



State of California

**MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Minutes of Meeting
May 22, 2014

MHSOAC
1325 J Street, Suite 1700
Sacramento, California 95814

866-817-6550; Code 3190377

Members Participating

Richard Van Horn, Chair
David Pating, M.D., Vice Chair
Assemblymember Bonnie Lowenthal
Khatera Aslami-Tamplen
John Boyd, Psy.D.
John Buck
Victor Carrion, M.D.
David Gordon
Paul Keith, M.D.
LeeAnne Mallel
Christopher Miller-Cole, Psy.D.
Ralph Nelson, Jr., M.D.
Larry Poaster, Ph.D.

Members Absent

Senator Lou Correa
Sheriff William Brown
Tina Wooton

Staff Present

Andrea Jackson, Executive Director
Kevin Hoffman, Deputy Executive Director
Norma Pate, Administrative Chief
Filomena Yeroshek, Chief Counsel
Renay Bradley, Ph.D., Research and Evaluation Director
Deborah Lee, Ph.D., Consulting Psychologist
Kristal Carter, Commission Coordinator

1. CALL TO ORDER/ROLL CALL

Chair Richard Van Horn called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 8:44 a.m. and welcomed everyone. Kristal Carter, MHSOAC Commission Coordinator, called the roll and announced a quorum was present.

Chairperson's Remarks

Chair Van Horn stated that a forty-eight-hour notice was given that a closed session was added to today's agenda. The Commission must vote to add the closed session to the agenda to comply with the Bagley-Keene Open Meeting Act.

Action: Vice Chair Pating made a motion, seconded by Commissioner Lowenthal, that:

The MHSOAC adds the closed session to the agenda of the May 22, 2014, MHSOAC meeting, because there exists a need to take immediate action, and that need for action came to the attention after the agenda was posted.

- Motion carried, 12-0

1A. APPROVAL OF THE MARCH 27, 2014, MEETING MINUTES (ACTION)

1B. MARCH 27, 2014, MOTION SUMMARY (INFORMATION)

Action: Commissioner Gordon made a motion, seconded by Commissioner Aslami-Tamplen, that:

The MHSOAC approves the March 27, 2014, MHSOAC Meeting Minutes as presented.

- Motion carried, 6-0 with 6 abstentions

1C. APPROVAL OF THE APRIL 24, 2014, TELECONFERENCE MINUTES (ACTION)

1D. APRIL 24, 2014, MOTION SUMMARY (INFORMATION)

1E. MHSOAC EVALUATION DASHBOARD (INFORMATION)

Action: Commissioner Miller-Cole made a motion, seconded by Commissioner Mallel, that:

The MHSOAC approves the April 24, 2014, MHSOAC Teleconference Minutes as presented.

- Motion carried, 5-0 with 7 abstentions

2A. APPROACH AND MENTAL HEALTH SERVICES ACT REQUIREMENTS FOR REVIEW AND APPROVAL OF INNOVATIVE PROGRAMS (INFORMATION)

Deborah Lee, Ph.D., MHSOAC Consulting Psychologist, presented to the Commission an overview on the review and approval process of Innovation (INN) programs. She stated that there is still much to be learned about mental illness. Innovation is the driver of new approaches in areas where there are no approaches or where the existing approaches do not fit for a particular county.

Fifty-five of California's fifty-nine counties have at least one INN program, 101 of which have been approved by this Commission. Staff offers support to all counties with the development, implementation and evaluation of INN plans, provides "friendly feedback" to counties, and hopes to provide support for the communication and dissemination of INN plans in the future. Staff helps counties understand the questions they are answering, such as what services are needed, what areas do not already have an available solution, and where to test new ideas.

When reviewing submitted INN plans, staff does not ask whether it is a good idea, if it is something counties should be doing, if it will work, how it will work, if it is familiar, or what it will cost per person, because those questions will be answered during the evaluation and testing of the INN program. Staff looks at what is in the Mental Health Services Act (MHSA) and how the INN plan is related to the task of developing and testing something that has not previously demonstrated its effectiveness, and asks three questions. Those questions are limited by trying to balance the need for responsibility to the law and the need to support county autonomy and flexibility.

The first question is whether or not the INN program represents a new or changed approach in the field. The second question is whether or not the INN program has to do with the prevention or treatment of mental illness or the system that addresses behavioral health. The third question is whether or not the INN program meets the MHSA general standards. The MHSA specifies four purposes for INN programs: to increase access to services, to increase access to services for underserved groups, to improve the quality and outcomes of services, and to promote interagency and community collaboration.

There are three components of staff's review tool that are not direct quotes from the MHSA but are derived from it: a timeline that is consistent with learning, an evaluation focusing on what is new or changed, and a budget that is consistent with the goals.

The California Institute for Mental Health (CiMH) is contracted to evaluate and assist counties' INN evaluations. Built into this evaluation is training and technical assistance. CiMH also has an INN clearinghouse where the results from this evaluation and other resources will be posted so counties can share new effective approaches.

Dr. Lee directed Commissioners to the MHSOAC website for INN resources.

Commissioner Questions and Discussion:

Commissioner Boyd asked if it is the same period of review and assessment with INN plans in terms of the effectiveness of that INN program; within the scope, if counties are allowed to make modifications, changes, or shifts; and if it is the same defined time period.

Dr. Lee stated that each county defines the time period for each program needed to complete the cycle of developing, testing, refining, evaluating, making decisions, and disseminating. Currently, there is no time limit because there are no regulations, but the draft regulations include a four-year limit with an option for a fifth year. It is expected that there will be modifications as the programs progress.

Commissioner Gordon asked what the most promising innovations are.

Dr. Lee stated that it is too soon to say, but there are innovations in integration of physical/behavioral health care, such as in Tuolumne County; innovations in ways to collaborate with communities in a fundamentally different way through partnership to give support to resources, such as in Stanislaus and Calaveras Counties; and innovations in ways to partner with diverse communities.

Commissioner Gordon suggested bringing promising practices to the forefront soon, rather than taking four to five years to process the evaluation data, because, by then, it is too late for counties that could have benefited from it.

Commissioner Poaster agreed with Commissioner Gordon. It is important to get the information out even if it is not finalized to make the services available. These tend to be the programs that catch the media's eyes. Since people do not understand what those programs are, they must receive correct information in order to avoid what has happened in the past. He stated that one of the reasons the Commission approves annual plans is to look for trends; anything to be gleaned from preliminary data, would be helpful.

Commissioner Carrion asked if the assessment of outcomes is part of staff's scoring system.

