

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH EQUITY

MEETING OF THE
OFFICE OF HEALTH EQUITY (OHE)
ADVISORY COMMITTEE

SIERRA HEALTH FOUNDATION
1321 GARDEN HIGHWAY
SACRAMENTO, CALIFORNIA

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Reported by: John Cota

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Also Present

Nicki King, PhD
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Pete Lafollette

Ricardo

Ruben Cantú
California Pan-Ethnic Health Network

Stacie Hiramoto
Racial and Ethnic Mental Health Disparities Coalition

Steve Leoni

Kate Karpilow, PhD
California Center for Research on Women and Families

Raja Mitry (via teleconference)

INDEX

	<u>Page</u>
Welcome and California Department of Public Health (CDPH) Update	6
Convene Meeting and Welcome Introductions Agenda Review Logistics	8
May 12 and 13, 2014 Agenda	10
Public Comment	14
Vote	14
March 25 and 26, 2014 Meeting Minutes	14
Public Comment	15
Vote	15
Bylaws Consideration	17
Public Comment	
Nicki King	29
Vote	--
OHE and Strategic Planning Update	
Jahmal Miller	43
Tamu Nolfo	58
Public Comment	
Pete Lafollette	101
Ricardo	102
Nicki King	105
U.S. Department of Health and Human Services (HHS)	--
Public Comment	--
Lunch Break	107
OHE Climate Action Team	108
Public Comment	
Pete Lafollette	147
Ricardo	148

INDEX

	<u>Page</u>
California Reducing Disparities Project Strategic Plan to Reduce Mental Health Disparities	151
Ellen Wu	152
Ruben Cantú	154
Public Comment	
Pete Lafollette	183
Stacie Hiramoto	185
Steve Leoni	186
Ricardo	188
Kate Karpilow	189
Raja Mitry	190
Nicki King (response to question)	194
Strategic Plan Small Group Discussions (to be continued on Day 2)	205
Debrief Public Comment Period Public Comment for Items Not on the Agenda	
Debrief	209
Public Comment Period	
Steve Leoni	211
Public Comment for Items Not on the Agenda	--
Closing Comments and Adjournment	213
Certificate of Reporter and Transcriber	214

P R O C E E D I N G S

9:12 a.m.

1
2
3 AC CO-CHAIR GÁLVEZ: Good morning everyone. We
4 are going to go ahead and get started, we do have a quorum
5 now. We are expecting a few more folks and hopefully they
6 will be with us shortly.

7 Actually, the first thing on our agenda today is
8 an update from Dr. Chapman so I'll pass it to him and then
9 we'll move on with the rest of the meeting agenda.

10 CDPH DIRECTOR CHAPMAN: Good morning.

11 (Good morning in unison.)

12 CDPH DIRECTOR CHAPMAN: Really appreciate you all
13 being here on this beautiful day in Sacramento. I do want
14 to share my apologies, a very busy time of the year so I am
15 going to have to head out very shortly. We are in the midst
16 of budget hearings so we have two budget hearings this week.
17 and of course May Revise is coming out shortly and then
18 we'll have May Revise hearings. So we are preparing for the
19 May Revise and May Revise hearings as we are still having
20 budget hearings. So anyway it's a very, very busy time of
21 the year.

22 So this is our fourth Advisory Committee meeting
23 in eight months and just thinking about the planning and
24 logistics of putting together these meetings is incredible.
25 So first I want to thank all of the Office of Health Equity

1 staff for their hard work and dedication.

2 (Applause.)

3 And I want to thank all of the Advisory Committee
4 Members for your hard work and dedication, actually
5 attending these meetings.

6 (Applause.)

7 And I get regularly briefed from Jahmal and his
8 staff, from Tamu, about the progress. I was briefed, in
9 fact, on Friday, last week, and it is just amazing the
10 progress that you all are making on the strategic plan.

11 You know, I have incredible faith in all of you in
12 the work that you're doing, not only with the communities
13 you serve but now as well on this Advisory Committee. It is
14 clear to me, I am confident we will be making the July 1st
15 deadline for the Legislature. And the product, the work
16 that I'm seeing it's just -- it's tremendous, it's
17 phenomenal. The input that we're getting from stakeholders,
18 from advocates, from people all over California is just
19 incredible, really impressive. I can see it, I can feel it
20 in the plan that's being formed before our very eyes and so
21 today and tomorrow a lot more hard work putting this
22 together.

23 And I want to thank Sandi and Rocco for their
24 great leadership on the Advisory Committee, thank Jahmal for
25 his great leadership and again thank all of you for your

1 time, your dedication. I know you all lead very, very busy
2 lives and to dedicate yourselves to this work I am extremely
3 grateful. So thank you all and look forward to continue our
4 great work together. Thank you.

5 (Applause.)

6 AC CO-CHAIR GÁLVEZ: Thank you, Dr. Chapman, and
7 good luck with all those hearings.

8 Okay. As you all know, we weren't able to get an
9 extension so we are still on the course of finishing up this
10 plan in the next two days as much as possible and then just
11 having very final finessing done after this meeting.

12 So I wanted to welcome everyone and just quickly
13 go around the room and do introductions. So I am going to
14 pass the mic this way to Aaron.

15 AC MEMBER FOX: Aaron Fox, LA Gay and Lesbian
16 Center.

17 AC MEMBER LOUIE: Dexter Louie, California Medical
18 Association Foundation and National Council of Asian-Pacific
19 Islander Physicians.

20 AC MEMBER PARKS: Good morning, Hermia Parks,
21 Director of Public Health Nursing and Maternal, Child and
22 Adolescent Health for the Department of Public Health,
23 Riverside County.

24 AC MEMBER LU: I am Francis Lu, Emeritus Professor
25 in Cultural Psychiatry at UC Davis and Past President of the

1 National Asian-American/Pacific Islander Mental Health
2 Association.

3 AC MEMBER BROWN: Willie Graham, Vacaville Police
4 Department and a pastor in Vacaville.

5 AC MEMBER JEFF: General Jeff, Skid Row.

6 AC MEMBER WU: Ellen Wu, Urban Habitat.

7 AC MEMBER CANTOR: Jeremy Cantor, Prevention
8 Institute.

9 AC MEMBER RYAN: Pat Ryan, former Executive
10 Director and consultant for the California Mental Health
11 Directors Association.

12 AC MEMBER GARZA: Good morning. Álvaro Garza,
13 Health Officer at San Joaquin County.

14 AC MEMBER NEWEL: Gail Newel, Medical Director,
15 MCAH, Fresno County Department of Public Health.

16 AC MEMBER WHEATON: Linda Wheaton, California
17 Department of Housing and Community Development and the
18 Health in All Policies Task Force.

19 AC MEMBER CÁZARES: Yvonna Cázares. I should say
20 I started with Gay/Straight Alliance Network, a national
21 LGBT youth organization but I have now since moved to
22 California State PTA. But I am here to represent as a
23 member of several communities, thank you.

24 AC MEMBER OGAN: Teresa Ogan, Sacramento's
25 MultiPurpose Senior Services Program.

1 AC MEMBER DERBY: Kathleen Derby, the State
2 Independent Living Council.

3 AC MEMBER OSEGUERA: José Oseguera, Mental Health
4 Services Oversight and Accountability Commission.

5 AC MEMBER BRODY: Delphine Brody, Mental Health
6 Client Survivor Advocate and LGBTQ Advocate.

7 AC CO-CHAIR GÁLVEZ: Thank you, everyone. I am
8 Sandi Gálvez, I am the Director of BARHII. And I -- just
9 since I am going to be up here with the mic I have to let
10 you all know I got very little sleep last night so I'm a
11 little bit of a mess. And my talking is usually the first
12 thing to go so catch me if I start not making any sense.

