

**MHSOAC**  
**Mental Health Services Oversight and Accountability Commission**  
**Meeting Minutes**  
**October 28, 2010**

**The Westin Long Beach**  
**333 East Ocean Boulevard**  
**Long Beach, CA**  
**(562) 436-3000**

**1. Call to Order**

Chair Poat called the meeting to order at 10:10 a.m.

**2. Roll Call**

Commissioners in attendance: Andrew Poat, Chair; Larry Poaster, Vice Chair; Richard Bray, Senator Lou Correa, Assembly Member Mary Hayashi, Patrick Henning, Curtis J. Hill, Howard Kahn, David Pating, Richard Van Horn, and Eduardo Vega.

Not in attendance: Don Pressley and Larry Trujillo.

Eleven members were present and a quorum was established.

**3. Welcome to Los Angeles County**

Commissioner Vega introduced Dr. Marvin Southard, Mental Health Director for Los Angeles County. Dr. Southard began by recognizing the three Commissioners from Los Angeles County: Commissioners Vega, Kahn, and Van Horn.

Dr. Southard spoke briefly on three issues currently paramount in Los Angeles County.

1. The 1115 Waiver negotiations in the coverage initiative: those in Los Angeles County believe that the expansion of the coverage initiative provides a wonderful opportunity for doing a reinvestment of the indigent care investments that many counties have continued to provide. It provides additional federal funds that will allow expansion of both health and mental health services – so the county can address the scandal in which people with serious and persistent mental illness die 25 years earlier than the general population.
2. The blue-penciling of the funding of 3632 has been a crisis for all counties. The county is trying to find collaborative ways with school districts to continue to provide coverage for seriously emotionally disturbed kids in the schools, but in such a way that county general funds are not put at risk. This issue is presently playing out in several legal forums.
3. The county is hoping that the implementation of the statewide stigma reduction opportunities that the Joint Powers Authority (JPA) and other

means allow, will have us address the social exclusion that has faced persons with severe mental illness and their families. We believe this will be a real opportunity to change the whole playing field, so that the inclusion of people with severe mental illness is designed into the system.

Chair Poat thanked Dr. Southard, and recognized Mr. Larry Gasco, Chair of the L.A. County Mental Health Commission.

Mr. Gasco welcomed the MHSOAC to L.A. and noted that his Commission is very much invested in MHSOAC's success.

**4. Adoption of September 23, 2010 Meeting Minutes**

Commissioner Vega noted a clarification needed on page 9 to a quote by Commissioner Hayashi: the word "as" should be inserted between "Suicide Prevention" and "Executive Committee Members". He also requested the Minutes to reflect his comment that former Commissioner Saul Feldman is an Executive Committee Member.

**Motion:** *Upon motion by Commissioner Hill, seconded by Commissioner Bray, the Commission voted to adopt the September 23, 2010 Minutes with the changes noted above, with Senator Correa and Commissioner Kahn abstaining.*

**5. MHSOAC Calendar, October 2010**

Chair Poat stated how much he has enjoyed the privilege of serving as Commission Chair. He was pleased that the statewide projects have gotten off the chalkboard and moving into actual implementation.

However, there is much work yet to be done for this Commission and the Mental Health Services Act (MHSA). The election of Chair is an important decision. That person will help keep this group organized and focused as it moves into the next chapter of administering the Act. Chair Poat then called for nominations of the next Chair.

**Motion:** *Upon motion by Commissioner Hayashi, seconded by Commissioner Vega, the Commission voted unanimously to elect Vice Chair Poaster as Commission Chair for next year.*

Vice Chair Poaster voiced his thanks to Chair Poat for his leadership, time, and skills as he has served during the past two years. Vice Chair Poaster also expressed appreciation for what the Commissioners do – they are all very busy people involved in a whole variety of enterprises; yet they always show up; they exert leadership; and they meet their own expenses.

Chair Poat stated that there is no one better positioned than Vice Chair Poaster to serve as Chair right now, because of the key role that evaluation and integration of services is going to be taking with the Commission. It is at a very critical point with the development of evaluation tools, and that's something that Vice Chair Poaster has been part of, along with financial assessments.

Chair Poat opened the nominations for the office of Vice Chair.

**Motion:** *Upon motion by Commissioner Pating, seconded by Commissioner Kahn, the Commission voted unanimously to elect Commissioner Van Horn as Commission Vice Chair for next year.*

Commissioner Van Horn stated that it will be a pleasure to serve with Vice Chair Poaster. They have the same set of values in looking at how MHSOAC will ensure that the transformation moves ahead. As the evaluation progresses, the Commission needs to take its accountability very seriously.