Dr. Lee answered affirmatively. Part of the scoring tool for evaluation requires that the program meet minimum standards of clear outcomes related to what the county is trying to learn, outcomes that reflect the selected primary purpose, and methods to determine what brought about the outcomes.

Vice Chair Pating recommended that Commissioners review a full plan, not just the two-page summary provided in the packets today.

Commissioner Mallel asked if evaluation is ongoing or done at the completion of the project.

Dr. Lee stated that staff notes whether the plan includes evaluation throughout in addition to evaluation at the end, because it shows what parts of the program are working.

Chair Van Horn stated that this is the most significant move towards innovation that has been made in the mental health world ever. This is real forward motion. The innovation component is extremely important for the state of California and is something no other state has been able to do.

3A. APPROVAL OF TUOLUMNE INNOVATION PLAN (ACTION)

Dr. Lee stated that Tuolumne County is a small, rural county that is 81.7 percent Caucasian. Ninety-two percent of residents speak only English at home. There are no threshold languages. The median age is older than in other counties, people tend to be more isolated with limited access to technology, there are few public resources, and there is a strong stigma related to mental health and mental illness.

Tuolumne County only recently began managing outpatient services. They recently closed their general hospital, but included an inpatient psychiatric unit. Their INN program is about integrating physical/behavioral health care for individuals with serious mental illness.

The first question is if this program is new. Tuolumne County does not believe it can take established practices related to physical/behavioral integration and implement them as is because of the rural, stigma, and connectivity issues. Part of the modifications the county has developed have to do with patient records, increased focus on client activation, client self-management, and client decisions about health. Another part of the modifications the county has developed involve a group of clients, family members, and providers from both the physical and behavioral health sides that will develop some of the other approaches to be used. They will be part of a training and collaborative with CiMH for the first year; then, they will make modifications based on what they learned will work in their county. This INN program meets the standard for something that is new or changed.

In answer to the second question, the INN is specifically for clients who have a serious mental illness and who do not have access to physical health care services or have only limited or inadequate access.

In answer to the third question, the program meets the purpose of improving the quality and outcome of services. It addresses all general standards. Dr. Lee noted the INN also meets all of the community planning requirements.

The INN program focuses throughout on evaluation activities. There are some system goals, but the main goal is improved health and mental health outcomes for clients. Dr. Lee stated that the Tuolumne County INN program meets all MHSA requirements and staff recommends approval.

Commissioner Questions and Discussion:

Commissioner Gordon asked if rural counties ever collaborate.

Dr. Lee stated that CiMH has many projects, several of which relate to this. They have a small county project where all small counties collaborate on their issues. They also have a physical/behavioral integration program that involves many small counties. In addition, there are a number of small counties that are doing similar INN programs to address the same issue. Staff is actively encouraging small counties to collaborate, specifically on the evaluations and dissemination.

Commissioner Buck stated that one of the Senate Bill (SB) 82 projects that was approved for a crisis residential facility is a consortium of five counties. There are counties that are beginning to work together, which is something that should be done more.

Commissioner Keith stated that it sounds like the Commission should require this kind of collaboration with counties that already have similar programs in order to be more cost effective.

Dr. Lee stated that, after a county demonstrates an innovation, another county cannot submit it as an innovation because it was done before. However, if counties are doing the same or similar things at the same time, staff regards that as multiple sites. Staff encourages them to collaborate.

Commissioner Boyd asked if Tuolumne County feels they have the primary care capacity to support increased utilization.

Dr. Lee stated that she was unsure that the county would say the capacity is sufficient for the need, but they think this is an important step in the preferred direction.

Commissioner Boyd stated that, under the process system outcomes, the decreased utilization of behavioral health services would be a longer-term target, and the shorter-term would actually see an increase in demand and request for those services.

Dr. Lee stated that the county is working with people who are already receiving behavioral health services, but who are not getting any physical health care or wellness activities. The reason for that decrease is the idea that once there is more connection with physical health care there will not be an inappropriate use of behavioral health care.

Action: Vice Chair Pating made a motion, seconded by Commissioner Poaster, that:

The MHSOAC approves the Tuolumne County Innovation Plan for the amount of \$153,607 for a forty-month term.

- Motion carried, 13-0

4A. GOVERNOR'S MAY REVISE (INFORMATION)

Presenters:

Kiyomi Burchill, Assistant Secretary, California Health and Human Services Agency (CHHS)

Karen Baylor, Deputy Director of Mental Health Substance Use Disorders, California Department of Health Care Services (DHCS)

Carla Castañeda, Principal Program Analyst III, Department of Finance (DOF)

Kiyomi Burchill

The Increase in Medi-Cal Enrollment

Ms. Burchill stated that the May revision to the Governor's budget was released last Tuesday. As part of California's implementation of Health Care Reform, eligibility was expanded for the Medi-Cal program to individuals up to 138 percent of the federal poverty level (FPL). Also, enrollment eligibility and retention rules were simplified, making it easier to enroll and stay in the program. The result has been that coverage has been expanded to many more individuals than expected. By June 2015, the end of the fiscal year (FY), 11.5 million Californians will be in the Medi-Cal program, which is 30 percent of the state population.

For the optional expansion - individuals who are newly eligible with this eligibility of up to 138 percent of the FPL - the May Revision increased the caseload estimate for the optional expansion from 679,000 to 1.6 million people. For the mandatory population - individuals who were previously eligible and are enrolling in the Medi-Cal program - the May Revision increased the caseload estimate, as compared to what was estimated in the January Governor's budget, from 508,000 to 815,000.

The result of these caseload increases and other changes in the Medi-Cal program is that it is estimated that the Medi-Cal program will cost an additional \$1.2 billion above what was estimated at the January Governor's budget. This is good news in that many more people are covered, but it does have a cost associated with it. The Legislature has already begun robust budget hearings on this issue of the Medi-Cal enrollment increase.

Chair Van Horn asked if the estimate is the Governor's estimate or the Legislative Analyst's Office (LAO) estimate.

Ms. Burchill stated that it is the administration's estimate. The nonpartisan LAO is also looking at this issue and advising the Legislature on what they expect and anticipate; there are some differences.

Federal Mental Health Parity

The May Revision includes a proposal for the Department of Managed Health Care (DMHC) to implement the final rules on federal mental health parity that federal regulators issued in November 2013. The federal rules lay out how commercial health plans need to comply with the federal statutes. States are expected to enforce this, and the Federal Centers for Medicare and Medicaid Services will only intervene if the state fails to act.