13 Okay. So the first part of this morning --
14 welcome. I'll let you get settled.

15 The first part of this morning we are going to
16 have a little bit of logistics and business and then we're
17 going to have a couple of presentations. We originally had
18 three presentations scheduled and we did get the feedback
19 and heard you loud and clear that, you know, we had way too
20 many presentations last time. I was assured that all three
21 of these presentations were really on point for our
22 discussions around the strategic plan.

23 However, the presentation on the US Department of
24 Health and Human Services Plan to Reduce Racial and Ethnic
25 Health Disparities is not going to be happening because the

1 speaker is very ill. So that presentation is not happening
2 and we are looking at how to adjust the agenda accordingly.

3 And then in the afternoon we'll be having -- we'll
4 start having our opportunity to have small group discussions
5 again on the plan.

6 So I guess -- Debbie, where are you? You wanted
7 to go over the logistics.

8 MS. D. KING: Good morning, everybody. It's good
9 to see you all here. I'm going to do my little spiel again.

10 So welcome to the May Advisory Committee meeting.
11 And as you know we are governed by the Bagley-Keene Open
12 Meeting Act. You have read this information before so I am
13 not going to read it to you. Just please make sure that you
14 remember when you go out on breaks and out at lunch that
15 what is said here stays here and you don't discuss that
16 outside of this venue, please.

17 If you wish to provide public comment we have
18 cards that are available. Please complete a card, hand it
19 to Mallika over here, please, and she will make sure that we
20 receive that card and call you up in the manner in which you
21 would like to be called so identify yourselves, please, if
22 you choose to or the organization that you are a part of.
23 And you will be called in the order in which we receive your
24 card. Depending on how many presentations or how many
25 comments we have you will probably be restricted to about

1 two minutes each.

2 Emergency evacuation plan. Everybody goes out the
3 front door or the side door and just leaves the building.
4 There is no definitive plan here, just make sure that you
5 exit the building.

6 Restrooms are right around the corner of this wall
7 on the other side of the wall.

8 Wi-Fi Internet access. If nobody -- if you have
9 devices that you would like to log into, on the sign stuck
10 to the wall up here you have all of the information that you
11 need to get yourself logged into this Wi-Fi.

12 If you have not been receiving our e-blast
13 notifications please sign up at the front desk. I'll review
14 that when we get back later this week and make sure your
15 name gets added if you want to have your name added.

16 And any of the OHE staff, would you all stand up,
17 please, and be recognized. OHE staff. Any of these folks
18 can assist you throughout the day, so if you have any
19 issues, any problems, any questions, please connect with any
20 of them. Thank you.

21 We have John up at the front. He is doing the
22 transcription today for us. He is linked into the sound
23 system.

24 (Teleconference message was heard.)

25 MS. D. KING: He gets feedback, audience can't

1 hear. So we have a little bit of an issue with microphones.
2 About a hand's distance away would be good. And please
3 speak directly into your microphone. I noticed last time
4 people would hold the microphone here and talk over here so
5 please make sure you speak into the microphone.

6 Sandi will recognize you prior to you speaking.
7 Please use the table tent turnaround procedure like we used
8 the last time so she is able to see who wants to speak.

9 And if you angle your cards a little bit toward
10 John that might help when you speak.

11 (Teleconference message was heard.)

12 MS. D. KING: Sorry. We'll get somebody in here
13 to help out with that.

14 So yes, also just make sure you angle the cards.
15 And state your name prior to speaking so that we can make
16 sure that that's on the record. This is being recorded so
17 if he cannot hear you, you won't be recorded.

18 Any questions? No? Thank you. Enjoy your
19 meeting.

20 AC CO-CHAIR GÁLVEZ: Additionally, as far as
21 logistics, I wanted to remind folks to please put your
22 phones on vibrate.

23 And as far as public speaking, when I call folks
24 forward I will probably call folks a couple at a time.
25 Please come --

1 (Teleconference message was heard.)

2 AC CO-CHAIR GÁLVEZ: Please line up over here so
3 that we can facilitate the public speaking process
4 relatively quickly.

5 Okay, so the first item on our agenda today is the
6 review of the agenda and I guess I have gone over the
7 agenda. Would anyone from the public like to comment on the
8 agenda?

9 Okay. So I guess we need to vote to approve this
10 agenda; is that correct? Is there a motion?

11 (Teleconference termination message was heard.)

12 AC MEMBER LOUIE: So moved.

13 AC MEMBER OSEGUERA: Second.

14 AC CO-CHAIR GÁLVEZ: All those in favor?

15 (Ayes.)

16 AC CO-CHAIR GÁLVEZ: All those opposed?

17 (No audible response.)

18 AC CO-CHAIR GÁLVEZ: Okay. Any abstentions?

19 AC MEMBER GENERAL JEFF: (Raised hand.)

20 AC CO-CHAIR GÁLVEZ: Okay, motion passes.

21 The next item is our meeting minutes from our last
22 meeting. Are there any --

23 (Teleconference line message was heard.)

24 AC CO-CHAIR GÁLVEZ: Okay, are there any comments
25 on the meeting minutes from our last meeting?

1 How about any public comments about the meeting
2 minutes?

3 All right. Would anyone like to make a motion on
4 the minutes?

5 AC MEMBER LOUIE: So moved.

6 AC MEMBER PARKS: Second.

7 AC CO-CHAIR GÁLVEZ: All those in favor?

8 Actually I do want to remind folks that according
9 to the decision we made at the last meeting, we do not need
10 to have seconds for motions. Okay. So all those in -- I
11 heard the favor; any opposition?

12 (No audible response.)

13 AC CO-CHAIR GÁLVEZ: Any abstentions?

14 AC MEMBER GENERAL JEFF: General Jeff.

15 AC CO-CHAIR GÁLVEZ: Okay, motion passes.

16 Our next item on our agenda is reviewing again the
17 bylaws.

18 Actually let me go back. So we also had an
19 additional document, which was the public comments. Is this
20 considered part of the minutes?

21 MS. D. KING: It's considered part of the minutes.
22 So when we had these documents printed the printer put a
23 slip sheet in-between each document. So the sections are
24 not sectioned off per section, they are sectioned off per
25 document. So the comments went with the minutes.

1 AC CO-CHAIR GÁLVEZ: Okay. Then I actually have
2 an issue because the date on them is today's date, not the
3 date for the last meeting, on the public comment section of
4 the minutes. So that needs to be corrected. Tamu wants to
5 address that.

6 DR. NOLFO: I'm sorry, it was a printing error,
7 you're right. And so the public comments say at the top
8 "May 12th and 13th" but it should be March -- was it 25th
9 and 26th? The 25th and 26th. And so you will also see
10 where it says "Day 1: March 25th" that should say "March
11 26th." I'm sorry, "March 25th." And then on Day 2, if you
12 flip, it should say "March 26." So I apologize. There were
13 some issues with the dates on this document.

14 (Teleconference connection message was heard.)

15 AC CO-CHAIR GÁLVEZ: Okay. So since the meeting
16 minutes were actually amended --

17 (Teleconference line message heard.)

18 AC CO-CHAIR GÁLVEZ: Okay. So since they were
19 amended we need to vote on them again, right?

20 SPEAKER (OFF MIC): Minutes as amended.

21 AC CO-CHAIR GÁLVEZ: Minutes as amended. So all
22 those in favor of approving the minutes as amended please
23 say aye.

24 (Ayes.)

25 AC CO-CHAIR GÁLVEZ: Any opposed?

1 (No audible response.)

2 AC CO-CHAIR GÁLVEZ: Any abstentions?

3 AC MEMBER GENERAL JEFF: General Jeff.

4 AC CO-CHAIR GÁLVEZ: Okay, motion passes.

5 All right, now we can move on to the bylaws. So
6 would anybody like to comment?

7 I do have one section that I recommend a language
8 change. Debbie, do I have --

9 (Teleconference line message was heard.)

