

# CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

**April 18 and 19, 2013  
Ontario Airport Hotel  
700 N. Haven Ave.  
Ontario, CA 91764**

## **CMHPC Members Present:**

John Ryan, Chair	Dale Mueller
Beverly Abbott	Monica Nepomuceno (Thursday only)
Karen Bachand	Adam Nelson, M.D.
Patricia Marrone Bennett, Ph.D.	Gail Nickerson
Josephine Black (Thursday only)	Jeff Riel
Doreen Cease	Joseph Robinson (Thursday only)
Adrienne Cedro-Hament	Daphne Shaw
Cindy Claflin	Walter Shwe
Caron Collins	Stephanie Thal
Amy Eargle, Ph.D.	Cheryl Treadwell
Lorraine Flores	Richard Van Horn
Steven Grolnic-McClurg	Jaye Vanderhurst
Suzie Gulshan	Chloe Walker
Rollin Ives (Thursday only)	Bill Wilson
Carmen Lee	Monica Wilson, Ph.D. (Thursday only)
Terry Lewis	Susan Wilson
Susan McGee-Stehsel (Thursday only)	Sandra Wortham (Thursday only)
Barbara Mitchell	

## **Staff Present:**

Jane Adcock, Executive Officer	Andi Murphy
Linda Dickerson	Narkesia Swanigan (Thursday only)
Mike Gardner	Tracy Thompson (Thursday only)

## **Thursday, April 18, 2013**

### **1. Welcome and Introductions**

Chair John Ryan brought the meeting to order. He requested the Planning Council members and the audience members introduce themselves.

### **2. Opening Remarks**

Susan McGee-Stehsel, Chair of the County of San Bernardino Behavioral Health Commission, presented their 2012 report.

- Alcohol and drug work is now part of the Commission.
- Ms. McGee-Stehsel named the members and their affiliations.
- The Commission reports to the CMHPC and the California Institute for Mental Health (CiMH), and connects with consumers, the Board of Supervisors, families, community-based organizations, faith-based organizations, and the Department of Behavioral Health (DBH) facilities to exchange information. The Commission has been pleased with DBH's responsiveness and support.
- Goals for the past year have been:
  - To increase participation in the District Advisory Committee meeting.
  - To increase awareness of available data and to use that data.
  - To develop a Transitional-Age Youth (TAY) task force.
  - To identify a strategy to promote behavioral health care as an integral part of Health Care Reform (HCR), especially transitions.
- The Commission is especially concerned about connecting with consumers and family members, and getting their information to the DBH, the Supervisors, and the many coalitions of San Bernardino County.
- The Commission is very involved in cultural competency.
- The Commission is currently updating its structure and working on its district advisory committees (Substance Abuse and Education).
- The Commission has successfully used Promotoras with the Hispanic/Latino community. That model is now being used with the African-American community.
- The Commission is using the Community Resiliency Model (CRM) for education.
- Currently the most significant substance abuse issues have to do with bath salts and over-the-counter drugs being sold. The combination of education and police efforts are reducing their availability.
- AB 109 has been a significant issue in the county.
- The Recovery Arts program is strong.
- Consumer education has been a focus.
- A Behavioral Health symposium is scheduled for May 28 at the University of Redlands.

### **3. Approval of the Minutes of the January 2013 Meeting**

Adrienne Cedro-Hament noted that some motions do not list the name of the person making the second. Staff member Tracy Thompson requested for people to state their names clearly when seconding.

Beverly Abbott, Jaye Vanderhurst, Daphne Shaw, Barbara Mitchell, Terry Lewis, and Chloe Walker gave necessary corrections.

**Motion:** The approval of the January 2013 Meeting Minutes with corrections was moved by Gail Nickerson, seconded by Lorraine Flores. Motion passed with one abstention.

#### **4. Executive Committee Report**

Executive Director Jane Adcock reported that the Executive Committee meeting had begun with a discussion on evaluation. The Planning Council needs to partner with the Mental Health Service Oversight and Accountability Commission (MHSOAC) in this area, as both agencies have responsibilities for evaluation of mental health services in California. The Planning Council needs to examine and provide input on the MHSOAC's Master Plan.

Ms. Adcock stressed that it would work the Planning Council's favor to partner with the MHSOAC, to start looking seriously at what is needed for evaluation, and to put together a concerted plan and request for additional funding – which would involve working with the Department of Healthcare Services (DHS) as well.

The Executive Committee felt that it would be a good idea to start looking into data that addresses the key reasons for why the public actually voted for Proposition 63 – getting the homeless off the streets and supported with housing and recovery services, as well as improved basic services for Californians with mental illness.

The Executive Committee discussed the vacuum of sorts in mental health leadership at the state level. Although the Governor's recent legislation moved much of mental health services down to the local level, it did not change the fact that the state does have a role to play in the administration of mental health services.

The Executive Committee meeting ended in a closed session that focused on an evaluation of Ms. Adcock. Chair Ryan reported that the committee discussed a process to establish an annual evaluation. They decided on a 360 evaluation whereby all Planning Council members can give electronic feedback via forms that they will receive; staff and other organizations will also be contacted for feedback.

When all the information is submitted, Chair Ryan, Ms. Nickerson, and Dr. Wilson will draft the evaluation. Ms. Adcock will do a self-evaluation and establish some goals. Chair Ryan encouraged Planning Council members to suggest goals as well.

Dr. Adam Nelson stressed the importance of this process in order to maintain a strong relationship and collaboration between the volunteer members and the administrative staff in any organization.

#### **5. Update on Workforce, Education and Training**

Lupe Alonzo-Diaz, Deputy Director, Healthcare Workforce Development Division, Office of Statewide Health Planning & Development (OSHPD), gave a background and overview of the Mental Health Services Act (MHSA) Workforce, Education and Training (WET).

Ms. Alonzo-Diaz focused on two key areas: the reconciliation of the state-administered WET funds, and OSHPD's process for engaging stakeholders for the development of the five-year plan. Below are highlights of the presentation.

- Since March, OSHPD has documented 137 mental health professional shortage areas in California affecting almost 4 million Californians.
- Ms. Alonzo-Diaz showed a summary of 10-year WET expenditures.
- Ms. Alonzo-Diaz showed actual reconciliation dollars available as of April 2, 2013.
  - The implementation of AB 100, with the realignment of funding and responsibilities going back to the counties, has impacted where WET funds sit. As programs and contracts have been transferred over to OSHPD, it has faced challenges in ensuring that those dollars continue to be tagged as WET funds.
  - WET funds available for re-appropriation – dollars that are already part of the OSHPD budget – total \$2,714,843. OSHPD wants these dollars to stay in its budget and not go back to the larger pot.
  - WET funds transferred from the Department of Mental Health (DMH) to liquidate contracts totaled \$1,540,702. These are dollars that were never technically part of OSHPD's budget. When the contracts transferred over from DMH, OSHPD received the dollars to liquidate the contracts, but did not receive the technical appropriation for the entire budget amount.
  - WET reverted funds from 2008 through 2010 totaled \$6,188,960. They may be available for re-appropriation. They were never OSHPD's to begin with – they were part of previous contracts and have already been swept as part of AB 100.

In answer to a question from Ms. McGee-Stehsel, Ms. Alonzo-Diaz stated that OSHPD is exploring all of its options with Finance to keep the funds in WET: considering how to recoup the dollars that went back to the counties, creating a trust fund, and so on.

