



**Meeting Minutes
April 29, 2010**

**California Institute for Mental Health
Sequoia Room
2125 19th Street, 2nd Floor
Sacramento California**

1. Call to Order

Chair Poat called the meeting to order at 9:10 a.m.

2. Roll Call

Commissioners in attendance: Andrew Poat, Chair, Larry Poaster, Vice Chair, Beth Gould, Don Pressley, Larry Trujillo, Richard Van Horn, and Eduardo Vega.

Not in attendance: Richard Bray, Lou Correa, Mary Hayashi, Patrick Henning, David Pating, Curtis J. Hill, and Howard Kahn.

Seven members were present and a quorum was not established. **Chair Poat** suggested for the meeting to continue, and the Commission would not take any actions until a quorum was established.

Chair Poat announced the sudden loss of a leader in the mental health community: **Mike Oprendek**, Solano County Mental Health Director. **Vice Chair Poaster** remembered him as a beloved colleague and an active member of the Services Committee. Vice Chair Poaster requested a moment of silence.

3. Welcome New MHSOAC Executive Director Sherri Gauger

Chair Poat was pleased to inform the Commission that after a year-long search, **Sherri Gauger** had been selected as Executive Director. On behalf of the Commission, he thanked her for joining the group.

Executive Director Gauger gave a brief summary of her background.

- She has been involved in state government for over 30 years.
- Most recently she spent two and a half years working with the California Department of Corrections and Rehabilitation, where she had been recruited by the Governor's office to implement substance abuse treatment programs.
- Prior to that, she had been appointed to work on Governor Schwarzenegger's Task Force for prison reform.

- She spent four and a half years serving as the Deputy Director for the Department of Alcohol and Drug program, managing all their legislative programs and external affairs while implementing Proposition 36. She also had oversight of eight constituent committees, working with unserved and underserved populations throughout the state.
- She spent about six years working as the Deputy Director for the Victims of Crime program, where she played a critical role in implementing benefits for victims of crime, both children and adults.

She was excited and pleased to be part of the Commission, recognizing its past accomplishments and looking forward to future tasks and projects.

Chair Poat thanked staff member **Ms. Bev Whitcomb** for the year she had spent as Acting Executive Director, keeping the group on track.

Commissioner Pating arrived at 9:15 and a quorum was established.

4. **Adoption of March 25, 2010 Teleconference Minutes**

Motion: *Upon motion by Commissioner Gould, seconded by Commissioner Trujillo, the Commission unanimously adopted the March 25, 2010 Teleconference Minutes, with the exception of Commissioner Vega, who abstained.*

5. **MHSOAC Performance Dashboard, April 2010**

Chair Poat pointed out the favorable numbers for money getting out into Services. He also pointed out updates on the work plan. **Commissioner Vega** remarked that some of the categories were unclear, i.e., CLCC on page 5, and items J and K on page 6. **Chair Poat** requested for staff to follow up in clarifying the categories.

Public Comment

- **Ms. Sandra Marley** inquired about item K on page 6: *“Recommend and/or provide various trainings and technical assistance to enable clients and family members to be effective advocates including improved and optimal interface with OAC. Provide public comment process training at MHSOAC meetings.”* She asked if the item will be completed in June or discussed in June. Commissioner Vega responded that it will be in place in June, and that anyone is welcome to participate in the Client and Family Leadership Committee (CFLC) discussions; staff will send the documents to anyone who is interested.

Ms. Marley also asked about accountability within the local agencies. **Chair Poat** directed staff members to supply the information Ms. Marley seeks.

6. MHSOAC Calendar, April 2010

Until September, the Commission will meet on the fourth Thursday of the month with the exceptions of April and July. The Commission will continue to meet in Sacramento to facilitate attendance by the Legislative members.

7. Adopt Meeting Locations for September, October, and November 2010

When the Legislative session is over, the Commission will meet out in the communities to facilitate participation of people who cannot come to Sacramento. The schedule is September 23 in Salinas, October 28 in Long Beach, and November 18 in San Diego, with no meeting in December.