## **6. Committee Structure for 2011**

Chair Poat said that MHSOAC has been keeping its Committee structures for two-year periods. The Commission is now starting to think about structures for 2011-12. A two-year structure gives people time to get to know the issues and to establish working relationships.

By January the Committees need to be ready to go. Today's question is, What will the Committees be? When that is established, the Commission will invite people to apply for those committees.

Currently the five existing Committees are:

- Evaluation
- Services
- Funding and Policy
- Client and Family Leadership
- Cultural and Linguistic Competence

Regarding structuring of committees: the first three committees, have specific outcomes associated with their charge; they can be called *operational* committees. Their specific outcomes are related to the administration of the Act. The next two committees speak more to the values of the Commission.

The Commission has three options:

1. Maintain the five committees as they are.
2. Better integrate the memberships of the Client and Family Leadership Committee (CFLC) and the Cultural and Linguistic Competence Committee (CLCC) into the core functions of the Commission. This follows the Best Practice Concept of integrating individuals who are responsible for the operation of the organization.
3. Form a new Community Outreach Committee, which would hold quarterly forums in an attempt to:
  - Listen to Public Comments in a separate setting
  - Meet at locations around the state so that more of the public can voice their concerns

Chair Poat asked for Commissioner comments. He noted that one of the goals of the meeting was to decide how to use MHSOAC resources to the maximum effect. There's a limited number of Commissioners and we have some big goals before us; creating additional committees make challenges for how the Commission can support them in terms of time.

Commissioner Hayashi asked if the existing committee structure has a maximum number of members per committee. Chair Poat responded that in general, 15 is the maximum.

Commissioner Hayashi suggested a committee on Suicide Prevention, this being an issue that the Commission needs to continue addressing. She would be willing to lead such a committee.

Commissioner Kahn clarified that the existing committee structure has no defined set of membership. Commissioner Hayashi noted that in the Commission's Rules and Procedures, there are guidelines that include:

- Two clients
- One family member of an adult
- One family member of a child
- Two representatives of underserved ethnic and cultural groups

Option 1 above proposes adding three more categories:

- One representative from a community-based organization
- One mental health professional
- One representative from the California Mental Health Directors Association (CMHDA)

Chair Poat pointed out that the Commission seeks diversity as measured in a variety of experiences. The members list represents the areas that the Act actually calls for; they can be written even more so into the process. Today the Commission has a chance to formalize its strategy moving forward. We want to make sure that we have all the categories that the voters clearly indicated they want for participating in this process.

Commissioner Kahn commented that additional committees mean additional workload for staff.

Commissioner Pating asked about charter-driven and task-driven committees: What are the major tasks that we anticipate for 2011, and how do we see our current committees meeting those tasks? How can we best organize around the work, rather than around the committees?

Chair Poat responded that the next two months will address this broad question. The committees should indeed consider the current Commission issues. This will be done through a charter similar to last year's.

Vice Chair Poaster brought up the 2010 Work Plan which included priorities and discrete sub-activities that had to occur. This Work Plan lined up with committee charters. Staff was now in the process of pulling together a proposed 2011 Work Plan with some adjustments from 2010. This will set the stage for the committee chairs to begin developing committee charters to be completed hopefully at the end of January.

Senator Correa commented that Commission goals for 2011 are not quite ready yet, but we are already establishing committees based on the new workload. Perhaps it would be better to hold off on establishing committees until we have a better understanding of direction for 2011. Committee structure should follow the work, not vice versa.

Chair Poat replied that usually the Commission Chair takes the responsibility of leading the Commission and staff in developing those priorities. Historically, those have been laid out in January – however, one outcome could be to do this next month.

Commissioner Kahn noted that certain core committees must exist in every organization. As a new Commission, MHSOAC needs to establish some stability going forward; it needs to get some rigor going into the organization.

Commissioner Van Horn stated that the idea of the Community Outreach Committee comes from several different pieces coming together. Commissioner Vega's community forum in Salina was very interesting, with a variety of people from different counties contributing information. The Commission has been remiss in one area: broadly listening to the grass roots. It doesn't have extended forums. The idea of quarterly forums around the state comes from the CFLC. This is a way to strengthen our oversight and accountability function.

Commissioner Van Horn continued that the Commission needs to listen to two major areas: what is happening to families as they encounter this system that's in transformation, and what is happening around the disparity issue. MHSOAC needs to have its strongest family members, consumer members, and cultural and community members on the three core committees.