Ms. Abbott asked about available funds for new WET programs. Ms. Alonzo-Diaz stated that as of the transfer from DMH, what OSHPD had in terms of statewide WET-administered dollars available for the next five years is about \$138 million.

Dr. Bennett asked what percentage of Mental Health Services Act (MHSA) dollars, collected from the tax, are dedicated to WET. Ms. Alonzo-Diaz stated that in essence, with the implementation of Proposition 63, the statutory language indicated that a certain percentage for the first three years beginning in FY 04-05 were to go into the WET trust fund.

Joseph Robinson asked if OSHPD has identified a process to expend the \$6 million in uncommitted funds. Ms. Alonzo-Diaz replied that OSHPD is waiting for the development of the Five-Year Plan, which will drive the way OSHPD spends the other \$138 million as well. OSHPD's intention is to work with stakeholders in order to develop the best Five-Year Plan based on the dollars OSHPD has.

- Ms. Alonzo-Diaz noted that for the Mental Health Loan Assumption Program (MHLAP), which OSHPD has administered from the beginning, all but one county since FY 08-09 have received at least one MHLAP recipient.
- OSHPD is responsible for developing a Five-Year Plan for 2014-19. One of the Planning Council's responsibilities is to review and approve it.
  - Ms. Alonzo-Diaz displayed OSHPD's schedule for stakeholder engagement, to be done through advisory committees, focus groups, and community forums.
  - Another opportunity for input is the Career Pathways Subcommittee, which OSHPD is reconvening in concert with the State Board.

### **Questions and Discussion**

Dr. Bennett asked what OSHPD is doing about the need for a much larger workforce to deal with the influx of people who will be eligible for mental health services with the Affordable Healthcare Act. Ms. Alonzo-Diaz replied that OSHPD is working with stakeholders and constituents to identify the areas of need. Much of the focus is on integrating primary care and mental health through five different areas: Awareness, Training & Placement, Financial Incentives, Systems Redesign, and Data & Policy.

Dale Mueller noted that for Phase 3, the Pathway for Psychiatric Nurse Practitioner has already been developed which may be of value in accelerating that phase. Also, Ms. Mueller wondered if data exists about numbers of graduates of the various programs that have been initiated. Ms. Alonzo-Diaz responded that OSHPD is actively working with contractors to document data. In addition OSHPD has a clearinghouse program that works with licensing boards and institutions to document and collect that data.

Ms. Thal asked about accessing webinars for the stakeholder process. Ms. Alonzo-Diaz replied that they will send the information to Ms. Adcock as soon as they have it.

Ms. McGee-Stehsel commented that in terms of WET, nurses at the baccalaureate and RN level can provide some of the bridges between health and behavioral health.

Chair Ryan asked if there is an evaluation of the first Five-Year Plan that the Planning Council will receive. Ms. Alonzo-Diaz replied that OSHPD is evaluating existing programs to see how programs are matching up with the statutory criteria; when this evaluation is done it will be available to the public.

Chair Ryan asked about the contracts that will go out to the various disciplines. Ms. Alonzo-Diaz responded that the contracts will be developed when the Five-Year Plan is in place.

## **6. Continue Committee Reports**

### **Patient Rights Committee**

Chair Daphne Shaw reported on the following.

- The second Ad Hoc committee member is yet to be assigned. People willing to act as resources to the committee have come forward.

- Ms. Shaw read the Purpose section of the finalized committee charter.
- The committee discussed the use of the term “patient” versus “client” or “consumer” in the legal sense, and decided to stay with “patient”.
- Via conference calls, the committee had developed a pilot survey that was sent to all Planning Council members. Feedback indicated confusion over the term “patient rights”; the committee decided to embark upon an educational effort in order to clarify. They will obtain copies of patient rights written policies from their counties.

Michael Gardner added that if the meeting times become problematic for the committee members, they might possibly cut down on the number of meetings per year rather than lose committee members.

### **Advocacy Committee**

Adam Nelson spoke about development of communication strategy and position statements.

- The Legislature has recently submitted a number of bills that the committee will be examining.
- The committee will be establishing position statements that represent the Planning Council’s platform. So that the full Planning Council can endorse them, the committee will begin posting them on the website.
- The five areas in which the committee has taken an interest are:
  1. Linkages between violence and mental illness, and the importance of unlinking the two
  2. The value of Prevention and Early Intervention (PEI)
  3. The integration of mental health services within the greater house of primary care medicine
  4. Support for reimbursable peer/provider hours
  5. The need for alternatives to inpatient institutional-based treatment services and programs

For the immediate future, the committee will concentrate on #1, 2, and 5.

Co-Chair Barbara Mitchell reported that the committee has taken positions on the following legislation.

- She distributed a letter on Gun Violence Prevention Task Force Policy Principles to Planning Council members; it had also been previously emailed.
- The committee is supporting SB 391, the California Homes and Jobs Act.
- The committee had extensively discussed topics related to Laura’s Law. The committee opposes SB 664 which stipulates that MHSA funds may be used for outpatient treatment.

- The committee is opposing SB 585, which also specifically says that Laura's Law may be funded through MHSA funds.
- The committee is opposing AB 1367, which talks about the same use of funds, and also says that MHSA funds may be used to do evaluations on schoolchildren who are suspended.
- The committee had not taken a position on AB 1265, which deals with whether people who are discharged after 5150s are going to be evaluated for assisted outpatient treatment (i.e., Laura's Law).
- The committee is opposing SB 561 which has to do with how MHSA funds may be used; it requires a student to submit to a mental health evaluation for readmission to school.

Ms. Mitchell reported that the committee is responsible for the June Planning Council meeting agenda and is developing that.

Co-Chair Gail Nickerson reported that the committee had updated its charter. The committee had also reviewed a mental health checklist covering all kinds of mental health services for women. The committee will scan it to make it available to everyone.

Dr. Bennett spoke about a new bill that would permit forced medication in jails, and requested the committee to take a look.

Amy Eargle requested for the committee to look at SB 226, which requires individuals with serious mental illness and are dangerous, to serve their time in state prisons instead of local county jails.

Mr. Robinson asked if the full Planning Council needs to endorse the positions of the committee. Chair Ryan stated that if the Planning Council has a legislative platform, and a piece of legislation is discussed in the context of that platform, the committee is authorized to write a letter. If the legislation is not in the platform, it comes to the full Council for information and action.

Ms. Mitchell noted that the committee felt that it took action consistent with the platform; the committee had discussed whether issues regarding Laura's Law should come before the full Council. Since it had been previously discussed, they believed that it would be left to the committee to see if it was consistent with the platform.

Ms. Mitchell added that the positions had not been passed with 100% agreement within the committee – they had passed by majority vote. Where there were too many abstentions the committee had taken no position.

Chair Ryan stated that because Laura's Law is so controversial, he preferred for all the Planning Council members to hear the considerations and see the actions that are being taken.

Ms. Abbott stated that she would like to see the Planning Council trust its committees; when a committee report is brought to the Council the Planning Council will endorse it. This means that the Chair signs the letters with the Committee Chair, and the Council as

a whole supports them. She added the caveat that if there is something controversial, the Council receives a draft. If anyone has a serious concern they can weigh in.