Public Comment

- **Mr. George Fry**, Calaveras County Mental Health Board and a member of the California Mental Health Planning Council, stated that 30 counties out of 58 in California are rural. He urged the Commission to select a rural area for meetings in the future, enabling rural residents to come. He offered Calaveras County, which is located amidst many other rural counties.

8. Introduction to Federal Healthcare Reform

Mr. Tim Smith, Health Policy Program Manager, Government Affairs, LA Care, provided an overview of the new health reform law and the ways it will affect mental health care directly or indirectly.

H.R. 3590 was enacted into law on March 23, 2010. Basically it will have four effects.

1. It integrates the concept of shared responsibility into the U.S. healthcare system, a major paradigm shift. Currently about 46 million people lack health insurance. This has resulted in a system in which insurance costs are going up and there is a huge disparity in the ability of people to access the market.
2. It will implement significant health insurance market reforms. In California, between 4.85 million and 6.6 million people lack health insurance. The health insurance market is supply-driven and companies have maximized profits. Since the advent of managed care, we have seen abuses such as rescissions and denials. The new law goes a long way toward addressing these.
3. The new law enacts changes in the Medicare program: rates, delivery models, and initiatives.
4. It also enacts changes that support the health care safety net, promote prevention and wellness, etc.

The concept of shared responsibility is that everyone – government, individuals, and employers – is responsible for sharing liability in the health care system. At its nucleus is the belief that the system works most efficiently when everyone is insured and everyone participates.

The shared responsibility concept will operate in three broad movements.

1. In 2014, Medicaid will be extended to all U.S. nationals (and some aliens) with incomes below 133% of the federal poverty level (FPL). States will also be required to implement premium assistance programs. About 20% of people with incomes below 133% of the federal poverty level already have insurance through their employers; the Medicaid program will be working with those employers so that those premiums will be picked up by the state or federal government.
2. Beginning in 2014, U.S. nationals and undocumented aliens will be required to insure themselves and their dependents or pay a fee. Only about half of uninsured people in the U.S. fall below the 130% FPL line – the rest are typically people who are younger, lower income but not living in poverty, and are healthy and taking the gamble that they will not need health care services. States will be required to set up insurance exchanges. Individuals in the exchange with incomes below 400% FPL will be eligible for a premium assistance tax credit. The states will implement high-risk pools to cover “hard-to-insure” populations until 2015.
3. The third stroke is the employer “mandate” – it requires all employers with more than 50 employees to cover them or pay a fee. Employers with 50 or fewer employees who cover them will receive tax credits.

We will see significant market reforms, such as restrictions against lifetime limits on benefits. We will also see changes to Medicare, including:

- Changing rates for certain classes of Medicare services
- Reforming the primary care and coordinated care delivery models
- Quality and transparency initiatives

H.R. 3590 will also make investments in the health care workforce; establish programs and funds that focus on prevention and wellness; and enact a number of miscellaneous provisions.

The new law will impact specialty mental health consumers in several ways.

- The basic benefits package will include mental health and substance abuse benefits.
- Insurance reforms will end discriminatory practices often experienced by those with mental illnesses.
- State Health Insurance Exchanges will make it easier and more convenient for individuals and small businesses to purchase insurance.
- Tax credits will assist low-income health insurance consumers.

- Out-of-pocket spending limits will help individuals manage the cost of their care.

The new law will impact the specialty mental health system with increases in these areas.

- MediCal primary care payment rates to Medicare levels for two years
- The demand for mental health services
- The number of providers
- Opportunity for providers to participate in cutting edge pilot projects (ACO, Medical Homes, etc.)
- Scrutiny of the system as a whole

Some impacts cannot be foreseen at this point.

- How will the Medicaid bright line work in conjunction with the employer mandate?
- How will the new coverage requirements influence individuals' and employers' responses – participation, hiring decisions, coverage decisions, and so on?
- How will the new model affect provider decisions? After all, they are businesses and must adjust to market conditions.
- What limitations will be placed on various benefits and by whom?

