

Alameda County Mental Health Board Minutes
November 13, 2006 ♦ 12:00pm-2:00pm
Lakeside Plaza Building, 1401 Lakeside Dr. Room 1107
Oakland, CA 94612

Meeting called to order @ 12:00pm by Chairperson Marsha McInnis

HOUSEKEEPING

Roll Call / Introduction of Guests

Mental Health Board Members:

Present: Deborrah Bremond, Karen Bridges, Rochelle Elias, Marsha McInnis, Sup. Gail Steele, Anthony Hare and Dr. Ron Tauber

Absent: Hal Zawacki

BHCS Staff: Agnes Catolos, Barbara Majak, Carolyn Novosel, Gary Spicer and Marye Thomas, M.D.

Public: Linda Smith (BMHC), Michael Diehl (BMHC), Lorenzo Kearney (Howie Harp Center), Pamela Barnes

ITEM	DISCUSSION	ACTION
<u>Approval of September 2006 MHB minutes</u>	No correction was made to the September 2006 MHB minutes.	Approval of Sept. 2006 minutes... M/S/C Ms. Bridges/ Sup. Steele All favor
<u>Correspondence</u>	Letter from Carol Patterson, C*AT (Choice, Advocacy and Transformation or Consumers at the Table)	MHB Supports this letter.
<u>Chair Report</u>	To allow more time for public comment, Marsha McInnis didn't not present a Chair Report.	

<i>ITEM</i>	<i>DISCUSSION</i>	<i>ACTION</i>
<p><u>Presentation</u> <i>Status Update on Medicare Part “D”</i></p>	<p><i>Douglas Del Paggio, PharmD, MPA</i></p> <p><i>Medicare Part “D” will continue to change year after year. The Office of the Medical Director is putting together handouts that will hopefully navigate the latter part of this year into next year. The main key year and every year is the timeline. Everything can be renegotiated. There will be new plans, plans coming and going, co-pays will change, and the cost will change. So the timeline for 2006 really will be for every year there after, so it seems the latter of each year will be up for change. That is what we came aware of from the mailings from Center of Medicaid Services (CMS). There is a little more detail on pages 3-4 of the Beneficiary Communications & Enrollment Timeline handout). What happens at least ideally from the CMS is no page 5 of the handout.</i></p> <p><i>It is imperative for people to understand too a lot of dual eligibles qualify for extra help for low income subsidy to pay for their premiums. Every year that will be reassessed for clients so some people may fall off the roles and were not Medicare or MediCal eligible for a certain month may fall off the roles. If you remember this is one of the biggest problems last year that still continues. If information doesn’t flow in time there are delays for several months. A lot of mistakes had happened that information isn’t flowing correctly. We probably should prepare ourselves for the same thing to happen in early 2007.</i></p> <p><i>On page 9, of the handout, there is a memo that refers to co-pays. in 2006 all of our dual eligible’s had co-pays for the prescriptions that ranged from \$1-\$3 or \$2-\$5, like everything else Medicare Part “D” cost will change every year as cost continue to rise. So what happens is that \$3 co-pay will become \$3.10, \$2 will become \$2.15, and \$5 will become \$5.35. This surprised me, as I didn’t expect the co-pay would change year after year. On page 10 of the handout the annual deductible is detailed. The co-sharing that people have to pay that are not eligible for low income subsidy, which will also rise each year. The total of out of pocket for year 2007 will be \$3,850. Last year, 2006, it was \$3,600. So it’s going to rise by \$250. So we’ll see that pattern continue year after year.</i></p> <p><i>There is good news on page 11 of the handout. Formularies must now include all or substantially all drugs in the antidepressant and antipsychotic classes. Which means that plans will be required to cover the majority of all those medications that really are an advantage for our clients? Clients don’t have to worry about plans not covering the medications at all.</i></p> <p><i>There are 208 plans in California this year up from 196 last year. So we didn’t have a real reduction in the number of plans. There are a couple of new plans this year. That is part of the reason there is a lot of confusion about Medicare Part “D” bills. There are so many formularies and so many different rules thus no standardization in plans. They have their own procedures, their own authorizations, and their own form. Now we have ten</i></p>	

