone asked if participants thought there was something better. He stated that he distributed a report on Laura’s Law in Nevada County to the members, and witnessed the note taker try to take the report away from the participants. It has upset him greatly.

**11. UPDATE ON EVALUATION CONTRACTS AND ACTIVITIES FOR FY 2013-14**

Chief Deputy Executive Director Carruthers stated that the Commission received clear statutory authority for evaluation in 2009. Since then, it has taken a stance to support and focus on evaluation, first through the Evaluation Policy Paper and then through the Evaluation Master Plan. The Commission’s evaluation efforts are designed to enable the Commission to provide continual monitoring and assessment of services, systems, and outcomes that stem from MHSA, and the broader California community-based public mental health system. This is imperative in order to build an approach that promotes quality improvement to both the services and the overall system.

Very recently, the Commission adopted two documents that will guide its evaluations over the next five-year period: the Evaluation Master-Plan and the Implementation Plan. Per the Implementation Plan, the Commission is going to begin eight new evaluation activities in FY 2013-14, including two new contracts and six internal activities. In addition, the Commission will continue to carry out eight evaluation contracts currently underway to be completed over the next two years.

The first new evaluation contract is to develop a system to track outcomes for adults receiving less intensive services than what are provided in FSPs. The objective is to learn how effective services are for those persons. The intermediate research question is how to develop a system for tracking relevant outcomes for a set of adult clients who are in these less intensive services.

So far, contracts have focused on FSPs, but there has been a growing interest in what the impact of the other services within CSS are. Currently, addressing the effectiveness of the mental health system for these other clients occurs only within the evaluations of specific programs. Broadening the scope will help the Commission understand the system-wide effectiveness for these individuals.

This request for proposal (RFP) is scheduled to be released this autumn. The contract will be awarded January 1, 2014, and the results of the RFP will be presented to the Commissioners at the November Commission meeting.

The second new evaluation contract is to determine the effectiveness of methods for engaging and serving TAY clients. The objective is to learn the type of programs for TAY that have been

implemented and are sufficiently well-defined to be evaluated, and to study their effectiveness in creating positive outcomes.

Through the Evaluation Master Plan, the Commission approved not only these two new contracts, but also new internal efforts:

The first new internal evaluation effort is to refine measurements of existing priority indicators. This work has already begun within the University of California, Los Angeles (UCLA) Phase II contract and an Evaluation Committee workgroup.

The second new internal evaluation effort is to develop a process for adding other indicators to the performance monitoring - a formal process of considering if indicators will maintain the integrity of a performance monitoring system. Suggestions about additional indicators are likely to be expensive and from multiple stakeholders. Having a clear process for evaluating suggestions will keep the process organized and allow a thoughtful, gradual increase in the number of indicators while minimizing false starts and other unrealistic expectations. The new Research Scientist II position will undertake this work effort once that person starts work.

The third new internal evaluation effort is to incorporate items that come out of work groups. Gaining consensus among stakeholders is going to be challenging, but it is desirable.

The fourth new internal evaluation effort determines the status of county efforts to evaluate one PEI project and make recommendations to ensure adequate evaluations. PEI guidelines require that each county conduct a formal evaluation on one of their PEI projects. The purpose of this effort is to assess and find out what counties are learning.

The fifth new internal evaluation effort develops an ongoing method for describing and cataloguing programs funded by PEI, using a system for continual tracking. Given the diversity of county PEI activities and the overlap of program descriptions, developing a new statewide system for describing PEI programs is going to be complicated. The purpose of this exploratory work is to develop alternatives for a categorizing system, and, after pilot testing, recommend the best method.

The final new internal evaluation effort is a summary and synthesis of county-level evaluations. The goal of this study is to look at how effective treatment programs are at producing positive outcomes for clients and families. Collecting and summarizing the results of county evaluation efforts is a relatively inexpensive way of promoting positive effects of the MHSA-funded programs.

#### **Commissioner Questions and Discussion:**

Commissioner Nelson asked if the CSS program would be the system to track outcomes for persons in less intensive services than FSPs.

Chief Deputy Executive Director Carruthers stated that it would be the CSS program minus FSP.

Commissioner Nelson stated that he thought that was intended for system development, which is not necessarily utilized for individuals.