Chair Poat thanked Mr. Smith for his concise presentation of a monstrously large issue.

9. Federal Healthcare Reform/1115 Waiver/Mental Health Parity: Behavioral Health Implications

Ms. Sandra Goodwin, President/CEO, CiMH, began the presentation by stating that the mental health community anticipates very significant major changes to services. They anticipate huge opportunities with the additional access possibilities and additional funding possibilities – and also significant risk, as they think about their recovery base system and how it fits into health care reform.

Ms. Goodwin pointed out that it is not just California that is struggling with a budget problem; 48 states are facing budget shortfalls this year. As we try to move the reforms forward, we are facing real funding challenges.

In the last few years, there have been significant changes in people's understanding of behavioral health. We have reached the tipping point. If we don't address the health care needs of people with serious mental illness *and* the mental health (MH) and substance use (SU) of all Americans, we can't begin to improve health care outcomes and bend the cost curve downward.

There has been much analysis of Medicaid data over the last several years. The new report *Faces of Medicaid III* provides a deep analysis, including pharmacy data and five years' worth of all data. It revealed that:

- 5% of beneficiaries account for more than 50% of overall Medicaid costs.

- Going further, 75% of Medicaid costs are related to people with three or more chronic conditions.
- People with disabilities plus three or more chronic conditions now account for 45% of Medicaid costs.
- Psychiatric illness among beneficiaries with disabilities has increased to 46% of Medicaid costs.
- The highest-costing 5% of people in the Medicaid system are those with a psychiatric condition and another chronic condition.

If we don't address the psychiatric needs of our population, we cannot improve their health outcomes and we cannot reduce costs. With that understanding, part of what we see throughout health care reform is a drive toward integration of primary care behavioral health, in the form of the *Person-Centered Health Care Home*.

To coordinate and integrate primary care, psychiatric care, and other specialty mental health care, we must look at the enormous opportunities and threats to community mental health and substance use systems.

Ms. Goodwin then gave an analysis of the root causes for national health care reform. They include:

- Lack of access due to 48 million citizens lacking insurance, and resource misallocation.
- Overuse of unnecessary, high-cost tests and procedures.
- Underuse of prevention and early intervention services
- Medical errors due to poor coordination among providers, poor communication with patients, etc.

Estimates are that as much as 30% of health care costs (over \$700 billion per year) could be eliminated without reducing quality.

Ms. Goodwin went on to look at health care reform from the perspective of mental health. There are four basic strategies: insurance reform, coverage expansion, delivery system redesign, and payment reform.

She addressed coverage expansion in detail. Health care reform will hugely push the number of those eligible for care. **Ms. Pat Ryan**, Executive Director, California Mental Health Directors Association (CMHDA), joined the presentation to explain parity legislation. She stated that in the overall health care reform context, probably the most revolutionary change in long term impact will be the intersection between the new mental health parity law and the health care reform bill.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), is currently in effect. The national mental health advocacy community feels that the final regulations are comprehensive, and have done a good job at closing loopholes enabling plans to avoid covering mental health and substance abuse services.

Ms. Ryan explained the contents of the parity legislation.

- It applies to large employers; it covers ERISA (group disability income policy) plans, where current state mental health parity law did not.
- It covers managed Medicaid plans.
- It will apply to health insurance exchanges for individual and small group policies.
- It will not apply to Medicare yet.

Ms. Goodwin summarized parity requirements and limitations. Parity requirements apply to deductibles, copayments, coinsurance, and out-of-pocket maximums. Treatment cannot be limited based on frequency, number of visits, days of coverage, days in a waiting period, and “other similar limits on the scope and duration of treatment,” unless the same limits are imposed on other benefits. The regulations call for quantitative treatment limitations and non-quantitative treatment limitations.

