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NOTES OF COMMUNITY HEALTH CARE ROUNDTABLE

Thursday, January 19, 2006

FOCUS:

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The purpose of our Community Health Care Roundtables and of our health care projects is to increase health care access that is appropriate medically, geographically, linguistically, and culturally and to improve public health. The Community Health Care Roundtables are funded by individual donors, congregations, Vitamin Cases Consumer Settlement, The California Wellness Foundation, The California Health Care Foundation, The Hewlett Foundation, The Kirsch Foundation, Kaiser Permanente, MAZON: A Jewish Response to Hunger, California Alliance for Family Farmers, California Nutrition Network, The Ecology Center, Occidental College, Roundtable Sponsors, (Health Net, Kaiser Permanente, Children's Hospital Central California), Event and Activity Sponsors, and others.

Giang Nguyen – Mental Health Director, Fresno County Department of Behavioral Health

Thank you so much for this opportunity to come here and present this information to you. I wish I was standing here this morning to talk about expansion and creating more services for clients in this community. I came to this department in June of 2005. Originally I came from the Department of Community Health, and I was the assistant director over there. When the former director for the Department of Behavioral Health left the county the board of supervisors and the CAO office asked if I could return to Behavioral Health because I worked there for almost 19 years in my career as a registered nurse, a director of nursing, and division manager, so I agreed to come back and help. I knew that there were some financial issues and I was willing to tackle it and I was willing to transform the department to move forward in helping the clients in the community. I didn't know how bad it was as far as the financial deficit until a couple months ago, so I'm here this morning to explain to you what happened and how we are going to move forward from here. Again, I am new in this role in this department and I have a lot to learn, and I'm here to learn from all of you. I'm very much interested in getting input and feedback. I haven't had a lot of time to go around and gather community input. In the meantime, we're facing a tremendous financial shortfall and we have to take some actions to bring the department

back on its feet so that it is no longer having to use county general funds like it did many, many years in a row.

The Department of Behavioral Health helps coordinate and administer mental health services for adults and older adults

When I joined this department I basically changed the upper senior management level. I deleted two assistant director positions and I brought in a deputy director who is helping me with budget and finance, so we have a new team of leadership in this department and this is our commitment. We are dedicated to give our resources, energies, and total commitment to create a state-of-the-art, culturally competent system that promotes recovery and wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. I'm here to talk about the strategies to reduce the deficit for adult and older adult mental health services. I am also the designated local mental health director for this county meaning I am responsible overall for the mental health, well-being, and safety regardless of the age groups in this community. I look at the system as a whole. I also like to look at the way we conduct business as not usual. Business has to be different to adapt to the changes, and so this is my attitude to my staff. Business is not going to be as usual. We have to be fiscally responsible. We run it like a business. Even though our bottom line is not about money, we have to be fiscally responsible and sustainable. If we are not responsible, pretty soon we won't have any services to provide to our clients, so as a registered nurse I'm very much about quality improvement, about services, about programs, but also as an administrator I want to make sure that we are fiscally responsible.

The department wants consumer and family participation as well as participation from mental health care providers and the public

We want to work with everyone in the community including the providers, the public, mental health professionals, consumers, families, etc., to make sure that we have consumer and family involvement. We want to make sure we have good programs and services. We want to provide age-specific needs. We want to have community partnerships. That's very important to me. One of the things that this department seems to be needing more of is involving the community, reaching out and partnering with folks to learn to be sensitive to the community needs and to make changes accordingly. We want to provide culturally competent services. We want to have outcomes and accountability. If we don't set our outcomes and accountability to achieve, it will be very difficult to provide good services. We want to take a comprehensive viewpoint of everything that we do. It has to be inclusive and we want to be open and transparent. That's my style. I'm very open and transparent and this is a public program. The public needs to know what's going on and the public should be able to give input and feedback.

Overestimating incoming revenues to the Department of Behavioral Health led to a deficit of approximately \$15 million

We have a budget that was approved by the board for this fiscal year 2005-2006. The fiscal year starts on July 1 of each year. This budget was prepared prior to my arrival to this department, so I really did not have input in it. The department estimated that they would get \$71.7 million for

this fiscal year. Within two months of my arrival, from looking at the trend of the Medi-Cal revenue that the department had received over the last few years, I knew that the revenue was way over-estimated by almost \$10 million. It took me a few months to come up with this because it takes the state usually 90 days or so to reimburse the claims that we submit. In October I knew that the department was in no way going to make that revenue that they estimated. We also discovered in very late October that the department put away invoices that were supposed to be paid to providers in the amount of about \$2.1 million, so when I came on board I had staff go through every invoice to make sure that we were up to date with payment, and I knew that it was not up to date, and so this \$2.1 million was not even budgeted for this fiscal year and we had to put that into this equation. We also had about \$82,000 that is not budgeted in the department as well to pay for HIPAA activities. We had to readjust our Medi-Cal accrual process. At the end of each fiscal year each department has the opportunity to say how much money they made for the last two or three months before the end of the fiscal year because, again, it takes the state about 90 days to pay us. In April and May the department would submit this to the CEO office and the board of supervisors saying from April, May, and June we believe we made this much revenue but we have not received it yet from the state; therefore we want to accrue this amount to bring it over to the next fiscal year. Well, they over-accrued that. Again, it's overestimation of accrual. It never became reality. That was another \$3.1 million that could never happen. That money never became reality. If you add all those up it's \$14.8 million approximately, so we had to adjust the revenue down based on what we believe we're going to get, so as a result it's about \$57 million that we believe we're going to get. That's how we came to this conclusion of the deficit.

