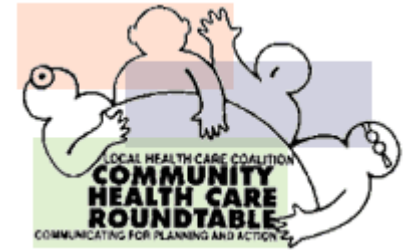




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## **NOTES OF COMMUNITY HEALTH CARE ROUNDTABLE**

Thursday, May 19, 2005

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### **What's Happening in Leadership Changes in Fresno County's Department of Behavioral Health and Community Health Department**

#### **Giang Nguyen, Interim Director, Fresno County Behavioral Health**

I'm the new interim director for the Fresno County Department of Behavioral Health. Last month I was standing right here being introduced as the interim director for the Department of Community Health and yet today I'm saying I'm the interim director for the Department of Behavioral Health. What happened to me was that within 36 days of my appointment as the interim director for the Department of Community Health I received another calling to come over to the Department of Behavioral Health and be a part of the team there. I just want to give you a little introduction of myself so you know how the appointment really came about.

#### ***Giang Nguyen has a long history with various county departments***

I started working for Fresno County Department of Mental Health back in the late 1980s. I started there as extra help staff as a student nurse. I was attending the Fresno State Nursing Program and I got my license as an R.N. and moved up to become charge nurse, then head nurse, and then director of nursing for the acute psychiatric unit. A few years later I helped develop the psychiatric health facility in the county, the 16-bed facility that we have right now, and a few

years later I became division manager for the Intensive Services Division. Two or three years later I wanted to expand my knowledge and practice and experience in another area of the healthcare field, so I applied for the division manager position of California Children's Services Division at the Department of Community Health. Brad Maggy and Mr. Gary Corosa accepted my request to transfer over, so I came over there and worked there as a division manager for less than two years. After that I was encouraged to apply for the assistant director position for the Department of Community Health, and I was lucky enough to receive that assignment as well. Mr. Brad Maggy retired from the county, and I was called to become the interim director for that department. A few weeks later Mr. Jerry Wengerd, who was the director of the Department of Behavioral Health in the system, also retired, and so the board and the CAO office with support from a lot of folks in the community helped the county to decide who would be the person to help the Department of Behavioral Health as an interim director. I received a phone call from the CAO office two Fridays ago around 4:30 p.m. and I said yes to the appointment.

***Ms. Nguyen is very dedicated to serving wherever the county needs her***

Let me tell you why I said yes. As a Fresno County employee I feel that wherever the county wants me, needs me to help, I will go there. Also, I really feel that this Department of Behavioral Health has done so much for me over the years. As you know, I've grown up in that place, so I feel that it's time for me to come back and help out. I know I'm facing a very challenging task. As you know, the budget is not at it's best position right now for this department, and I know that I will need a lot of help from every single one of you and of my staff as well. I am very committed and I'm very devoted to support this department. The goal for me is to help lead staff and work in collaboration with every single one of you in the community to move forward and to come out of these budget problems next year. I'm hoping in the fiscal year of 2006-2007, which is past next fiscal year, that we will come back to baseline and move forward again

***The senior management staff and supervisors within the Department of Behavioral Health are topnotch***

I don't have a lot of data to share with you about why we are in this position because I basically only have been working there for eight days. I really want to take some deliberate time to do a good assessment and to report back to you, but I know from my quick assessment some of the problem has to do with a system-wide problem with some mis-posting, with some receiving grants or money from the state. I know from meeting with all of my senior management staff and supervisors that they are very committed. They are very hardworking people. We have topnotch senior management staff in this department. They know that we value collaboration and we value community input. I'm very pleased and very committed to be part of this team and I really need all of your help. Anything at all that you can give us as far as feedback, input, how we can move forward, I would really appreciate that.

***Dr. Larry Levy is the medical director of the Behavioral Health Department***

**Dr. Larry Levy:** I'm the medical director here and I have been doing this for about two-and-a-half years now having come out to Fresno County from New York where I was

clinical director for a big hospital in Westchester County in New York. It's been great coming out to Fresno and being part of this department because California in general in terms of its wellness and recovery approach is in my opinion way beyond what's going on in New York, a much more comprehensive, integrated approach to mental care. Since I've been here in two-and-a-half years I've really gotten to know what we do as a county department in terms of servicing people. I've concentrated a lot of my energies on the emergency services that go on in our Emergency Service Division, trying to bring a more crisis-oriented approach to the emergency room rather than people coming in and either just being hospitalized or not, but trying to provide some crisis services. We also developed a program called ACT, Assertive Community Treatment Program, modeled after a program that has been shown to be a best practice around the country for serving people with serious and persistent mental illness by providing them with outreach services that find the people that have the most difficulty coming in for services in a regular way. While that program is small now, we're hoping that the new Mental Health Services Act, which is Proposition 63, is going to help support the enhancement of that service. The strategic planning group is underway for the Mental Health Services Act. Four taskforces have been formed – an adult taskforce, children's taskforce, transitional-age youth taskforce, and an older adult taskforce. You can get information about those on the website. There will be stakeholder meetings and I encourage everybody to participate in that. If there are any questions about how we provide mental health services, specifically crisis services or our outpatient services, I would be happy to talk to anybody about it. Thank you.