Chairman Van Horn stated that it is for anything else the county is doing. There are unknown outcomes and they cannot be evaluated if their significance is not identified for the amount of money expended.

Vice Chairman Pating added that FSP is easy to measure, because there are case identifiers with unique individuals who receive unique services. The first part is to understand what this is, and then to see what the outcomes will be. Although it is stepping into unknown territory, it is necessary to develop an accountability system.

## **Public Comment:**

Mr. Mitri, representing the California Stakeholder Process Coalition, stated that the coalition is aware that evaluating the community planning project as structured via two contracts, one to Resource Development Associates (RDA) and one to PEERS, is to be participatory by nature. Since the project is on a tight timeline, evaluating the local stakeholder process is one way to assure quality improvement. The draft Community Program Planning Evaluation plan of gathering current processes and program planning to measure their quality and impact must ensure cultural competence and the inclusion of underserved, underrepresented, racial and ethnic groups, and special needs groups. This takes into account who is not at the table, if the interviews have been conducted only with those who have attended the community planning process. It is important for RDA to ensure that interviews and focus groups be conducted with individual stakeholders from unreached, underserved communities, rather than solely relying on the usual participants; otherwise, certain stakeholder groups will not be included in the evaluation. The coalition would be happy to assist RDA to ensure that the evaluation process is satisfactory and reaching community constituencies of diverse stakeholders.

Jane Adcock, the Executive Officer of the California Mental Health Planning Council (CMHPC) but is speaking as a member of the California Stakeholder Process Coalition, encouraged RDA to collaborate with the coalition about program planning. The coalition has been working for a year to develop additional detail to go along with the statutory requirements for the stakeholder process. It would be valuable to use that information in RDA contract as they look at the counties' processes and determine which are best practices. The coalition has developed recommendations that will assist RDA in determining what these best practices are.

Chairman Van Horn stated that there has been discussion with Dr. Bradley about reaching out to the California Stakeholder Process Coalition.

Ms. Hiramoto stated that she is also a member of the California Stakeholder Process Coalition. The coalition is happy that the Commission is undertaking the study of the community program planning process, because they were concerned about the lack of accountability and oversight at the local level. The stakeholder process is one of the few things that remain for stakeholders to try to affect their local process. She stated that REMHDCO and the coalition required more than the week they were given to provide comments on this proposal. She stated that her concern was that she was told she was not yet allowed to know who was on the advisory committee or who attended the planning retreat for the proposal, but was instead given a demographic portrait of who belonged on this advisory committee and the planning body. She stated that she was pleased to see that there was a lot of diversity, but it is important to note that there is a difference between diversity and cultural competence. Diversity is important, but what is needed is people who are knowledgeable and represent those ethnic and racial communities when they are sitting at the table and making connections.

## **12. COMMISSIONER COMMENTS**

### **A. Discuss Future Commission Agenda Items**

Chairman Van Horn recommended hearing a presentation, for the September meeting, from a group in Long Beach that is attempting to pull together a variety of agencies, public and private, to construct a total safety net - not just behavioral health, but primary care, social services, and housing.

He stated that there are seven agencies coming together in Long Beach for a discussion on integration. He stated that his hope that they will have had enough conversations by September

to enable them, as an extension of what the Commission started this morning, to sit in a forum-type roundtable among the Commissioners at the full Commission meeting in September to discuss this total safety net concept. The Commission needs to include representatives from social services, housing, and faith communities to look at a whole health model.

The next phase for a forum-type roundtable would be to take a comprehensive look at child and family issues and the money being poured into Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). There are many places where the Commission can start looking, and where the broader parameters are needed to encourage dialogue.

Commissioner Aslami-Tamplen suggested hearing a presentation from agencies that have done research in the peer crisis respite centers. They are an emerging model that is growing in California.

Chairman Van Horn agreed that this would be an interesting fourth forum-type roundtable, taking a look not just at peer-run respite but at the first steps to doing crisis houses.

Vice Chairman Pating recommended, in the January Commission meeting, when Commissioners hear the plan, also hearing a presentation - matching the two.

Commissioner Aslami-Tamplen volunteered to reach out to some of the agencies and individuals for these roundtable discussion panels.