The department used to have a trust fund of over \$30 million, but this money was all spent over the last six years

At one time the Department of Behavioral Health and Children and Family Services had a trust fund of more than \$30 million. That's a savings account that they put away because they didn't spend all of the money that the state provided to us. Over the last six years, actually, that money was all spent down. When I came into the department in June the trust funds were zero. We didn't have any trust funds left. They spent the last \$3 million in the last fiscal year from that trust fund because they had to pay back the state for what they call cost settlement. Cost settlement is a process that the state has been conducting throughout the state, not just Fresno County, and usually it's three, four, five years behind. There are three steps in cost settlement. The first step is six months after the fiscal year is ended, the second step is about 18 months after the fiscal year is ended, and then if they feel there are some things wrong they can go back five years after the fact to do another audit, and so this is what happened to this department. They faced a five million dollar payback for fiscal year 1999-2000, and that took the whole trust fund account away, so when I came on board there was nothing left, and it's not over yet because the state is still auditing. We just submitted the cost settlement report for 2002-2003 and 2003-2004 for the state to review. What happened with that is that the department has a little unit called Managed Care, which is the mental health plan for Fresno County. In 1998 when the state started the consolidation for inpatient and outpatient mental health, the county decided to become the mental health plan versus contracting it out, and that Managed Care was under Human Services System administration. The board of supervisors decided to delete that superagency called Human Services System in 2003, so Managed Care landed in this department. We

absorbed the Substance Abuse component as well in this department. Over the years Managed Care pretty much has had a state fund allocation to provide specialty mental health services for the Medi-Cal population, and so for children and adults that Managed Care organization contracted most of the outpatient mental health services to private providers. These private providers contracted with the county and provided services for kids and adult mental health services and they would claim those services to the county and the county would turn around and send those claims to the state and get payment. What happened was the county got paid more from the state than what they paid to providers, so for a while the county became for-profit and the state caught up to that. Almost all Central Valley counties were doing that, but the difference between this county and other counties was that other counties put away the money just in case the audit caught up to them so they could pay it back. We didn't do that, so as a result the payback is part of that. With the assistance of the auditor controller's office we have fixed that to make sure that we don't have that for-profit situation. Also, it has to do with how the state provides the estimated rate, which is maximum allowance rate for Medi-Cal. Somehow the cost of providing services in this county is much higher than what the state pays us as their fixed rate. For every procedure that we provide Medi-Cal has a rate for it and the state only pays up to that rate. The cost to provide services continues to escalate over the years because of the cost of salaries and benefits for our staff.

The department has had to determine what is mandated by the state in terms of providing community mental health services and then ensure that those services are provided

I want to go over what the state requires counties to do as far as providing community mental health services. It's unfortunate that we have to look into this because healthcare should be provided to everyone regardless, but in times of fiscal situations we have to see what we have and narrow it down to what's mandated. We have to make a decision, and it's a very tough decision. I have to look at what's mandated and make sure we are doing that and then figure out what we need to do differently. For adults we are required to provide involuntary treatment for those clients who are on 5150s and 5250s. These are the clients that come into the emergency room with psychiatric 5150 criteria or clients coming to the PACT unit for acute inpatient services. The state gave us some money to do that. We have to have a patient rights advocate in the county, and we have **Mr. Stan Lum** from **Alliance University** contracting with the county for that service. We have to provide residential treatment for our clients. We have to have a mental health advisory board, and we do have a very good board. We have to have administration to spell out the law. We have to provide EPSDT services. This is supplemental Medi-Cal service for children from age 1 to 21. We need to provide services for longterm mentally ill adult patients, meaning the target population that has diagnoses such as schizophrenia, bipolar disorder, schizoaffective disorders, and major depression. These are the folks who are on conservatorship. We need to provide substance abuse programs and we need to give some local match in order to pull down the federal and the state money.

