

Alameda County Mental Health Board Minutes
February 9, 2009 ♦ 12:00pm-2:00pm
First 5 Office Suite 130
1100 San Leandro Boulevard
San Leandro, CA 94578

Meeting called to order @ 12:10 by Chair Rochelle Elias

HOUSEKEEPING

Roll Call / Introduction of Guests

Mental Health Board Members:

Present: Pat Buchanan, Kelly Dulka, Rochelle Elias, Alane Friedrich, Lisa Gifford, Luvenia Jones, Dorothy King, Sheldon Koiles, Laura Mason, Maxine Oliver-Benson, Dr. Stephen Post, Ravi Sodhi and Sup. Gail Steele

BHCS Staff: Barry Hall, Barbara Majak, Carolyn Novosel, Marye Thomas, MD and Rosa Warder

Public: Lorenzo Kearney (HHMSC), Joseph Carter (HHMSC), Abdul Olorede (HHMSC), Hillary Dias, Darnell Levingston, Paulette Hogan, Troy Banner and Patricia Sweetwine

ITEM	DISCUSSION	ACTION
<u>Approval January 2009 MHB Minutes</u>	Ms. Friedrich made a correction to the January 2009 minutes...she stated that the draft of the End of Life Adhoc Committee mission statement should be included in the January minutes.	Approval of Jan. 2009 MHB Minutes M/S/C Ms. Friedrich/ Ms. Oliver-Benson All Favored
<u>Correspondence:</u>	<ul style="list-style-type: none"> • Ms. Elias related that she had a conversation with 2 Psychologists from San Leandro USD concerning funding issues and added that she made some recommendations and forwarded info to Mr. Spicer. • Mr. Hall provided info re: mileage reimbursement and stipend for board members. 	
<u>Action Items:</u> A. Creation of Consumer/ Family Advocacy Ad-hoc Committee	Mr. Koiles distributed the mission statement for Consumer/Family Advocacy Ad-hoc Committee which was described as follows: The Consumer/Family Committee is comprise of mental health consumers and family members who will bring consumer voice and policy decisions to improve quality services to consumers with family members requiring a humane, respectful and dignified approach in particular the committee will move to destigmatize mental illness and to accomplish social inclusion to obtain proper treatment or medication, desirable independent housing, meaningful appointment and to	

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<p><i>Creation of Consumer/Family...(Cont.)</i></p>	<p><i>have the overall acceptance of the greater community. The group’s effort is supported by the ACMHB and by their own consumer committees employing resources from within and beyond the MHB.</i></p> <p><i>Ms. Jones stated that as a board member, she would like to make a difference and be able to find where she fits.</i></p> <p><i>Ms. Friedrich addressed that part of what the Consumer/Family Advocacy Ad-hoc Committee wants to do is also the mission of the PAC and she felt the need to be sensitive to the role of other committees that are already in existence and not duplicate the effort of the board.</i></p> <p><i>Mr. Koiles stated that their mission statement is from the consumer perspective which is unique to the consumer and family members and that the last phrase “resources beyond the MHB” what they want to do is to bring community resources to be able to collaborate with other communities and still bring the consumer and family members perspective.</i></p> <p><i>Ms. King stated that they would like to include various consumers and family members in this committee. She expressed that as a family member she would like to be part of a committee that she could be an advocate.</i></p> <p><i>Ms. Dashiell stated that she would like to see a little bit more information on what the family members role in this committee and to understand its goal.</i></p> <p><i>Mr. Koiles would like a clarification on why it has to be an ad-hoc committee rather than an official committee.</i></p> <p><i>Ms. Friedrich clarified that when the MHB is establishing an official board committee the bylaws has to be changed and any changes in the bylaws has to go to the Board of Supervisors (BOS) for approval if the board wants to start a committee immediately and start some actions on it an ad-hoc committee will be established.</i></p> <p><i>Sup. Steele felt that the goals of the consumer/family group to get better treatment and to have people understand what the needs are seems similar to what the PAC is doing.</i></p> <p><i>Sup. Steele suggested that the PAC and consumer/family group get together for a meeting and have a discussion to see whether they can work on something together because she felt that both groups are basically on the same purpose.</i></p>	<p><i>Ms. Elias established the creation of Consumer/Family Members Ad-hoc Committee</i></p>