10 AC CO-CHAIR GÁLVEZ: Okay, I don't have -- Debbie
11 has it, okay.

12 So on the voting section on page 5, Voting Rights.
13 The language in there is not completely clear as to whether
14 or not a committee member can vote via phone, via the phone
15 conference so I want to propose amending it as follows:

16 "In person" shall be defined as physically
17 present at a meeting or another publicly noticed
18 location if a teleconference meeting is in
19 conformance with the Bagley-Keene Open Meeting Act
20 requirements.

21 And then that would go in place of the current
22 sentence that reads -- beginning with "In person." So that
23 is my one suggestion for changes that I think need to --
24 would clarify what we mean by participation via phone for
25 committee members.

1 So it would read:

2 "Each appointed member shall be entitled to
3 one vote to be exercised in person. "In person"
4 shall be defined as physically present at a
5 meeting or another publicly noticed location if a
6 teleconference meeting is in conformance with the
7 Bagley-Keene Open Meeting Act requirements."

8 And then followed by: "There is no allowance for
9 vote by proxy."

10 So that's my recommended changes for that, that
11 part of the bylaws. Are there other -- is there any
12 discussion about that suggested change? José.

13 AC MEMBER OSEGUERA: So just a -- there would be a
14 clarification question. And that is, so you are suggesting
15 that someone can actually vote if they are participating in
16 a conference call as opposed to being here in person. So --

17 AC CO-CHAIR GÁLVEZ: If the meeting is a publicly
18 noticed meeting. So they can't just call in from their
19 office. But if we are doing a teleconference site off-site
20 somewhere in Southern California or what have you, and it's
21 a publicly-noticed site here the public can go and
22 participate at that site, they can be there.

23 AC MEMBER OSEGUERA: All right.

24 AC CO-CHAIR GÁLVEZ: And call and participate from
25 there.

1 AC MEMBER OSEGUERA: Okay.

2 AC CO-CHAIR GÁLVEZ: It's a little bit different
3 than the way I think of -- in my world teleconference means
4 phone. But here I guess we're meaning by -- in another
5 location.

6 AC MEMBER OSEGUERA: All right.

7 AC CO-CHAIR GÁLVEZ: Any other comments about that
8 change?

9 Okay. And I will entertain any other comments
10 about other parts of the bylaws if anyone has anything they
11 would like to say. Álvaro.

12 AC MEMBER GARZA: I have a question on page 8,
13 number 6 at the top, about agenda building. And it does say
14 that the agenda will be drafted by the Chair with input from
15 the advisory committee members where we are invited to
16 submit agenda items at least 20 days before a scheduled
17 meeting. And I am not sure but I don't think that has been
18 happening so I request that that happen so that we help
19 build the agenda. But not to change the bylaws, I agree
20 with what is there.

21 Because specifically, I think for a good public
22 health practice we should have some exercise time after two
23 or so hours of work in these meetings and we haven't been.

24 And one other question, which is maybe in the
25 bylaws but it's regarding the voting on the agenda because

1 you will have to clarify for me. The Bagley-Keene says the
2 agenda is finalized 10 days before the meeting and it isn't
3 changed. So I am not sure why we vote for the agenda.

4 That's for the lawyers, perhaps, I'm not sure.

5 AC CO-CHAIR GÁLVEZ: Katie, are you available to
6 speak to that because I am not clear either.

7 MS. BELMONTE: You are correct, the agenda needs
8 to be put up --

9 THE REPORTER: Please identify yourself.

10 MS. BELMONTE: Sorry. Katie Belmonte, Office of
11 Legal Services, California Department of Public Health.

12 The agenda has to be posted and we can't make
13 substantive changes to it 10 days before the meeting. So
14 you are correct, we don't need to vote on the agenda itself,
15 just the meeting minutes.

16 AC CO-CHAIR GÁLVEZ: Okay. No, and I agree,
17 Álvaro, about the fact that we haven't -- because I haven't
18 been primarily responsible for making the agenda either,
19 it's been primarily staff up to this point. I think now
20 that we are going to complete the Strategic Plan, I think
21 moving forward our meetings will be much more what we want
22 these meetings to be.

23 AC MEMBER GARZA: Okay.

24 AC CO-CHAIR GÁLVEZ: Dexter. The microphone is
25 coming.

1 AC MEMBER LOUIE: Thank you. Dexter Louie. I
2 have three items.

3 One is for clarification. One is I think more
4 important. It's on page 7, Section H, Item 2. And as it
5 reads, the "Meetings may be conducted by any accepted rules
6 of procedure, including Robert's Rules of Order." That is
7 somewhat arbitrary. We haven't named -- we haven't adopted
8 a specific code that we are going to follow. It tends to be
9 Robert's but Robert's has been, if I might expand, replaced
10 over time by what's called the Standard Code of
11 Parliamentary Procedure. And it really makes Robert's
12 easier to understand but follows Robert's in -- not the
13 language of Robert's, which is old, very old English.

14 And this particular standard code is put out by
15 the American Institute of Parliamentarians. When it first
16 came out in the '50s it was endorsed by Justices of the US
17 Supreme Court and parliamentarians of the US Senate and
18 House of Representatives. It currently has a permanent
19 board of advisors including people from the American Bar
20 Association and a number of others, the US Chamber of
21 Commerce. So it's used quite frequently. It's used at the
22 California Medical Association and the American Medical
23 Association.

24 So I would suggest that we amend Section H, number
25 2 with a comment that meetings will be conducted according

1 to the Standard Code of Parliamentary Procedure in its
2 fourth edition.

3 Leaving that for consideration it brings us to
4 Section G, which is -- and we just demonstrated that. On
5 Item 1 we voted on a motion with a voice vote, not by a show
6 of hands. In other words, it follows -- what we did follows
7 the Standard Code of Parliamentary Procedure, we did a voice
8 vote before we did a show of hands. A show of hands or a
9 stand-up vote or a roll call follows the voice vote. So
10 that is consistent with Sturgis or the Standard Code. So we
11 take care of number 2 by adopting the Standard Code, we take
12 care of Section G because then that would have to be
13 amended.

14 And the last item is for clarification. Page 6 at
15 the bottom. I am not sure exactly what it means by limiting
16 or specifying a time for public comment and that becomes
17 administrative regulation. It is just not clear to me that
18 we can create a regulation. Maybe the wording is not
19 correct but I don't know, I have to ask Legal on that. I am
20 not sure we as a committee can do regulations.

21 Anyway, those are my three comments. So I would
22 hope -- when the opportunity arises I will make a motion to
23 adopt the Standard Code of Parliamentary Procedure.

24 AC CO-CHAIR GÁLVEZ: Okay, so let's take those one
25 by one. Let's start with the easier. Katie, would you be

1 able to comment on the issue of on the bottom of page 6, the
2 second to the last paragraph, if the committee may adopt an
3 administrative regulation regarding the time allowed.

4 MS. BELMONTE: I'm going to have to research that
5 one, I didn't write this language. It was kind of cobbled
6 together, I think, from other advisory committee bylaws
7 prior to when I started providing legal advice. So I will
8 research that one.

9 AC CO-CHAIR GÁLVEZ: Okay, thank you.

10 Then the -- I'm sorry, Dexter, I only heard two.
11 What was -- I have the one related to adding --

12 AC MEMBER LOUIE: Section H, Item 2 is --

13 AC CO-CHAIR GÁLVEZ: Right, I got that. What was
14 the other one? You said there was three.

15 AC MEMBER LOUIE: It would be Section G, the
16 voting.

17 AC CO-CHAIR GÁLVEZ: Oh, so to change --

18 AC MEMBER LOUIE: The rules that we follow, us
19 here.

20 AC CO-CHAIR GÁLVEZ: Okay.

21 AC MEMBER LOUIE: That we do it correctly. But
22 it's not what's here on the document.

23 AC CO-CHAIR GÁLVEZ: Well also G-1 and G-2 are in
24 -- they are not in agreement with each other.

25 AC MEMBER LOUIE: Correct.

1 AC CO-CHAIR GÁLVEZ: So we need --

2 AC MEMBER LOUIE: Correct.

3 AC CO-CHAIR GÁLVEZ: -- for those to agree.

4 AC MEMBER LOUIE: That's correct. And if we take
5 care of Section H with adoption of the Standard Code of
6 Parliamentary Procedure that would take care of G, which
7 would have to be amended to follow the Standard Code. It
8 would take care of all the corrections in G.