Two strategies the department has come up with for reducing the deficit are cutting staff or outsourcing

These are some of the strategies that the department has come up with, and we agonized over this. I looked at the costs. We looked at every single program in the department. The

department has about 547 employees, eight divisions, and a variety of programs. We looked at every single program and we looked at last year, what clients they served, how many clients they served, what payer source they served, what revenues they brought in, and what expenditures they spent. I looked at five years prior to that and we could tell which programs were hemorrhaging financially speaking over the years. The programs that we really have been hemorrhaging from over the years financially speaking are the programs that have to stay open 24-7, and unfortunately they are the programs that are mandated by law. Seventy-six percent of the costs to operate these programs were on staffing costs. I have a master's in nursing and we learn a lot about business in that program. If it was my own money operating these programs and I know 76 percent of my cost deficit was about staffing, the logical question would be how do I reduce that cost. The union really doesn't like this, but I have to make sure that we become stable as an organization, so the option would be either re-engineering the programs, meaning cut down staffing, or consider the option of outsourcing to see if somebody else out there could do it more cost effectively and yet we make sure we put in the language for outcome accountability. We're not just thinking of outsourcing and just letting it run. We're going to hold folks accountable. So I'm running two tracks right now. The first track is considering outsourcing. If the board of supervisors approves this then we'll see who's out there who would be willing to do the job for what cost. It's not a done deal. This is an option. The second track I'm doing is I've been mobilizing the whole department about re-engineering and looking at what can be reduced. Layoffs could happen because, again, 76 percent of the cost involves staffing. The department has done a good job cutting the expenditure down in terms of services and supplies. They cut it very deep to the bone now, but what they cannot cut right now is staffing and they're hurting.

The Apollo Program, the Psychiatric Health Facility, and the Institute of Mental Disease are all being considered for staffing cuts or outsourcing

The first services that we're considering outsourcing or re-engineering is the Apollo Program, which is the program on Blackstone. I'm not sure if you're familiar with that program. It's been around since 1976 and it's a 16-bed transitional crisis residential program. It's unlocked. The mission is to allow clients from an acute psychiatric setting to transition in that facility and then move out to live in a lower level of care, meaning in the community like in a board and care home or back to the family. Outsourcing means the services will continue. We're just looking at ways to reduce cost in staffing. That's the bottom line. This is a strategy to keep the services going. Other counties actually have done this very successfully, outsourcing and holding folks accountable for making sure they meet the contractual agreements. Monterey County is one county that I visited right before Christmas. They have done this for 28 years very successfully. I looked at the outcome measures. I visited all the clients in that facility, and there is a lot of satisfaction. They treat their clients very well with a lot of dignity. The second program is the inpatient facility, PHF, or Psychiatric Health Facility. This is the facility located on Kings Canyon right next to the University Medical Center. Formerly it was the APU, or Acute Psychiatric Unit. I worked there. I started out there as a nurse, and later on because of the merger with Community Medical Centers we closed down the APU and opened up the PHF. I was the one who singlehandedly in three months developed this PHF facility, and so this is not good for me because I actually built this place. I know the staff very well and am very close to them, but yet I'm putting this down for outsourcing. Why? Because we've been hemorrhaging financially speaking and we need to reduce the cost. The last one on this list that we're looking

at outsourcing is the service called Institute of Mental Disease. I don't like that term at all, but it's in the law. Basically, this is the service for conservatees of Fresno County. As of last week we had 361 clients on conservatorship. When folks are placed on conservatorship by a judge it means they are gravely disabled due to a mental disorder. They're unable to care for themselves. Someone else has to make decisions for them, someone else manages their finances, and someone else could sign treatment consent for them. Each year it has cost the department an average of eight or nine million dollars to provide services for this group. I looked at some of the outcomes and I'm not happy with it because this county seems to have a very high number of conservatees compared to other counties. Kern County has a population of four, five, six hundred thousand folks. They only have 90 conservatees. Fresno County has around 800,000 folks and we have 361 folks on conservatorship. I'm just naming one county for you, but it's like that everywhere, and so I know we're not doing something right. Maybe that's my wrong assumption, but when I compare volumes and look at the trend I know there's something different about this county. Also, out of the 361 conservatees, more than 150 of them are being placed in an institution that is locked and is spread throughout the state. These are Institutions for Mental Disease facilities. These are locked institutions, and we have 150-plus folks being placed throughout the state in a locked institution away from their families, away from their community. The average age for these folks in these locked facilities is 51 years old, the average length of stay in those facilities is 368 days, and the average length of stay on conservatorship for these folks is six years to seven years.

***Outsourcing of some mental health services has been done very successfully
in many counties throughout our state***

I used to know a client that I served as a nurse in the APU. He was 18 years old at that time. Two Saturdays ago I looked at the list. He was still on the list on conservatorship. He's now 38. All these years he's been in and out of these facilities, didn't make it, kept on being in and out of these locked facilities. When I saw him when he was 18 I was sad because he has schizophrenia, he was hearing voices, but he was such a polite, respectful young man, and now that I came back to the department and looked at this I wonder if we have missed the boat of helping him live independently in the community, helping him get a job, helping him with getting better medications, helping him with having a good family or staying in the community. I'm sure there are many cases like that. I'm not saying that we could do this for every single one because mental health and mental illness can really affect people differently and sometimes it's very difficult to help people stay away from having relapse. I understand that. I worked in the field as a direct provider for many, many years. But I know we need to do something differently here because I've talked to other mental health directors throughout the state, I've visited counties, and they have done things differently to serve this population, very differently, best practice models that we need to follow. This outsourcing idea here is to follow those best practice models. In Monterey County they have a nonprofit organization doing this for 28 years. They would actually provide different levels of housing in the community for these clients, transitional, crisis, permanent housing, independent living, and board and care homes. They would build a housing network. They have the ability to work in the community and get housing for these folks. They also provide 24-hour wraparound case management services to help these clients stay out of these locked facilities and be maintained safely and effectively in the community. It's being done everywhere, Stanislaus County, Monterey County, L.A. County,