Commissioner Vega pointed out that all Committee members must reapply for next year. On the topic of work, we have moved to shorter Commission meetings, and put more demands on committee work. This makes sense as a way of getting work done – but the work has not diminished. The Commission needs more staff support, but staff is already stretched. If we think about committees as a place to get work done, we need to know what work is getting done by what committee.

Commissioner Vega continued that there is tremendous value in the community feedback forums. We look forward to bringing the results into the Commission's thinking in a structured way. The CFLC has accomplished a lot with an ambitious work product in its focus. No matter what, the Commission needs to

make a clear commitment to keeping the voice of clients and family members at the fore front.

Vice Chair Poaster noted that staff has prepared a 2010 calendar showing accomplishments meeting by meeting. That might help validate Commissioner Vega's point that the work isn't getting less complicated.

### **Public Comment**

- Mr. Richard Krzyzanowsky, Chair of the Orange County Stigma Elimination Task Force, stated that he opposes the proposed restructuring. He urged postponement of the vote. He felt distressed that the stakeholders and committees have not been fully engaged in this conversation up until now. This may reflect on the style and culture of this organization.

Senator Correa asked specifically what he disagreed with. Mr. Krzyzanowsky replied that he agreed with the goal of the exercise, that expanding representation on the more business-oriented committees is good. However, combining the other two committees into a community outreach committee is ill-advised because it diffuses the focus. He felt that the visibility of the existence of these committees is a great political asset to MHSOAC.

- Ms. Carolyn Chadwick, of Tessie Cleveland Community Services, said that she didn't see Option 1 as being an option at all, because it is already a part of what the committee structure should look like. If the Commission has not been able to ensure that the committees meet that requirement, how will putting a new option on the table make that happen? Also, why couldn't Option 2 have been a charge of one of the existing committees?

Senator Correa agreed: the minority is being overtaken by the majority of the perspectives. Also, when funding decisions are being made that don't adequately address linguistic and other cultural issues, then the Commission is short-changing itself.

- Ms. Gwen Slattery asked who on the Commission represents her community. She stated that putting a person from her community on each committee will not eliminate any issues it has. MHSOAC needs to leave Option 1 in place, because without it, the underserved and the unserved may go totally unnoticed by this Commission.
- Ms. Delphine Brody, MHSA and Public Policy Director of the California Network of Mental Health Clients (CNMHC), reminded the Commission that for far too long, the seats of one client-designated Commissioner and two family member Commissioners have been vacant. This has put a strain on the Commission in terms of Commissioner resources. She proposed Option 3 as delineated in a letter by CNMHC, which would expand the slots for clients, family members, and unserved and underserved community members throughout all committees.

- Ms. Donna Barry, teacher, trainer, and CFLC member, stated that the issue is the voice of the stakeholders. MHSOAC cannot operate without values. Client and family leadership is the conscience of Evaluation, Services, and Funding and Policy Committees. We must remember that people have died and suffered. We have our charter; we have done an enormous amount of work during the past two years. To disband CFLC and CLCC is like saying that we haven't done anything. She proposed Option 3: that we add Community Outreach; and that Option 1 include a spectrum of clients of all ages.
- Ms. Gwen Wilson, consumer and provider, pressed that Option 3 is the best solution for her. On the first three committees, she didn't see a representation of ethnic and minority communities. Keep the other two committees the way they are, and maybe give them a bigger charge of structural transformation.
- Ms. Tina Mata commented that we need to keep the five committees, and possibly add others: Suicide Prevention and Community Outreach. Combining the CFLC and CLCC with the other ones would water them down. There are more than enough Commissioners to sit on those five committees. Everyone should be represented and heard.

Senator Correa asked the reason for the vacancies on the Commission; who needs to appoint them? Vice Chair Poaster replied that it's the governor. MHSOAC, the Department and the Agency have repeatedly tried to get them filled.

Commissioner Kahn suggested sending a message, as we notify the governor's office of vacancies, that we would like to increase the diversity of the Commission. Senator Correa stated as a footnote that many other state Commissions are looking at the same challenge.