Dr. Bennett fully supported that statement. To be more effective, the Planning Council needs to empower its committees to take positions and take actions. To ease any discomfort, the Planning Council should establish a process of revisiting the platform, making sure that it is timely.

She continued that because of the vast quantity of legislation being introduced, the Planning Council needs to narrow its focus; it cannot respond to everything. It needs to choose the topics that it is championing (perhaps in the current legislative session) in order to be effective.

Carmen Lee shared the news that the name of Laura's Law has been changed at least in New York.

Monica Nepomuceno asked how the committee chooses bills to look at. Ms. Mitchell responded that Planning Council members can fill out an Issue form and send it to the committee in advance of the meeting. Otherwise, Ms. Murphy, committee members, and partner agencies identify issues.

Dr. Nelson raised the process question: how does the Planning Council intend to deal with interested people who may represent a minority opinion? If the Planning Council does not have a unanimous opinion, it runs the risk of furthering the disenfranchisement of a few members who may continue to feel that they do not have a voice in the process.

Chair Ryan responded that historically, the Planning Council has followed a majority decision-making process.

Chair Ryan referred to the existing policy on the Chairs. People continue to ask about it; maybe the four existing Chairs should take a look at it. He felt that all the Planning Council members have a right to hear what position is going out under the CMHPC's name.

Ms. Mitchell noted that it would take 3-4 hours to present all the legislation to all the Planning Council members.

Mr. Gardner suggested that when the Advocacy Committee meets and endorses a slate of recommendations, perhaps there could be two different items. Those clearly in agreement with the Planning Council's direction could go into a consent group; if there are one or two that are clearly more controversial, they could come into discussion.

Ms. Shaw commented that the legislative platform that the Advocacy Committee looked at that allows them to make these decisions, was the language that referred to the use of MHSA monies.

Ms. Shaw then responded to Dr. Nelson's comments. The only positions held by the Planning Council that are named in law are those held by various departments of the state. All the other positions basically say things such as "consumer-related advocate," "provider," etc. Planning Council members have backgrounds and beliefs, but they are not representing an organization.

Dr. Bennett felt that there is a difference between an organization with a history and positions it has taken, and the individuals on that body. The Planning Council could not have existed during these years with everyone perfectly happy with every position. At the end of the day, the Planning Council must take an organizational position.

Chair Ryan's point was that the individual should have the opportunity for input and the opportunity to hear the decision and understand it.

**Motion:** The approval of the positions taken by the Advocacy Committee on the Thompson bill, the Laura's Law bill, and the bills that deal with MHSA funding was moved by Barbara Mitchell, seconded by Jo Black. Motion passed unanimously.

### **Continuous Systems Improvement (CSI) Committee**

Committee Chair Pat Bennett reported that Dr. Stephen Bright of the Alcohol and Other Drug (AOD) State Department had talked with the committee about the California Outcomes Measurement System (CalOMS) data system, as well as other reports – one of which is a cost-benefit analysis of evidence-based practices. From the committee's discussion with Dr. Bright there emerged recognition of the need to send data out rather than just to collect it.

The committee had moved forward with its Work Plan, articulating projects and goals. It will be ready in June.

The committee will formally review the state performance measures. It will also look over the MHSOAC's Master Plan for Evaluation.

Susan Wilson, Subcommittee Chair of the Data Notebook (formerly "Workbook") Committee, reported that during a teleconference they had decided that their most significant issues were the Notebook timeline, the Notebook topic, and plan development. It is a staff-intensive effort and they receive continual input from Ms. Adcock. Ms. Wilson noted that the whole Data Notebook project is based on the requirement that local mental health boards report back to the CHMPC.

Dr. Bennett added that California Association of Local Mental Health Boards (CALMHB/C) members actively participate in the teleconference calls regarding the Data Notebook; it is looked upon as a joint effort.

### **7. Overview Healthcare Reform**

Ms. Abbott stated that the purpose of the presentation was to familiarize the Planning Council with the components of HCR. The committee focused on the components most important to the population the Planning Council serves, and the committee shared how they are approaching their work.

- As requested at the last meeting, the committee had included a list of acronyms.
- The five components of HCR upon which the committee is focusing are:
  1. Medi-Cal Expansion (MCE)
  2. Health Benefit Exchanges (HBE)

3. Dual Eligible Demos – CCI – Cal MediConnect
  4. Health Homes
  5. Children’s Services
- Whenever the committee looks at these components, it will remain focused on the five core elements of the MHSA:
    1. Consumer and family-oriented services
    2. Cultural competence
    3. Recovery/wellness/resilience orientation
    4. Community collaboration
    5. Integrated service experiences for clients and families
  - Ms. Vanderhurst gave an overview of the importance of the Behavioral Health Service Needs Assessment and the pending Behavioral Service Plan.
    - She stated that the Behavioral Service Plan is meant to be the roadmap for how counties or providers will be providing those services that tie up to the Essential Benefits package. The committee feels it important to stay connected to the Service Plan in terms of stakeholder involvement.
    - The committee has studied the Behavioral Health Service Needs Assessment draft and revised it. The draft’s purpose was to look at service utilization of current Medi-Cal recipients and identify opportunities for the expansion in the increased demand for HCR services.
    - The committee spoke with Rollin Ives, Special Advisor for Mental Health and Substance Use Disorder Services at DHS on their next steps. The committee wanted to communicate that there needed to be a similar, if not more robust, stakeholder process in the actual Service Plan Development than there was in the Needs Assessment.
  - Ms. Abbott stated that the committee is going to track the Health Benefit Exchanges and work with the California Coalition for Whole Health (CCWH).
  - Cindy Claflin stated that the committee is also looking at where children come into play as they are changed over from the Children’s Health Insurance Program (CHIP) and Healthy Families to Medi-Cal.
  - A concern is children in rural areas because of lack of facilities and decrease in payments to doctors.

### **Questions**

Ms. Nickerson commented that she would like to see rural health clinics included in the analysis.

Ms. Lewis commented that the information had been technical and confusing. She commended the committee members on their diligence. Ms. Lewis asked that the

Committee Chair or Co-Chair, as well as Ms. Adcock, have opportunities to speak with DHC officials. The earlier the subcommittee is involved in the process, the better it will be for them to be able to share information with the Planning Council.

Dr. Bennett expressed confusion about the realm of the state level versus the county level. Ms. Abbott referred her to a Legislative Analyst report in the packets regarding whether or not California should select a state-run option or a county-run option for the Medi-Cal expansion program. Indications are that the Legislature will go for a state-run option, which would make it look more like Medi-Cal now. Counties will then decide how to implement it.

Cheryl Treadwell pointed out that part of the expansion includes former foster youth up to the age of 26. This group needs to be watched for emerging issues in the system.

Jeff Riel asked about state disability insurance coverage. Ms. Abbott stated that this would be a good question to add to the list.

### **New CMHPC Members**

After the lunch break, Chair Ryan asked new members to provide thumbnail sketches of their backgrounds.

**Suzie Gulshan** worked on Wall Street for 16 years, and is now a paralegal for a criminal defense firm. She is a member of the Orange County Mental Health Board.

**Caron Collins** has a private practice as a solution-focused, goal-oriented private therapist in Sacramento. She began her mental health work experience at a children's agency, and worked as a therapist for many of the EPSDT clients. She was also a clinician at the Sacramento County Mental Health adolescent treatment unit.