9 AC CO-CHAIR GÁLVEZ: Okay. So comments then
10 around changing subsection H -- Section H to read -- I'm
11 sorry, the name of the -- the Standard Code of Parliamentary
12 Procedure.

13 So Patricia, you had your card up first.

14 AC MEMBER RYAN: Yes. On page 7, section H,
15 number 2. It seems like it would be more broad and generic
16 just to put a period after "procedure" and take out the
17 "Roberts Rules of Order." That means that we could use
18 whatever procedures we want without specifying what they are
19 as long as we agree to them.

20 AC CO-CHAIR GÁLVEZ: Aaron.

21 AC MEMBER FOX: Well, I'm someone who appreciates
22 good parliamentary procedure. I think that we have been
23 working off the parliamentary procedure already in our
24 committee and I would really urge us not to get bogged down
25 in process as we start these meetings. I think it can get

1 extremely cumbersome, especially for public who are here,
2 when we are really digging into, I think, minutiae that
3 detracts from our main goal, which is to get to the Plan.
4 So I would say, let's keep moving.

5 AC CO-CHAIR GÁLVEZ: Aaron, I am not clear. So
6 are you saying to adopt the change that -- you're saying
7 don't adopt it, okay.

8 Any other comments? Hermia.

9 AC MEMBER PARKS: So in our last meeting we agreed
10 to adopt a more concise, condensed version of Robert's Rules
11 and we made a motion to approve that. So can we undo that?
12 I guess this is a question. Can we now change that motion
13 that was approved at the last meeting?

14 AC CO-CHAIR GÁLVEZ: Well, I would say we follow
15 what Patricia suggested which is, don't specify here at all.
16 We can continue to then abide by the decision we made at the
17 last meeting. And if at a later point in time we decide
18 we're rather do something else, like Sturgis for example, we
19 can bring that up and decide at that point to go forward
20 with that. Delphine, you had --

21 AC MEMBER BRODY: I just wanted to follow up on my
22 proposal from March, from our March meeting, that we -- that
23 we look at Section E, paragraph --

24 AC CO-CHAIR GÁLVEZ: Delphine, can I interrupt
25 you?

1 AC MEMBER BRODY: Yes.

2 AC CO-CHAIR GÁLVEZ: Right now I just want to -- I
3 think in order to make this be more productive let's stay on
4 one. Let's have like a full discussion about any one
5 item --

6 AC MEMBER BRODY: Okay.

7 AC CO-CHAIR GÁLVEZ: -- and then I'll call for a
8 new item and then I'll go to you first, okay?

9 AC MEMBER BRODY: Okay, sure.

10 AC CO-CHAIR GÁLVEZ: So any other comments related
11 to Dexter's motion for section -- not motion but suggestion
12 for Section E, number 2? Dexter?

13 AC MEMBER LOUIE: Just one last comment on having
14 a specific code, whether it be Robert's or Sturgis or any
15 other is that it is specific, it is procedural. So that
16 when it becomes complicated it's really clear, you follow a
17 certain order so that we can proceed. Whereas if you don't
18 have a code it then becomes what's known as chaos because
19 you don't know where you are in the order of what you're
20 trying to accomplish. It takes you through it step by step.
21 So I would recommend that this body adopt this, thank you.

22 AC CO-CHAIR GÁLVEZ: General Jeff. This is still
23 comment about this issue? Okay.

24 AC MEMBER GENERAL JEFF: Thank you. I was led to
25 believe that our meetings would be overseen by Bagley-Keene,

1 so it seems like it should state --

2 AC CO-CHAIR GÁLVEZ: Bagley-Keene is different.
3 Bagley-Keene is a requirement around how we need to conduct
4 the meetings in a publicly accessible and open process.
5 This is a way to -- like the process that we will use for
6 our discussions, how do we -- how do we organize our
7 discussions. You know, like what we say first, what we say
8 second, how we make decisions, that sort of thing. They are
9 not in -- they are not in disagreement with each other, is
10 what I'm saying.

11 Any other comments related to this? Hermia.

12 AC MEMBER PARKS: The only concern that I have
13 about actually putting a specific edition in, if we say the
14 third edition, whatever we decide to go with, then if that
15 edition no longer exists we'll have to then revise the
16 bylaws again. So even if we go with what Dexter is
17 suggesting or what the group as a whole decides to vote on,
18 I think putting in an edition is going to really bog down
19 the bylaws because then it will be -- you know, it won't be
20 effective. I mean, it will be outdated, so to speak.

21 AC CO-CHAIR GÁLVEZ: José.

22 AC MEMBER OSEGUERA: Yes, I would just like to add
23 that in regards to the Standard Code of Parliamentary
24 Procedure, it is very well known and is basically a standard
25 for how to conduct meetings and it would ensure for

1 consistency in terms of making those difficult decisions
2 that we will have to make sooner or later.

3 AC CO-CHAIR GÁLVEZ: Any other comments? I guess
4 I'll add my two cents. Personally I would err -- I think, I
5 guess, where Aaron is leaning of not specifying. We did
6 agree at the last meeting to use a more simplified process.
7 And then in the future if we decide we'd rather use Sturgis
8 we could elect to do that and move forward doing that and
9 the bylaws don't have to reflect that we decided to use one
10 or the other. I would go with however the group wants to do
11 it, however. I would like us to just be able to put closure
12 on this and, you know, move on because we do need to
13 eventually adopt our bylaws.

14 So are there any other comments? About is,
15 Delphine? Sorry, about this issue.

16 Dexter, do you want to make a motion and then just
17 have us just vote on in and decide whether or not -- how we
18 are going to move forward?

19 AC MEMBER LOUIE: I would like to move that --
20 thank you, Madame Chair. Dexter Louie.

21 Section H, Item 2, I would move that it be
22 restated. The amendment of the draft by substitution.
23 Meetings may be -- Meetings shall be conducted according to
24 the Standard Code of Parliamentary Procedure, period.

25 AC CO-CHAIR GÁLVEZ: Let me check. Do we need to

1 get public comment? We need to get public comment about
2 this specific thing before we could vote on it, correct?

3 Okay. Is there --

4 (Teleconference line was unmuted.)

5 AC CO-CHAIR GÁLVEZ: Is there any public comment
6 related specifically to the motion around the amendment to
7 H-2 by anybody from the public?

8 (No response, teleconference line muted.)

9 DR. N. KING: I would only encourage you to --

10 AC CO-CHAIR GÁLVEZ: Please come to the podium,
11 please.

12 DR. N. KING: Nicki King, University of
13 California, Davis. I would only encourage that you adopt
14 something that people can have -- that the public can have
15 access to and easily follow so that they understand what
16 your rules of procedure are. And that's all I am
17 suggesting. So if there is a decision you need to make
18 between one code or another, I hope you will select the one
19 that is most easily available to the public.

20 AC CO-CHAIR GÁLVEZ: My understanding is that the
21 one we adopted last time that Cynthia brought is publicly
22 accessible. I actually don't even remember what it's called
23 but it is publicly accessible. She had a book that she
24 brought.

25 Okay, any more discussion about the motion or

1 could we take a vote on it?

2 Okay, all those in favor of making the change that
3 Dexter suggested please say aye.

4 (Ayes.)

5 AC CO-CHAIR GÁLVEZ: All those opposed?

6 (Nos.)

7 AC CO-CHAIR GÁLVEZ: I want to see a show of hands
8 because it is too close. So all those in favor please show
9 your hands.

10 (Show of hands.)

11 AC CO-CHAIR GÁLVEZ: It's seven. All those
12 opposed?

13 (Show of hands.)