***Mr. Frank Torrez is a division manager overseeing 325 employees***

**Giang Nguyen:** Mr. Frank Torrez is one of our assistant directors. Frank has three divisions under him and is overseeing about 325 employees in those three divisions. One of the divisions he oversees is the Senior Care and Specialty Division. The division manager is Grace Gomes. Grace has the In-home Supportive Services Program, the Adult Protective Services Program, and the Older Adult Mental Health Services. Under Frank Torrez we also have the Community Integration Division, and the division manager is **Ms. Debbie DeNoto**.

***The CREW Program provides services that help people integrate back into the community***

**Debbie DeNoto:** CREW stands for Center for Recovery, Empowerment, and Wellness. We provide outpatient services, individual and group therapy as well as what we call rehabilitative groups and activities. We provide services that help people integrate back into the community and live independently on their own. A component of that that's very important is our Peer Support and Recovery Component, and those services are provided alongside with the other therapeutic and rehabilitative types of services. The AB 2034 program is our Homeless Grant Program. That particular program provides 24/7 crisis and outreach services to homeless. We currently have a population of 143 that we serve, and we have a wait list of about 170. Job Options is our county program providing supported educational services and vocational services for those folks. Also, an integral part of that is our Peer Support and Recovery Component within that particular program. Another program that's an offspring of that program is something that we call FACT, which stands for Fresno Assertive Community Treatment Program. We do diversion from jail for mentally ill inmates and we provide services 24/7 including housing, vocational services, therapeutic services, and peer support services. Our

statistics are quite impressive. Less than 8% of people recidivate back into the jail after our first year of operation, and we've reduced hospitalizations by 91%. I also happen to have a housing grant program under me that's just finishing up with the state Supported Housing Initiative. I also have the Employment Services Program under me. That's our partnership with the Department of Employment and Temporary Assistance, and we provide mental health services, vocational services, dual diagnoses services or co-occurring disorder services, and domestic violence services for people that are recipients of CalWORKS or welfare.

*The Intensive Services Division programs run 24 hours 7 days a week*

**Sue Gonzalves:** I'm the division manager for the Intensive Services Division. The programs are pretty much 24 hours 7 days a week. There is a staff of about 160 in the division. It has the Psychiatric Assessment Center for treatment, which is a 24-hour crisis stabilization unit. We also have the psychiatric health facility, which is a 16-bed acute inpatient facility, and we have Community Response Services, which is crisis intervention. They respond out in the community if there is a crisis to UMC Emergency Department. We also have the Apollo Residential Program. There are 16 beds there. Fourteen of them are crisis beds and the other two beds are transitional beds.

**Giang Nguyen:** Thank you, Sue. Moving on to another section of the department, we have Assistant Director Joe Sebastian. Joe has four divisions under him and he has about 218 employees.

**Joe Sebastian:** We have four divisions. The Substance Abuse Program is a new program adjoined to us several months ago. Dennis Cook, the division manager, is up in Sacramento making sure we get our fair share of the money. I'm an acting division manager over the forensics, which includes the jail, and with me is Lola Aguiniga, who is over our Rural Program, and Dr. Laird, who is over our Metro Program.

*Regional Services provides services for children as well as adults*

**Lola Aguiniga:** I'm the division manager for Regional Services. We operate ten community-based clinics from Coalinga, Huron, Firebaugh, Mendota, Kerman, Sanger, Reedley, Selma, Pinedale, and West Fresno, and we actually have a child therapist who goes out to Auberry. Even though Regional Services is under the Department of Behavioral Health, it's not just about adults. It's about families. We have clinicians out there from the Department of Children and Family Services and also from the Department of Behavioral Health who see children as well as adults. I also head up the Education and Wellness for mental health, and by that I mean that I handle the student placements. Last year the county placed over 40 students – nursing students, social work students, counseling students – so we're real proud of that because we're growing our own. I arrange the trainings for staff as well. I also have the Critical Incident Disaster Response Team. We go out into the community and do critical incident debriefing. I'm also the cultural competency chair for mental health, and I have a committee of 12. It's made up of staff members and community members as well as consumers. We have a de-stigmatization committee that is working right now and it's being led by Norma Perez, who is one of my supervisors. It is a community-based clinic and so there are representatives from

some of your organizations who sit on that committee. Their mission is to de-stigmatize mental health services and bring more education into the community. Thank you.