In California, the intention is to act. The May Revision includes a budget proposal for the DMHC in this regard. The proposal is that health plans will certify that they comply with the requirements of the final rules in the federal mental health statutes, and will submit that certification with a methodology of how they determined they are in compliance with the DMHC. The DMHC will then engage actuarial and clinical consulting services to review those methodologies prior to January 1, 2015. It is anticipated there will be a back end review after a year of experience of the health plans following through on how they said they were in compliance.

Ms. Burchill stated that she provided the overall Medi-Cal numbers, which are inclusive of mental health plans, and Ms. Baylor will go through the Medi-Cal specialty mental health estimates specifically for what the county mental health plans deliver.

Karen Baylor

Child Caseload Estimates for the May Revise

The unduplicated number of children enrolled in Medi-Cal is expected to increase by 4.5 percent from an estimated 265,000 to 277,000 in the budget year. Therapy and targeted case management are the highest number of services and most common services that are provided to children. In the current budget year, 92 percent of the children served are expected to receive therapy, and 30 percent are expected to receive medication. The number of children who receive therapeutic behavioral services (TBS), crisis residential, crisis stabilization, and inpatient is expected to increase by 4.5 percent; the number of children who receive TBS is expected to increase by 8.89 percent; and the number of children who receive crisis stabilization is expected to increase by 9.8 percent.

Adult Caseload Estimates for the May Revise

The unduplicated number of adults enrolled in Medi-Cal excluding the optional expansion population will decline. Fewer adults received therapy and other services compared to children, but most adults receive case management and medication management. Estimates for the optional expansion are contained in a separate part of the DHCS Medi-Cal estimate. The DHCS expects that the optional expansion for specialty mental health services will increase in the Governor's budget. Ms. Baylor noted that there is a supplemental Medi-Cal estimate on the DHCS website.

The Expansion

Services were expanded for those experiencing mild to moderate mental illness to the Medi-Cal managed care health plans (MCPs). MCPs have been working with their county partners in developing a memorandum of understanding (MOU), and that MOU has to be submitted to the DHCS by June 30, 2014, and is subject to DHCS approval. The DHCS has been asked to provide clarification regarding the definition of "moderate," and has been working closely with MCPs and others to create guidelines of what it means to have a moderate mental illness.

The DHCS is also working on a dispute resolution process with the MCPs, the counties, and stakeholders, so that no consumer “falls through the cracks” due to the unclear definition of who will serve moderate patients. The DHCS wants to ensure that there is access to services.

SBIRT and Substance Use Disorder Benefits

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) for alcohol screening has been implemented through the MCPs. The DHCS has issued a number of all-county plans that can be found on the DHCS website. Inpatient detox is the other voluntary service that the DHCS implemented and is working closely with the Hospital Association to ensure it is implemented effectively.

The DHCS issued two information notices this week regarding base and growth. For FY 2012-13, there was 27.9 million in growth. The DHCS looked at the behavioral health sub-account as a whole to see where counties had over-expended. There were eight counties for a total of about \$8 million, most of which was in Los Angeles County. The remaining \$19 million should be distributed to the counties in May 2014.

Carla Castañeda

The Mental Health Services Act Funds

The Mental Health Services Act (MHSA) funds increased from the Governor’s budget in all three FYs: 2012-13, 2013-14, and 2014-15. The 2012-13 revenues in January were \$1.5 billion, and at the May Revision, they were \$1.7 billion, which was a \$207 million increase. The FY 2013-14 revenues went from \$1.4 billion to \$1.5 billion, which was a \$79 million increase. The FY 2014-15 estimated revenues are from \$1.6 billion to \$1.7 billion, or about a \$150 million increase.

With those increases, the administrative cap has increased to \$72.7 million in the current year and \$86.9 million in the budget year. The May Revision appropriations have been revised to adjust for the grants that have been processed by the three departments receiving Investment in Mental Health Wellness Act funds. The 2013-14 state appropriations at Governor’s budget were \$82.2 million; at the May Revision, they were \$62.8 million; in the budget year, they will be \$81.3 million. There is some room in both years, so, in the May Revision, the administration proposed additional positions for the Office of Statewide Health Planning and Development (OSHPD) for their Workforce Education and Training (WET) administration, as well as three positions for MHSOAC staff to continue administrating the triage personnel grants. Both houses have adopted these proposals.

The DOF also re-appropriated \$19.4 million, which was the remaining triage grant appropriation in FY 2013-14 to be allocated depending on room in the administrative cap as the revenues continue to change. FY 2013-14 will be adjusted next fall, but will not be final until next March.

Additionally, there was one minor re-appropriation for liquidation for outstanding MHSOAC evaluation contract. Ms. Castañeda clarified that there was no change in the appropriations, only an extension in the payment period.

Both houses are nearing completion this week in the subcommittees and have adopted the positions for the two departments and the re-appropriation of funds with the modification to direct \$7 million for suicide prevention efforts. Additionally, the Senate has adopted a \$5 million appropriation for grants to UCLA and UC Davis for Behavioral Health Center grants.

Commissioner Questions and Discussion:

Commissioner Poaster asked for additional information on the Mental Health Centers of Excellence and the \$5 million.

Ms. Castañeda stated that UCLA and UC Davis have established partnerships with Los Angeles and Sacramento Counties. The \$5 million will enhance the partnerships to meet community

needs. They are working on understanding how to address mental health disparities, early intervention, psychosis, and other concerns, such as violence, incarceration, and recidivism, and how to get those resources together.

Commissioner Poaster asked where the \$5 million comes from.

Ms. Castañeda stated that it comes from the MHSA administrative funds.

Commissioner Lowenthal stated that her concern about access and mental health parity with the increased numbers in Medi-Cal, and whether there will be a clear ratio of mental health providers. She asked about the rules for network adequacy in the future.

Ms. Burchill stated that the way access is assessed in MCPs is through network adequacy and the DMHC, which regulates health plans and licenses, plans, based on ability, to have adequate networks. Federal mental health parity has some definition now with the final rules that the federal regulators released in November 2013, but the rules include complicated formulas for classifying services and mathematically determining parity. That is why it is important to ensure the plans are in compliance and meet requirements on the front-end initial review of their methodologies. In terms of the mental health workforce, there has been significant dedication of resources in the WET component through the MHSA. The OSHPD recently released its next five-year plan for the WET component and has a little under \$200 million more to distribute.

Commissioner Lowenthal asked, with regards to realignment, whether the money going to counties will go to county jails or to programs following release.

Ms. Baylor stated that the money goes into the behavioral health sub-account; then, it will be decided locally how that money will be spent. The DHCS hopes counties will use it for a variety of resources to ensure they also have capacity to serve this new expanded population. The behavioral health sub-account is dedicated to mental health and substance use disorder services.