14 AC CO-CHAIR GÁLVEZ: Any abstentions? Did you
15 just add your hand, General Jeff, or did you have it up
16 already? Okay.

17 So we had 7 yeses, 11 nos. Any abstentions?

18 Okay. So the wording will -- so I guess, Pat, did
19 you want to make an alternate motion then? Please do.

20 AC MEMBER RYAN: Patricia Ryan. I would like to
21 move that we put a period after the word "procedure" and
22 eliminate the words after that.

23 AC CO-CHAIR GÁLVEZ: Any discussion about that?

24 Any public comment specifically related to that
25 motion?

1 (Teleconference line was unmuted.)

2 AC CO-CHAIR GÁLVEZ: Okay, so let's take a vote.

3 All those in favor of supporting Pat's recommendation --

4 (No response, teleconference line muted.)

5 AC CO-CHAIR GÁLVEZ: -- to have the sentence end
6 with "procedure" please show your hands.

7 (Show of hands.)

8 AC CO-CHAIR GÁLVEZ: All those opposed?

9 (Show of hands.)

10 AC CO-CHAIR GÁLVEZ: Any abstentions?

11 (Show of hands.)

12 AC CO-CHAIR GÁLVEZ: So 14 yeses, 3 nos and 1
13 abstention.

14 So I guess even though I didn't hear any debate
15 about the motion that I made around the voting rights
16 section that I should, just to be clear, let's go ahead and
17 vote on that. So once again my suggestion was changing the
18 second sentence of page 5, the one that begins with "In
19 person" to:

20 "In person" shall be defined as physically
21 present at a meeting or another publicly noticed
22 location if a teleconference meeting is in
23 conformance with the Bagley-Keene Open Meeting Act
24 requirements.

25 Any discussion about that?

1 Any public comment about that?

2 (Teleconference line was unmuted.)

3 AC CO-CHAIR GÁLVEZ: Okay, let's vote on that. So
4 all those in favor of that change please say aye.

5 (Ayes.)

6 AC CO-CHAIR GÁLVEZ: Any opposed?

7 (No audible response.)

8 (Teleconference line was muted.)

9 AC CO-CHAIR GÁLVEZ: We only need a show of hands
10 when it's not clear that it's a clear majority. Any
11 abstentions?

12 Okay, so motion passes.

13 Okay. So the other change that Dexter has
14 suggested was on Section G. This is, I think, a clarifying.
15 That currently Section G, 1 and 2, don't even conform with
16 each other. So it's actually having -- the suggestion was
17 to have the number 1 say "shall be by voice vote" and then
18 number 2 is "in lieu of voice vote." So Dexter, you want to
19 speak to that?

20 AC MEMBER LOUIE: Thank you. Dexter Louie.

21 I can clarify Section G. First of, if we are
22 using any accepted rules of procedure, the rules of
23 procedure in the standard code say that under number 1,
24 voting on elections is by ballot.

25 Number 2, motions and resolutions shall be by,

1 first, voice vote, and then in lieu of -- it's not in lieu
2 of a voice vote. It's if a voice vote -- if necessary the
3 Chair or any committee member can request a show of hands,
4 that's the second way, and a third way is a roll call.

5 AC CO-CHAIR GÁLVEZ: So do you want to restate
6 that, rephrase that one more time?

7 AC MEMBER LOUIE: Okay. I would renumber Section
8 G, number 1: Voting on elections shall be by ballot.

9 Number 2: Motions and resolutions shall be by a
10 voice vote. If necessary, the Chair or advisory committee
11 may request a hand vote or a roll call vote.

12 AC CO-CHAIR GÁLVEZ: Any discussion of that?

13 AC MEMBER LOUIE: That is consistent with both
14 Robert's and the Standard Code.

15 AC CO-CHAIR GÁLVEZ: Any public comment about that
16 specifically?

17 (Teleconference line was unmuted.)

18 AC CO-CHAIR GÁLVEZ: Okay. So all those in favor
19 of the suggested change please -- Patricia, did you --
20 please, a show of hands.

21 (Show of hands.)

22 AC CO-CHAIR GÁLVEZ: Seventeen. All those
23 opposed?

24 Any abstentions?

25 Okay, so that change is now made. Debbie.

1 MS. D. KING: So this is Debbie. For clarifying
2 purposes, because of Bagley-Keene we can do it by ballot but
3 we have to open the ballot and we have to read who voted
4 how. Just so you guys know that, it won't be -- it won't be
5 anonymous.

6 AC CO-CHAIR GÁLVEZ: We haven't done it that way
7 in the past. We have not -- we have not said who voted how,
8 we just count the ballots.

9 MS. D. KING: Right.

10 AC CO-CHAIR GÁLVEZ: And so we were not following
11 Bagley-Keene the way we did it prior?

12 MS. D. KING: Apparently not. We were -- we were
13 following counsel that we were given at that time and we are
14 given different counsel at this time. We have more
15 understanding of Bagley-Keene now. And so when we do do it
16 by ballot we have to open each envelope like we did before.
17 And instead of just counting them we have to read who did
18 it, so it will not be anonymous.

19 AC CO-CHAIR GÁLVEZ: Okay. Well do we need number
20 1 then for elections? Do we need -- Dexter, you want to --

21 AC MEMBER LOUIE: Dexter Louie. Just a point of
22 clarification then, Debbie. So Bagley-Keene requires a
23 ballot for elections?

24 AC CO-CHAIR GÁLVEZ: It requires an open ballot
25 that it's clear who voted how. So it kind of defeats the

1 whole purpose of a ballot.

2 MS. D. KING: So if we are going to write into the
3 bylaws a ballot then we need to understand that it is not
4 anonymous. Or we just leave that part of it out of this
5 vote that just happened and re-vote removing the word
6 "ballot." It won't be private any longer. We should
7 probably not have done that from the beginning. And there
8 was a lot of debate about that early back in September and
9 that was decided to do because we wanted to make sure that
10 there was no harsh feelings, people didn't feel bad about
11 getting elected or not getting elected. And so -- but we
12 can't do that per Bagley-Keene we have to keep it open.
13 Does that make sense?

14 AC CO-CHAIR GÁLVEZ: Dexter.

15 AC MEMBER LOUIE: Dexter Louie. So Debbie, just
16 for clarification. Should we amend what we just passed for
17 number 1, elections shall be by show of hands or roll call?
18 I am not sure exactly what Bagley-Keene requires now.

19 MS. BELMONTE: Just as a point of clarification.
20 It doesn't matter which voting -- Katie Belmonte, Office of
21 Legal Services, California Department of Public Health.

22 It doesn't matter what means of voting you do, you
23 can do it by ballot, show of hands, voice vote, but it needs
24 to be open. There isn't anything in Bagley-Keene, the law
25 itself, that expressly addresses, you know, what form of

1 voting it needs to be. But there are some old Attorney
2 General's opinions that talk about the Brown Act, which is
3 the equivalent for local agencies. And in that they discuss
4 that the purpose of these open meeting act laws is for full
5 and complete disclosure of the action taken and the
6 participation of individual members in each action. In
7 brief, the public's right to know who in government is
8 responsible for the actions taken by public agencies is just
9 as important as the public's right to attend and participate
10 in deliberations.

11 So in order to be as open as possible, even for
12 purposes of this voting, we would like it to be open. So
13 yes, if we want to do show of hands that's fine too. If you
14 want to do ballots I recommend that it be open ballot.

15 AC CO-CHAIR GÁLVEZ: Dexter, would you like to
16 comment?

17 AC MEMBER LOUIE: Then if I might I would move
18 that we amend what we just passed for number 1, voting shall
19 be by, how do you say it? Open ballot. And then the Chair
20 can determine whether it's show of hands or paper.

21 AC CO-CHAIR GÁLVEZ: Okay, I want to speak to
22 that. I guess me being an environmentalist I feel like
23 that's just a waste of paper. If at the end of the day it's
24 still going to be non-secret we might as well not have the
25 paper in the first place and choose a different method, so I

1 would suggest show of hands. So I am making that motion.
2 We amend what we just amended to show of hands versus by
3 ballot. Any discussion?