San Diego county, you name it, so it's time that we looked at the methodology of how we're delivering services. Outsourcing sounds very horrible to staff. They don't like this. But my bottom line is to serve our clients. I'm loyal to my staff, too, but my loyalty rests very much with our clients and we have to do what's best for our clients. The Apollo Program, the crisis residential service that I talked about earlier, last year spent \$1.7 million, and \$1.3 of that was on staffing. Staffing was about \$1.3 million and supplies for clients were \$361,000, so the total expenditure was \$1.7, but the revenue that they actually could bring in last year was only a half million dollars, so every year they have been in the deficit mode of about \$1.1 or \$1.2 million. It's not just this program. It's throughout the department, and the reason they didn't know about the deficit was because they had that \$30 million trust fund that they could use every year to balance the budget until we ran out last year.

If the board of supervisors approves outsourcing these programs, many county employee positions will be impacted

If the board of supervisors approves this outsourcing option to be considered, 24 positions in the department will be impacted. Monterey County has the same facility being run by nonprofit for 28 years with good outcomes. They have 15 beds. We have 16 beds. We have 24 employees. They have 14 employees. We have an urgent care center for emergency psychiatric services. That's the PACT unit. It's on Kings Canyon right next to UMC campus. The inpatient facility is the PHF, same location, same building. The expenditure of last year for those three programs, Apollo, PACT, and PHF, was \$11.4 million approximately and they could only bring in \$3.7 million in revenue, so the deficit was about \$7.6 or 7.7 last year. The PACT program stands for Psychiatric Assessment Center for Treatment. They spend \$4.4 million on staffing and \$1.1 million on supplies. Same thing with the PHF. They spend \$2.6 million on staffing and only \$766,000 on supplies. It's like that everywhere. The logical choice is to maintain services while bringing the cost down, so you've got to do something with staffing costs. It's very obvious. They cut their supplies down to the bare bone. The supplies we're talking about are getting laboratory work done for clients and medications. The cost to do staffing is so out of control. If the board of supervisors agrees for this option about 136 employee positions would be impacted. This is a big operation. I worked in this division and I managed this division for a long, long time. This is my baby, but I'm putting it out there because I have to look at the whole company and how to keep this company alive and moving forward. This is the option I had to consider. The next one is the conservatee services that I talked with you about, the Institution for Mental Disease services. Last year they were \$11.9 million in deficit. If this was approved by the board 18 employee positions would be impacted. Consumer services, I believe, would be better because we would have 24-7 wraparound services and we would have housing for clients in the community. They wouldn't have to live in these locked facilities throughout the state. We send clients everywhere, Eureka, San Diego, Bakersfield.

Six positions for mental health services in the jail may need to be cut this year

This is something that a lot of people are not pleased about. It has to do with six positions in the jail. These six positions were put out for cut last year right before I came on board because the department at that time thought they were only short about \$600,000, so they put it out for the board of supervisors to cut. I felt we needed to do something to keep these positions, so I put out

two assistant director positions for cut in order to save the six positions. The board approved my recommendation, so we cut two assistant directors, which were top-notch, senior management, and we saved these six positions last year and this year. But this time since we have such a huge deficit this has to be put out again. These six positions I was told provide group therapy for inmates in the jail. Title 15 of California Code mandates what services we need to provide in the jail. It basically requires counties to provide crisis evaluation and treatment. These six folks provide group therapy, which is not crisis evaluation or intervention or treatment. Last night I heard something differently. One of the clinicians belonging to one of these six positions actually stood up and said, "We do more than just group. We also do crisis intervention," so I'll be talking with him more about that. Dr. Moreno, our public health officer and health director of the County Health Department, is the leader of managing this team. In August of last year we went to the board of supervisors and asked if we could put this team under his leadership in this department because we had two separate teams doing pretty much the same thing in the jail. We had Jail Medical Services Team belonging to the Community Health Department and then we had a 26-position team belonging to Behavioral Health Department that provides jail psychiatric services. Over the years there was not a whole lot of integration of services. It was confusing with different leadership styles and different leadership approaches, so we worked together and we went to the board of supervisors and with Dr. Moreno's support we moved that program over to the Department of Community Health consolidated under one leadership, so now this program has about 26 employees providing jail medical and psychiatric services under the Community Health Department. But six positions would be impacted, and there is a lot of controversy over this because no one wants to see cuts, especially in the jail.