- Dr. Chong Soh, PhD, Director of Asian Pacific Treatment and Counseling Centers, stated that going backward by abandoning the CFLC and CLCC doesn't make sense. We have come a long way but not long enough. We don't want to dismantle our work. On those two Committees, we need to do outcome evaluations with data; they aren't just value-driven.
- Mr. Sherman Blackwell, National Alliance on Mental Illness (NAMI) California State Board, found the disbanding of the Family Leadership Committee problematic. He was particularly concerned about the term "unserved" in the MHSA; it needs extreme attention. Within California's 58 counties' official rosters, how many of the unserved have been included? So many African Americans have no way of accessing mental health services because they don't know what services are available. Any method of reaching out to engage these communities is worth exploring. He proposed having an Unserved Committee. Have an extensive discussion with the African

American community, before you go forward with these committees that represent nobody.

- Mr. Russell Vergara, family member and Executive Director for Multiethnic Collaborative of Community Agencies, opposed the potential disbanding of the Family Leadership Committee and the Cultural and Linguistic Competence Committee for three reasons:
  1. Disbanding them runs counter to the stated goal of restructuring the three committees in order to facilitate better listening in the field. Combining the tremendous work that both committees need to do will gloss over much of the specific discernment of community needs.
  2. It puts the cart before the horse: Setting the agenda will be influenced by what committees are in place.
  3. The future of health is integration. We need to build and strengthen helpful institutions, not disband them.
- Mr. Ruben Cantu, California Pan-Ethnic Health Network, voiced his concern about the proposed elimination or merger of the two committees. It is very difficult to have one or two voices represent the needs of communities of color and underserved communities, especially when we've recognized the fact that communities of color are the majority in California. We are concerned that the voices that need to be heard will be lost.
- Ms. Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), read for the record the names of organizations who have written letters being passed out to the Commissioners, whose representatives were not able to be present because of the short time notice for this agenda item. They were all in opposition to disbanding the CFLC and CLCC. Ms. Hiramoto stated that she is in favor of Option 3 as presented by the California Client Network. Cultural competence must not only be embedded generally in all areas – but it must be called out, and special and direct efforts must also be included. The plan to dismantle those committees is a step backward.
- Ms. Carmen Varela, representing Disability Rights California, stated that the group understands the need to ensure that the voice of people from underserved and marginalized communities exists in these types of forums. It opposes the disbandment of the two committees for two reasons:
  1. It will seriously compromise your ability to provide culturally competent services to these communities.
  2. By having a committee with only two representatives out of fifteen, you cannot accurately reflect the needs and desires of people with psychiatric disabilities from underserved communities in California.

Chair Poat pointed out that getting rid of committees is off the table; the question is how best to structure them.

- Ms. Carmen Diaz, former MHSOAC Commissioner, voiced her concern that the Client and Family Leadership Committee is not a mandate of the law, but it is mentioned in the law. It is very hard for one parent or caregiver to stand among seven consumers and one family member when the issues are totally different. The adults don't understand the children, and sometimes the children don't understand the adults. If you want to break the categories down, you must break them down more accurately. Looking at the composition of the Commission, where's the parent and where's the family member? She stated that she is in favor of keeping the same structure and don't disband the CFLC.
- Ms. Kathleen Derby, MHSA Coordinator for NAMI California, had distributed the written version of her comments. She commented on the short notice of this meeting. She then pointed out that Option 1 appeared to be increasing the diversity of government representation and professional service providers. She agreed with Option 3 as presented by the California Network of Mental Health Clients and REMHDCO. There is definite need for more diversity of lived experience and cultural diversity on all of the committees. The MHSOAC has been a leader in modeling MHSA values. To say that these committees are not necessary would be ill-advised.
- Ms. Bernice Torres, family member and consumer, urged the Commission to keep the five committees. She supported Option 3 with three points:
  1. Don't eliminate the voice and choice. Be open to what the experts who have "walked the walk" have to say.
  2. By your committee structure options, you are opening the door to address new needs by having new committees.
  3. All five committees should have an increase of seven points: funding, information, access, shared decision-making, partnership building, empowerment, and transformation.
- Mr. Rafael Metzger, United Advocates for Children and Families, commented that regarding the committee structure, one idea would be to keep the CFLC and CLCC intact and separate, but take the other three and make them workgroups that report to those two. He brought a letter from his organization and read excerpts from it.
- Mr. Vernon Montoya, newly elected president of NAMI, brought a historical note: a document titled "The Year of the Consumer," prepared by the Citizens Advisory Commission and distributed in 1982. He read excerpts regarding the need for consumers to participate in the mental health system. In 1991 he had participated in Cultural Competency by means of Affirmative Action. As a member of the Mental Health Planning Council, he had initiated the client-driven component for the MHSA.