**Karen Bachand** has worked in school, college, and business settings. Twelve years ago she caught a virus and has been receiving treatment at various locations; currently she is in remission. She is an employee of Carmen Lee, and is interested in stamping out stigma.

### **8. Presentation: Health Homes**

Steven Grolnic-McClurg gave a presentation on Health Homes.

#### **Concept**

The concept of Health Homes is to have overall care situated in one location. For those with serious mental illness, it involves having primary care and mental health care at one site. Health Homes are convenient for patients, and care is more coordinated if a team is working together and concerned about the patient's treatment.

There are many models. Most California counties are involved in planning for what Health Homes are going to look like in their counties. There may be specialized planning for some individuals with serious mental illness.

A Health Home may be created by taking a typical ambulatory primary care site, and building out the behavioral health services within that site. For specialty care, a patient may be referred out to a mental health clinic.

Another option would be to take the ambulatory primary care and situate that within the behavioral health clinic. California has very good rehab services; physical healthcare people may want to be working with this population and working within these sites.

### **The CMHPC Healthcare Committee Strategy**

One of the core principles of Health Homes is having stakeholder involvement in planning. The Health Care Reform Committee is taking a tack of advocating for the Mental Health Boards and other stakeholders to be informed and to know what questions to ask their county health departments. They need to be able to request stakeholder involvement in their county's planning processes.

Mr. Grolnic-McClurg added in closing that the physical health care outcomes for individuals with serious mental illness are truly abysmal. Data indicates that they die 25 years younger than their peers. It is important that Health Homes move forward, because what is currently in place does not work for the population that the Planning Council is charged with representing.

### **Questions and Discussion**

Ms. Nickerson mentioned additional terminology: Patient-Centered Medical Home (PCMH) or Patient-Centered Health Home. The state of Oregon has already passed a rule that if a clinic does not achieve the Patient-Centered Health Home status, it cannot see Medicaid patients. The National Committee for Quality Assurance (NCQA) is one of the main groups performing this recognition.

Ms. Abbott requested Ms. Nickerson to email the standards used for clinics to achieve PCMH status.

Ms. Lee asked whether people would have choices for their primary care in Health Homes. Mr. Grolnic-McClurg replied that his understanding was that it is the patient's choice whether to enter into a Health Home. The issue of primary care providers is complicated; the Affordable Care Act is requiring many of them to make many changes to their practices.

### **9. Presentation: Medi-Cal Expansion**

Dr. Roderick Shaner, Medical Director, County of Los Angeles Department of Mental Health, spoke about what Los Angeles County is doing to prepare for Health Care Reform. His presentation was titled "Healthy Way LA – LA's Low Income Health Plan in the Context of Health Care Reform Readiness."

- LA County is a very large county with 10 million residents. Three different departments deal with health care.
- The LA County Department of Mental Health serves about 80,000 individuals per month.
- LA County is preparing for health care reform via a number of connected programs.
  - The Low-Income Health Plan (LIHP) – Healthy Way LA – is part of MediCal, the 1115 Waiver.

- The LIHP allows the county to enroll people newly eligible for MediCal ahead of time, into a system that will be much like the Medicaid expansion system.
- Cal Mediconnect is the new name for the dual eligible plan, connecting Medicare and MediCal.
- The MSHA provides money for programs that help to prepare: Innovations, WET, and PEI.
- Objectives for coverage expansion are:
  - Get coverage expanded to meet all county responsibilities under the LIHP.
  - Get services into primary care.
  - Get quick referrals.
  - Coordinate providers with strategic alignment.
  - Use technology in LIHP administration.
  - Develop electronic health records.
- The system needs to be redesigned by:
  - Building new structural models for bidirectional care.
  - Introducing evidence-based mental health treatment strategies.
  - Ensuring effectiveness of new integration models.
  - Ensuring integration of substance abuse services (historically a problem).
- Regarding payment reform, the county is trying to prepare for the unknown. We need to learn to work with managed care companies who explain why people need or don't need services; Cal Mediconnect will enable this.
- The LA County Department of Mental Health feels that it will continue to exist after health care reform, because it does critical things that no one else can do.
  - It is the local mental health authority and will oversee the evolution of the new system.
  - It will continue to be the behavioral health provider.
  - It will be a safety net provider.
  - It wants to push to provide quality mental health services in the context of primary care – to be able to take insurance from the insurance exchange and have the benefits from Medicaid expansion match the basic benefits in the insurance exchange.
- Preparation under Healthy Way LA includes expanding coverage, co-locating providers in primary care clinics, implementing innovative integrated treatment models, and developing the workforce with training in evidence-based practices and tele-mental health.

- A big concern is that people can enroll in Healthy Way LA in the low income health plan, but they have to keep coming back to re-enroll. If they don't re-enroll, they fall off.
- Dr. Shaner explained various graphs and tables.
- Showing performance outcomes is crucial. If we can't show what we do and correct ourselves, we will be lost. Currently one of the biggest gaps nationally is outcomes.
- We must show people across the system that managing care works to everyone's benefit. Getting the right care to the right people means that we can pay the right amount of money for it. It's the only way in the future that we can really get good outcomes.
- Dr. Shaner requested the Planning Council's help with the following:
  1. Reduce and simplify re-enrollment for LIHP, and later, Medicaid.
  2. Find out when the Medicaid expansion is going to happen.
  3. The state versus county option: do we have counties develop a new policy to Washington and an entirely different set of rules and a different kind of Medicaid? We need one Medicaid plan operated by the state.
  4. A corollary to #3: Mandate the same benefits packages – the state option should have the same benefits.
  5. Don't forget that we have a residual uninsured population; don't take away the rest of the Realignment.
  6. The carve-out cannot disappear yet, but we can develop a path so that ultimately we get good care. We have got to get substance abuse benefits into Medicaid expansion.
  7. It would be good to contract with Federally Qualified Health Centers (FQHCs) for mental health.
  8. It would be good to clarify over time what kind of integrated contracts we can really have.
  9. We must have continuity: the county plans may deliver Medicaid expansion services, but we have to be able to play in the insurance exchange, and it must be explicit.

### **Questions and Discussion**

Ms. Abbott asked if LA County has a position on the level of mental health benefit – and expanded substance abuse – for the MediCal expansion; would it be the Rehab option?

Dr. Shaner replied that they are pushing the Kaiser Small Business Plan. It is not the full spirit of rehab, but it gets us about 85% of the way there.

Ms. Nickerson stated that what LA County does, considering its huge population, will instruct the whole country.

Ms. Bachand inquired about the people who are on SSDI and have the Medicare “donut hole” when it comes to their prescriptions. Dr. Shaner answered that the county had determined to work with the benefit plan that people have. For people with Medicare, they work with them as best they can to get them medication through the indigent medication plan among others; but they do not pick up automatically where people who are solely on Medicare leave off. For the duals plan, the “donut hole” goes away with Cal Mediconnect and with the Special Needs Insurance Plans (SNIPs).

Ms. Lee asked who will be responsible for the physical plans that need to be established with the increase in people to be served. Dr. Shaner replied that for the low-income health plan, the counties in California have a monopoly. They must either provide services directly or contract out.

Ms. Lee also asked about specific programs for the senior population. Dr. Shaner responded that Cal Mediconnect will really help with outreach to seniors. A big question is what will happen with Alzheimer’s and other dementias, and how that will play with LPS conservatorship.