In terms of coverage expansion, there will be an increase of 15 million Medicaid enrollees (43%) and 16 million privately insured (8%). Most members of the safety net will have coverage, including an expansion of \$15 to \$23 billion for MH/SU. There is no credible information yet on the dollar impact of the Parity Act on mental health, although estimates are between \$15.4 billion and \$23.2 billion.

California’s safety net currently provides for about half the need in the state – a little over 500,000 people. With coverage expansion, a much greater demand for service providers will arise. Finding them will be a huge challenge.

Ms. Goodwin then gave some information on insurance reform. For mental health treatment, the important element of insurance reform is that *it creates an essential health benefits package that provides comprehensive services including MH/SU at parity*. She reminded the group that parity is written all through health care reform.

Regarding service delivery redesign and payment reform, Ms. Goodwin underscored the “\$700 billion question”: Will the current legislative and regulatory tools at our disposal be enough to improve the health status of Americans and bend the cost curve? And is the answer to that question the same for Americans with MH/SU disorders?

Ms. Ryan then explained other relevant service delivery redesign opportunities.

- A new Medicaid state plan option permits Medicaid enrollees with at least two chronic conditions or at least one serious mental health condition to designate a provider – which could be a community mental health center – as a health home.
- A new grant program supports co-location of primary and specialty care services in community-based mental and behavioral health settings.

- Another new grant program funds community health teams to support primary care practices with interdisciplinary resources.
- A new demonstration program allows Medicaid coverage of private inpatient psychiatric facilities.
- A new program at Health and Human Services (HHS) develops, tests, and disseminates shared decision-making tools to facilitate collaboration between patients, caregivers and clinicians, and incorporation of patient preferences and values into treatment decisions.
- A new office within Centers for Medicare and Medicaid Services (CMS) better integrates Medicare and Medicaid benefits for dual eligibles, and improves coordination between the federal government and the states.
- A new community transformation grant program will be established to support delivery of community-based prevention and wellness services.
- Early childhood home visitation will be promoted with \$1.5 billion in grant funding.

Ms. Goodwin noted that SU is underfunded in this country. She contrasted the number of those in treatment (2.3 million) with those in the abuse/dependence category (23 million), and with those in the unhealthy use category (estimated to be tens of millions). She posed the question, How do we even begin to address these gaps as states and health plans realize they have to provide SU services at parity?

Ms. Goodwin then addressed national healthcare reform strategies and the MH/SU safety net system. She posed questions about treatment for those with mild to severe MH/SU disorders, funding levels versus need, and new payment models versus existing payment barriers.

She stressed that safety net BHOs will need to ensure that they meet a set of core competencies necessary to continue being an important part of the health care delivery system.

Another challenge is to untangle health care funding. Current funding does not pay for mild to moderate levels of SU; and current funding needs to go toward people with serious and severe SU conditions.

Ms. Goodwin described current actions being taken in California.

- Many counties are working seriously to integrate reform.
- CalMEND has pilot integration projects at work.
- The Department of Health Care Services (DHCS) has developed 1115b Waiver, an agreement between state and federal governments on how to utilize Medicaid dollars.

Ms. Ryan named pertinent questions about budget/policy issues, regarding the impact of Maintenance of Effort (MOE) provisions on Medicaid; California's definition of "essential

benefits package” and the selection of a “benchmark” package; and the impact of parity on both. Other questions loom on the impact of the new Chronic Conditions state plan option; opportunities with the Home and Community state plan; and how to ensure that California participates in the acute IMD Demonstration Project.

Regarding policy/practice issues, questions are present on commercial plans addressing new responsibilities under parity and the role of safety net providers; opportunities for training and technical assistance for safety net providers; and retaining recovery oriented services in a more “medicalized” system.

Public Comment

- **Mr. Steve Leoni**, Client Advocate, California Network of Mental Health Clients (CNMHC), commented on the Institution for Mental Disease (IMD) exclusion, which has been federal policy for some time as an incentive for limiting Medicaid reimbursement for services in county psychiatric hospitals. His hope was that the Commission can look at ensuring that money saved goes into community services. Realignment dollars could go into acute services, which is contrary to HHS Substance Abuse & Mental Health Services Administration (SAMHSA) initiatives. Although it is largely a county fight, Mr. Leoni asked the Commission to do anything they could at the state level to encourage money to go into community services.