- Ms. Vickie Mendoza, United Advocates for Children and Families, stated that if there were a vote today, the Commission would have to go with what the public had said, take Option 2 completely off the table, and keep those two committees intact.
- Ms. Viviana Criado, California Elder Mental Health and Aging Coalition, voiced the need to keep the committees as they are, and to expand them to include older adult and family representation. She also mentioned that the Commission should consider adding alternates to solve the vacancy problem.
- Mr. Jim Gilmer made two specific points. He mentioned Peter Drucker, who emphasized customer centeredness. This recommended approach devaluates the importance of the customer and flies in the face of sound business strategy. The other issue is not to appoint individuals, but to plumb down to the depths of our culture-specific populations and spend some quality time so that we can truly transform this system. He supported Option 3.

Chair Poat called on the Commissioners for their questions and thoughts.

Commissioner Vega commented that those who had made comments showed not just lived experience but lived expertise. The MHSA was founded on the principles that the lived experience of being a client, parent, or family member is an expertise that the MHSA needs to keep in play.

He noted that the first three committees are expert committees. It wouldn't be a good idea to replace the experts on those groups. We need expertise. We need the clients and family members, and representatives of underserved communities to be experts for the Commission.

He submitted that the Commission should not take action today, but come back with a more developed set of solutions for the next meeting. He also noted that Option 3 needs to be clearly stated for everyone present.

Commissioner Kahn thought the discussion was extraordinarily good and the thoughts well-stated. He felt that the Commission should think this through more. He also stated that the objective of this Commission is to improve the mental health status of Californians; it needs to maximize the input. A consideration for today is that most of the speakers are on the CFLC and CLCC – not necessarily active on the other committees where a lot of the programmatic decisions are being made. The driver here should be how to get the best input not just from the people on the committees but also from the communities.

Commissioner Pating commented that he supported Senator Correa's suggestion to look at the functional task that the Commission is anticipating. Also, a strategy of inclusion and calling out is an acceptable best practice. He liked the idea of focus and inclusion, but also that somewhere we have a forum where these issues can be given precedence. Balanced with that is the need to be efficient, and having more committees doesn't necessarily achieve that.

Commissioner Henning said that he hoped not to spend too much time on re-evaluating committee structure, but instead getting to the actual act of accountability and oversight. In addition, for “one mental health professional” the Act says that the Commission has a union representative. Commissioner Van Horn clarified with him that one of the principles around committee structure is that the composition of the committees should reflect the composition of the Commission.

Commissioner Vega requested Ms. Brody to come forward and articulate Option 3. She explained that Option 3 looks like Option 1 with several additions. It would have all five existing committees and retain the current membership of the CFLC and CLCC. For any additional committees, there would be five clients and five family members/caregivers, with at least three of those being of a child diagnosed with SED. There would be a minimum of three representatives of unserved, ethnic, and cultural communities among the five clients, and a minimum of three among the five family members. The total number on each committee would not exceed fifteen.

Commissioner Hayashi wondered why the Commission needs to create a new committee structure if the existing one is working. Chair Poat replied that the challenge we have found is the ability to support this number of committees from the standpoints of staff, Commissioners, and capacity. The question is not how to get rid of people, but how to use people’s time most effectively.

Chair Poat noted that no one has argued against the first three committees. There’s consensus that we want to ensure broad participation. To that we can bring to Option 1 the allocation of seats; all of the parties enumerated in the Act should indeed be participating in each committee. We know that we’re going to proceed with Evaluation, Services, and Funding and Policy Committees and we’re going to include (at least loosely) membership that’s listed in Option 1.

If the Commission can agree to that, it can get the listserv out so people can start applying to those three committees. There is also considerable interest in understanding a third option with respect to keeping the CFLC and CLCC committees, or pursuing a different arrangement into these other committees.

Commissioner Vega suggested keeping the CFLC and CLCC, and having them work together to conduct the community outreach forums as part of their major charter items.

Vice Chair Poaster stated that for him, the critical issue is the creation of the quarterly “listening” to obtain information from different communities. Commissioner Vega observed that this task needs more energy and more people.

**Motion:** *Upon motion by Commissioner Pating, seconded by Commissioner Bray, the Commission voted to re-establish the Evaluation, Services, and Funding and Policy Committees, and to use the general outline listed at the top*

*of Option 1, so that the Commission can open up that process to public application for membership.*

Following group discussion, Commissioner Pating withdrew the motion.