Executive Director Jackson stated that one of the challenges is the compensation of Medi-Cal physicians. Physicians often do not accept Medi-Cal clients because they are compensated less than the cost to serve the patient.

Commissioner Lowenthal stated that there is a proposal in the budget to increase the fee rates.

Commissioner Keith agreed that one of the largest barriers to access is the fee schedule. He asked if there is something in the process to look at the services provided and the outcome of treatment.

Ms. Baylor stated that the DHCS is working with subject matter experts on a performance outcomes system plan to look at the effectiveness of treatments that will be rolling out next year.

Commissioner Buck agreed with the issue about the Medi-Cal rates and was alarmed by a letter to the editor this morning from an organization that provides intermediate facility services for people with developmental disabilities regarding their belief that the down side to the expansion of the Medi-Cal expansion may be to drive the rates down. He was concerned that if rates are driven too low, the quality of care received by those individuals may be compromised. He encouraged the CHHS to take careful consideration before rates are dropped further.

Vice Chair Pating stated that the OSHPD presented at a Commission meeting about six months ago before the completion of the five-year plan, where the Commission asked about the location of identified needs and the staff, counties, and programs that will address them. The Commission was told there was data but it was hard to get specifics. Vice Chair Pating encouraged the CHHS and the DHCS to ask the OSHPD to be more specific in where they feel growth needs to happen.

The issue with the final rules on federal mental health parity that federal regulators issued in November 2013 is that there are several departments responsible for implementing it, which will

make coordination difficult. Vice Chair Pating recommended also coordinating with the Department of Insurance.

Vice Chair Pating asked if there is a provision for the state to set aside a reserve like the counties do with administrative funds.

Ms. Castañeda stated that there is nothing about that in the May Revision, but there has been discussion on the need to set aside funds for statewide efforts.

Commissioner Aslami-Tamplen commended the OSHPD for including peer certification in their five-year plan, but emphasized the need to expedite the process to pull down Medi-Cal for paraprofessional peer specialists. The definition of “moderate” mental illness has huge implications for the community. She asked how to ensure that the organized client community is involved in the conversation.

Ms. Baylor stated that the DHCS has established a behavioral health forum that gathers all the issues from the service-and-needs plans and puts them into a grid on their website. She stated that she anticipates this is where some of those conversations will happen with the stakeholder groups.

Commissioner Gordon stated that he serves on the local realignment committee, and the discussions tend to focus around the law enforcement elements of it. The mental health services issue is a big one; he recommended that there be some way to identify good practices, because that could help counties do a better job.

Commissioner Nelson asked if a timeline can be established to move the peer certification planning forward, because this is something that other states have done in a short period of time. He asked if the state and federal governments are putting anything into educating health care workers, since the correctional system and the veteran’s administration are soaking up so many of the health care providers.

Ms. Burchill stated that the May Revision does not have any proposals in those areas.

Commissioner Carrion asked if Medi-Cal sponsors training programs in the state.

Ms. Burchill stated that there are two programs that take place in the OSHPD. One is the balance of the MHSA WET funds, which is a little under \$200 million, and the other is in partnership with the California Endowment focused on primary care as well as mental health, which are scholarship and repayment programs.

Commissioner Carrion asked if those programs will be expanded in parallel with the expanded numbers.

Ms. Burchill stated that the \$52 million, which is half from the California Endowment and half federal financial participation (FFP) through Medi-Cal, is what the OSHPD is ramping up, and that is in recognition of the coverage expansion and Health Care Reform.

5A. FINANCIAL REPORT (ACTION)

Kevin Hoffman, the Deputy Director of the MHSOAC, stated the financial report graphically presents what the previous panelists were speaking about. He showed a graph titled “Role of Major Funding Sources,” and pointed out the California Health Facilities Financing Authority (CHFFA) grants in the state general fund for 2013-14. Realignment I and II, MHSA dollars, and FFP are also represented. Mr. Hoffman noted the projections for 2014-15 are the highest that have ever been represented on this report.

Mr. Hoffman showed a graph titled “MHSA Funding,” and stated that this also includes the administrative money. The projected dollar amounts for 2014-15 are \$1.7 billion, which is the highest amount the Financial Oversight Committee has ever recorded.

Mr. Hoffman showed a graph titled "Mental Health Services Fund Distributions," depicting the monthly allocations to the counties. This information comes from the State Controller's Office. So far, \$1 billion has gone out to the counties.

Mr. Hoffman showed a graph titled "MHSA Housing Program," and stated that there was \$400 million set aside for the housing project, and some counties assigned some of their community services and supports (CSS) dollars, for a total of \$404 million. There are still \$79 million in uncommitted funds, but the DHCS will be updating these numbers in the near future.

Mr. Hoffman showed a chart titled "State Administered Funds by Department," and pointed out that \$32 million of the \$41 million under the MHSOAC were for triage grants.

Mr. Hoffman showed a chart titled "Revenue and Expenditure Report," and stated that the Financial Oversight Committee will review these numbers and compare them to annual updates and three-year plans to see what the plan was and if the counties met their goals.

Commissioner Questions and Discussion:

Chair Van Horn asked how the annual adjustment is distributed and how much will be distributed this fiscal year.

Ms. Castañeda stated that the \$480 million for FY 2012-13 will be deposited in the fund in July 2014 and will be distributed around August 2014. This FY, the amount to be distributed is \$1.1 billion.

Chair Van Horn asked if there is a sense of the amount of funds the counties have in the bank.

Mr. Hoffman stated that the Annual Revenue and Expenditure Report that comes out in June will show unexpended dollars at the county level.

Commissioner Aslami-Tamplen asked where the funds go if the county does not spend them in the time allowed.

Mr. Hoffman stated that the funds are listed as unexpended money. The DHCS is currently working on a reversion policy, but the counties know they spend the money that comes in from prior years first to ensure they do not have funds that revert.

Chair Van Horn added that the unexpended funds go back into the MHSA fund to be redistributed to counties.

Commissioner Nelson asked what percent of the \$2.7 billion for the MHSA Housing Program went to people with mental illness. The graph is misleading because it appears that people with mental illness are getting more beds than they actually are.

Mr. Hoffman stated that he can work with the DHCS for that figure, but it is partially paid for with MHSA funds, so it is showing as leveraged.

Chair Van Horn stated that the entire \$400 million will fund housing for people with mental illness. It is the share of the leverage that goes to mental illness that is unknown and may be hard to tease out.