Extra help that is used to reduce overtime costs will need to be cut

Currently we have 55 positions as extra help in the department and they include clerical and clinical staff. Every department uses extra help to reduce the overtime costs. When programs that have mandated staffing levels have staff who is sick or on annual leave, vacation, we will bring in extra help staff to reduce the overtime costs instead of having regular staff work overtime. However, with the proposal to cut permanent positions we're going to have to let extra help go first. That's a personnel rule. If we cut these 55 extra help positions, each year we would save about \$420,000. We would need to keep the extra help for those 24-7 programs to reduce overtime costs. If we let go of extra help staff in those programs that require staffing 24-7 the overtime would go up and that's not a good business strategy. So we're proposing to cut extra help staff in the non-24-7 operations.

Some of the rural sites that provide mental health services may have to be closed and some may have fewer hours of service. Another option would be to outsource those services.

Right now we have 12 sites that provide adult mental health services in rural areas. The manager said, "Giang, these 12 sites can be consolidated to reduce overhead costs, reduce administrative costs, and bring more revenue in. Basically this strategy is that we will keep three main sites out there, Selma, Kerman, and Coalinga. Those are regional centers. We co-locate with other departments in these three sites. It's very important that we keep that. The other sites like Pinedale and West Fresno we need to close down because we pay lease costs out there and staff told me that clients who come into the Metro Outpatient Clinic actually live in Pinedale and

West Fresno and they still come to Metro, so as a business strategy we can consolidate. I was told there are bus lines that clients could take from Pinedale and West Fresno to go into the main Metro Clinic to continue getting services. Also, we are committed to do home visits if clients do not have transportation, so this is not like we're not going to do services anymore. This is a strategy to reduce overhead costs and also to bring in more revenue. At the other sites in Firebaugh, Huron, Healthy Start Center, United Health Center, and California Hotel, staff are out there more than 28 hours per week right now and per state regulations when you are located at a site or if you go out to those sites and provide services more than 20 hours per week and have medical records stored there, the state considers that a certified site. Once we're certified if we travel from one site to make a home visit to a client by passing another site we don't get paid for those travel costs. You can only bill for travel costs from the closest certifying site to the field, and so because we have so many certified sites in these areas we lost \$40,000 last year approximately not being able to bill for travel costs. Again, it's a business strategy to increase revenue from the state and reduce overhead costs. This strategy will also cut a division manager position, a supervising position, and a secretary position along with 14 line staff positions. Consumers will continue to receive services in these three key locations in rural Fresno and at least five satellite sites. We will have to decertify them, meaning we need to bring the service hours down to less than 20 hours per week so that we can bill for travel costs, and staff will make home visits if clients need it. If the board approves this I will track this to make sure that we deliver our promises. That's my commitment because I don't want any impact on clients. The other option that I didn't put out here, which would make the union upset, is that we could outsource this operation also so we don't have to decertify, we don't have to reduce service hours.

Six peer support positions are in jeopardy because they are not mandated by the state

Something that is very emotional for a lot of folks, very difficult right now, is that we have six occupied positions and one vacant position that provide peer support services and advocacy for clients. These positions are occupied by recovering clients, clients who have mental health problems and have recovered, and we hire them to provide peer support services for clients. These positions are very, very good positions, very valuable, very viable to help clients understand that I made it, so can you. The state doesn't recognize these services as billable. They're not mandated by law. Last year we needed about \$764,000 to pay for these positions. But there's hope. In the Mental Health Services Act, Proposition 63, we have a strategy in there to build a village model, a best practice model like Long Beach has been doing, and it has a peer support component in there, so when the state approves that strategy from Proposition 63 money we will have that money to continue the services.

LeeAnn Parry: I'm a very, very strong advocate of peer support. However, I would see the department's role as being very limited in terms of just being able to advocate for the client and encourage them to learn more about the resources available in the community. On the issue of reducing hours and so on in rural sites and centralizing to three main sites and providing the home visits, that's a better practice, actually, than maintaining all of the sites out there, and if you can do it in a way that's reimbursable, home visits are documented to be much more successful in engaging the whole family in a treatment plan and being able to build trust and so

on, so I hope that you will be able to communicate that to the county and to our residents, too, that these are moving toward better practices, actually, in this way of trying to cut costs.

Participant question: I've been observing for a good many years lots of outsourcing stuff. My impression is usually it either doesn't give the services or else it pays a lot of people at minimum wage rather than a decent salary. Is this what's usually happening? You've mentioned a couple places where there seem to be very good services provided. That certainly is not what I've observed ordinarily in all this outsourcing frenzy.

Giang Nguyen: I'm actually very pro-county, pro-employee, and pro-government because I know the government's bottom line is not about money. I'm not saying the nonprofits' bottom line is about money either, but I looked at all the counties and I think it depends on how you write your contractual agreements. You have to have outcome managers and criteria to be met. On January 21 I'm going to the board to present a very innovative idea for this county. San Diego County has done this for many, many years. The proposal I'll put out next week with Supervisor Perea's assistance is that we want to do what is called managed competition. In managed competition pretty much we re-engineer the programs that we think are not cost effective and not producing good outcomes for clients and we put it out as a proposal and we allow the private sector and employees to bid on it together. The bottom line is we want outcomes for our clients, so this is giving employees the opportunity to make changes. We want the outcome of quality service and cost containment. I think this approach is going to be fair across the board. If employees feel that they can make changes and contain the costs and keep the organization sustainable financially, this is their opportunity as well.