**Motion:** *Upon motion by Commissioner Kahn, seconded by Commissioner Bray, the Commission voted to solicit public membership listing all five existing committees but noting that at the November Commission meeting the Commission will consider how best to structure the Client and Family Leadership and Cultural and Linguistic Competence Committees. The motion passed with Commissioner Vega voting no.*

**Motion:** *Upon motion by Commissioner Kahn, seconded by Commissioner Bray, the Commission voted to return in November with a simplified framework of activities that could be part of the charters for the Client and Family Leadership Committee and the Cultural and Linguistic Competence Committee, as well as the potential new committee. The framework of activities would be drafted with the understanding that all committee activities for 2011 are to support the Commission's Work Plan for 2011 which will be adopted by the Commission. The motion passed with Commissioner Vega abstaining.*

#### **7. Update on Approved State Budget for Fiscal Year (FY) 2010/11**

Vice Chair Poaster began with a comment about the Commission's financial projecting: it is trying to move to a format where every month the scorecard is brief but provides important information. Possibly on a quarterly basis, we'll do a more detailed financial projection.

He also noted that at this point in the Commission's development, financial projecting is based on the financial projecting of the Department of Finance and the Department of Mental Health.

Ms. Janna Lowder, Staff, presented the FY 2010/11 Funding Score Card for Community Mental Health Funding. She explained the Funding Sources, their Primary Obligations, Changes to Programs for 2010/11, and Impact to the MHSA and Overall County Mental Health.

Dr. Stephen Mayberg, Director of the Department of Mental Health (DMH), went over salient highlights of the budget for the Commission.

- The new budget was protracted. There will still be problems in the coming year; Moody's predicts a \$20 billion deficit.
- The Mental Health budget in the General Fund was increased \$167 million from the previous year. Funding streams for Mental Health are as such: 33% is funded by General Fund, 20% by the MHSA, 19% by realignment, and 25% by Medi-Cal. 74% of this money goes to the community for services. The rest goes to 24-hour care state hospitals.
- A major change is a \$30 million reduction in state hospital costs, asking the state to find savings in outside medical expenses.

- There was a transfer of General Fund into the Mental Health budget, as opposed to the proposal to use MHSA funds or other funds to pay for match.
- AB 3632 was vetoed, and litigation is in process. The children impacted are non-Medi-Cal-eligible.

Dr. Mayberg took questions from the Commissioners. He noted that MHSA funds have not and should not be paying for AB 3632 services. It is because of a mandate that those funds are separate. The question raised is whether preventive programs in the schools keep kids out of 3632 referrals or IEPs. Commissioner Bray commented that it costs the schools more than it costs the counties to pay for the services because counties have the ability to leverage their money so much better than the schools.

8. **Priority 4: Envision Opportunities for Restored Financial Growth 2014 through 2019**

Vice Chair Poaster introduced the panel presentation on the whole issue of Healthcare Reform, the 1115 Waiver, what they mean with regard to behavioral health services, and how that ties in to the parity law.

Ms. Sandra Naylor Goodwin, PhD, California Institute for Mental Health (CiMH), began the presentation. Highlights were as follows.

- We have reached the tipping point in our understanding of healthcare services that if we don't address the needs of people with serious mental illness, and the mental health and substance use needs of all Americans, it won't be possible to improve overall health outcomes in our country and it will be impossible to bring down the ever-growing cost curve.
- Fewer than 5% of Medicaid beneficiaries account for more than 50% of the cost. 75% of Medicaid cost are the result of services delivered to people who have three or more chronic conditions. 49% of Medicaid beneficiaries with disabilities have a psychiatric illness.
- Ms. Goodwin had distributed a document called "The Business Case for Bidirectional Integrated Care."
- Employers ranked depression as the greatest cause of lost productivity among workers.
- Substance use accounts for an even greater underfunding problem than mental illness.
- Changes will drive integration of primary care and behavioral health in the form of the person-centered healthcare home, and create greater demand for mental health and substance use treatment services.

- National healthcare reform comprises four key strategies:
  - Insurance reform
  - Coverage expansion
  - Delivery system redesign
  - Payment reform
- Coverage expansion will result in a 43% expansion of Medicaid enrollees and an 8% expansion in those privately insured. This will result in increased spending of \$15 to \$23 billion.
- The state and the federal government developed a new benchmark that all health plans will have to meet: all private insurance must provide mental health and substance use coverage at parity.
- Opportunities for healthcare cost reduction on the hospital side include: improving efficiency of inpatient care, using lower cost treatments, reducing adverse events, and reduction in preventable readmissions. On the primary care practices side they include: better prevention and early diagnosis, improved practices, reducing emergency admissions, and unnecessary testing.
- Accountable care organizations (ACOs) can be used to develop coordinated systems.