Public Comment:

Anqunett Fazil, of Christian Partnerships, Inc. (CPI), stated that she is a stakeholder and family member and is concerned why Covered California has not included some of the health plans that generated from the Affordable Care Act. The DHCS includes broad perspectives, but there is a piece missing by not hearing from Covered California that the Commission should be aware of. She recommended that the Commission collaborate with the California Department of Corrections and Rehabilitation (CDCR) and prisoners coming back into the community. The university grants are spectacular, but do not always have good connections with the community.

There are providers that are trying to get into these schools, and this Commission needs to prompt the equity in admissions and retention of these students.

Eduardo Vega, the Executive Director of the Mental Health Association of San Francisco and President of the California Association of Mental Health Peer-Run Organizations (CAMHPRO), stated that what a person with a mental health condition wants most in life in order to advance their recovery is employment. Approximately 90 percent of people with serious mental health conditions in the US are unemployed. This is the one thing that has not been addressed in California through the MHSA. He stated that this is the time to bring that forward. Supported employment is an evidence-based practice for mental health recovery. He stated that he has several ideas to prioritize employment as the next step for the MHSA.

Commissioner Aslami-Tamplen suggested the Commission put together a work group on the employment piece in collaboration with the OSHPD.

Chair Van Horn agreed that the Services Committee should discuss the employment issue soon.

Charlene Jimerson, consumer and advocate, with the Pool of Consumer Champions (POCC) and Peers Envisioning and Engaging in Recovery (PEERS), stated that she was a victim of stigma and discrimination recently with her landlord. Disability Rights California reinstated her MHSA housing subsidy. She asked that the MHSA funding be used for more permanent housing for consumers at risk of homelessness.

Jane Adcock, the Executive Officer of the California Mental Health Planning Council (CMHPC), stated that the Role of Major Funding Sources chart and Appendix I are missing the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant fund source. The totals that are depicted for community mental health are off. She apologized to Commissioner Poaster and Mr. Hoffman for not bringing this up in the last meeting. She stated that she supplied the figures to staff. She suggested that, in order to show an appropriate depiction of the total amount of funds available, the SAMHSA Block Grant dollars should be included.

Chair Van Horn agreed and asked how much the Block Grant dollars were.

Ms. Adcock stated that it was approximately \$57 million dollars.

Action: Commissioner Carrion made a motion, seconded by Commissioner Buck, that:

The MHSOAC accepts the May 2014, MHSOAC Financial Oversight Committee Financial Report as presented.

- Motion carried, 13-0

6A. TRANSGENDER PERSPECTIVE AND CHALLENGES: A CULTURAL LINGUISTIC PRESENTATION (INFORMATION)

Presenters:

Ben Hudson, Executive Director, Gender Health Center

David Nylund, LCSW, Ph.D., Professor of Social Work, California State University, Sacramento, and Clinical Director, Gender Health Center

Evan Minton, Executive Cabinet, LGBTQ Caucus, California Democratic Party

Chair Van Horn stated that the Commission has committed to hearing a presentation on cultural competency annually. In years past, there have been presentations on the CLAS standards, which are the federal standards on cultural and linguistic appropriate services awareness and

sensitivity. The presentation this year changes the direction to looking at various cultural communities, which have been left out, underrepresented, misunderstood, or not understood.

Chair Van Horn stated that one of the things the Commission is trying to learn through the Cultural and Linguistic Competence Committee (CLCC) and these presentations is a term called cultural humility; to not be too proud of one culture to the denigration of other cultures. That is one of the reasons the Commission is doing these kinds of presentations - to increase the sense of cultural humility, increasing fairness in turn.

Ben Hudson

Mr. Hudson presented a list of definitions of terminology to have a common language when discussing this community, such as the word "transgender," which describes a wide range of identities and experiences of people whose gender identity does not match their biological sex. For someone undertaking transition, there is no beginning and there is no end. It is a journey and it is a highly individual journey about becoming an authentic person who is true to oneself. Mr. Hudson stated that the transgender community is the most marginalized within an already marginalized community.

Mr. Hudson stated that Dr. Nylund is internationally recognized as an expert in working with transgender individuals and is the author of many books. The Gender Health Center in Sacramento is also nationally and internationally recognized and serves three hundred clients per week. The Center does not accept insurance. Over 80 percent of the people the Center serves pay ten dollars or less, making the Gender Health Center one of the most accessible mental health organizations in the Sacramento area. Half of the people who go to the Center are not transgender, because, by meeting the economic and income disparities of a particularly oppressed community and by becoming experts in their health needs, the Center is able to meet the needs of many other underserved populations.

David Nylund

Dr. Nylund stated that he started a counseling program several years ago and soon realized the needs of the transgender community were not being met. The Center has been open since 2010 and is better known in other parts of the country than in Sacramento. Unique challenges in mental health issues for transgender individuals include therapists that misdiagnose because they feel uncomfortable discussing gender, the expense of the services to transition, the fear of discussing transition with a physician, the overwhelming numbers of transgender individuals that are fired, the difficulty in changing identity documents, and the fear of violence and hate crimes.

He stated that there is a need for training for teachers and administrators. Many people want to understand, but do not have the information and training.

Commissioner Aslami-Tamplen asked if there are any curriculum or training that counties and other agencies can contract with the Gender Health Center to provide this information.

Mr. Hudson stated that the Center does have curriculum and has provided trainings. He stated the need for people to value this type of training and to put trainings into their budgets. The best type of training is to have transgender individuals sharing their personal narratives about their experiences, because of how diverse these narratives are; those narratives need to come from people who are reflective of the communities they are speaking to. The challenge is that transgender individuals are unable to step into the leadership position to provide the training because their needs are not being met and they do not know how to be advocates for themselves. Mr. Hudson stated that it is not the responsibility of a consumer to educate their provider.

Evan Minton

Mr. Minton stated that he works in the California State Legislature. He gave his personal testimony of at the age of thirty beginning to question the gender he was assigned at birth and

finding the Gender Health Center. He stated that just because there is access to care does not mean there is access to competent care.

Commissioner Questions and Discussion:

Vice Chair Pating asked if Medi-Cal pays for transgender services. Health plans are now moving transgender services and care into mainline benefits. He asked where the public sector is with Medi-Cal. He also asked if the issue of transgender care is a medical service or a mental health service, because who pays for it is where the issues will get addressed the best.

Mr. Minton stated that it is a medical issue. He stated that the part that is hard is the outside prejudice received. The natural response is to internalize that and that is where mental health needs need to be met. Therefore, it is a two-part issue.