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<i>B. Approval of End of Life Issues Ad-hoc Committee</i>	<i>Ms. Friedrich distributed the End of Life Committee Mission Statement (please see attachment) and she mentioned that the End of Life Committee process will be similar to the Front Door Project.</i>	<i>The End of Life Issues Ad-hoc Committee was approved.</i>
Presentation: <i>Budget Presentation</i>	<p><i>Dr. Thomas presented a Powerpoint Presentation on Budget Basics FY 08/09-09/10 that consisted the following info:</i></p> <ul style="list-style-type: none"> <i>• BHCS Mission Statement</i> <i>• Funding Dictates Service Mandates and System Capacity-Mental Health (MH) system was never conceived as an entitlement and services were to be provided to the extent resources that are available.</i> <i>• Origins of the Community MH System- began in CA with the Short-Doyle Act which was intended to shift people and funding away from the state hospitals and to build community MH system.</i> <ul style="list-style-type: none"> <i>◦ In 1972 and 1973 the Governor vetoed some of the Short-Doyle Act i.e. the community MH system only got treatment resources and did not get access to other resources like housing, recreation, vocational etc.</i> <i>• Major Funding Sources for MH Services:</i> <ul style="list-style-type: none"> <i>◦ Realignment-in 1991, AB1288 (the Bronzan and McCorquodale MH Act) replaced the Short/Doyle Act; it's a funding source which was a ½ ¢ in state sales tax and vehicle license fees. The realignment did the following:</i> <ul style="list-style-type: none"> <i>▫ It clearly defined and specified the target population-1) people with serious persistent mental illness 2) children with serious emotional disturbances.</i> <i>▫ It specified the range of services and programs e.g. psychiatric crisis or emergency treatment, inpatient treatment, etc.</i> <p><i>MH Programs that were realigned from the state to counties were:</i></p> <ul style="list-style-type: none"> <i>▫ All community based MH services</i> <i>▫ State hospital services for civil commitment</i> <i>▫ "Institutions for Mental Disease (IMD)" which provided long-term nursing facility care.</i> <p><i>Benefits of Realignment in Alameda County:</i></p> <ul style="list-style-type: none"> <i>▫ It completely eliminated state hospitalization of children and adolescents- opened STARS Sub-acute which became Willow Rock</i> <i>▫ Brought home more than 400 clients placed in out of county IMD/Skilled Nursing Facilities</i> <i>▫ Reduced state hospital utilization form 164 beds to 17 beds for adults-opened Gladman, Morton Baker; instituted ACCESS Program; developed 800# and Service Teams</i> 	

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<p><i>Budget Presentation (Cont.)</i></p>	<p><i>Challenges and Shortcomings of Realignment:</i></p> <ul style="list-style-type: none"> ▫ <i>Pressure was exerted to expand Realignment beyond MH</i> ▫ <i>Public health programs and some social services e.g. In-Home Supportive Services and Foster Care were added to Realignment formula</i> <ul style="list-style-type: none"> - <i>these sub-accounts are caseload driven and MH is not</i> - <i>allowed transfer of funds annually to other sub-accounts</i> ▫ <i>This structural inequity has not allowed Realignment to keep pace with MH needs.</i> <p>◦ <i>MediCal (state level) and MediCaid (federal level)- is the 2nd largest revenue source for MH</i></p> <ul style="list-style-type: none"> ▫ <i>in 1971, counties agreed to take on responsibility for managing MH services that the federal govt. requires the state to provide.</i> ▫ <i>also gave counties the opportunity to draw down federal funds and to serve more people.</i> ▫ <i>In 1993, A Medicaid State Plan Amendment added more services under the federal Medicaid Rehab Option e.g.: Psychiatric Health Facility; Adult Residential Treatment; Crisis Residential; Intensive Day Treatment, etc.</i> ▫ <i>In 1995 through 1998, the private MH “fee for service” MediCal System was consolidated with the public Short/Doyle MH MediCal System into Specialty MH managed care program.</i> <p><i>Benefits of MediCal Consolidation:</i></p> <ul style="list-style-type: none"> ▫ <i>Single system of services</i> ▫ <i>Local responsibility</i> ▫ <i>Easier access to services by MediCal beneficiaries</i> ▫ <i>Large Diverse provider network</i> <ul style="list-style-type: none"> -<i>Alameda County contracts with 600+ individual and group practitioner in AC MediCal provider network and 12 private inpatient hospitals</i> ▫ <i>Greater collaboration between private MH practitioners and public MH</i> <p><i>Challenges and Shortcomings of MediCal Consolidation e.g:</i></p> <ul style="list-style-type: none"> ▫ <i>Split responsibility leads to confusion: Dept. of Health Services rather than DMH is responsible for general (non-specialty) MH care needs and Pharmaceutical benefits not carved out.</i> ▫ <i>Counties have not received COLAs for the MediCal Program since 2000</i> ▫ <i>In FY 03-04 state budget, the MediCal allocation to counties was reduced by 5%</i> 	