Ms. Patricia Ryan, MPA, CMHDA, continued the presentation.

- Most counties are currently exploring integration of primary care and behavioral health. Some CiMH CalMEND integration pilots are underway.
- The state's vision for the 1115 Demonstration Waiver is that by January 2014, California will have made significant strides in implementing key components of the Patient Protection and Affordable Care Act.
- California proposes to immediately begin phasing in coverage for newly eligible adults aged 19-64 with incomes up to 133% of the federal poverty level (FPL), by creating new "Coverage Expansion and Enrollment Demonstration" (CEED) programs.
- Health Care Coverage Initiatives (HCCIs) under the new proposed waiver aim to have at least 56 of the state's 58 counties, representing 98% of the state's population, participating in the second generation HCCIs.
- Proposed CEED financing would have participating counties incur total cost for providing medical services and administration; federal reimbursement to those under 133% of the FPL; and expansion to those between 133% and 200% of FPL who will be eligible for federal reimbursement up to a new Safety Net Pool Cap.

- Behavioral health benefits for CEEDs would include primary and preventive services, acute care services, mental health and substance use services, and pharmacy services.
- The Department of Health Care Services has proposed a minimum benefits package that includes up to 10 days per year of acute inpatient hospitalization, psychiatric pharmacy, up to 12 outpatient encounters per year, benefits beyond the minimum for counties that wish to establish them, required mental health benefits for enrollees who meet the criteria, and restrictions to network providers.
- Future issues involve substance use benefits, the state-proposed minimum mental health benefits, local level directors' involvement in MH/SA benefit decisions, and agreement of CMS and the state on the terms and conditions of the 1115 Waiver by October 15.

Sheree Kruckenberg, representing psychiatric hospitals in the state of California, gave a presentation on mental health parity. Highlights are as follows.

- Parity means "equal benefits," and the mind and the body are now considered one by some people, mostly at the federal level.
- Laws governing parity are AB 88 (state) and the Paul Wellstone & Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (federal).
- Parity law applies to private managed care plans (HMOs) and insurance contracts (PPOs).
- California parity law requires specific services to be covered while federal law does not.
- California law requires maximum lifetime benefits, copayments, and individual and family deductibles to be the same for mental health as for physical health.
- State enforcement entities are the DMHC and the California Department of Insurance.
- Federal parity law has size limitations in group health plans, and includes ARISA plans and Medi-Cal managed care plans and other nuances different from California state law.
- Federal enforcement entities are the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Department of Health & Human Services, and the State Insurance Commissioner.
- Healthcare reform-driven service delivery redesign and payment reform is unfolding rapidly. To bend the cost curve, payment reform and service delivery redesign will change how health, mental health and substance use services are integrated, funded, and managed.
- Some aspects of California parity law are stronger than federal law and vice versa. All of this must be worked out.

- There will be a huge increase in the number of individuals who are eligible for services.
- The provider community's biggest challenge will be to educate people about how to get the services they deserve.
- The full impact of parity won't be known for years.

Ms. Ryan added in closing that with all the people newly eligible for services, the healthcare workforce will have to expand.

Ms. Ryan and Chair Poat emphasized that MHSOAC is one player in a now very busy environment – how do we leverage what we have in order to work with everyone else to make serious changes? Ms. Kruckenberg added that there hasn't been collective effort to bring big groups together; the federal government is crying out for parity, and our state is not necessarily embracing that. Ms. Goodwin noted that we don't have a statewide center where discussions are taking place.

Ms. Goodwin and Ms. Ryan stressed that we need a lot of policy work at the state level, but the action of how to make it work is all at the local level. They urged everyone to get involved at the local level.

Senator Correa suggested a town hall or joint hearing by both the Assembly and the Senate health committees, along with MHSOAC, to address the issue of parity. Commission members agreed to draw up a letter to the Chairs of both health committees, requesting such a meeting for early January with the new Administration.

#### **9. PEI, Innovation (INN) and Annual Update Plan Approval/Status Update**

Commissioner Pating, MHSOAC Services Committee Co-Chair, presented a correction, and asked for a re-approval of the dollar allocation for the Santa Barbara County Innovation Plan from last August. The total request of \$3,048,000 was a typographical error which was on the DMH website. It should be corrected to \$2,948,000.