He also addressed the issue of medicalization of mental health. He felt that there is danger of losing the spirit of recovery, as the playing field has grown larger in terms of the tipping point. Many other players are present now who don't know the client movement or the issues of recovery (for example, they may perceive the use of restraints as a positive).

- **Ms. Delphine Brody**, CNMHC, stated that the organization was still reviewing the federal regulations for parity and health care reform, and planned to respond to them. She gave its interim considerations. CNMHC agreed with **Ms. Ryan** in that recovery services must be retained in the new system. Changes being proposed will have a huge impact on funding, and require vigilance that we not lose what's good about the mental health system, including wellness recovery services, peer support, alternative and holistic programs, etc. Community services must retain goals of helping people live independently and not be institutionalized.

Like **Mr. Leoni**, Ms. Brody hoped that the acute IMD demonstration project will free up county money to better fund community services and supports that will have a sustainable and preventive impact in helping people to live independently. She hoped that additional IMD funds would not result in a higher number of people being warehoused.

Question and Answer Discussion on Presentations

Chair Poat called the three presenters forward for a Question and Answer discussion. He stressed that the Commission did not want to become captive to the immediate financial problems that it anticipates – he wanted the Commission to look to the latter part of this decade, when the economy is in better shape, in identifying challenges and opportunities. He asked what role the Commission might play in the following areas.

- Outreach. Many more people can be brought into the system. People not familiar with it will need encouragement.
- Staffing issues. 5,500 – 11,00 skilled mental health care workers will be needed.
- State funding for MediCal. Around \$2 billion will be added in one year to the state budget.
- Service transformation. Individual health records, models of wellness, early intervention, care of chronic and multiple illnesses, and recovery-oriented services.

Vice Chair Poaster asked the broad question of why the MHSOAC is important in terms of the Mental Health Services Act, health reform, parity – what’s the connection? **Ms. Goodman** responded that it all impacts the people the Mental Health Services Act is intended to serve. There are opportunities and real risks that the philosophical thrust doesn’t get lost. Focus on recovery and focus on underserved populations must be kept.

Vice Chair Poaster also inquired as to who the safety net providers might be under the new law, and whether any will be added. **Ms. Ryan** responded that it’s assumed that public hospitals will be the absolute safety net, but for serious mental illness, it will be specialty mental health Medical system and MHSA in the short term. Long term, MHSOAC’s responsibility is to help give information and training to those who are now required to provide MH/SU benefits to clients. Outcomes are going to be important for controlling the cost of the new coverages – and providers must show that their benefits are achieving good outcomes. Both the private system and the newly expanded public system need to learn from what MHSOAC already knows about treatment.

Ms. Ryan remarked that another huge issue is actually having providers to deliver the benefits. Under the current state mental health parity law, we know that people have had a very difficult time accessing parity benefits that they should be entitled to. Under the new law, sufficient providers will be needed to deliver the services, especially in the area of SU.

Commissioner Pating stated that with health care reform, many formerly uninsured people will now be insured. For the 20% of people uninsured in California, the county mental health system is providing 40% of the services. Under the new model, it would be nice if the counties could receive coupons that would have possibilities of bringing federal match drawdowns.

Many are optimistic about the future of parity. Insurers in the past have skirted parity. Currently we have a wonderful opportunity to look at the positives, rather than the risks and fears surrounding change. New people and new dollars will be coming in. By June of next year the new population will be insured – and this will be a very large number of people. Consequently during the next six months, new social workers, therapists, peer counselors, etc. must be brought up to speed. The MHSOAC and its partners must also be ready to play a leadership role in workforce development.

Commissioner Pating then asked how the MHSOAC should proceed with the transformation. How can its six core values be effected?