ITEM	DISCUSSION	ACTION
	<p><i>benchmark plans in 2006; on page 13, of the handout, the chart shows that only five of the plans will continue in 2007. The first column show the plans that will continue to be offered in 2007; next the plans that were offered in 2006 that will continue in 2007 (clients that are already enrolled in these plans can continue in their plan. Next columns shows that Sierra will not be a benchmark plan for 2007. Clients in the Sierra plan will be allowed to stay in the plan, but no one new will be allowed.</i></p> <p><i>Two plans costs have increased 1) AARP where our majority of clients are enrolled; 2) Health Net. These plans will not be benchmarked plans next year so that means clients will be enrolled in different plans. Two plans are gone 1)PacifiCare; 2) United Health.</i></p> <p><i>Page 15, of the handout, lists the five new plans for 2007. The way plans become benchmark plans is to keep the premium below \$21.03 that CMS has decided the premium cost fee on average. If you're below that it'll become a benchmark plan. So we have a number of new plans on page 17, of the handout. What the implications are because we are losing a number of plans.</i></p> <p><i>We're going to have clients that are reassigned into new plans. Page 19, of the handout, speaks to why people being reassigned. Because of the smart plan will no longer exist and client will transition to a new plan now like last year when people switch plans we had some problems. Some people were enrolled in two plans. Most people were identified as being eligible so they have very large payments or full cost for medication. So we should prepare ourselves for that again beginning January 1,2007. They be notifications sent out supposedly during this timeframe. There is a copy of the notification on page 21, of the handout. So if clients receive mailing from CMS on blue paper that means they'll be in a new plan. As I mentioned a large percentage of our clients in California (almost 300,00) are dual eligible need to be reassigned to new plans.</i></p> <p><i>On page 23, of the handout, there are contact phone numbers for the benchmark plans. Something to remember is even though plans are retained their formularies can change as well as their procedures and requirements. Even though your medications are covered right now, doesn't mean they are covered in 2007. Plans must mail out to their subscribers any plan changes for 2007. These should have occurred in October.</i></p> <p><i>Last year a lot of people were not grandfathered in, in other words they were on medication for many years. January 1, 2006 came and they went to a pharmacist and were told the medication is no longer covered. So the State stepped in and covered the medications and tried to work out all the snafus. CMS sent a memo to all plans saying that there has to be a transition policy that all clients after January 1st even if the medication is not covered in the formularies for 30 day supply. This should help prevent what happened last year. But as I mentioned, there are 208 different programs 55-56 of that PDP which ten of them are benchmark plans. Each plan will have different procedures and different</i></p>	

ITEM	DISCUSSION	ACTION
<p>Update on MHSA- Prevention and Early Intervention</p>	<p><i>billing techniques for the pharmacies.</i></p> <p><i>Complaints should be sent to CMS Region 9. I've got to say that Region 9 office has been very receptive to a lot of feedback and problems that are encountered in Alameda County. I worked with them very closely to alert them we are having problems up to the second and third quarter of this year. The Region 9 office works very diligently to gather information and try to push for change throughout CMS as well as respond and try to clear some of problems.</i></p> <p><i>I finished up last week a comparison of our plans for 2007. If you remember this form last year it's a comparison I did of the formularies of our top medications. This information will be on the web site shortly.</i></p> <p><i>Gary Spicer presented an update on MHSA – Prevention and Early Intervention</i></p> <p><i>Prevention and Early Intervention represents about 20% of the MHSA funding, Alameda County then would receive about \$4,500,000 if the funding was a county by county distribution. What makes Prevention and Early Intervention a little different is the fact that we expect there will be a higher level of statewide program dollar amount where greater amount of the funding will be used directly by the State. Another important area is regional prevention activities. An example is within Prevention and Early Intervention by common definition we are including suicide prevention and stigma reduction. When you talk about suicide prevention and stigma reduction you are talking about programs that can be rolled out in larger than county levels. There is some reason to expect that there will be some statewide or regional program funding out of Prevention and Early Intervention funding . County level planning will account for a lower level of MHSA funding.</i></p> <p><i>The other significant areas around Prevention and Early Intervention has to do with non-traditional service delivery models. A good example in our county that emerged from MHSA planning is using Prevention and Early Intervention funding for services in minority communities or communities not normally well served.</i></p> <p><i>The other major dilemma that has occurred is that there are recommendations that a prevention subcommittee would make to the Oversight Accountability Commission. The Oversight Accountability Commission has approval authority for Prevention and Early Intervention. The subcommittee forwarded recommendations that stress spending across all of these groups. Also recommended supporting County level autonomy in spending and planning and also supported an emphasis on children and dependents. We are going to face one of those great difficulties when it comes to planning and if the only difference is if</i></p>	

ITEM	DISCUSSION	ACTION
5150 Issues	<p><i>where are emphasizing or not emphasizing something we're not quite sure how we will measure that how we will know we are emphasizing children. So that is the recommendation.</i></p> <p><i>The remaining issues:</i></p> <ul style="list-style-type: none"> - <i>Timeline – Rollout of funding</i> - <i>Guidelines</i> - <i>Funding distribution</i> <p><i>Anthony Hare gave a presentation of the 5150 issues.</i></p> <p><i>BHCS and MHB worked together and form an ad-hoc committee.</i></p> <p><i>Sasaul Creek remains at half capacity.</i></p> <p><i>Early intervention does not appear to have an impact.</i></p> <p><i>There were 700-800 5150's a month referred to John George Pavilion in 2006.</i></p> <p><i>This is important to keep the issue on the horizon and will remain a discussion item on the Adult Committee agenda.</i></p> <p><i>Barbara Majak wanted to remind the Board that one of the pieces of the MHSA is a mental health staff in court room settings and all the Full Service Partnerships (FSP) will have a responsibility to work with clients that are assigned to those FSP to avoid incarceration to avoid hospitalization as well as the MIOCRA grant that which did get submitted last week for Alameda County.</i></p> <p><i>Dr. Thomas added that while it is difficult to tease out anyone thing is able to impact 5150 involuntary treatment etc. its certainly is one of the goals of the MHSA. In the overall scheme things to allow for much more voluntary treatment to focus more on wellness and recovery and so these will be things that we will be tracking in that overall context. Because I fully believe that all of those efforts together should have an impact on reducing 5150 usage.</i></p> <p><i>Karen Bridges committed having worked in the courts for years, probably the best direction</i></p>	