**Motion:** *Upon motion by Commissioner Henning, seconded by Chair Poat, the Commission voted unanimously to adjust the dollar amount as described above.*

Ms. Ann Collentine, Staff, presented Ventura County's new plan under their annual PEI update. The plan meets all the requirements for PEI.

Recommend approval of \$775,000.

**Motion:** *Upon motion by Commissioner Van Horn, seconded by Commissioner Vega, the Commission voted unanimously to approve the Ventura County plan.*

**10. Progress Report from California Mental Health Services Authority (CalMHSA) on PEI Statewide Projects**

Mr. Edward Walker, California Health Services Authority, introduced the topic. The first presenter was Board President Allan Rawland. Highlights were as follows.

- A major milestone for healthcare reform came in 1965, when Medi-Cal and Medicare were signed by President Johnson. This was a major move toward universal healthcare.
- The new JPA was developed over the last 14 months.
- 29 counties are now members, representing 85% of the \$160 million that was allocated through the statewide project.
- The Executive Committee has a cross-section of members from across the state.
- The Purpose Statement, Vision Statement, and Mission Statement incorporate CalMHSA's identity as a collaborative of counties under the Government Code as designated by the respective Boards of Supervisors.
- In July 2008 the first six counties agreed to establish a JPA.
- The most significant milestone came in April 2010, when DMH signed a contract with CalMHSA for implementation of the Statewide PEI Projects.

Dr. Wayne Clark, Board Vice President, reported on the stakeholder process. He is also Chair of the Ad Hoc Committee, which has been delegated by the Board for implementation.

- In August, stakeholders met with the Ad Hoc Committee to work on the implementation plan. They developed a preliminary Work Plan and timeline.
- In October the Ad Hoc Committee submitted a Work Plan for 30-day review. In November the Work Plan will go to the Full Board for approval. In December the Work Plan will go to the MHSOAC for review.
- On January 5, the first Request for Proposal (RFP) is scheduled to go out. It will be on Suicide Prevention. A contract is scheduled to be finalized by the end of March.
- On January 17, another RFP will go out for Stigma and Discrimination Reduction. The final RFP will go out on February 2 for the student Mental Health Initiative.
- All three RFPs will use the process of 30-day RFP response, review panel, and contracting.
- CalMHSA is moving quickly, as requested by Chair Poat, to get the programs on the ground by spring of this year.

The presenters and Commissioners discussed timelines, the RFP process, and the budget.

### **Public Comment**

- Ms. Hiramoto commended CalMHSA for getting up and running so quickly. Stakeholders have had some challenges trying to keep up. She thanked Executive Director Gauger and the MHSOAC for being the neutral facilitator at times. The primary concern is that there's no formal mechanism for stakeholders and CalMHSA to discuss and work together as partners, as envisioned by the MHSOAC.
- Ms. Brody echoed Ms. Hiramoto's concerns. She commended CalMHSA for being "better" and "smarter" – but "faster" may be a little too fast for the eight stakeholders at their table to keep up. She requested a more participatory role for stakeholders and having additional clients participating would be good.

The group discussed prioritizing the rollouts of the plans. Chair Poat hoped to agendaize this for the November meeting, so that the Commission would be in a position to make some decisions.

- Mr. Metzger commented that he had read in the CalMHSA policies that they would retain documents for five years. If they had started in '07, that would mean (theoretically) that next year those documents would be inaccessible. He felt that keeping the historical record preserved is important. Also, there was a question about the voting and how votes are allocated.

Mr. Rawland clarified that CalMHSA began on July 1, 2009. Also, the vote allocation parallels the California Association of Counties: one vote per county.

Chair Poat asked that after the staff has seen the proposal that comes out, they update the Commissioners at the next meeting. A few extra weeks, going to the January meeting, might be worth the time. Having the Commissioners discussing it in person in January, rather than via teleconference in December, may be best.

### **11. General Public Comment**

- Ms. Diaz commented that she talked with parents and caregivers of children who had attended the morning portion of the meeting. They had told her that they felt like they were being blatantly disrespected during Public Comment, because their comments were then discounted by certain things that were said.
- Mr. Mark Karmatz, Los Angeles County Client Coalition, stated that peer-run crisis centers do work. They should be placed in hospitals and on the outside as well. Also, those listening to the Commission meetings on the phone need to be included during Public Comment.

**12. November Meeting Agenda**

Executive Director Gauger reviewed the draft November meeting agenda.

**13. Adjournment**

Chair Poat adjourned the meeting at 4:54 p.m.