### **13. GENERAL PUBLIC COMMENT**

Eva Slover, the Program Assistant for REMHDCO, gave an invitation to a reception shortly after MHSOAC meeting in Long Beach on September 26<sup>th</sup>. The CMMC is hosting the reception to allow the public to see what the CMMC is about. There will be refreshments and entertainment.

Mr. Gilmer stated that many of the stakeholders spend a lot of time and resources to attend these meetings. He stated that it would mean a lot to racial and ethnic communities and stakeholders for MHSOAC to work on cultural competency being dominant here - to learn to share and work together to create an affirming environment.

Ms. Brody agreed with having a roundtable discussion on peer-run respite and promised to spread the word. She also agreed that one week for stakeholder comment on the RDA evaluation plan was not enough time to reach out to constituents and return comments to the Commission. Also, the draft community planning process evaluation states inventory and evaluation of that process will be done based on the sound principles laid out by the American Evaluation Association Ethics Committee. The RDA evaluation plan missed a number of those principles in its summary: to ensure cultural competence; to disclose conflict of interest; to understand contextual factors; to maximize the benefits and reduce unnecessary harms that might occur from an evaluation, and judge when the benefits from the evaluation should be foregone because of potential risks; to conduct the evaluation in a way that respects stakeholders' dignity and self-worth; and to understand and respect their differences in terms of culture, age, ethnicity, etc.

Ms. Brody echoed others' comments on cultural competence, and emphasized that the American Evaluation Association Ethics Committee principles make it clear, along with the federal CLAS standards and California's cultural competence plan requirements. These principles state it is central to take into account who is not at the table. She stated that her hope that these, and other factors related to these, will be included in the final plan.

Vice Chairman Pating stated that, in regard to the one-week input timeframe, the grants being issued were with research projects that have already been approved in the Master Plan. Staff was not allowed to talk about the content of the RFP during the design period, but they were allowed a small period of time to obtain some stakeholder input. Once the RFP writing begins, it

becomes confidential. Also, there was a timeline to get the monies out as quickly as possible, due to the annual funding cycle. When the RFP is assigned, the researchers will go back to the community to ensure that, before they start doing the research, they have stakeholder input.

Mr. Fox asked the Commission to adjourn in memory of the twelve people who died in Aurora, Colorado, one year ago Saturday, when a person living with serious mental illness opened fire on a movie audience. He stated that Laura's Law is a rational response to Aurora and, subsequently, similar events that took place in Michigan, Texas, Connecticut, Santa Cruz, and Santa Monica. Because it produces positive outcomes by creating a treatment-compliant behavioral situation and is certified to be effective, efficient, and economical by the Department of Justice, forty-five states have enacted assisted outpatient treatments and addressed the consequence of treatment resistance and treatment not in compliance. He asked the Commission to provide persons living with mental illness, who do not understand the need to seek treatment voluntarily, with the opportunity to change how they behave based on facts. No one's rights are protected by a law that incarcerates a person living with mental illness who does not understand their need to seek treatment voluntarily one day, and then frees that person the next day.

Alan Striple, consumer and advocate, stated that he serves on MHSA Advisory Committee, MHSA Evaluation Support Group, and other organizations within the city and county of San Francisco. He stated that he is also a part of the Evaluations Committee Workgroup for MHSA in San Francisco. The workgroup does evaluations on many of the components of MHSA, following the regulations that are set forth by this Commission and the Legislature on these programs. He requested that the Commission consider setting up some of the evaluations on the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) population.

Michael Diehl, consumer and advocate, stated that he has been a peer counselor for twenty-three years at the Berkeley Free Clinic. He talks to people on the streets and encourages them to get into programs and housing. He has been leading support groups with clients for many years, but the system does not trust peers to do that. He stated that his hope for a peer specialist training program to validate his work in reducing chronic homelessness in Berkeley. In terms of integrating physical and mental health, California has a long way to go. He suggested looking at the physical elements that lead to shorter lives, such as high blood pressure, diabetes, and obesity, along with the outcomes of reducing hospitalization, homelessness, and incarceration of mental health clients.

#### **14. ADJOURNMENT**

There being no further business, the meeting was adjourned at 4:20 p.m.