LeeAnn Parry: As recently as 2000 I started being part of review committees for proposals for outsourcing services and in the past five years there has been a tremendous improvement in asking for and getting competitive proposals. When I started out there might be one proposal. The outsourcing is bringing more services into our community as services that did not exist before and it improves things in the sense that the services by being competitive have to show that they're having good outcomes for the patients. That isn't to say that we shouldn't be very cautious about outsourcing and we should always use it to improve services rather than the opposite.

Billy Gray, Bioterrorism Coordinator, Fresno County Public Health Laboratory

I am the bioterrorism coordinator for the Fresno County Public Health Laboratory. I'm also a certified public health microbiologist and a clinical laboratory scientist. Basically, those certifications mean I can work in the other hospital laboratory, clinical laboratory, or do public health work and work in a public health laboratory. They both have separate licensures even though they cross over. Today I'd like to give you an overview of the public health laboratory. We actually have a very diverse, very good public health laboratory. We cover a large area of material. Some of the testing that we do is our typical clinical chemistries and hematology, some drug testing, microbiology, serology, and virology. What sets us apart from most public health labs is that we also do environmental chemistry and some radiological testing. We also have a dairy/food lab component. Like most labs, we have to follow regulations set out by certain associations. One of those associations is CLIA, which is the federal regulatory group for all

clinical laboratories. We're a member of the Laboratory Response Network, which I will go into a little later. We're also a member of the Food Emergency Response Network, also known as FERN, and part of the Chemistry Laboratory Response Network and ELAB. ELAB is the Environmental Laboratory Testing Regulatory board. They actually are the environmental counterpart to CLIA.

The Fresno County Public Health Laboratory is broken into two departments, the public health side and the environmental side

We are one laboratory with multiple sections. Our laboratory is basically broken up into two main departments or two sections underneath the public health laboratory title. We have a public health side and an environmental side. Both of those are then also broken down into two other components. The environmental side is broken up into our environmental/water chemistry side and they also have the dairy/food laboratory component over on the chemistry side. The public health side is then broken up into our clinical side and public health microbiology. Over on our environmental side, the water/chemistry side, we mainly do mostly water testing for both drinkable water and also waste water. We started doing water testing back in the mid 80s. Back in about 1982 the federal government regulated and declared churches, schools, trailer parks, and whatnot small water systems. At that point we started doing water testing and also opened our doors to the public to help small water systems figure out what's going on with their water. As I said, we do organics, inorganics, and radiation testing on not only small water systems but also private wells. We do waste water testing for all of the same also.

The Chemical Laboratory Response Network is a web of labs throughout the nation that will work together in the event of a bioterrorism attack

A large component of what we do is hazardous materials work. This is where we work closely with our local hazmat teams identifying unknown substances or the "white powders" that started cropping up in abundance after 9-11 and the anthrax scares back east. I mentioned earlier that we are a member of the Chemical Laboratory Response Network. Chemical Laboratory Response Network is basically a web of labs throughout the nation. It's designed so that if there's some kind of a chemical terrorist event everybody would respond in a cohesive manner. It's broken up into three distinct levels. You have level 3 labs, which are considered all hospital labs and public health labs. Their responsibility is just to collect samples and send them on somewhere else for testing. Level 2 labs are labs that have been given procedures and methods to do certain levels of testing. Normally, the basic level 2 ones would be heavy metal analysis in urine and also testing for ricinine in body fluids. Level 1 labs are those labs that would do everything. I'm happy to say we were designated a level 2 laboratory, which is actually quite a feat. At the time that we were designated level 2 there were only four localities in the nation that were given that designation. By localities I mean not a state laboratory or a federal laboratory. Those four localities were New York City, Chicago, Los Angeles, and Fresno, so that kind of puts us in elite company and gives you an idea of how our lab is looked upon nationally for our chemical abilities.

The dairy/food side of the laboratory tests milk for impurities and water and food for bacteria

On the dairy/food side we are a state and federal regulatory dairy laboratory, and the testing that we do is mainly on milk. We test for impurities and also to make sure that they haven't been watering down their products. This section also handles our water bacteria section where we look for iron bacteria as well as coliform bacteria and we do coliform counts. This section also does food bacteriology. We don't do a whole lot of food on a daily basis. Most of the food samples that come through our laboratory are usually linked to some kind of a consumer complaint, whether it's part of an outbreak investigation or someone that has gone out to a restaurant and complained about feeling sick afterwards. They can file a complaint with our environmental health agency and then through the investigation if they haven't eaten all of their food sometimes we'll get food in and we'll do an analysis to see if we can pick up something. Also, we do get just regular consumer complaints, somebody that might have thought that they got something bad from a carton of ice cream. We do a lot of work with the general public. The general public can bring in water, but for things such as food and dairy they usually need to go through our environmental health branch.