***Metro Services provides adult outpatient services for the metropolitan Fresno area***

**Dr. Bud Laird:** I'm the division manager of Metro Services. I handle access and intake, which is a very, very difficult area. Metro Services provides adult outpatient services for the metropolitan Fresno area. The programs that we run are the traditional target case management programs for consumers in metropolitan Fresno. I also run the Placement and Conservatorship Team, which manages our consumers who are conservatees placed in IMDs or state hospitals and also coming back to the community placement. That is a financially intensive area. Our costs that we pay for people in locked facilities is a huge part of our budget. I think last year we spent \$12 million on this, and we do not feel this is optimal treatment. These are what we call "lock em up dollars" and they don't really help people recover, we feel, and so we've made a major push at moving these people back to the community and limiting the use of the IMDs and state hospitals. I also oversee the Medication Services Team, which is a small unit that provides the injectable medications, our samples program, distribution of medications to reduce our pharmacy costs. We also provide the direct nursing support to the consumers in our program. I also have the Latino Services Team, which is a small unit of bilingual, bicultural clinicians and case managers specifically targeted to serve the Hispanic community. We're trying to have specialty services to attract and assist this population, which is a very significant part of our cultural heritage in this community and is very underserved. Access to mental health services is a problem that as far as we can tell no one has ever solved. How to meet an overwhelming demand with limited resources and a very short time frame is a huge project. We want to form a unified concept of access, in partnership with others, to solve a problem that we have, and that is that we are recovery oriented. The community and the national consciousness of America is not recovery oriented. The national consciousness of America identifies access as getting to a physician to get medications. That is not recovery. That's assist. We're trying to forge a compromise between the public expectation and recovery to unite with consumers to bring them into the mental health system, and that's our job for the next year.

**Dr. Edward Moreno, Public Health Officer; Interim Director, Department of Community Health**

Many years ago we still had an agency and responsibility for the county hospital. In 1997 the board of supervisors agreed to sign a contract with Fresno Community Medical Centers to delegate the responsibility for providing healthcare to medically indigent people over to Fresno County, primarily University Medical Center. Around that time we formed a system which brought together under an umbrella the HS departments, Behavioral Health, Community Health, Children and Family Services, and Adult Services. I believe four or five years after that, that was pretty much disbanded. The departments were asked to continue to collaborate as a health system under Brad Maggy, and under Giang Nguyen as interim we continue to make that effort. In the last two years we've had some changes, and we can continue to expect changes. Gary Carosa was the director, and when Mr. Carosa left the department Brad Maggy served as an interim director for quite some time without an assistant director, and he did a fantastic job. He made a special effort to engage the community and Fresno Metro Ministry in particular. I came

on as the full-time health officer, and that was primarily driven by a community effort recognizing the need to have a health officer with a passion for public health who is willing to take on the health officer duties as delegated not just by the department but by the State of California through health and safety codes. I was very honored to take on the full-time health officer position.

***Dr. Moreno has accomplished many things as the public health officer over the last two years***

I want to mention a few of the activities that I have been able to accomplish, which of course wouldn't have been possible without the support of the community, Fresno Metro Ministry, the director, Mr. Maggy, the board of supervisors, and the CEO, Mr. Bart Bohn. One of the things that I've really worked towards is demonstrating effective enforcement of public health statutes. Just to give you an example, one of the requirements of the health officer is when necessary to issue orders for an exam, for example, orders for treatment for tuberculosis. It has to be done according to the statutes and it has to be done in a culturally competent manner. I have also made a particular effort to try to demonstrate leadership in a variety of areas. One area in particular is disaster preparedness. We have a lot of money coming down through the Center for Disease Control and HRSA through the states to the local level. With adequate training in preparedness and response, **Dr. Byrd** and I participate in disaster drills including bioterrorism drills primarily with hospitals but also with the fire department and law enforcement.

***Dr. Moreno has taken a leadership role in public health threats such as West Nile virus and influenza***

I have also taken leadership in public health threats, for example, West Nile virus. Last year and this year I'm the co-chair for Fresno County's West Nile Virus Taskforce. We have brought together agencies throughout the county that are responsible for controlling and preventing breeding of the mosquito population, tracking the West Nile virus, and informing the community on how to prevent getting bit by mosquitos and coming down with West Nile virus. In my role as co-chair I testified at Senator Flores' hearing last year. We also have been very vocal at the state level to try to get additional funding. Another public health threat always looming is influenza. We look at the trends and influence epidemics. Most people are familiar with the shortage of influenza vaccine this last flu season, and while the Center for Disease Control and the manufacturers and the state were trying to figure out what they were going to do about it, we went ahead and took the lead and sent surveys out to healthcare providers who offered the flu vaccine. We took inventory of availability of influenza vaccine in our county and who was willing to give up their vaccine and share vaccine with other providers, and while the state and the Center for Disease Control were making recommendations, we were able to immunize all the occupants of special care facilities, people who were most at risk.