Bill Wilson inquired about members looking to work with the counties and volunteers getting trained to help out both staff and clients. Dr. Shaner stated that part of Workforce Development concerns people with lived experience: they are what we need. Other parts of the community, notably the spiritual community, do a tremendous amount of work that should not be a parallel universe. LA County has been working to become competent to talk to them; there is now a Clergy Council.

#### **10. Presentation: Dual Eligible Demonstration**

Dr. Peter Currie, Clinical Director of Behavioral Health at Inland Empire Health Plan, gave a presentation for the Planning Council.

- IEHP is the Inland Empire Public Health Plan for San Bernardino and Riverside Counties, serving about 600,000 members in government-sponsored programs.
- In 2009, Medi-Cal was under a carve-out to county mental health, as it is throughout the state. Through 2009, the Medi-Medi (or Dual Choice) population was assigned to a carve-out mental health entity in the private sector, much like L.A. County. It is a Managed Behavioral Health Care Company (MBHO).
- With health care reform and the Dual Eligible transition, IEHP is expected to grow to about 900,000 members.
- Four years ago there was a disconnect that existed between the behavioral health providers and the primary care doctors.
  - There was no coordination of care.
  - 50% of the behavioral health dollars paid to the MBHO did not go to the providers and hospitals.
  - Outpatient mental health services and substance abuse services were basically nil – a clear absence in that model.

- Dr. Currie convinced the CEO to bring it in-house and truly integrate at the health plan level. This meant that IEHP had to come up to speed quickly and achieve National Committee for Quality Assurance (NCQA) accreditation.
- The IEHP used the 50¢ per dollar savings to fund expanded services. They saw outpatient utilization go up dramatically.
- The network was opened to every provider in the county. Providers were selected based on whether they met the needs of IEHP members.
- The network grew, one by one, throughout the two counties. They eliminated the reliance on the MBHO for behavioral health expertise and for NCQA compliance.
- A side benefit was to infuse behavioral health competency in all the departments within the health plan.
- They leveraged web-based technology by downloading the members' Patient Hospital Record, making it available to the behavioral health providers on the first visit. Those providers can then forward the information from the visit, with the patient's permission, to the primary care doctor.
- The IEHP can leverage best practices throughout the counties, and there will be emerging providers and best practices that can be included. Subcontracting with one provider does not allow this.
- To set up for good access, they used a higher rate of pay than average for the initial visit, instead of pay-for-performance which is frequently used on the medical side.
- They added new behavioral health services, including innovative wraparound services such as tele-care; IOP (partial hospitalization); and particularly for substance abuse, referral of all cases to IOP.
- Cost to the health plan did not increase – it was paid for with the 50¢. The more expensive hospitalization care went down while the needed outpatient services went up.
- They created medical cost offsets by applying specialized behavioral health service to high-risk populations, such as severe diabetics that are non-compliant and have co-existing depression.
- Behavioral health has become more valuable and better funded because its real value has been shown to the health plan payer.
- In the first NCQA audit of 2012, IEHP met 100% of standards.
- Dr. Currie showed graphs of the results of the first two years.
- In-house behavioral health capabilities have led to a meaningful collaboration with both county health departments. New collaborative initiatives include:
  - Eating disorder specialty treatment.
  - Teen depression screening for pediatricians.

- Using web-based technology to hand off referrals to the county mental health system.
- An autism collaborative.
- A care integration collaborative in Riverside County to provide primary care at mental health clinics and vice versa, while integrating substance abuse.
- Riverside County looked at mortality rates in their severely mentally ill population and found that the average age of death is 41.8 years – even younger than the national average for that population. That is the reason that integrating behavioral and physical medicine is critical.

Dr. Currie spoke next about Cal Mediconnect.

- In Riverside and San Bernardino Counties, Cal Mediconnect will involve IEHP and Molina.
- The Medi-Cal benefit now includes full long-term care and in-home health services. Duals can opt out of the Medicare benefit, creating a problem for IEHP because of mandatory enrollment on the Medi-Cal side. Because they like Medicare fee-for-service, many physicians will advise their members to opt out of that health plan. Success will come only from coordinating the two benefits under the same health plan.
- For those who don't make a choice there will be passive enrollment beginning October 2013. It will roll over a 12-month period.
- Plans are fully at risk for all benefits, including long-term care, IHSS, and MSSP.
- The MOU is signed. IEHP is preparing for the readiness review in which all health plans have to show that they are ready to take HCR on.
- Those who can use Mediconnect qualify for both Medicare and Medi-Cal. 37% have both chronic conditions and functional limitations. They are high utilizers of Medicaid services.
- IEHP has redesigned care management around the member instead of around the departments.
- Strategies as a health plan are:
  - To contract with more medical groups, larger medical groups, and medical groups that never worked with Medi-Cal before.
  - To enhance transition of care teams.
  - To develop new long-term care and long-term support services, expertise, and capacity.

Dr. Currie spoke about Medicaid expansion.

- IEHP anticipates that Health Care Reform will add about 250,000 Medicaid members to the population.

- Two proposals are being considered to handle the influx:
  - The county option: to continue using the LIHP program.
  - The state option: to use local health plans such as the IEHP.
- The population will be new for the IEHP; the uninsured will be moving into the health plan.
- It is 100% federal funding.
- It is good for PCPs, who will be paid Medicare rates instead of Medi-Cal rates.
- There will still be uninsured people in the two counties to address.

Dr. Currie noted that we need to reconsider the concept of specialty mental health criteria – is it actually exclusion criteria? Dr. Currie felt that it is. It leaves a huge gap in care for those with mild to moderate conditions that must go back to their primary care doctors. Dr. Currie requested that the Planning Council think about what parity really means, and what would have to change if we change this specialty mental health criterion.

He closed with the following thoughts.

- Parity is not enough – it is a mandate. Integration is the work that needs to be done. Coordination of care is only a stepping stone towards true integration.
- We need to leverage the private and the county providers to pursue excellence.
- Open access to behavioral health services pays for itself in medical cost offsets in a well-integrated program.

### **Questions and Discussion**

Dr. Bennett asked Dr. Currie to weigh in on whether the state or the counties should run health care. He replied that the strengths of counties are critical, but at the same time they do not have the resources of managing the whole picture of a person's medical care. A health plan must have sufficient infused behavioral health expertise.

Mr. Wilson asked about alternatives to psychiatric medications. Dr. Currie replied that when systems of care are heavily weighted toward psychiatry, the main tool is going to be medication management. Sufficient psychotherapists are necessary.

Mr. Robinson asked about acute diversion units and transitional programs in addition to increasing access to outpatient services. Dr. Currie responded that at the top of their list is doing a better job with other levels of care (including tele-care) than just acute hospitalization.

Ms. Flores asked how they determine the leads in the interdisciplinary teams, and the role of peers in those teams. Dr. Currie replied that he and the Senior Medical Director function as the leads. They also hire and employ peers to go into homes to help people get connected with the proper care. They also bring members in for treatment planning meetings.

Ms. Abbott asked if the skilled nursing facility cost will be included in the capitation rate; Dr. Currie responded that it was under long-term care.