4 Any public comment?

5 (Teleconference line was unmuted.)

6 AC CO-CHAIR GÁLVEZ: Okay, all those favor?

7 (No response, teleconference line muted.)

8 (Ayes.)

9 AC CO-CHAIR GÁLVEZ: Okay, called majority, it
10 passes.

11 Okay, Delphine, you had a different issue you
12 wanted to raise about the bylaws.

13 AC MEMBER BRODY: Thank you. So just briefly
14 returning to my recommendation in March. I'm just wondering
15 if the CDPH Office of Legal Affairs personnel has had a
16 chance to investigate and provide feedback, specifically on
17 page 4 of the bylaws, Section E, paragraphs 4 and 5. I
18 should have spoken up, sorry, when we were approving the
19 minutes about a slight typo there where it called paragraph
20 5, paragraph 3. But I am actually talking about paragraphs
21 4 and 5 and about the participation of members of the public
22 in subcommittees.

23 I see that there has been a slight amendment
24 already but not -- but members of the public are not being
25 given a vote in the current draft of the bylaws. So I would

1 like to again propose that members of the public be - who
2 are appointed duly to the subcommittee - be given a vote.
3 And specifically paragraph 4, Section E, outside experts can
4 participate.

5 I think that has already been -- well, no, it
6 still says "shall be comprised of OHE AC voting members. So
7 yeah, I'd like to make it clear that outside members could
8 participate in that paragraph and that they would be
9 appointed by the chair of the subcommittee who would be an
10 OAC -- OHE AC member. And in paragraph 5 that outside
11 members or non-OHE AC members may not only be invited to
12 contribute and participate but also vote.

13 AC CO-CHAIR GÁLVEZ: There was actually a reason
14 for the change, right? I understood that it was Legislative
15 Analyst --

16 MS. BELMONTE: Let me jump in; Katie Belmonte,
17 Office of Legal Services, California Department of Public
18 Health.

19 So my comment to that is only this advisory
20 committee as a whole is statutorily authorized to take
21 formal actions in voting to provide recommendations to CDPH-
22 OHE, not necessarily any subcommittee so I don't feel
23 comfortable necessarily with using the word "voting" for
24 subcommittees. What the subcommittees are doing are serving
25 in an advisory capacity to OHE AC as whole. So once the

1 subcommittee provides a report or recommendation to OHE AC
2 then it's up to OHE AC as a whole to take that matter under
3 consideration and do the vote to bring it along to CDPH. So
4 that was why I made that change.

5 It's recommended that subcommittees be comprised
6 specifically of OHE AC staff but that outside experts and
7 non-OHE AC members, when appropriate, can serve in a non-
8 voting, contributing, participating role in preparing the
9 subcommittee research and advice to OHE AC who would then
10 take the formal vote. I hope that provides some
11 clarification; thanks.

12 AC CO-CHAIR GÁLVEZ: Katie, can I -- I do want to
13 get clarification. So you are saying that the subcommittees
14 don't take votes at all or that in the subcommittees the
15 only people who can vote are the current AC members?

16 MS. BELMONTE: I think it's a little bit easier to
17 just comprise the voting of OHE AC members, just to comprise
18 the subcommittees. Yes, they could vote, technically, but
19 what they are voting on is a recommendation to bring, you
20 know --

21 AC CO-CHAIR GÁLVEZ: Right, right. But you are
22 saying that -- but your recommendation is that non-AC
23 members on subcommittees cannot participate in the voting
24 that is made -- although all the voting is to make a
25 recommendation to the larger body anyhow.

1 MS. BELMONTE: Yes.

2 AC CO-CHAIR GÁLVEZ: But that they do not have a
3 vote, a formal vote.

4 MS. BELMONTE: Correct.

5 AC CO-CHAIR GÁLVEZ: Okay. José.

6 AC MEMBER OSEGUERA: What Katie has just explained
7 is consistent with what the OAC does.

8 AC CO-CHAIR GÁLVEZ: Any other comments?

9 AC MEMBER OSEGUERA: It's actually longer than
10 OAC, the Oversight and Accountability Commission, but it's
11 actually the Mental Health Services Oversight and
12 Accountability Commission.

13 AC CO-CHAIR GÁLVEZ: Is there any comment from the
14 public about this issue specifically?

15 (Teleconference message heard.)

16 AC CO-CHAIR GÁLVEZ: Okay then, let's vote on it.

17 (Teleconference message heard.)

18 AC CO-CHAIR GÁLVEZ: So do you want to make a
19 motion, Delphine?

20 AC MEMBER BRODY: Given the opinion of our legal
21 counsel it seems that the only possible change, I mean,
22 within those parameters might be that paragraph 4 of Section
23 E, page 4 of the bylaws, would be amended so that the
24 subcommittees shall be comprised of both OHE AC voting
25 members and non-OHE AC members who are outside experts.

1 And that paragraph 5 would then be amended to say
2 -- well, it would not need to be amended.

3 So that it's clear to all, that the actual
4 subcommittees will include outside experts. That would be
5 my only clarification.

6 AC CO-CHAIR GÁLVEZ: Any comment on that? Aaron.

7 AC MEMBER FOX: Yes, I just wanted -- this is
8 Aaron Fox. I just wanted to comment that all of these
9 meetings are still public, no matter what, so anyone can
10 show up. Obviously people can be invited to offer expertise
11 but anyone from the public is more than welcome to come and
12 speak on any of the issues and so I think that's extremely
13 clear in Bagley-Keene. And again I would urge us to adopt
14 the changes that we have already made and vote on the
15 bylaws.

16 AC CO-CHAIR GÁLVEZ: So you are saying to not make
17 the change that Delphine --

18 AC MEMBER FOX: No, I don't think we should make
19 it. I don't think we need to make that change.

20 AC CO-CHAIR GÁLVEZ: Okay.

21 AC MEMBER FOX: I think we probably need to move
22 it along.

23 AC CO-CHAIR GÁLVEZ: Okay. Any other comments
24 about --

25 Okay, any public comment?

1 (Teleconference line was unmuted.)

2 AC CO-CHAIR GÁLVEZ: Okay, so all those in
3 favor --

4 (No response, teleconference line muted.)

5 AC CO-CHAIR GÁLVEZ: All those in favor of the
6 suggestion Delphine made please show your hands.

7 (Show of hands.)

8 AC CO-CHAIR GÁLVEZ: All those opposed?

9 (Show of hands.)

10 AC CO-CHAIR GÁLVEZ: Any abstentions?

11 Two yeses, 16 nos, zero abstentions.

12 Any other changes that folks would like to see
13 addressed in the bylaws?

14 Okay, well I'm hoping now that hopefully at our
15 next meeting we can adopt these. I think we have had a
16 thorough discussion. We've had -- everybody has had a
17 chance to read them, we've had the opportunity to get legal
18 feedback on the existing bylaws, so with that I'll move this
19 agenda item along.

20 Our next -- wait, we were supposed to get a break.
21 Why don't we take a break now since we have extra time. So
22 let's take a 10 minute break since we do have extra time
23 since we are not going to have the third speaker or the
24 second speaker, so a 10 minute break.

25 (Off the record at 10:10 a.m.)

1 (On the record at 10:25 a.m.)

2 AC CO-CHAIR GÁLVEZ: Let's get started again.

3 Before Jahmal comes on I did want to make, just make a note
4 about the obnoxious phone. It's going to continue to be
5 obnoxious and we have to deal with it. It's just -- the
6 volume issue can't be adjusted so I apologize in advance.
7 Just kind of prepare yourself with your preparatory wince
8 every time we turn it on and off.