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<p><i>Budget Presentation (Cont.)</i></p>	<ul style="list-style-type: none"> ◦ <i>EPSDT Funding- resulted from a settlement of lawsuit against the state in 1995...</i> <ul style="list-style-type: none"> ▫ <i>Expanded MediCal services to: beneficiaries less than 21 years of age; needing specialty MH services to correct or ameliorate mental illnesses and whether or not such services are covered under the Medicaid State Plan</i> ▫ <i>State agreed to provide State General Fund to counties as the match for expanded specialty MH services</i> ▫ <i>DMH developed an interagency agreement with DHS through which county MH plans were reimbursed the entire non-federal share of cost for all EPSDT eligible services during FY 1994-95</i> <i>Benefits of EPSDT:</i> <ul style="list-style-type: none"> ▫ <i>Strategically expanded infant, child and youth behavioral health services</i> ▫ <i>Funded 63 new programs in the following priority areas: 0-5 programs; Co-occurring Disorders; Foster Care Programs; Probation Programs; School Programs and Transition Age Youth</i> ▫ <i>5,311 additional children are being served (increased from 4,386-9,697)</i> ▫ <i>Increased services from 130,000 visits annually to almost 350,000 per year</i> <i>Challenges and Shortcomings of EPSDT:</i> <ul style="list-style-type: none"> ▫ <i>Cost-shift to counties.</i> ▫ <i>Extremely stringent audit requirements.</i> ▫ <i>Delay in payments to counties spanning multiple years resulting in cash flow problems.</i> ◦ <i>AB3632: MH services to special education pupils.</i> <ul style="list-style-type: none"> -<i>it entitles all children with disabilities to a free, appropriate public education. Entitlement includes MH treatment for children and adolescents who are less than 21 years of ages; have an emotional disturbance and are in need of MH services to benefits from a free and appropriate public education.</i> -<i>it is a federal entitlement and must be provided irrespective of parents' income level or availability of funds.</i> <i>Challenges and Shortcomings of AB3632:</i> <ul style="list-style-type: none"> ▫ <i>Services were never adequately funded (counties were forced to sue the state through SB 90 local mandate reimbursement process</i> ▫ <i>The state budget (in prior years) placed a moratorium on mandate reimbursements for local government</i> ▫ <i>The state currently owes counties approx. \$345 mil in mandate reimbursement</i> 	