***Dr. Moreno has also focused on chronic public health issues such as obesity and diabetes***

Another activity that I focused on was demonstrating commitment to some of the public health chronic issues, in particular the need for better eating, more healthy nutrition and activity. Kathleen Grassi and I have been able to participate with Fresno Metro Ministry in working with

Fresno Unified School District to develop the Healthy School Policy and prepare that for presentation for Fresno Unified School Board. I have also had the honor of meeting monthly with the state superintendent's group on making recommendations to the superintendent in the area of health and nutrition and activities within our schools.

***The public health officer needs to demonstrate effective collaboration and interaction at the local, state, and federal levels***

Finally, the health officer needs to demonstrate effective collaboration and interaction not just at a local level but at a state and federal level. What I've been able to do in the last year and a half is really build relationships at the state level with my colleagues. We're all members of the California Conference of Local Health Officers, and we meet monthly. I was recently nominated to the board of that group, and I am a member of three committees. Health officers get together on a regular basis to discuss environmental health issues, chronic disease issues, maternal, child, and adolescent health issues, and communicable disease issues. I can't do it alone, so I've invited several of our division managers who oversee many of the programs that have services to address those issues to join me in those conference calls. From those conference calls we get firsthand information from the state and federal level that otherwise we would wait weeks or months to see in the newsletter, so our divisions are really up to date on the health issues that we're dealing with in those particular areas.

***Dr. Moreno has worked with the Center for Disease Control to address the issue of tuberculosis in Hmong refugees coming to California***

I have also worked with the Hmong refugees. I've been able to engage through the state the Center for Disease Control to address the issues both in Thailand with tuberculosis among our Hmong refugees who are coming to live with us and also the issues here. As a result, the Center for Disease Control sent a team out to Thailand to look at tuberculosis and do an assessment and try to get better identification and control of tuberculosis for all our Hmong refugee families who are going to be moving to the Fresno area or to California to live with us. We also had the Center for Disease Control team come to Fresno County and spend a couple of weeks working with us to help us more quickly complete our disease outbreak investigation with tuberculosis.

***The interim director of the Department of Community Health will need to bring to life the vision and mission of the department***

What is being asked of the interim director in the Department of Community Health? Let me touch on five things. The first is leadership. I believe an effective leader has to have a clear understanding of what the vision and mission of the department is, and that vision and mission really needs to reflect what the staff and the individuals who work in that department believe. It would be unreasonable for me to create a vision and mission and expect everyone to abide by that and believe in it and have a passion for it. This vision and mission really comes from the program, from the staff, from our nurses, from our environmental health specialists. They believe in what they do, they have a passion for it, and that really drives our vision and mission, so I see the interim director or any director taking that leadership and trying to bring that mission and vision to life.

***The interim director will need help from an interim assistant director to manage the department***

I also see the interim director being asked to manage. It's impossible to micro-manage every aspect of the department, but there is some management that is required in assisting division managers in a variety of programs. The director is called upon from time to time to pay particular attention with some hands on in the department. In order to do that effectively, the department head needs some assistance. I feel that is one of the roles of the assistant director, and I plan very soon to appoint an interim assistant director to help me in that respect.

***The interim director will be expected to make important decisions, which requires input from a variety of sources***

Something else that the interim director is expected to accomplish would be governance, which is essentially making important decisions. This is not one person pondering for five minutes and then making a decision and then moving on. This really requires input from our principal analysts who understand the administration of the department as well as input from our division managers, many of whom came up through our programs and have a lot to offer in support of making important decisions. The last week and a half I've gotten a lot of support from each of those division managers and principal analysts and the CAO's office prior to making some of the decisions that I've already been asked to make.

***The interim director needs to be an advocate for the department programs***

I see the interim director as an advocate for our programs. I tell our division managers and our supervisors that they are public health. They have a passion for what they do, and in order to provide them the work environment and conditions to do what they want to do, to want to come to work, I need to be an advocate for them both at the administrative level and the community level. Finally, I see the interim director as a public servant. I have a responsibility to serve the public, to identify what the public needs, and to the best of my ability address those needs and provide the services if at all possible.