The public health side of the laboratory is broken up into the clinical laboratory and the public health microbiology side

Our public health side of the laboratory is broken up into the clinical laboratory and the public health microbiology side. Our clinical section is like any other hospital laboratory. We do our clinical chemistries, hematologies, drug confirmations, and blood leads. We work with our local clinics on this, Jail Medical Services, Juvenile Hall, and a couple of drug programs. With the blood leads we actually have an extensive network of clinics and hospitals that send us stuff from all over the state. The public health microbiology side is your traditional public health stuff. This is the section where we do bacteriology such as salmonella, shigella, and whatnot. We do microbacteriology, so looking for TB mycology and the funguses, parasitology, and we do serology including all the hepatitis viruses and HIV both on serum and on oral fluid. Also this is the section that takes care of West Nile virus. We do some virology, mainly herpes work. We also do some influenza work when asked to.

The Fresno County Public Health Laboratory partners with local hospitals and labs as well as labs all over the state so that they can respond to crises quickly

We've been designated as a level B reference laboratory by the Laboratory Response Network, which is a web of labs that will have a coordinated response to any kind of biological attack. Our role as a level B laboratory is to coordinate with all of the hospitals in our catchment area. Our catchment area extends from Merced all the way down to Kern County and everything in between in the Central Valley. It accounts for the majority of OES Region 5. With that our responsibility is to make sure that all of the hospital labs are trained in how to rule in and rule out potential bioterrorism agents, those agents being anthrax, plague, tularemia, brucella, those that the CDC and FBI and federal government have deemed "the list." This program is mostly grant funded, which has advantages and disadvantages. Advantage one, we have a good source of income coming through this. Disadvantage, you have to spend it on exactly what they tell you, but the beauty of it is that through this grant we have gotten quite a bit of technology that we

wouldn't have had otherwise. Our role in all of this is that we are a support service. We provide support to quite a few different people when it comes to our partnerships. We partner up with the local hospitals, local clinics, and clinics all over the state. We work closely with animal control and vector control on rabies, West Nile virus, and things of that nature and with our local first responders. We happen to be very fortunate that the Community Health structure has all of Community Health including Emergency Medical Services, environmental health, and the CD Outreach branch all in the same building, so we actually work very closely with all those first responders, which allows us in cases of crisis or emergency to respond quicker and better because we work on a daily basis with these people. We also have one boss, so if Dr. Moreno says you guys are going to do this there is no fighting over it and it gets done in a more timely manner. One of our partners is the U.S. Postal Service. As part of our role in bioterrorism we are the regional support laboratory for both the Fresno and Kern County U.S. postal sorting facility distribution centers. I don't know if you're aware of it, but a couple of months ago both Fresno and Kern County launched the BDS system. The BDS system is an add-on to their sorting system. As mail is going through and getting cancelled out it hits a pinch point. At that pinch point they have an instrument that is collecting air samples and then goes through and tests for anthrax. Actually, the BDS system is a nationwide system that's expanding all the time. It includes FBI, law enforcement, fire, first responders, laboratories, post office, you name it. Everybody is involved in this. On the off chance that one of these analyses comes up positive for anthrax there will be alarms that go off all over the place, people are going to be responding like crazy, and eventually the samples that were from that analyzer will be brought to us and we will do final analysis and do confirmation work. The facility will end up being closed down for three days or until we've given the answer that, yes, it is anthrax or no it is not, and at that point they will proceed until it's safe for everybody. So that's how we collaborate and have a partnership with the post office.

The Fresno County Public Health Laboratory is here to serve the community

Again, we work with the general public. Not only do we provide testing in the form of water testing, we also help out with other projects that go on through the Department of Community Health such as health fairs doing cholesterol screening and things of that nature. We provide tours of our labs to groups. We help out with training nurses that are going through Fresno State. We also help out with giving lectures and training seminars to different facilities around the area. We are here to serve you. If there is ever any kind of laboratory question that anybody has you can feel free to call us. We have wide range of expertise at the laboratory. As you can see, we work in such a diverse group of things that people know a little bit about everything it seems, and any questions that we can't answer we have the full support of the state public health laboratory to help find the answers.

Jessica Rothhaar, Health Access, Sacramento California Health Access

My name is Jessica Rothhaar. I'm the Northern California organizer for Health Access Foundation and Health Access California. We're the statewide consumer healthcare advocacy coalition. I want to talk about bills, ballots. Let me start with the big picture, which is obviously SB 840, Sheila Kuehl's bill to provide universal healthcare coverage through single payer or Medicare For All. SB 840 passed the Senate last year, which was quite remarkable and

significant. It passed on a straight party line vote, and Sheila Kuehl wants to move that bill now through the Assembly this year and get it to the governor's desk. This governor will certainly veto it, but he will have to do so moving into an election where he has not yet in three years proposed a single solution to California's healthcare crisis. We want to work with all of our local partners around the state to make sure that the expansion of health coverage to California's uninsured is part of the debate as we go into the election this year. This bill will need your support because Juan Arambula and Nicole Parra have been part of a group of legislators who have been obstructive on a number of pieces of consumer healthcare legislation this year. Juan Arambula and Nicole Parra have both voted against key bills on the health access agenda and if those same ten members of the Assembly vote against SB 840 it will fail, so we need all of you, if you support single payer, to get in touch with Arambula's office now. Let him know it's going to be coming to the Assembly and you want him to vote yes and it's a voting issue for you. I would encourage everyone to reach out to the groups that can mobilize voters, that can do voter forums, and make sure that as you go particularly into the primary in June that this becomes a key issue as people are thinking about who to endorse in the primary.