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<p><i>Budget Presentation (Cont.)</i></p>	<p><i>for this program. (Alameda County is owed approx. \$18 mil.)</i></p> <ul style="list-style-type: none"> ◦ <i>MHSA (Prop 63)-voters approved initiative passed in Nov. 2004</i> <ul style="list-style-type: none"> ▫ <i>Imposes a 1% income tax on personal income in excess of \$1 mil to fund new MH services</i> ▫ <i>Requires a spending plan developed according to state guidelines including consumers, family and other local stakeholder input and involvement</i> ▫ <i>Plans require state approval (DMH and MHSA Oversight and Accountability Commission)</i> ▫ <i>Each plan is a 3-year plan that must be updates annually and each update must be submitted to the state for review.</i> <i>Benefits of MHSA e.g</i> <ul style="list-style-type: none"> ▫ <i>Significant new funding source</i> ▫ <i>Intended to be an addition to existing funding not to replace (very strong language against supplantation by the state or local authorities)</i> ▫ <i>Funds 5 essential local components: 1) Community Services and Supports 2) Prevention and Early Intervention 3) Workforce Education and Training 4) Capital and Technology 5) Innovation</i> ▫ <i>Alameda County was able to develop over 20 new programs and initiatives to improve how individuals with serious mental illness are treated.</i> ▫ <i>Funds to create and secure more affordable housing for mental health consumers.</i> <i>Challenges and Shortcomings of MHSA e.g:</i> <ul style="list-style-type: none"> ▫ <i>Fragmented roll-out from the state</i> ▫ <i>Stringent regulations re: types of services, percentage of allocation, etc</i> ▫ <i>Very labor and resource intensive process</i> ▫ <i>Funding source dependent on economic fluctuations</i> ▫ <i>2 year delay between collections and allocations out to counties</i> ▫ <i>Governor is proposing (via April ballot initiative) to change drastically the MHSA prohibition against supplantation. He wants to be able to back-fill, replace and supplant lost funding with MHSA funds and also proposing to cut state general fund support for MH managed care.</i> ◦ <i>County General Funds:</i> <ul style="list-style-type: none"> ▫ <i>Counties are required to provide general fund dollars as a match in order to receive certain state and federal funds.</i> ▫ <i>Promotes local investment/ownership for programs.</i> 	

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<p><i>Budget Presentation (Cont.)</i></p>	<ul style="list-style-type: none"> ▫ <i>CAO’s office defined “match” for state and federal dollars as discretionary</i> ▫ <i>Alameda County is one of very few remaining counties providing “excess county contribution” to BHCS.</i> <i>Benefits of County General Funds e.g.:</i> <ul style="list-style-type: none"> ▫ <i>Deliver services that the county is mandated and obligated to provide such as: MH and substance abuse services to adult inmates in the county jails and juvenile offenders in Juvenile Hall etc.</i> ▫ <i>Deliver MH and substance abuse services for other county departments designated as local priorities by the Board of Supervisors e.g. Children in group homes and out of home placements, vocational training, etc.</i> ▫ <i>Serve clients who need intervention in life threatening crises but ineligible for services through the DMH mandated target population definitions.</i> <i>Challenges and Shortcomings of Additional County General Funds</i> <ul style="list-style-type: none"> ▫ <i>Are considered discretionary though services being funded are not.</i> ▫ <i>Continuation of services and distribution of the county general funds is at the discretion of the BOS and is determined through the annual budget.</i> ▫ <i>Subject to being cut in tough fiscal times.</i> ◦ <i>Measure A-local voter approved ½ cent sales tax for health care services: 75% for Alameda County Medical Center and 25% for other health services.</i> <i>Benefits of Measure A: BHCS allocated-\$2 mil for Detox and Sobering Services and \$2.5 mil for CBO maintenance of effort.</i> <i>Challenges and Shortcomings of Measure A:</i> <ul style="list-style-type: none"> ▫ <i>Decreasing revenues due to economic down turn</i> ▫ <i>Subject to reallocation every 3 years</i> ◦ <i>Tobacco Master Settlement Funds: BHCS receives approx. \$2 mil to provide the newly mandated 10% EPSDT match and this funding leverage more than \$30 mil in MediCal/EPSDT funding for expanded services to children.</i> <i>Challenges and Shortcomings of Tobacco Master Settlement Funds: Decrease in revenues and subject to reallocation.</i> 	