***The public health officer will enlist the help of a deputy health officer to accomplish the many responsibilities of that position***

What is currently being asked of the health officer and how is the health officer going to accomplish that? The health officer is being asked to be an advocate for the community and to provide health officer duties and responsibilities as mandated through health and safety codes. The manner in which it's going to happen or who is going to carry out those responsibilities will have to change during this period, and in order to do that I need the full support of a deputy health officer. **Dr. Ken Byrd** is going to speak in a moment to describe how a deputy health officer fulfills the expectations of the health officer in this county. What does the health officer have to offer to the community as the interim director? When I think of public health there are two sides of this. There is the public side it, which is basically accountability to taxpayers, residents of this community, and that's an important responsibility that in many respects falls into the hands of the administrative side or the director side of a health department. The other

side of this is the health side, and as a healthcare professional who has provided healthcare in this community, trained in public health with a passion for public health, I bring that other component to the interim position. With that I just want to say the future of the Health Department really does require the support of the community. Your input has been invaluable in the two years that I've been in the Health Department, and we need to continue to collaborate with our other departments, Behavioral Health and Employment and Temporary Assistance. In the last eight days we have already had several meetings to address some important issues that affect all of our departments.

***The deputy health officer's primary responsibilities are going to be in bioterrorism and disaster preparedness and communicable disease control***

**Ken Byrd:** I have been Ed's backup deputy health officer since February of last year when he was called out of the country for a couple of weeks. I've been with the Department of Community Health since 1987 when I had a public health position in a rural clinic in Coalinga. At the same time I was the lead physician in the department's Clinician Peer Review Program and provided physician coverage in the STD Clinic for the department. They asked me in 1990 to be medical director of the Jail Medical Services Division, and I held on in that position until the first of this month. In the past I've filled in as a TB Clinic physician on several occasions. For the first eight months of 2003 I was asked to be the interim health officer while the county was recruiting for Dr. Moreno. At that time the department was heavily occupied with smallpox vaccinations for public health and hospital response teams, the Crippen fire, surveillance for the newly emerged SARS illness, and the beginnings of West Nile virus public awareness. In addition to the deputy health officer I'm currently the TB control officer for the department. In that I'm responsible for overseeing case management, contact management, and surveillance for this disease in the county. I participate in Mexico/US binational multidrug-resistant TB conferences, I'm a member of the California TB Controller Association, and I work closely with the California Department of Health Services TB Control Branch staff. As Dr. Moreno's deputy health officer my primary responsibilities are going to be in bioterrorism and disaster preparedness and communicable disease control where I will work closely with Emergency Medical Services, Environmental Health, Communicable Disease, Nursing Outreach Services, and Education and Preventative Services divisions in our department. I also work with local facility infection control staff, local hospital emergency room staff, and school nurses in addition to the regional disaster medical health specialist for Region 5, the State Office of Emergency Services, the State Emergency Medical Services Authority, and bioterrorism preparedness staff from other valley counties. I'm a recent member of the California CD Controllers. Further, I plan to work more closely in the future with the city's Medical Reserve Corps in recruiting and training medical professional volunteers in preparation for any bioterrorism or emerging infectious disease event. Finally, my hope is that I am able to relieve Dr. Moreno of much of the day-to-day acute and communicable public health issues in order for him to concentrate his very considerable energies on enlisting community-wide support in addressing the more chronic public health issues facing our community.

## **What's Happening in California That Will Impact Valley Health Care**

**Jessica Rothhaar, HEALTH ACCESS**

I am the Northern California organizer for the statewide organization called Health Access. We are a coalition of organizations like Fresno Metro Ministry and the Community Health Coalition from all around the state. Groups that are statewide like AARP, and the California Council of Churches are both on our board as well as groups that are small and local like the Valley Seniors Group out of Hanford and Healthcare for All. We advocate for consumers, and our mission is quality, affordable, accessible healthcare for all Californians. Today I'm going to talk about the Sacramento update in three parts – proposals to expand access to healthcare, the state budget including the Medi-Cal Redesign proposal, and the very likely special election in November and the proposals that would affect health access that we'll be looking at there. What I'm going to talk about is stuff that requires advocacy that county staff by definition can't do, and so the importance of a group like Fresno Metro Ministry which brings everybody together and the importance of county staff and CBOs and nonprofits working together collaboratively cannot be overstated. When it comes time for a special election and we're looking at defending the funding for healthcare that we have against further cuts, the CBOs and the nonprofits become the front line on that stuff.

***Health Access is working to get legislative changes to protect consumers from overcharging by drug companies and hospitals***

Proposals to expand access are what we call steps forward and steps back. There are a lot of proposals to expand access ranging from the single payer and Universal Kids, which are the biggest and most important on the agenda right now, to smaller more incremental changes, which are also important because of the political difficulty of getting the large revolutionary changes as represented by the bigger bills. We at Health Access call ourselves strategy incrementalists. We believe it is really important to work on both fronts at once. We have to move forward and demand universal coverage. We have to demand a fundamental change in the way we approach access to healthcare, but given the reality of the politics, it may be many years before we have a comprehensive single payer system, so we also need to continue to chip away to protect consumers who are in that individual insurance market, which is practically unregulated, we have to protect consumers from overcharging by drug companies and hospitals, and we have to continue to expand access through public programs wherever possible.