Mr. Hudson stated that Mr. Minton's story is extraordinary. It is extraordinary that he has been able to maintain his employment through this transition. It is extraordinary that he was able to get to a level of education and experience in his professional career before he allowed himself to explore gender identity. Most transgender individuals do not have jobs.

Mr. Hudson stated that Medi-Cal does cover transgender-related services, although they are limited in scope. In addition, the DMHC and the Department of Insurance have released directives to the HMOs and PPOs that they govern that if they provide these services for non-transgender individuals, they must also provide them for transgender individuals. Every person everywhere needs to understand and know how to treat people appropriately.

Commissioner Aslami-Tamplen offered to work with the Center on increasing peer employment with the empowerment employment work group through the Commission.

Commissioner Gordon asked how the Center is funded.

Mr. Hudson stated that it is by sacrifice and commitment, the small revenue from the ten-dollars-or-less services provided, one grant, and twelve donors.

Commissioner Carrion stated that right now it is good clinical practice in California for an agency or clinic to say they do not know anything about this and they refer these cases somewhere else. Although this is better than assuming knowledge and misguiding or misdiagnosing individuals, this needs to be changed. The Center's curriculum should be disseminated to the state.

Mr. Hudson agreed and stated that organizations such as Kaiser, Sutter, and U.C. Davis are referring clients to the Gender Health Center because they are unwilling to take this on. He stated that the Center contacts the providers to encourage them to take the training on how to provide care, because it is the cultural competence that is confounding them.

Public Comment:

Delphine Brody, consumer and advocate, and peer support and health equity specialist, gave her personal testimony and stated that she is grateful for the Gender Health Center's support. Many transgender individuals are falling through the cracks even with the Medi-Cal expansion.

Ms. Jimerson stated that her support for the Center and transgender individuals for employment.

7A. UPDATE ON PREVENTION AND EARLY INTERVENTION (PEI) AND INNOVATION (INN) REGULATIONS (INFORMATION)

Filomena Yeroshek, Chief Counsel of the MHSOAC, stated that the Commission adopted the proposed PEI and INN regulations in November, and authorized the Chair and Executive Director to make non-substantive changes to the regulations and to file all of the required documents. The PEI regulations will be published by the Office of Administrative Law (OAL),

which starts the 45 day public comment period. There will be a public hearing on the proposed regulations at the July 24, 2014, MHSOAC meeting. The forty-five day public comment period ends at 5:00 p.m. on July 24, 2014. All public comments are required by the Administrative Procedures Act to be summarized and staff will provide recommendations. At the August 28, 2014, meeting, the Commission will determine whether the regulations should be changed based on the public comments. If changes are made, the revised language will go out for another public comment period.

The INN regulations will be published by the OAL on July 1, 2014, and the August 28, 2014, MHSOAC meeting will fall within the forty-five-day public hearing period. Chief Counsel Yeroshek recommended that the August 28th teleconference meeting be an in-person meeting.

Chief Counsel Yeroshek reviewed the non-substantive changes to the PEI regulations. She stated that all of the sections in the PEI regulations were renumbered. Staff coordinated with the DHCS and the OAL to fit the PEI and INN regulations into the current MHSA regulatory scheme. There were also grammatical and clarifying changes, and there were changes for consistency among sections. A conversion table is in the meeting packet showing the old and new section numbers.

Commissioner Questions and Discussion:

Commissioner Miller-Cole asked about the process used for the categories for race and ethnicity.

Chief Counsel Yeroshek stated that the categories come from the federal minimum requirements from the Office of Budget Management and a report from the National Institute of Medicine.

Public Comment:

Ms. Brody stated that when changes and decisions are made, it is important to include the voices of clients, family members, and caregivers of children and youth, and unserved, underserved, and inappropriately served populations. Too often, these voices are excluded. She suggested that representatives of these populations be included both early on when the revisions are first proposed, and when it comes time to revise regulations, even if the intent is to find non-substantive types of revisions.

Adrienne Shilton, of CiMH and the California Mental Health Directors Association (CMHDA), stated that the CMHDA is in support of the non-substantive changes reviewed today and will be weighing in formally during the forty-five-day public comment period.

Ms. Jimerson requested that PEI be mandated for contracted housing and services, because providers do not comply with program services and can suspend housing subsidies at their discretion and because a grievance process is not in place.

Stacie Hiramoto, the Director of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated that PEI holds a special promise to underserved communities. These regulations are important to the REMHDCO and the racial, cultural, and ethnic communities it represents.

MaryAnn Bernard, of counsel to the Mental Illness Policy Organization, and a family member, stated that there are two mandatory aspects of the MHSA that these regulations ignore. She requested that the word "may" in Sections 3710(e) and 3720(d) of the regulations be changed to a "shall" to comply with statute.

The statute also says every PEI program is to be modeled on a program that is either successful or proven. The regulations are still allowing counties to make up their own programs. Counties need to identify a successful or proven program to model, and would be measured against that program.

7B. GENERAL PUBLIC COMMENT

Sean Walker, of the Client Stakeholder Project, stated that his concern that consumers are not guaranteed to receive the expected services for MHSA programs at the service provider level. He requested that agencies that are contracted to deliver services be mandated to deliver those services.

He also suggested that centers and programs offer next step guidance to wellness, recovery, and rehabilitation for graduating clients. Mr. Walker stated that he is soon to graduate and is unsure of his future direction because there has been no clear accreditation of a peer specialist program. He stated that his interest in the OSHPD guidelines for peer specialists and what their involvement in the MHSA programs would be.

Mr. Walker stated that there are opportunities for engagement outside of Assembly Bill (AB) 1421. The service provider level is not the best time to engage consumers. He suggested doing more outreach to meet the consumer where they are, because people are more open to discussing available resources when accessing other programs, such as a program that provides meals.

7C. 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.

Chairman Van Horn reconvened the meeting after the lunch break and stated that the Bagley-Keene Act requires the Commission to report actions taken during a closed session. He reported that the Executive Director had been separated from her position, effective immediately.

8A. MENTAL HEALTH AWARENESS IN SCHOOLS, TK - 12 (PRESENTATION)

Presenters:

David Gordon, MHSOAC Commissioner

Rusty Selix, Executive Director, Mental Health Association in California (MHAC)

Robert Oakes, Executive Director, CMHDA

Terrence Rooney, Ph.D., Director, Colusa County Behavioral Health

Commissioner Gordon

Commissioner Gordon reminded Commissions about the round table discussion in the March meeting titled, "Breaking the Fail First Cycle - Primary Grades Kindergarten through Third." The thought was to launch an effort to create an early intervention program, which would be a partnership between mental health and TK-12 education throughout the state. This program would focus on early identification and intervention at the earliest possible point to head off potential problems down the road, and not only save lives and improve the quality of young people's lives, but also save future costs for placements in special education and other services. The concept was to build partnerships at the county and school district level between mental health providers and leaders and education leaders. A working group comprised of leaders from education and mental health would be convened to produce a working plan. Several of those leaders are here today to ask the Commission to authorize its involvement with this innovative task force because it has great promise to improve services to young people throughout the state.