Ms. Treadwell asked if Dr. Currie had run into any barriers regarding HIPPA issues, confidentiality, and data sharing. He answered that they had run into HIPPA barriers. A colleague, Dr. Dennis, had developed a universal release form now used throughout the county.

Ms. Black inquired about long-term care. Dr. Currie stated that when Adult Day Health Care (ADHC) rolled into the health plan a year and a half ago, they revealed a whole other level of care. IEHP contracted with them, as did other counties around the state, and they became life-savers. The health plan understands their value; ADHCs help people stay healthy and provide an efficient level of care. If managed correctly, IEHP is going to use them. The same is true for long-term support services. These services are better managed at the local health plan level than the state level.

## **11. Action Items**

### **Endorse HCR Planned Actions in Future**

Ms. Abbott concluded the Health Care Reform overview by stating that the Health Care Reform Committee planned to do the following.

- Continue participating in the California Coalition for Whole Health.
- Look at the mental health benefit.
- Look at the issue of how the service plan rolls out.
- Look at how this pilot rolls out.

The committee has tried to explain the context of these important components of health care. They will continue to advocate on the MHSA Core Values and give attention to the stakeholder process.

Dr. Bennett asked if the Committee has discussed taking a position on the state versus local option. Ms. Abbott responded that the issue is being discussed on a level that the Planning council is not going to impact. The Legislature's direction seems to be moving toward the state option.

Mr. Robinson stated that the CMHPC's Michael Cunningham and the MHSOAC's Sherri Gauger were providing testimony that day to the Senate Budget Subcommittee 3, chaired by Senator Bill Monning. Rusty Selix had testified that each county should be analyzing the Mental Health Substance Use and Needs Assessment as it pertains to their own individual plans.

## **12. Public Comment**

There was no public comment.

### **(13. continued)**

### **Endorse CMHDA-CADPAAC HCR Principles**

Ms. Vanderhurst stated that at the previous Planning Council meeting, there had been a question around the ten common agreed-upon CMHDA-CADPAAC HCR Principles. The tenth principle used the term “coordination” rather than “integration.” Ms. Vanderhurst stated that the word was chosen as part of a dialogue between CMHDA and CADPAAC because it recognized the specialties of the disciplines.

**Motion:** The endorsement of the CMHDA-CADPAAC HCR Principles was moved by Beverly Abbott. Motion passed unanimously.

### **13. New Business**

Ms. Mueller drew everyone’s attention to a flower brought from her garden in light of the incredibly destructive events that had occurred in our country. She dedicated the flower, a variety called “Love and Peace,” to the resilience of the American people.

Chair Ryan asked the Planning Council to consider the issue of low attendance at the Friday meetings.

## **Friday, April 19, 2013**

### **1. Welcome and Introductions**

Chair Ryan greeted everyone attending the Friday morning meeting. Members of the Planning Council and the audience introduced themselves.

### **2. Opening Remarks**

CaSonya Thomas, Director, County of San Bernardino Department of Behavioral Health, welcomed everyone to the county. She provided an overview of the Affordable Care Act and its impacts and challenges in San Bernardino County.

- San Bernardino County has formed its approach to both the low income health plan and the preparation for the Affordable Care Act through a collaborative that includes the public hospital, the Transitional Assistance Department, the Department of Behavioral Health, the Department of Public Health, and Aging and Adult Services.
- For more than two years the collaborative has been evaluating opportunities, enrollment, and financial impact.
- Ms. Thomas showed how the county applied the Federal Poverty Level demographics to its low-income health program and its preparation for the Affordable Care Act.
- Ms. Thomas gave figures for low-income populations in the county.
- The county has two plans: IEHP and Molina Health Plan.
- In 2010, the collaborative, the health plans, and supportive agencies developed a low-income health plan which they named ArrowCare. They leveraged 50% of their current funding.
- They built on existing processes and automated systems.

- Public health and behavioral health are under the Human Services umbrella, and the hospital is a standalone entity. They had to broker a unique partnership and trust between the hospital and Human Services, in order to accomplish eligibility sharing and information sharing.
- They feel that they are ready, with partnerships and infrastructure, to have a seamless transition in 2014.
  - 26,000 residents will have access to health care who were previously uninsured.
  - The county has been able to increase its federal revenue.
  - They have been able to build on the C4 consortium system to help streamline the LIHP transition to Medi-Cal.
  - They have created a no-wrong-door approach: eligibility workers have been placed in the various departments.
  - They have a co-located site in the city of Rialto, with a primary care clinic, a public health clinic, a behavioral health clinic, alcohol and drug services, and a crisis walk-in center.
- Ms. Thomas reviewed the objectives and principles of the Affordable Care Act. The county had based ArrowCare on those principles.
- She showed a timeline of the course of the Affordable Care Act and displayed its mandates.
- She listed the individuals who will not be subject to a penalty if they do not enroll. They are the ones the county seeks to impact if it wants to achieve its objectives.
- She showed the system of coverage.
- Because California has chosen to participate in the Medicaid expansion, the question of county option versus state option has arisen. The feasibility of the state option will be looked at first.
- Covered California is a primary health insurance marketplace that will start in 2014. Consumers can apply in local eligibility offices or online.
- Premium subsidy access will be built upon locally with the no-wrong-door policy.
- Ms. Thomas displayed the proposed county option and state option.
- The Administration assumes that there will be savings coming from having more individuals eligible for Medi-Cal. However, there still will be a number of residual uninsured.
- Ms. Thomas explained local realignment funds at the public hospital and the services the funds are used for.
- She showed an overview of mental health realignment for the county.

- A main concern about the public hospital is whether it will continue its competitive position when 2014 arrives and people can choose.

### **Questions and Discussion**

Ms. Collins asked about the shortage of behavioral health professionals to meet the coming needs. Ms. Thomas replied that individuals entering medical school are not tending to choose psychiatry as a specialty. The same goes for nursing students.

Ms. Nickerson mentioned that 46% of psychiatrists in the U.S. are 65+ years old, and that MFTs are not eligible for Medicare and Medicaid payment.

### **3. Report from the California Association of Local Mental Health Boards/Commissions**

Cary Martin, President of CALMHB, stated that many individuals are relatively uninformed about the responsibilities of mental health boards and commissions.

He referred the Planning Council to sections of the California Welfare and Institutions Code (WIC) that he had highlighted. The responsibilities named there are formidable, should we attempt to bring them to reality. Mr. Martin emphasized his dedication to seeing that the mental health boards and commissions across the state are so equipped as to be able to carry out that mandate.

If Boards of Supervisors are not adequately informed about the responsibilities that fall on their shoulders, as is required by WIC, the entirety of our larger community is the worse for it. Mr. Martin made a plea for the Planning Council to help CALMHB meet the goal of educating and informing the boards and commission members. CALMHB needs state support in order to provide the needs of the local boards and commissions to fulfill that mandate from the Legislature.

An educational program called “How Numbers Tell a Human Story” will be presented at the CALMHB meeting that afternoon. Mr. Martin mentioned how much he looked forward to having the MHSOAC Chair there.

Mr. Martin spoke about the heroic efforts of the late State Senator Marks to establish a collaborative venture to eradicate the scourge of mental illness.

Mr. Martin stated that to fund CALMHB/C, counties voluntarily send a yearly contribution of \$300. Carole Marasovic added that this year 34 of the 58 counties have contributed.