***The bills that Health Access support have all moved forward in the legislature***

This is the first year of a two-year legislative session, and all the bills that we support have all moved forward. By June 3 all bills that were introduced at the beginning of this year have to get out of their house of origin. SB 840 is a Senate bill and it has to be passed by the full Senate by June 3. Technically, even if it doesn't there is a way to keep it alive, but it is a tremendous amount of work, so really what we're looking at is that June 3 is the drop-dead date to get SB 840, the single payer bill, out of the Senate, and then June 6 to July 8 we have to get all those bills through the policy committees of the second house. Single payer, SB 840, basically is a program where Medicare would be extended to everybody, so you would continue to have

private doctors and private hospitals but everybody would have the same deal that Medicare patients have, which is they get the healthcare and then the doctor would send the bill to the government, which would be the only insurance company, so all the private insurance companies would be out of the equation in California. SB 840 did actually pass out of the Senate Health Committee and the Senate Business and Professions Committee and is now pending in Senate Appropriations. In Fresno you have two members on Senate Appropriations, Dean Flores and Charles Poochigian. If you want to do something to help SB 840 you need to send a letter of support to your two members on Senate Appropriations and tell them you want to be sure the bill gets out in time for a floor vote on June 3. I know Laurie has probably told everybody about Californians for Healthy Kids. Everybody here probably is aware of this wonderful opportunity to finally finish the job and cover all kids in California through an expansion, essentially, of Medi-Cal and Healthy Families. That bill has also passed its policy committee and is pending in its appropriations committees, so again, you can write Dean Flores and Charles Poochigian and say that you want to be sure they approve these bills and move them forward in the legislative process by June 3.

***Health Access believes that the way to make improvements in healthcare access is to increase risk pools, which could best be accomplished by going to a single-payer system***

The important thing about all of these expansion proposals is that they reflect a fundamental debate that's happening in Sacramento and at the federal level right now, which is a crucial debate about how to move forward in expanding access to healthcare. Should it be by building on what we've been doing so far and pooling risk? Medicare is a risk pool, Medicaid is a risk pool, and employer-based coverage is a risk pool. Your employer may have ten workers or 10,000, but your risk is pooled with that of everybody else and your cost is distributed. That's why when you have to go and buy your own health insurance it sucks because you're not in anybody's risk pool and they look at your record, and if you've been to the doctor two times in the past year you might get denied. There is another side of the debate that says the reason health costs are so high is because people use too much healthcare and what we really need to do is increase the burden on individuals. We need to make individuals better consumers, we need to make them more responsive to the cost of their decision to use healthcare, so we need to break apart the risk pools, we need to break apart social security, Medicare, Medicaid, we need to send people into the private market as individual purchasers. That's also related to increasing co-pays and increasing deductibles, which is to make the consumer weigh every time they decide to see a doctor what it's going to cost them and make a cost/benefit analysis. At Health Access we do not believe that that is going to increase access to healthcare. We believe that the studies indicate that cost has a direct proportional relationship to access to healthcare and increased co-pays make people decide not to see the doctor. We already know people can't afford to see the doctor. We believe building risk pools and increasing risk pooling is the way to go. That's why we support single payer, that's why we support protecting Medicaid, and that's why we support efforts to increase employer coverage until we can move to a more rational system of organizing our risk pools for working-age people.

***Health Access is working to lower the cost of prescription drugs in California  
with the Rx Bill of Rights***

We also believe in protecting consumers. The driving costs of healthcare are primarily drugs, hospitals, and insurance. In addition to supporting single payer to deal with the insurance cost, we have a number of proposals that I'd like to let you know about and I'd like to ask your support for. The Rx Bill of Rights is our effort to begin reigning in the cost of prescription drugs. We're working with a coalition of various groups. This is a different approach than what the governor is proposing. We're saying that drug companies who want to sell their prescription drugs in California should offer us a discounted price, and if they're not willing to do that we're going to make it harder for them to sell their drugs to the Medicaid program, which is worth \$30 billion a year to them. The governor has a proposal which says they want the drug companies to offer discounts but they are just going to ask them to do it. They're going to negotiate deals with them that will last as long as the goodwill lasts or as long as that governor is in office. We don't think that's strong enough, and so we talk about having the Medicaid hammer. It doesn't work based on drug company goodwill. We want to make sure there is some way to basically put a hammer in so that they have to comply. We have a legislative package known as the Rx Bill of Rights that is moving through the legislature, and we have a ballot initiative, and if in fact there is a special election in November our ballot initiative will be competing with the governor's ballot initiative. You may already have been asked to sign one or the other petition, but we've now qualified ours so it definitely will be on the next ballot. We call ours the Cheaper Drugs For Californians Act. We are asking for organizational endorsements for both the legislative package and the ballot initiative. The governor vetoed our bills in the last session so we do expect that even if we manage to get them to him he'll probably veto, so we are planning to go to the ballot.