Rusty Selix

Mr. Selix stated that he detailed the purpose of this effort in the March meeting. The concept of a multi-tiered approach to school mental health has demonstrated it is cost-effective for schools.

The key is what it will take to develop the partnerships between counties and schools throughout the state, as this becomes the rule rather than the exception. Right now, it is the exception, but it has the potential to become the rule and quite possibly to do more to accomplish PEI efforts than everything else ever thought of. The logical next step is to bring together the key players of the providers of services that Mr. Selix represents, the county mental health people that Dr. Rooney and Mr. Oakes represent, and the school officials that Commissioner Gordon represents. That is the purpose of the task force, and the expectation is to fill in the roster of key people, to move forward, and to report to the Commission quickly.

Terrence Rooney

Dr. Rooney stated that he supported school-based services. He has been involved in implementing them on a small county, rural level. Larger counties may have contractors or organizational providers who provide services in the schools, but it also works on a small county level.

Robert Oakes

Mr. Oakes stated that he supported the proposal. The relationship between the schools and the county offices that provide the services are different, so having the Commission participate in this effort to bring a statewide perspective will be helpful. It will be implemented county by county, so the overarching state support would be appreciated.

Commissioner Questions and Discussion:

Commissioner Poaster recommended that the Commission join in this important effort. He asked how it will be supported administratively.

Mr. Selix stated that it is only supported through the participants' staff support.

Commissioner Poaster offered any resources within the Commission's means to help make it a successful effort.

Commissioner Mallel stated that she has many ideas for this effort and asked if there was anything she could do to help.

Mr. Selix asked to meet with her offline.

Public Comment:

Ms. Bernard stated that she is the parent of a severely mentally ill young adult, who for seven years was in public schools with an emotionally disturbed (ED) label, which is what mentally ill children are labeled in public schools. Part of her professional life was representing not only mental hospitals but school districts.

The school systems have children with different disabilities. Most of them are not ED; most of them are labeled learning or developmentally disabled. She reminded the Commission that its funding is for people who are already seriously mentally ill. It is also supposed to be going into early intervention in serious mental illness as defined in Welfare Code 5600.3. This goes back to the third problem Ms. Bernard found in the regulations. There seems to be a perception that the Commission is supposed to be generally preventing mental illness. Its function is much narrower than that. The PEI programs are to prevent mental illness from becoming severe mental illness. Some of that can be done through the schools, as long as the Commission is coordinating with them, because they have a separate set of statutory obligations that do not necessarily line up with the Commission's, which has to do with many conditions that are beyond the purview of this Commission.

Ms. Fazil asked the presenters if they were aware that there are already communities that are working on this issue, developing a trauma-sensitive school, because parents, administrators, and caretakers do not recognize the misdiagnoses that occur with children that are trauma-

impacted. They throw them in a category, such as ADHD, when really they are responding to traumatic incidents. Research shows that they are reacting to it as though it is happening to them. When something triggers that, then the school needs to know what to do, and the parents and child care providers need to know how to help abate those triggers.

A group of parents got together in Sacramento County and worked with a charter school to keep their children from being transferred because they have been trauma victims. They procured the services of Juli Alvarado out of Colorado and got information and training on trauma sensitivity in a program called Honey Bees. Ms. Fazil recommended that the Commission work with parents, stakeholders, and care providers; she also recommended mentoring teachers that are being trained on developing a trauma-sensitive school and working with communities as well as the parents and the school administrators.

Chair Van Horn asked Ms. Fazil to provide Mr. Hoffman and Mr. Selix with her contact information.

9A. CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP) (INFORMATION)

Presenters:

Jahmal Miller, Deputy Director, Office of Health Equity (OHE) at California Department of Public Health (CDPH)

Ruben Cantu, Program Director, Cal Pan-Ethnic Health Network (CPEHN)

Jahmal Miller

Mr. Miller acknowledged some of the OHE partners in the room who have been instrumental in advancing this multi-cultural effort on achieving mental health disparity intervention and prevention efforts throughout the state of California. The majority in California is now minorities; over the next fifty years, this diversity will continue to grow. An important component in recognizing that demographic shift is understanding that health and mental health disparities and inequities continue to disproportionately impact these populations, and it is important to better understand the consumer moving forward.

Mr. Miller shared the Health and Safety Code definition of mental health disparities. He stated that disparities in and of themselves are not bad; they are just differences. It becomes a bad situation when there are health and mental health inequities, because they are avoidable and, therefore, unjust or unfair. Many of these inequities often turn into stressors that emotionally and mentally impact people. It is critical to better understand the broader environmental and societal context to get at the root of many of these persistent disparities and inequities. He stated that his belief that the CRDP allows that.

Between 2003 and 2006, the combined costs of health inequities and premature death were \$1.24 trillion. Eliminating health disparities would have reduced medical care expenditures by approximately \$230 billion.

The OHE looked at mental health disparities and general health disparities. Ten percent of these disparities are driven by medical care. The CRDP looked at the social determinants of health that drive these persistent mental health disparities. Once people have been stabilized and have the necessary PEI resources, the CRDP addresses the question of whether they are going back to environments that will exacerbate their conditions.

Mr. Miller gave an example of a community in the Central Valley where poverty and income intersects to create an environment that is emotionally and mentally stressful. Another example of a direct connection to mental and emotional wellbeing is climate change and violence in communities and the stressful impact they have.

There is a need to address issues in health and mental health disparities and inequities that are associated with the broader social determinants of health. In order to achieve this, mental health and health equity must be achieved at every level.

The OHE currently has trailer bill language that is going through the legislative process to replace the previous public contract code exemption when this original program resided within the Department of Mental Health (DMH). After consolidation took place, that exemption was lost. The OHE is going through the trailer bill language legislation process to secure the public contract and code exemption, which has been critical to advancing this culturally and linguistically appropriate effort. The OHE has made several revisions in the last year to the current CRDP Strategic Plan.

Ruben Cantu

Mr. Cantu stated that the CRDP Strategic Plan has not been released yet to go out to the thirty-day public comment period. The current version of the plan has been reviewed by Commission staff. He stated that his appreciation for the Commission's feedback, and stated that it has been incorporated into the current version of the strategic plan that is being reviewed by the CHHS.