9 Are you ready, Jahmal?

10 OHE DEPUTY DIRECTOR MILLER: Yes.

11 AC CO-CHAIR GÁLVEZ: Okay.

12 OHE DEPUTY DIRECTOR MILLER: Can you guys hear me
13 when I speak in my normal voice?

14 AC CO-CHAIR GÁLVEZ: Not really.

15 OHE DEPUTY DIRECTOR MILLER: Through the system or
16 -- Okay, I'll use a hand-held. Thank you.

17 Hello, is that better? All right. Okay. All
18 right.

19 Good morning.

20 (Good mornings in unison.)

21 OHE DEPUTY DIRECTOR MILLER: That was horrible.
22 It was horrible. Good morning.

23 (Good mornings in unison.)

24 OHE DEPUTY DIRECTOR MILLER: I know that was just
25 so fun this morning. That's why I want to really get a good

1 morning. Very important work. So no presentation from me,
2 you guys don't have to sit through another boring
3 presentation from me, but I am really happy to provide some
4 updates on the activities for the Office of Health Equity
5 since our last convening.

6 And as Dr. Chapman mentioned earlier, four
7 meetings in like eight months has been like we are moving at
8 an accelerated pace. And I appreciate everyone's commitment
9 and patience with the process and your contributions that
10 you've made, not only as an advisory committee but the
11 public, I appreciate your patience and your participation.

12 I want to give a shout-out to a couple of folks.
13 Delphine, like to come in on crutches with ice on your
14 ankles and all that stuff, that's the model of a prototype
15 of commitment and sacrifice.

16 Mr. Graham, he was on like his deathbed almost
17 last meeting, he had pneumonia, so we are glad to have you
18 here.

19 General Jeff, we missed you the last go-around.
20 Yvonna, those who weren't here, we're glad to have you guys
21 here. Who else? Pete, where is Pete? Okay. Pete, we
22 missed you last go-around as well. We appreciate all of our
23 public participants, not to slight anyone, not to slight
24 anyone, but Pete had some challenges last go-around and we
25 truly appreciate his participation.

1 And once again, everyone in our public. I am glad
2 to say that I have met with all of the folks in our public
3 comment section so it's good to have a personal and
4 professional relationship with you all since the time I
5 started in this role.

6 So some quick updates. Are there any mothers,
7 aunts, stepmothers in the -- please stand. While we deal
8 with the audiovisual technical stuff in the background.
9 Please, all the women, please, would you stand. We want to
10 honor you by just saying -- even if you aren't a biological
11 mother you are someone's mother. You've had some maternal
12 contribution in developing someone, whether it's raising an
13 adult child that stills in the home that should be out
14 already or being a mentor to, you know, a child. We want to
15 say Happy Mothers Day and we want to recognize you for your
16 hard work and the sacrifices that you made in someone's
17 life. So let's give them a round of applause.

18 (Applause.)

19 OHE DEPUTY DIRECTOR MILLER: So Happy, Happy
20 Mothers Day.

21 And for those of you -- I know sometimes it can be
22 sensitive. I'm sure there are those who have lost a
23 grandmother or a mother or someone in their life that was
24 very influential who is no longer here with us, so even in
25 their memory we want to honor their commitment and

1 sacrifices that they made.

2 I want to celebrate today, it's a historic day for
3 the Assembly Member that represents District 58. I don't
4 know if you guys know, today Assembly Member Toni Atkins is
5 going to be sworn in this afternoon as the speaker for the
6 California State Assembly. That will be a historic
7 ceremony. She will be the third woman to serve in that
8 capacity. The first lesbian to serve in that capacity as
9 well.

10 So today is a historic date when we think about
11 those who have come from those who we represent, vulnerable
12 populations. And it's important that in the legislative
13 process that we have representation, and meaningful
14 representation where people are sensitive to the issues
15 around health equity. And we see them as partners, as
16 ambassadors, and to have people in unique positions like
17 that to provide leadership on our behalf is really, really
18 important. That's why I bring it to your attention today.

19 I am happy that things work out the way that they
20 do when we think about -- you know, we had a plan to have
21 three presenters today. At the federal level, we have a
22 mental health presentation on our CRDP project and our
23 climate and health, all three very stimulating and
24 informative presentations.

25 It just so happens that our federal partner is not

1 going to be able to make it so we'll have that presentation
2 later. But what that allows us to do is really optimize
3 these two days to commit and focus on refining and
4 finalizing that strategic plan for health equity in the
5 state of California when things work out the way that they
6 are supposed to do; so I am really looking forward to that.

7 Looking forward to the contributions that our
8 public will make to the small group process so I thank you
9 once again, public participants, for being here.

10 I want you also as an advisory committee to think
11 about not only for you personally as an individual but think
12 about how your organization and the constituency that you
13 represent, how work that is currently being done in your
14 organization or work that you are leading can plug into the
15 action plan and implementation of the Strategic Plan. So I
16 want you to start thinking about, are there any
17 organizations or best practices that exist that when we get
18 beyond July 1, as we start to look at implementation and
19 action plans, where can we plug in resources, human and
20 financial resources, to advance the work?

21 So start thinking about ways in which -- you know,
22 whether it's the LA County Public Health Department.
23 There's activities that are taking place in the Skid Row
24 district. Whether it's PTA and we think about education and
25 public health nurses or the like. Think about how your

1 organization can plug in to that next step, which is going
2 to be about action and implementation. And I would invite
3 the public to join us in that process as well.

4 The demographic analyses and disparities report
5 that will complement the Strategic Plan. You have a sample
6 narrative in your packet today. We hired a contract writer
7 who I have worked closely with in the past who has a very
8 adept skill set at providing a narrative to tell the story
9 around health equity and the social determinants of health.
10 And we wanted to provide a sample narrative for you that
11 aligned with A-N, the social determinants of health and the
12 key factors by which we need to do the demographic analyses
13 and report that to the Legislature. And I hope that you
14 will spend some time to check that out.

15 We brought on a graphic designer that is going to
16 provide a template and the design for the actual disparities
17 report. So once we -- as we make progress on that and get
18 the report and the graphic design and template to a place
19 where we feel comfortable we'll make sure we share that with
20 you electronically to get your feedback and input on how we
21 amend that.

22 Also before I move on to just Assembly and Senate
23 hearing updates. I wanted to kind of give, once again,
24 another special shout-out so I call Pete out. I know he
25 comes from Southern California. Are any of our other

1 members of the public today, anyone come from Southern
2 California or maybe the Central Valley area? Okay.

3 So our Marin City partners. We're used to hearing
4 like a guy named Ricardo when you open up public comment.
5 It's like, hey, this is Ricardo, I have something to say. I
6 glanced over today and was really happy to see the Marin
7 City group. So if you guys could stand, I just wanted to
8 recognize the Marin City folks for driving up over two hours
9 to come join us today, Ms. Alberta and Ricardo.

10 (Applause.)

11 OHE DEPUTY DIRECTOR MILLER: Their model for the
12 collective impact work that they are doing to address
13 disparities on their community I really think is a prototype
14 and it sets the tone, I think, for what a comprehensive,
15 cross-sectoral approach to achieving health equity looks
16 like. And they have been great partners and supporters of
17 our office and I really appreciate you guys for -- no
18 problem, I enjoyed it. I enjoyed it, it's very inspiring.
19 And keep the invitations coming, please.

20 A quick update on the Assembly/Senate hearing
21 updates process. We have two either budget or legislation-
22 related activities that are going through the legislative
23 process. And it has been very educational to me, someone
24 who comes from the private sector to the public sector, to
25 actually see how policy and legislation gets done.

1 And we have our public contracting code exemption
2 request. We have trailer bill language that is going
3 through the process right now that will afford us a public
4 contracting code exemption that we previously had when the
5 California Reducing Disparities Project resided with the
6 Department of Mental Health. And when the Department of
7 Mental Health went away and the programs and the resources
8 transitioned to other offices, departments and agencies,
9 when we inherited NCDPH, the California Reducing Disparities
10 Project, there was a legislative glitch in how the law was
11 created that didn't afford us that exemption that we
12 previously had.