***AB 774 would prevent hospitals from charging uninsured consumers five  
to ten times more than insured consumers***

We also are trying to deal with hospital pricing in a couple of ways, mainly by protecting uninsured consumers. People have probably heard by now that when an uninsured person goes into the hospital they end up getting charged five to ten times more than a person with health insurance. We have been carrying for several years legislation that would prevent hospitals from doing this. It would require that they inform consumers of the options of things like Medicaid and medically indigent adults programs that they may be eligible for as well as any charity care program that the hospital offers, and it would require if the person is uninsured and low-income that the hospital couldn't charge them for any procedure more than they could charge the government under Medicaid, Medicare, or the Veterans Administration if that person were eligible. We're not saying the care should be free. This is not a charity care requirement. This is a consumer protection requirement against overcharging. We are seeking support for this bill AB 774 by Wilma Chan. It did pass the Assembly Policy Committees. It's pending in Assembly Appropriations and we expect that it will go to the governor. We would really like organizational letters of support to Assemblywoman Chan so that we can show how broadly groups are supporting this.

### ***Health Access is trying to help consumers have the power to fight insurance companies***

It is very hard to regulate the insurance industry. Those people have a lot of money and they fight every time you try to regulate them. Groups have gone head on and have been defeated, so we try to be canny and use our resources effectively. We are really trying to focus on the individual insurance market, which is like the wild, wild west. It is unregulated. We're trying to let consumers get some power by essentially creating the same thing as a credit report. There is a company in Florida that keeps all of our medical records similar to the credit reports. Whenever you apply for health insurance as an individual, the insurer goes to this company in Florida to get your records to see whether or not you have what they're going to count as a preexisting condition. Up until now people haven't known that and they haven't had any way to contest. The idea of this is that people can get their record, see if there are any mistakes or outdated things on it, and they can actually fight with the insurance company to get a lower rate or to get coverage. That's AB 1199. AB 977 is about reigning in the out-of-pocket costs. These are really small bills, but they're just beginning to chip away at the power the insurance industry has had to act in this unregulated way and to raise costs without anybody having any ability to check their power.

### ***Governor Schwarzenegger wants to reduce Medicaid spending for seniors and the disabled***

Now I want to move to the budget and Medi-Cal Redesign. The good news is that we collectively did such a good job the last couple of years fighting the proposals to cut health spending at the state level that Governor Schwarzenegger really didn't even come back with most of them. The huge cuts to Medicaid eligibility and the elimination of whole categories of benefits were not in the January budget, but what Governor Schwarzenegger and his health secretary Kim Belshé are really concerned about is the part of the Medicaid budget that is spent on seniors and people with disabilities. That's the piece they see rising and that's the piece they really want to try to bring down. Their effort to bring it down is at the heart of this Medi-Cal Redesign. There are five pieces of Medi-Cal Redesign that we are concerned about. The first is the imposition of premiums on low-income people, which is estimated to lead to about 110,000 people dropping off Medicaid, and once they drop off it gets hard for them to get back on because they end up owing money that they have to pay up front before they can get back on. Both the Senate and the Assembly Budget Committees rejected this out of hand. The question is, since the governor in his May Revise has re-proposed it, it is not entirely clear to any of us what the relationship between the budget and Medi-Cal Redesign is if the governor is successful in getting his waiver. The governor is seeking a five-year waiver from the federal government for Medicaid that will give him a great deal of power to make policy in Medicaid, which may in fact give him the power to make these changes even if they don't get approved by the legislature. The other really scary thing about Medi-Cal Redesign is the way it would change financing for the public hospitals. Mandatory managed care and hospital financing are linked. The governor wants to require all seniors and people with disabilities to go into managed care as a way to save money. Since this is a high-need population, the question is how are you actually reducing your spending on their healthcare. Is it because you're using managed care as a gateway to prevent people accessing needed services? That's not something we want to see. The other concern, of course, is that people who have been in fee-for-service for years have networks of providers that they have created, providers who understand their disability and their health condition, and if you