In the first four days of January there were 36,000 denials for prescriptions under Medicare Part D

The next issue that's huge for everybody, of course, is Medicare Part D. Health Access is working with the California Alliance of Retired Americans, the Congress of California Seniors, Older Women's League, and Gray Panthers in a coalition along with other groups to try to fix the problems created by this new Medicare legislation. We were telling Governor Schwarzenegger for months that on January 1 when this legislation came into effect seniors who are dual eligibles, Medicaid and Medicare, were going to be in a pile of trouble and people would die, and in fact that's what we saw. Basically what is happening right now is that people are not in the computer system. They've lost their coverage under Medicaid, are supposed to be in Medicare, the federal Medicare computer system is not taking care of it, and people are getting turned away without their prescriptions. We had 36,000 denials in the first four days after January 1 in California. The governor has agreed to use his emergency powers to reimburse pharmacists for up to 30 days if they will fill the prescriptions of people who don't show up in the Medicare database but did have Medicaid coverage. Whether you believe the federal government is going to fix the problem in 30 days depends on who you talk to. The program is fundamentally flawed and the problems are going to go on for a long time. With Medicare D we are also going to be pressing for more extensive wraparound protection. The problem is that even if you fix the computer problem, Medicare D made people with dual eligibility and others pay more and get less. We want to fix that both through federal legislation and with the petition that CARA is circulating to Congress.

When insurance companies sell plans that have very high deductibles or very low annual benefit caps they discourage the insured from seeking primary preventative care

While we wait for single payer legislation and for the change in the national consciousness that will be required we need to ensure that we don't lose the coverage that 18 million Californians depend on. Our whole system of insurance is based on having risk pools that are big enough so that you can have sick people and healthy people in them and everybody's paying premiums and

then there's money in the pool for when people get sick. As employers back away from that, the pools are getting smaller, young and healthy people are the ones losing coverage, older sick people are the ones who retain coverage, and everybody's costs go up. Health Access is the only organization in the state that works on a comprehensive range of fronts to address that issue. I want to tell you about one piece of legislation. It's called AB 977 by Pedro Nava. When insurance companies sell plans with very high deductibles or very low annual benefit caps and they say this is how we're going to keep insurance affordable what they're doing is actually creating a policy that by design discourages the insured from seeking primary preventive care. If you have a \$5,000 deductible have to spend \$5,000 out of your pocket before you get a dollar's worth of benefit from your health insurance. Those deductibles are already becoming common and the insurance companies are marketing them to large employers who want to reduce their healthcare costs, but what's happening is then you have this whole class of people who are underinsured. They don't seek care, they don't fill their prescriptions, they don't go to the doctor, and if they end up in the hospital and the bill is higher than \$5,000 they're still on the hook for \$5,000. A family whose monthly income is \$1,000 is still going to be in a financial mess. Hospitals hate these plans because it leaves them exposed to bad debt. Again, Juan Arambula and Nicole Parra were part of the group who voted against this bill in June under intense lobbying by the insurance industry. We have a chance this month to bring it back. It's our last chance to bring it back or it's dead for the year. Please, if you can, send a letter by fax or call Juan Arambula and Nicole Parra. We really need them to change their votes. That would be something to do as soon as possible.

***Healthcare needs to be part of the debate as we go to the June primary
and November general election***

Let me just briefly cover the ballot. The Tobacco Tax Initiative to cover children is not perfect. Some of the money goes to cover kids. A lot of the money goes to emergency rooms. Too much of the money goes to reimburse emergency rooms for care they've already been reimbursed for because it covers care delivered to the insured. We're not happy with that. We did get some consumer protection legislation in that. A weaker version of the Chan Bill that we've been talking to some of you about to protect the uninsured from being overcharged by hospitals is in that Tobacco Tax Initiative, but the key issue that we'd like to work with you on would be making sure that healthcare is part of the debate as we go to the June primary and then the November general election. On the budget the big problem, of course, are the federal budget cuts to Medicaid. A vote in Congress will be the first week of February. If anybody is interested in hearing some detail about both the Medicaid and TANIF cuts that are in that, there is a conference call on Thursday, January 26 at 10 a.m. I've got the details that the California partnership is organizing for low-income advocates. We don't have legislators. We have only one possible swing vote, Mary Bono in Palm Springs, and we are working with partners on swaying her.