Ms. Goodman shared his enthusiasm for the future, and wanted to identify issues surrounding the coming changes and develop plans around them. **Ms. Ryan** added that she and Ms. Goodman had a conversation the previous day with a group at the DHS, and realized that the state has not put a lot of thought into the implementation or even the meaning of the parity law. They are trying to deal with it now, so this is a good time for the MHSOAC to step forward. **Commissioner Pating** remarked that clients, commissioners, and counties should present a unified front at this time.

Mr. Fry stated that he spoke with Patrick Johnston, former Assemblyman and state Senator, and current member of the statewide health reform project, and supplied him with a list of suggestions.

Commissioner Van Horn remarked that from 2001-2007, the California Health Care Foundation funded a frequent users initiative (of emergency rooms and hospital beds). They learned what the MHSOAC knows about how to avoid acute hospitalizations – that case management and coaching, etc. is the way to bend the cost curve. In the health policy arena, some people already realize that what's been done in MH/SU is extremely beneficial to the general health care arena. In a sense, "de-medicalizing," health maintenance, health promotion, and lifestyle changes can alter the way those costs are structured. The MH/SU world is now in a position to provide some real leadership.

Commissioner Van Horn also commented that Medical and Medicaid will become available to everyone from 133% of the poverty level on down. Most of the uninsured people that we treat now in the public system are in that cluster. Instead of having to treat them for free, we will get paid for it or receive the match for it. This will be a huge benefit for the public system.

Ms. Ryan noted that the expansion into 133% doesn't occur until 2014. Also, when it does expand to that population, they will most likely be covered by the exchanges and will not be eligible for the specialty mental health system. We shouldn't assume that they will be eligible for all the services that the public system now provides.

Commissioner Gould noted that the MHSOAC also has a perspective through its collaborative experience with the transformed system; it should participate now as the state begins to implement the reforms, rather than after the fact. **Chair Poat** agreed that the MHSOAC will

certainly want to be part of the discussion for changes in workforce, digital health records, models for appropriate care, etc.

Commissioner Trujillo stated that this might be an opportunity for the MHSOAC to take the lead in developing focus and direction, as opposed to waiting to see whom the state will appoint. Other Commissioners agreed.

Mr. Smith named opportunities to get in on the ground level: the state is discussing two bills that would implement the health insurance exchange: SB 900 and AB 1602. The benefits package, whatever it may be, will be part of the bills. **Ms. Ryan** added that they will be required to include parity MH/SU benefits in the benefit packages.

Mr. Smith continued that at the outset of the federal discussions around health care reform, there was a huge focus on quality. As negotiations continued, the focus shifted a bit to mechanics. The focus on quality has dimmed somewhat. We are already seeing ideas for reforming the reform. Pushing forward with what the Commission has focused on historically will probably be of great value in forming federal and state discussions.

Chair Poat asked if there is any organized effort around implementing the parity legislation.

Ms. Ryan responded that DHS may pass it to the new administration for lack of staff time.

Chair Poat summarized four major areas of Commission interest.

1. Outreach; bringing people into the system who are now eligible for coverage.
2. Staffing; meeting the need for 5,500-11,000 new service providers.
3. State funding; monitoring the \$2 billion funding obligation.
4. Service transformation; contributing to the dialogue on:
 - a. Digital health records
 - b. Wellness
 - c. Early intervention
 - d. Chronic and multiple illness strategies
 - e. Recovery-oriented service model

Commissioner Van Horn suggested examining the intersection of the public system with the private. The private system has a huge history of “phantom” provider lists. There isn’t any body in the state that is looking at the interface between the public and private systems.

Commissioner Trujillo remarked that the private provider industry must adapt to the new way of thinking. They will incorporate some systems within their respective entities, making sure not to lose their opportunity for market share.

10. PEI and Innovation (INN) Plan Approval/Status Update

Ms. Ann Collentine, MHSOAC staff, presented a PEI Plan and two Innovation (INN) Plan for approval.