put them into a managed care plan they lose access to those providers and there could be real health impacts on people. If you take all those people out of the county hospitals where they have been going for their fee-for-service care, then those hospitals lose those dollars, so as part of this five-year waiver the governor is seeking a total restructuring of the way public hospitals in California are financed. We would need a billion dollars more every year from the feds in Medicaid dollars to come up to the average level of Medicaid spending of other states. We're lowest right now per beneficiary. This waiver would cap the amount of money we would get from the federal government every year for five years, so no matter what happened in the state or in the health of the people in the state there would be no way of getting more Medicaid dollars. It seeks an increase of \$700 million a year over current spending, but the problem is, although that would be an increase over current spending, the increase is capped. You can't spend more to draw down more. The other really big problem is OMB has looked at our numbers and said, "You're not getting \$700 million." The last I heard is they were talking about \$300 million. The real issue is how dollars get counted. County hospitals are currently in a partnership with the state so that the state can put up money to draw down federal dollars. This proposal would take the state out of the financing of the public hospitals so it would be totally up to the county to bring down more federal dollars if something happened. Have you done a ballot initiative to do a sales tax at the county level for their hospitals? Alameda county did it and passed it. Monterey county did it and it failed. San Francisco is going to try to do it. You would be looking at having to pass a sales tax to fund your hospitals. The other concern is there will be distributional fights. It changes the whole funding system in a way that's making everybody pretty nervous. The problem is it's all being done between the governor and Washington. It's not a public process and the usual advocates are not really at the table and the county hospitals are not really at the table. The deal will come down and then it's unclear whether the legislature is going to have a say in it or not. As Denise Ducheny, who is the chair of the Health Subcommittee, said recently, even the legislature doesn't quite know how they are supposed to pass a budget because they don't know how much money they're going to have through Medicaid. For anybody who is new to the policy issues, the really key thing, of course, is that Medicaid finances our care for the uninsured as well as for people who actually get Medicaid. So that's the bad news. And now I have some more bad news.

***The Live Within Our Means Act would give the governor unilateral power to make budget cuts***

Has anybody heard of the Live Within Our Means Act? It's a little bit under the radar screen. This is the budget cap proposal. The bottom line, I'm going to say, is we oppose this and we're going to throw everything we have into defeating it if there is a special election in November and we're going to ask you for your help. The challenge is that it doesn't seem immediately to be about healthcare, so why should health advocates care about it? Everything you've heard today about funding shortfalls in every county department would be much, much worse, and the health cuts that we're looking at in this budget under Medi-Cal Redesign would be like nothing compared to if we had to live under this Live Within Your Means Act. It would do three primary things. It would create a new statewide spending cap which would limit spending almost based on revenues for the three previous years, but it would also be based on forecasts. It's quite arbitrary. It would limit spending that's never been limited before including county realignment dollars, Proposition 63 funds, Proposition 99 tobacco tax funds, and specially passed taxes that the electorate has passed in order to fund specific programs. The spending from them could be

capped even if there was plenty of money in those funds. The second real concern is it gives the governor complete arbitrary power to make the cuts without the legislature having a chance to weigh in. Under the Live Within Our Means Act the budget cuts to health that Gray Davis and Arnold Schwarzenegger proposed in the last several years could have been made unilaterally by fiat like a king without the legislature. The legislature has stepped in over and over again and stopped these cuts from happening, so now the governor would have complete power to make these cuts. The third is, for anybody who also cares about education, it would lead to a ratcheting down of Proposition 98. I'm not going to take the time now to go into the detail, but the California Budget Project has a wonderful primer on this Live Within Our Means Act, and their at [cbp.org](http://cbp.org) if you want to see it. I suggest that everybody try and wrap their brains around it.

*Signing the "Fighting for California's Future" statement will make you part of a coalition to oppose the Live Within Our Means Act*

In terms of a call to action, if you're interested in getting information and being kept up to date and hearing about what you can do on all these things, please send me an e-mail and get on our e-mail list. We send regular updates that we try to keep very concise and very action oriented about what's happening in Sacramento. In addition to sending letters of support, we always need stories. If you're an organization that works with people who are either suffering because of a lack of access to healthcare or who rely on the programs that could be cut if these cuts happened then let me know and let's work together to figure out how to do story collection as a capacity-building exercise for your organization. Particularly for faith-based groups, we are developing a module for a congregational study exercise that includes story collection that really helps people to understand what's happening in their community and also learn how to act on it. At the very back of the packet there is a statement called "Fighting For California's Future." This is a statement about our budget priorities as a state. It says, "We believe California's budget should invest in California's future. We support a balanced solution to the budget crisis. You can't do it just with cuts. You need revenues. We oppose automatic mechanisms to cut vital and needed services." If you sign this you will automatically become part of our coalition to oppose this Live Within Our Means ballot initiative should we have a special election in November, so I would encourage everybody to sign onto this if you can.

**Participant question:** I keep looking and haven't found it. Just where is the good news?

**Jessica Rothhaar:** The good news is that in terms of public understanding healthcare and lack of access to healthcare we've come a long way. We used to do a whole lot of back story that people who are uninsured live sicker and die quicker and that the uninsured get overcharged. You don't have to explain that anymore. Everybody gets that. I also just saw some polling that indicates that 78% of voters support Medicaid, and of course voters don't use Medicaid by and large, so that's huge. As far as the argument that there is a moral obligation to ensure access to healthcare, particularly for vulnerable populations, the public is there. It's just that the politicians aren't there yet, but if we can organize and if we can continue to work through the media and through our legislative process, I think as we lead they must follow.