Richard Van Horn, MHSOAC Chair, stated that the MHSOAC is working with CALMHB to adjust their contract so that they can participate fully in the program planning process evaluations, and have some help with basic business functions.

### **Questions and Discussion**

Ms. Lewis felt that each of the 58 boards and counties should be able to use WET funding to develop one position to work with the boards and commission. At the MHSOAC state level, there needs to be an administrative liaison with a responsibility for linking all the communication.

Mr. Martin regretted the lack of staff for CALMHB to allow the organization to function effectively.

Adrienne Cedro-Hament agreed that more money needs to be given to the CALMHB Board, and she agreed with Mr. Martin that it is important to have one body at the state level doing that kind of staff work. She stated that not only at the local levels with stakeholders, but also at the state level, we have given the CALMHB Board more work to do. Since there is MHSA money at the MHSOAC, funding the CALMHB Board should be considered.

Ms. Abbott expanded on what Ms. Cedro-Hament said: in the QI Committee and the Health Care Reform Committee it has come up that we see some expectations and roles that could be filled by the local boards. The time is probably right to have a call with the MHSOAC regarding how we are going to support the boards in their new function.

Dr. Bennett ascertained with Chair Van Horn that the MHSOAC is indeed working on a contract for CALMHB.

Ms. Thomas stated that the San Bernardino County of Behavioral Health does provide the local board with support outside of having staff directly assigned.

Ms. Vanderhurst stated that Napa County assigns support staff to its Mental Health Board. As a Planning Council member, she asserted that the strong conversations the Council has had around increased opportunities for collaboration, and the committee structures that have been set aside, make it clear that if we are standing behind supporting increased resources to the CALMHB Board or the local mental health boards, that there are deliverables and work that is carried forward. We have already laid the foundation down to build those collaborations.

#### **4. Report from California Mental Health Directors Association**

Ms. Vanderhurst represented Pat Ryan, Executive Director of the California Mental Health Directors Association (CMHDA). She reported on items that the CMHDA is working on.

Ms. Thomas had earlier explained the Governor's two Affordable Care Act options of state versus county. The difficulties with the county option have led CMHDA to support the state option. Future conversations related to that option will focus around the funding and the difficulties with the state administration thinking that counties should pay the state forward around their anticipated savings from health care reform. Significant negotiation will be taking place, even if the state option is selected.

The CMHDA is also working on the Governor's proposed trailer bill language to reduce the 1991 mental health realignment growth. The previous day, the Senate Budget Committee had voted to reject the proposed bill. It is now sitting in the Budget Subcommittee, not officially dead yet. Ms. Vanderhurst explained the trailer bill.

CMHDA is working with the California Mental Health Services Authority (CalMHSA), the Joint Powers Authority created by the County Mental Health Directors, to address statewide MHSA PEI projects. Those three projects will be winding down at the end of

2014, and CalMHSA is looking at ways it can support the counties as a group in other significant projects. One of those is the use of the state hospitals.

Proposition 30 had provided constitutional protections against future state cost shifts for realigned programs. CMHDA is very invested in making sure those constitutional protections remain, and that any new federal mandates, programs, or expectations are not assigned back to the counties without proper funding.

The Katie A. lawsuit addresses services to foster children. It is a collaborative effort between the Child Welfare Services and mental health programs to identify county implementation readiness by May 15, via a readiness assessment survey and service plan. The counties are concerned about this short timeline.

CMHDA and the counties are still working with the Department of Healthcare Services on transitioning individuals currently covered by Healthy Families into the Medi-Cal system.

CMHDA is working with the state and federal governments on the use of psychotropic medications for foster children. The goals are reducing their use and/or making sure that the dosages and duration of time on the medications are consistent with their treatment goals.

For the month of May, a new Lime Green campaign for mental health awareness is one of the statewide MHSA projects related to eliminating discrimination.

### **Questions and Comments**

Ms. Treadwell commented that the Department of Social Services (DSS) is providing weekly Katie A. technical assistance calls that will be open to all stakeholders beginning Wednesday, April 24. DSS will also be sharing information related to Katie A.

Ms. Vanderhurst made the point that it might be helpful for the Health Care Reform Committee to have Ms. Thomas' PowerPoint presentation, so they could use the Recommendations slide to continue examining issues relating to the counties.

Ms. Cedro-Hament commented that counties are showing improved relations between mental health and substance abuse. She inquired about how many counties have achieved this integration and collaboration. Ms. Vanderhurst responded that about 38 of the 58 counties have combined their mental health and substance abuse services into behavioral health. In all of CMHDA's work, there is a partner component with CADPAAC to present the benefit of this integration to DHCS.

Dr. Bennett cautioned that the establishment of a behavioral health department at the county level does not guarantee an integrated system.

### **5. Report from Mental Health Services Oversight and Accountability Commission**

Chair Richard Van Horn of the MHSOAC reported on several items.

- Recently reappointed MHSOAC members are Dr. David Pating (medical doctor with substance abuse expertise), Tina Wooton (direct consumer), and Bill Brown (sheriff).

- New appointments are LeeAnne Mallel (parent of child) and Dr. Paul Keith (insurer).
- Mr. Van Horn stated that the five-year Workforce Development Plan at the state level is up now for public comment. He encouraged Planning Council members to comment on it.
- Most of the county innovation plans are focused on efforts to integrate mental health, substance abuse, and primary care services.
- As we move toward Affordable Care Act implementation, the issue of mental health/substance abuse federal parity with physical health is going to be on the front burner.
- The MHSOAC has several new evaluation deliverables coming between now and June.
  - An evaluation brief on capital facilities and technological needs: how the money has been spent and what it is producing.
  - An evaluation brief on outreach and engagement: how the funds were utilized and whether they produced the results the MHSOAC was looking for.
  - A report on county-level variation of Full-Service Partnership costs and cost offsets.
  - The final UCLA report and recommendations for all Phase 2 deliverables, including the Full-Service Partnership cost and cost offset evaluation, and the participatory research evaluation.
- The development of the Evaluation Master Plan has been important. AB 1467 required the MHSOAC to collaborate with the DHS, the CMHPC, and the CMHDA to design a comprehensive joint evaluation master plan. Most of the work has happened at the MHSOAC through the Evaluation Committee and the work of consultant Joan Meisel.

The Evaluation Master Plan was adopted at the March meeting. It was presented yesterday to the Senate Budget Subcommittee 3.

- Last year the MHSOAC engaged the services of Jennifer Whitney to be the communications chief. She has engaged the MHSOAC in a variety of efforts, which Mr. Van Horn listed, to provide the public with information about mental health.
- Mr. Van Horn will be meeting with the CALMHB Board later in the day regarding how their operations can be improved and assisted.

### **Questions and Discussion**

Ms. Cedro-Hament thanked Mr. Van Horn for coming and for looking into the CALMHB Board issues. She mentioned the promotional items done by CalMHSA; she had seen appealing magazine-type literature that did not say who really is the target audience. The language needed to be toned down.

Dr. Bennett commented that the Continuous Systems Improvement Committee was meeting with the CALMHB Board that afternoon to discuss the Data Notebook joint project. It was their hope that such tools will be useful for the mental health commissions and advisory boards at the local level, because they are anticipating that the Boards of Supervisors, who now hold the authority to review and pass plans, will look to their boards. Mr. Van Horn stated that the processes that involve stakeholders toward comprehensive planning efforts will be intense.