- The PEI plan was for Sierra County, a very small mountain county of 3600 people. The unique feature of the plan is the addition of an outdoor recreational aspect, requested on behalf of the consumers and family members and their community. Recommend approval of \$171,967.
- The first INN plan was for Contra Costa County, a medium-sized Bay Area county. The review team felt this was the gold standard of INN plans in terms of their communication materials. The project largely targets Lesbian, Gay, Bisexual, Transgender Queer, Questioning, Intersex, 2-Spirit (LGBTQQI2-S) youth program. This model, if successful, could be used outside of the community. Recommend approval of \$1,454,228.
- The second INN plan was the Humboldt County Innovation Project. This is another small northern California county. They have already made a huge commitment to the Transition Age (TA) population. The plan allows TA youth and peer support to be involved in local projects, as well as peer policy planning. It could also be a model used by other counties. Recommend approval of \$818,700.

Motion: *Upon motion by Commissioner Pating, seconded by Commissioner Trujillo, the Commission unanimously approved the PEI and Innovation (INN) Plans.*

11. General Public Comment

- **Ms. Kathleen Derby**, National Alliance on Mental Illness (NAMI), expressed the opinion that the MHSOAC could better spend its time on issues and accountability, rather than health care reform. She stated that clients and family members are experiencing frustrations that need to be addressed. Extreme budget cuts impact already scarce services and implementation in many counties. Some counties are very successful with their implementation, but disparities between counties and among populations are prominent, testifying to the need for keener oversight. They want the Commission to be more responsive to the needs on the ground.
- **Ms. Stacie Hiramoto**, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), echoed the comments of **Ms. Derby**. REMHDCO members also have been asking what the Commission does as far as oversight and accountability at the local level. Like Ms. Derby, she appreciated the panel on the health care reform, and felt that it was an excellent beginning. She would have liked to have speakers from the client and family community in addition.
- **Ms. Ashley Burton** addressed the issue of the complexity of American health care. The system should discern what works and doesn't work to be more sensitive to consumers.

In addition, she felt that psychiatric records should not be shared with anyone, as they are filled with hearsay and misinformation.

- **Ms. Delphine Brody** also affirmed the comments of **Ms. Derby**. Clients are experiencing lack of access to community services; already sparse services are being cut; and in counties such as Sacramento, MHSA dollars are being shifted around even after plans are submitted. Problems like this warrant the attention of the Commission.
- **Ms. Yvette McShoan**, California Mental Health Network, expressed concern for the underserved population. As a mental health care worker, she works with clients that have Medical and are in a medical facility, but cannot get services because the majority of their money is spent on housing. The Medical money won't allow them to get therapy. Other clients can't get Medicare which would allow them to be independent.
- **Mr. Frank Topping**, Sacramento Convention and Visitors Bureau, stated that Sacramento is having a terrible time housing its homeless population which includes the mentally ill. Permanent housing is needed for their safety. Also, with Memorial Day coming he hoped the Commission would remember returning veterans needing mental health care. Last, he agreed with **Ms. Brody**: Sacramentans are upset and will be asking locally for a grand jury investigation into where MHSA funds are going. They will be asking the Department of Health and Human Services (DHHS), as well as Senate and House members sitting on related committees, to take a look at movement of the funds.
- **Ms. Jane Fowler**, Sacramento County Mental Health Board and MHSA Steering Committee, spoke about the closure of four of the eight Regional Support Teams (RSTs). Of over 8,500 clients, only 6,000 are being served presently – 2,000 clients slipped between the cracks. Now the county wants to take over the care, despite the fact that they haven't done it in over a decade. She detailed the effects of other budget cuts in Sacramento County. She believed that MHSOAC needs to make sure that the county follows state-mandated care policies, and needs to watch county attempts to hijack state funds.
- **Ms. Sandra Marley**, client advocate and family member, stressed that the state has a right to say to the counties or agencies receiving the money, that there must be a review process for how they use the money. Further, consumer and family members must be able to access this information online. Transparency is needed with the new fiscal year approaching.