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<p><i>Budget Presentation (Cont.)</i></p>	<ul style="list-style-type: none"> • <i>Summary of BHCS Budget: BHCS is part of Health Care Services Agency (HCSA) and its total budget is \$552.25 mil; BHCS is 53% of the HCSA budget; BHCS generates 56% of revenues that come into HCSA; 86% of BHCS budget is supported by revenue; BHCS gets 39% of county general fund which represents about 13% of BHCS overall budget. BHCS is consist of 529 FTEs-county positions only and 2880 System of Care FTEs not including 541 individual and group practitioners in Medi-Cal Provider Network or the 12 non-ACMC inpatient hospital</i> <p><i>BHCS spending by age group: Adult Services-58.5% of budget; Older Adults-3.5%; Children’s Services-38.3% and TAY Services-1.7%</i></p> <p><i>Historical Threats to System Stability e.g.:</i></p> <ul style="list-style-type: none"> ◦ <i>MH services not considered an entitlement</i> ◦ <i>Funding for MH services not caseload driven</i> ◦ <i>History of cost shifting from state to counties</i> <ul style="list-style-type: none"> -<i>MediCal-e.g. Administrative fund held by state never give to counties; growing population</i> -<i>EPSDT-Match requirement imposed “after the fact”</i> ◦ <i>Threats to System Stability: Other Funding Challenges...</i> <ul style="list-style-type: none"> -<i>Realignment Revenue-e.g. HCSA projected a \$17 mil shortfall of Realignment revenue I FY 08-09</i> -<i>MHSA-e.g. Governor’s proposed use of funds to supplant MediCal Managed Care funding; Decrease in funds due to the economic crisis, etc.</i> -<i>State General Fund (SGF) for Alcohol and Drug Services- The Governor proposes:</i> <ul style="list-style-type: none"> ◦ <i>Eliminating SGF for existing alcohol and drug services (BHCS would lose approx \$8-9 mil in SGF and Prop 36 funding)</i> ◦ <i>Increase in the alcohol excise tax 5¢ per drink to back fill SGF cuts</i> -<i>County General Fund e.g. Anything about required match is considered discretionary and are subject to being cut in tough fiscal times</i> -<i>Cash flow: e.g. The state announced deferring payments owed to counties starting in Feb. through possibly Sept.; an analysis is being done to determine whether the county has reserves to fund cash flow problem.</i> 	
<p><u>Discussion Items:</u></p>	<p><i>Discussion item was deferred due to time constraint. Ms. Elias stated that what she would like to do is to set up a meeting time to talk about creating board goals and directions and related that Mr. Hall will be emailing and calling everyone to set a meeting that will take place out of the board session probably schedule it on a Saturday and prior to the meeting the board needs to look for someone who can facilitate the meeting.</i></p>	

ITEM	DISCUSSION	ACTION
<u>Director's Report</u>	<i>Covered under the presentation.</i>	
<u>MHB Chair Report</u>	<i>Ms. Elias announced that the board needs to start planning the MHB Community Service Awards banquet in May and asked for volunteers to be part of the selection committee, 1st meeting is scheduled on Tuesday, Feb. 17th from 1pm-3pm.</i>	
<u>Committee Chair Report</u> <i>Adult Committee</i>	<i>Ms. Friedrich stated that the Adult Committee had a presentation from Hospice Care last month and mentioned that the February meeting is rescheduled to the 4th Monday, 2/23rd due to County Holiday and it will be held at Fairmont Hospital Cafeteria and they will do a site visit to Cherry Hill and Safe House.</i>	
<i>Children's Advisory Committee (CAC)</i>	<i>Ms. Novosel stated that at the CAC previous meeting they've done the school base behavioral health care coalition and they've talked about where the committee have been and where they are going; they've identified 4 goals in relationship to school based behavioral health care which includes: Our Kids, school based mental health services and student health clinic.</i>	
<i>Public Awareness Committee (PAC)</i>	<i>Ms. Elias stated that the PAC is moving forward trying to get a story on print media involving the Pool of Champions.</i>	
<u>Public Comments</u>	<i>Ms. Hogan addressed her concern about services for HIV/Aids in mental health and other personal hardship she has experienced.</i> <i>Mr. Levingston addressed the lack of African-American male in the mental health field i.e. no African-American doctors.</i>	
<u>Board Comments</u>	<i>None.</i>	

*Meeting was adjourned @ 2:20PM
Minutes submitted by Agnes F. Catolos*