Ms. Lee asked if Mr. Van Horn thought that Mariel Hemingway's film about her family's struggle with mental health would make it to the big screen. Mr. Van Horn directed her to contact the producers about the interest the film received at the Sundance Film Festival.

Chair Ryan noted that the Executive Committee referred to policy development in the midst of the gap in state leadership. He suggested that the CMHPC and the MHSOAC share a forum on policy deliberations. Mr. Van Horn agreed that it should happen – with the elimination of the Department of Mental Health, there is a huge gap in policy direction. The transfer of almost all authority to the county level means that the local boards are going to be extremely important and have much more responsibility than they have had in the past; there needs to be some serious training of those boards on policy issues.

Chair Ryan added that the Planning Council has written a letter to DHS Director Toby Douglas, requesting to be involved in the screening process for Vanessa Baird's replacement. Historically the Planning Council has had a role in that process.

Mr. Wilson emphasized the need to keep the level of educational materials simple.

## **6. Council Member Open Discussion**

Dr. Bennett said that during the introductions earlier in the morning, she had neglected to identify herself as a family member. She had never been sure what her status was when she had been appointed to the Planning Council: professional or family member. She felt that it was important not to pigeon-hole oneself, but to own as many identifications as one can.

Chair Ryan noted that people get appointed based on one of the four categories, but the reality is that we all have many hats that we wear at the same time.

Ms. Cedro-Hament mentioned a grid from several years ago that showed the categories and ethnicities of the Planning Council members. It would be a good idea to revisit it. Chair Ryan commented that it would bring up a self-disclosure issue.

Ms. Treadwell suggested that a presentation could be made about links and touch points to Social Services, as there have been many changes in terms of what that department has inherited. Children's mental health issues would be part of such a presentation.

Dr. Wilson suggesting holding a celebratory meeting that would recognize the hard work done by the executive team and the committees. There are many accomplishments that have been made for the state of California – Planning Council members are offering

commitment and dedication. Such an evening event could energize the Planning Council after a hard day's work.

Ms. Nickerson agreed; as well as sitting in meetings, the Planning Council can also be friends and interact socially. Our connections shouldn't just be about issues.

Mr. Wilson concurred: there is value in understanding each other socially as well.

Ms. Claflin felt that a social event would be great for the new members. She volunteered to help.

Dr. Wilson clarified for Ms. Thal that she was thinking of a process of doing more than just sitting around a table, rather than just a one-time event.

Ms. Shaw recalled the Conference of Local Mental Health Directors, with yearly meetings structured so that everyone could get together for dinner. It was well worthwhile.

Chair Ryan brought forward the idea of ordering pizza and sodas on Thursday nights.

Ms. Lewis stressed the importance of camaraderie and collaboration. She commended Ms. Wilson for the idea. Also, acknowledging staff for their support is important. She volunteered to help.

Ms. Thal liked the informality of pizza and soft drinks – when the group eats at restaurants with long tables, they can only talk with those next to and across from them.

Ms. Nickerson reminded everyone that at the June meeting, the Advocacy Committee will be organizing the presentations. She asked the Planning Council members if they would like a presentation on Laura's Law, as there is much diversity of thought on that topic.

Ms. Lee commented that the Planning Council had previously voted not to support Laura's Law. Ms. Nickerson responded that it is a law, and a couple of counties are starting to take action, and there are more laws coming into place to support different aspects of it.

Ms. Adcock pointed out that at the last meeting, the Planning Council had discussed having information presented around the issue of Laura's Law. New members would benefit from being informed.

Dr. Bennett requested to have information presented that is based on research and evaluation, that could go along with making an informed decision as to whether or not this is good public policy.

Mr. Grolnic-McClurg mentioned that San Francisco has a look-alike Laura's Law program that the Planning Council could learn about at the next meeting.

Dr. Nelson noted that discussion of Laura's Law will certainly broaden out away from specific arguments for and against involuntary assisted outpatient treatment, and will end up incorporating other contentious areas of concern as well.

Ms. Mitchell stated that only two counties have funded Laura's Law; the Planning Council would have to obtain information from other states that have versions of it.

Dr. Nelson agreed with Dr. Bennett that there is data worthwhile to consider: Nevada County's small study and New York's experience with Kendra's Law.

The Planning Council members discussed topics already lined up for the next meeting, and whether or not to include the topic of Laura's Law. Members agreed that the topic of housing was important.

Chair Ryan held a straw vote. 14 members wanted to have a presentation on Laura's Law at the June meeting, six did not, and three abstained.

## **7. Public Comment**

There was no public comment.

## **8. New Business**

Chair Ryan raised the issue of ensuring that speakers know how much time they have. Dr. Bennett felt that speakers need a clear set of guidelines – to include allotted time for questions and answers, an understanding of the Planning Council, and knowledge of the members' existing background on the subject.

Ms. Cedro-Hament commented that reading the Cultural Competency Guidelines had greatly benefitted the CSI presenter. It works out nicely when the speaker is cued on what the Planning Council would like to hear.

## **9. Meeting Highlights**

Chair Ryan summarized that two main issues had come up during this meeting: concern over changes to the MHSA, particularly in terms of funding and involuntary care; and health care reform, particularly the behavioral health plan issue.

He asked the Planning Council what topics they might want to inform legislators about.

Ms. Mueller commented that she would like to broaden the Planning Council's concerns about workforce. The WET plans are great, but not all of the public schools in the state are impacted by WET.

Dr. Bennett noted that the WET funds are very insignificant in light of health care reform. A large population of people will suddenly have health insurance and the ability to get behavioral health care, but we need a workforce to meet the demand.

Frank Topping, Secretary of the Sacramento County Mental Health Board, made the public comment that Sacramento County has a respite partnership collaborative that is seeking new members. He added that over \$2.4 million in Round 2 grant funding is available.

Ms. Bachand shared the difficulty she had encountered in locating a Medicare provider.

Ms. Collins stated that as an MFT provider excluded from the Medicare loop, she has found it frustrating not to be able to meet the demand from consumers.

Ms. Dickerson noted that the Planning Council needs more and timely access to reports at the state level – for example, from alcohol and drug programs. Reports submitted to the state are not being processed quickly, but they should drive policy decisions.

Dr. Nelson brought up the problem that insurers say that they have full panels and there is no problem finding providers. Yet when you call the providers, they say that they are not accepting that insurance anymore, or their practices are full, and so on. As a provider, Dr. Nelson said that actual reasons may be paperwork or reimbursement. Also, as more and more psychiatrists age out of the field, medical students are choosing not to pursue psychiatry.

John Sturm, Chair of the San Diego Mental Health Board and CALMHB member, stated that San Diego County is combining its mental health board with its drug and alcohol services board. Also, their Board of Supervisors is currently contemplating whether to enact Laura's Law. The discussion has been heated. They came up with a program called In-Home Outreach Team that addresses many of the concerns around people who would qualify under Laura's Law.

Chair Ryan requested copies of any research information San Diego County uses in its deliberations.

Ms. Marasovic, a CALMHB member, stated that Alameda County is again having discussion of Laura's Law because of a murder committed in Berkeley by a person who had mental illness. Chair Ryan requested written documentation they might use.

## **10. ADJOURN**

Chair Ryan adjourned the meeting at 11:50 a.m.