The CPEHN is a statewide health advocacy organization founded in 1992 during a time of racial tension, but also a time of hope for national health care reform through a proposal by President Clinton. Four major ethnic organizations came together and created the CPEHN to be a multicultural unified voice for health advocacy.

Mr. Cantu stated that the strategic plan is a synthesis of the five population reports that were developed specific to the five target populations of the CRDP. The population reports are available on the OHE website. The strategic plan is a representation of the steps needed to improve services in the state. During Phase II of the CRDP, projects will be funded to implement promising practices identified by the strategic planning work groups and to evaluate them.

The strategic plan was a few years in the making and included an extensive stakeholder process. Records were compiled from the five population reports. Through an extensive process, it was determined which of the recommendations were applicable to all five populations. They were categorized into four themes and five goals. Within the five goals, there are twenty-five long-term strategies for reducing disparities. There are also recommendations for implementing these strategies over the next five to ten years.

Once the strategic plan is approved at the Agency level, there will be a thirty-day public comment period later this summer where the strategic plan will be widely disseminated, and there will be three community forums for stakeholder input. After the thirty days, the strategic plan will be finalized and released jointly with the Request for Proposal (RFP) for the Phase II funds, which will be followed by the implementation of Phase II.

Commissioner Questions and Discussion:

Commissioner Poaster stated that he joined this Commission in 2007, which was when the two-year strategic plan began. He asked what has taken so long in getting the \$40 million out.

Mr. Miller stated that part of the delay has been to do the right thing. This project is the first of its kind with the respect of having five strategic planning work groups and closely working with the strategic planning work groups who have engaged stakeholders deeply across the state, especially unserved, underserved communities. There was feedback on the need to take more critical, qualitative time to get information from those that ultimately are going to be impacted by these mental health investments. This project has been driven by the community. Key stakeholder engagement has been one of the primary reasons for the delay.

One of the other challenges has been with the transition of this program from the DMH to the CDPH and its integration into the new OHE. Building the capacity of an existing OHE staff simultaneously with limited staff for a period of time has been one of the other delays.

One of the biggest challenges has been recognizing that when the DMH went away and the OHE inherited services, programs, and budget, it did not, by a legislative glitch, inherit the public contracting code exemption. This positioned the OHE to have to go through a process of renewing and establishing contracts with the strategic planning work groups. That technical glitch is one of a few reasons why the project has been delayed. Mr. Miller stated that he was encouraged in that, with the stakeholder engagement, with the revisions that have been made to the plan that is currently with the CHHS, that the OHE is in an accelerated position to catch up. With the support of stakeholders, the project can be done right.

Commissioner Poaster asked when the strategic plan is expected to be released.

Mr. Miller stated that the OHE has just engaged a technical writer, who is leading the effort to go into solicitation to begin Phase II, ideally in this summer. He estimated the strategic plan will be released as early as late fall, and as late as the beginning of 2015, when funding will be staggered and will be implemented and invested into communities.

Chair Van Horn stated that disparities are not just in behavioral health care but in all health care. He suggested that it might be a productive discussion with the Legislature and the CHHS to ask them to share in the funding.

When the CRDP is through the approval process and out in public comment, there must be some warranty that this will go beyond four years, because disparities will not be cured in that time.

Public Comment:

Janet King stated that she is glad there is a merger between behavioral health and public health, because the health of communities that experience disparities is a public health issue. Disparities are a large financial burden on the populations. In order to solve the problems with the budget, behavioral health difficulties and disparities within these populations must also be investigated. She echoed the MHSA claim that prevention is less expensive than treating severe mental illness. The intention is to serve more people who have not been served in culturally competent ways and move away from the fail first system. She felt Phase II will promote those principles. This has been one of the most robust stakeholder processes yet in the MHSA, where many thousands of people have provided input.

Jim Gilmer, of the California MHSA Multicultural Coalition (CMMC), the REMHDCO, and the African American Strategic Plan Workgroup (SPW), commended Chair Van Horn for hitting the target on leveraging and capacity building. He stated that Chair Van Horn sees the big picture. He was glad to see the OHE talk about the integration of mental health, social determinants, and health disparities, because they increase stress in communities. He appreciated the opportunity to expand the vision around health and building capacity. He stated that the Commission cannot do it all; however, using its statewide influence and leadership in collaboration with the OHE stakeholders and others, the Commission could substantially reduce disparities throughout the state of California.

Noemi Castro, the Assistant Director of the REMHDCO, and staff to the CMMC, stated that the REMHDCO and the CMMC support the CRDP under the leadership of Mr. Miller and the OHE. The CMMC is a proud partner of the CRDP, addressing the needs of multiple underserved communities, and recognizes the powerful impact this initiative can make in improving services for diverse underserved communities. With the Commission's support, the CMMC looks forward to continuing to make inroads towards improving services and access to services for these communities.

Nicki King, Ph.D., of the CRDP, UC Davis, and the African American SPW, stated that the SPW held thirty-five focus groups statewide. Disparities for African Americans are like the disparities for other cultural and linguistic minorities, but also points to things that are wrong with the system for everyone. By having a stronger mental health system and thinking about health in all

policies, and creating a more unified system, the incidence and severity of mental illness for racial and ethnic minorities will be significantly reduced for a stronger health care system in California. In order to do this, serious emphasis must be put into ongoing, informative evaluations of programs.

Ms. Jimerson stated that the 10 by 10 wellness campaign is important to consumers. She stated that she is a participant of a homeless outreach harm reduction and stabilization program for chronically homeless and dual-diagnosed consumers, where deaths, largely attributed to unattended chronic medical conditions, could have been reduced or prevented by education in substance use, recovery, and medication; blood tests; physical exams; and PEI. This would enable consumers to keep housing subsidies when failure to comply or violating housing lease or rental agreements is an issue.

Ms. Brody stated that Phase I of the CRDP has been historic in terms of breaking all records for inclusion and setting a new standard for what meaningful community stakeholder involvement for those most directly impacted by inequities can look like.

9B. GENERAL PUBLIC COMMENT

Ms. King stated that this location is beautiful but is not accessible. What goes on in the lobby will keep all but the most determined consumers from attending meetings to hear what the Commission is doing on their behalf. If it is a public meeting, it needs to be held in a place the public can access without duress.

Chair Van Horn stated that the Commission is housed in a secure building and is working on how to streamline access for hearing days.

9C. ADJOURN

There being no further business, the meeting was adjourned at 4:33 p.m.