Chair Poat noted for the record that the MHSOAC is aware of some of the issues that have been raised with respect to Sacramento County. The Commission is in the process of conversation and discussion with the County. He assured the speakers that they have been heard, and the Commission will report back.

- **Mr. George Fry** spoke about his 14-year misdiagnosis as bipolar. In reality he suffered, as a Vietnam era veteran, from Post-Traumatic Stress Disorder (PTSD). His 26th

psychiatrist discovered it; Mr. Fry is now free because of this VA hospital doctor. We are now in the 21st century, and it's time to stop the stigma by replacing the term "mental health" with "behavioral health." Rural counties have begun this change in terms. He ended with a lighthearted invitation to those present to visit Calaveras County in May for the Jumping Frog Jubilee.

At that point **Commissioner Pating** thanked **Commissioner Gould** for her excellent work on the statewide PEI effort. He noted that the statewide PEI guidelines are out – officially stamped by the DMH – and the counties are giving the feedback that they appreciate the clarity.

Related to that, **Commissioner Pating** announced that the Services Committee will be meeting with the pre-existing stakeholders of the Student Mental Health Initiative on May 13.

Commissioner Pating then stated that the DMH and the JPA are in the process of negotiating a contract to further our efforts regarding the statewide PEI.

Last, **Commissioner Pating** spoke of a wonderful report by the Petris Center, heard by some of the commissioners and staff. If a client is in a full-service partnership, and is there for one year, the client has a 100% chance of getting off the street. It's a totally successful program. **Chair Poat** agreed that the Commission is interested in its findings, which validate a lot of the work that's going on in the communities.

Commissioner Van Horn reminded the Commission that it was **Commissioner Gould** who originally brought new **Executive Director Gauger**'s name to the group.

- **Mr. Leoni** addressed the Sacramento County issue. Skilled and experienced staff at wellness centers are being let go, and ill-trained workers are taking their place. This completely undermines the intent of the wellness center – and it's not confined to Sacramento County. The MHSOAC has a stake in monitoring the funding.

12. Closed Session.

The Commission moved into Closed Session to review performance expectations with the new Executive Officer, per Government Code Section 11126(a).

The public session resumed at 2:16 p.m.

Chair Poat noted that there were no reportable actions taken during the Closed Session

13. Public Comment

- **Ms. Patty Gainer**, Sacramento Steps Forward, spoke about the mental health system in Sacramento County. Basically, it is being dismantled. The County has made some proposals and is moving ahead with them. All outpatient treatment centers, with psychiatrists and other services, will be totally closed. The MHSA funds are being

moved around, with the County describing it as *expanding* the programs – but they are cancelling contracts with agencies and eliminating experienced employees, and setting up county workers to be quickly trained in their place. County charters have been ignored. Ms. Gainer requested the Commission’s oversight and accountability assistance.

- **Mr. Pat Hubbert**, Wellness and Recovery Center, addressed the County’s decisions to close four RSTs, remove the Wellness and Recovery medical staff in both places, and take out T-CORE. Money from all these programs will be used to open four “Wellness Centers.” Mr. Hubbert felt that this cannot be done so quickly. 6,000 people must be placed in the four programs, but the programs are not ready to go. He then read from a statement he had written on these issues, and requested help from the Commission.
- **Ms. Alice Newman** thanked the Commission for hearing the public comments, and asked what it was prepared to act on as the result of today’s session. **Chair Poat** replied that a formal review will be underway from the DMH – a process that has been adopted for this sort of situation. The Commission will evaluate whether any provisions of the Act or state law have been violated. He instructed Ms. Newman to contact the staff within the next week.

Ms. Newman emphasized that in saving these 26 county jobs, a retraining of the workers will cost \$2.1 million. She mentioned the \$21 million in MHSA funds that were re-appropriated, that were not supposed to be touched according to the referendum.

14. Adjournment

Chair Poat then adjourned the meeting at 2:31 p.m.