ITEM	DISCUSSION	ACTION
	<p><i>is to go to certain judges that have actually served on the MHB for at least one year. Those particular judges get known and have a sensitivity and are knowledgeable about this rather than working court staff. Dr. Thomas responded: We would love to, in fact we would love to have dedicated, we did for years we did have someone that was dedicate to the Mental Health Court (it wasn't a Mental Health Court), but that is what Judge Jackie Taber did. She became to be a real expert in the law, the clients coming through the interventions that could be made .in the community etc. We face the same sort of thing, we would like to have dedicated court calendars for example our Prop. 36. Because, as you so accurately pointed out Karen, when you have a judge that has an interest and real passion for the people they're serving and the particular problems the outcomes are generally a lot better both for society and the individual client. What happens, and this is really unfortunate, often they rotate judges. The courts rotate judges unless they chose to stay in one particular place, and it is really sad but mental health, alcohol and drugs, and the juvenile justice system are seen as things you have to do and not assignments that you want to do. Especially if you have aspirations in the courts, because these assignments are seen as career killers. That's really sad and it really speaks to the stigma etc. that associated with the people that we serve. So when we find a judge that who is really interested we try to really work with them and assist them in any way we can and we keep hoping lightning will strike and we get another Jackie Taber or somebody who is willing to stick with it for a period of time. Because it does make a difference.</i></p>	
<p><u>Discussion Items</u> <i>Orientation Manual</i></p> <p><i>MHB Membership Update</i></p>	<p><i>Tabled until the January meeting.</i></p> <p><i>Ron Tauber sent a letter to all Mental Health providers seeking nominations for membership in October with no response. The question came up should this letter be sent to Alcohol and Other Drug providers. It was decided that Ron will send a letter to the AOD providers.</i></p> <p><i>Three people has expressed interest in membership. One prospective candidate was present at the meeting.</i></p> <p><i>A procedure needs to be developed of how to communicate with the Board of Supervisors. A report will be brought forward at the December 11, 2006 meeting.</i></p>	

ITEM	DISCUSSION	ACTION
<i>Mental Health Board December Meeting</i>	<i>It was decided that there would be a regular meeting on December 11, 2006.</i>	
<u>Action Items</u>	<i>None</i>	
<u>Director's Report</u>	<i>To allow more time for public comment, Dr .Thomas didn't not present a Director's Report.</i>	
<u>Committee Chair Reports</u> <i>Adult Committee Report</i>	<i>No report given.</i>	
<i>Awards Committee Report</i>	<i>No report given.</i>	
<i>Children's Advisory Committee (CAC) Report</i>	<i>Had scheduled a presentation on Team Decision Making, unfortunately the presenter could not attend the meeting. There was a discussion regarding Adolescent Crisis Recovery Center and the Juvenile Center redesign.</i>	
<i>Housing Committee Report</i>	<i>No report given.</i>	
<i>Public Awareness Committee (PAC) Report</i>	<i>Ms. Elias stated that she had met with Maxine Heiliger regarding an Anti-Stigma Conference possibly in May 2007.</i>	
<u>Liaison Committee Report</u> <i>Criminal Justice Oversight Committee</i>	<i>No report given.</i>	
<u>Public Comments</u>	<p><i>Michael Diehl – Berkeley Mental Health will hold a public hearing . There are a lot of people that don't know that Sasaul Creek exists. Berkeley Mental Health is working with Bonita House in regards to 5150's. Dr. Thomas wants suggestions on how to publicize Sasaul Creek. Voluntary inpatient is available at Gladman.</i></p> <p><i>Pamela Barnes – She is experiencing difficulty in receiving mental health services. Dr. Thomas and Barbara Majak requested that she meet with them after the meeting to discuss her concerns so they could address them. She was also offered support from Howie Harp Center and Berkeley Mental Health. Expressed difficulty in finding information about today's MHB Meeting.</i></p> <p><i>Lorenzo Kearny – discussed 5150 treatment.</i></p>	

<i>ITEM</i>	<i>DISCUSSION</i>	<i>ACTION</i>
<u>Board Comments</u>	<i>None</i>	

*Meeting was adjourned @ 2:15PM
Minutes submitted by Agnes F. Catolos*