13 So we are going through a process now to request a
14 statutory exemption from the public contracting code process
15 so that we can expeditiously move on things that we need to
16 do in the Office of Health Equity around our mental health
17 disparities. And it is not dependant on going through the
18 Department of General Services with respect to this
19 extensive bidding process to contract with providers of
20 services and vendors that help accelerate and advance our
21 work in a way that affords those organizations and people
22 who have culturally and linguistically appropriate expertise
23 to advance that work. It affords them a way to get involved
24 and it really takes out many barriers and obstacles that
25 keep us from doing this work in a more seamless way.

1 So I and some of our staff members have been going
2 before Assembly and Senate subcommittees on the budget side
3 and on the health side to kind of plead our case and justify
4 our position as to why we need this exemption. Fortunately,
5 we have garnered all the support that we need going through
6 the process; the Assembly and Senate subcommittees have been
7 very supportive. And I really do appreciate our partners
8 from CPEHN, REMHDCO, from our other mental health partners
9 who have come to the hearings and have provided public
10 comment in support for our public contracting code
11 exemption.

12 And it has been a learning process for me, and
13 also I think for us, to see how we get things done through
14 the legislative process. And it has been quite fascinating
15 and we have been very fortunate to have the support that we
16 need from elected officials that hold those positions.

17 And then we also have our budget change proposal
18 to have four permanent positions to advance our Health in
19 All Policies work and that process has been quite seamless.
20 We have had the support that we have needed from the elected
21 officials as well. I appreciate the leadership and support
22 that Dr. Connie Mitchell has afforded us in this process
23 where she created the BCP, the Budget Change Proposal, and
24 we work closely with our budget department, our Department
25 of Finance, to go through this process to secure those four

1 positions we need to advance our Health in All Policies work
2 in the broader health equity agenda when we think about
3 working closely with agencies, departments and offices
4 across government to embed health and equity.

5 And I throw those two examples out as really
6 prototypes for when we think about what it is going to take
7 to bring that Strategic Plan alive and make meaningful
8 infrastructure changes. These are two processes that I
9 would encourage because it's publicly available to go
10 online, secure information, just to see what that process
11 looks like. And it demonstrates how we as an office, a
12 staff, as CDPH, can partner with our advisory committee and
13 the public in a very open and transparent way on how we
14 advance our health equity agenda. And that's why I
15 highlight those two particular experiences that we are going
16 through in the Office of Health Equity.

17 Workforce staffing updates. I am pleased to
18 introduce Eugenio Garcia. Eugenio, where are you? Could
19 you please stand. He is one of our newer staff members. He
20 is our Health Program Specialist I who has joined us from
21 the Tobacco Division within the California Department of
22 Public Health, a master's in public health. Really
23 delighted to have him on board and wanted to introduce you
24 all to him today. His expertise and experience is something
25 that we need. And I appreciate Marina's leadership along

1 with her staff. Going through the interview process,
2 evaluating, you know, résumés that we receive. And I
3 appreciate his patience. Once again, the process can be
4 interesting when bringing staff -- when bringing staff on
5 board. So give it up for Eugenio, welcome to the team.

6 (Applause.)

7 OHE DEPUTY DIRECTOR MILLER: I also want to
8 introduce Michelle Grant. At our last meeting, you'll
9 recall, we had two interns through the UC California Center
10 Program, we had Gladys Preciado and we had Angie Kim. And
11 they finished up their, I think, six to eight weeks with us.
12 Shortly thereafter we were able through the same program to
13 bring on Michelle Grant from the UC center and she is a
14 student at UC Davis. She'll be -- are you wrapping up this
15 year? You're graduating this year, right?

16 Okay, five weeks, the countdown begins. And we
17 are glad to have her on board. So let's give it up to
18 Michelle, Michelle Grant.

19 (Applause.)

20 OHE DEPUTY DIRECTOR MILLER: I highlight our
21 interns once again. There is a facet of the Strategic Plan
22 draft where we need to infrastructure on workforce
23 development, so what we are trying to do is model that in
24 the Office of Health Equity by bringing on interns,
25 establishing a fellowship program that's a part of our

1 broader strategy in CDPH and we are delighted to have
2 Michelle and Eugenio on board.

3 We are -- we started the interview process to
4 bring our supervisor on for our Health Research & Statistics
5 Unit. We interviewed three great candidates last week and
6 we have a few more interviews to conduct this week, hoping
7 to hire for that position very soon.

8 And then lastly, over the last few weeks many of
9 us have been in the office, whether it's me or Marina,
10 Dr. Mitchell, some of our Health in All Policies colleagues
11 have been speaking in a variety of different settings and
12 participating in different forums to advance a broader
13 agenda that coincides with health equity.

14 I, myself, had the privilege a few weeks ago of
15 speaking at a hearing in LA on childhood maltreatment that
16 was hosted by Assembly Member Roger Dickinson at the LA
17 Public Library and I was honored to share that platform with
18 Dr. Steve Wirtz from CDPH. He, at that time, shared -
19 Dr. Wirtz that is - shared some recent findings in a report
20 that they are working on around adverse childhood
21 experiences. And he shared that information with our Office
22 of health Equity staff a few weeks ago. And the information
23 shared around ACE and really the psychosomatic implications
24 that trauma has on people was literally ground-breaking.
25 And the CDC is paying close attention, it was a CDC funded

1 project, and he spoke about that work.

2 I was able to speak about how that links to the
3 Office of Health Equity work, particularly around our mental
4 health disparities work. That was a great platform and I
5 think he and I, we did something right that day because as a
6 result he has been requested to come speak at -- I believe a
7 boys and men of color hearing that is coming up soon around
8 that same work. I was asked a few days ago from Roger
9 Dickinson's office to come back and speak on the same topic
10 as well so we were delighted about that.

11 Assembly Member Steven Bradford hosted a special
12 hearing in Stockton on the boys and men of color effort that
13 is taking place across the state but specifically in the
14 Central Valley and in San Joaquin County. Served on that
15 forum and that was a great experience.

16 A few weeks ago I on behalf of the Office of
17 Health Equity and our Chair, Sandi Gálvez, we actually spoke
18 at the CCLHO annual board meeting. I spoke on -- we both
19 spoke on social determinants of health. And CCLHO,
20 Dr. Garza, might you want to share what that acronym means.

21 AC MEMBER GARZA: California Conference of Local
22 Health Officers.

23 OHE DEPUTY DIRECTOR MILLER: Great. Can you speak
24 a little bit more to what that convening is about?

25 AC MEMBER GARZA: Well, the California Conference

1 of Local Health Officers is a group of all health officers
2 from all jurisdictions because they -- 58 counties and three
3 cities, I think, something like that. I might have my
4 numbers wrong. Three cities, Pasadena, Long Beach and
5 Berkeley.

6 So we have semi-annual meetings and you were -- I
7 missed the recent one because I just switched counties, from
8 San Benito to San Joaquin. But they are excellent meetings
9 and we review policies and public health practice and what
10 we should be doing in our counties. And health equity, of
11 course, we are pushing a lot and we have been for awhile.
12 And thanks for attending. I wasn't there, I missed you.

13 OHE DEPUTY DIRECTOR MILLER: No problem. I
14 enjoyed it and it was great to -- that's a key group of
15 stakeholders. Everyone is very, very important. Our local
16 health jurisdictions, local leadership is critical. And I
17 know Tamu is going to speak to it but we actually did a
18 webinar with that group as well to get their feedback on the
19 health equity strategy and that will be included in the
20 updates that are forthcoming on the strategic plan
21 stakeholder engagement process. For the health equity
22 statewide strategic plan, that is.

23 And then lastly two comments. I spoke last week
24 actually with the National Hispanic Medical Association.
25 They have a California Physician Leadership Program and

1 Dr. Elena Rios is the President and CEO of NHMA based out of
2 Washington DC. They represent over 40,000 Latino physicians
3 across the country and the largest group of physicians
4 actually are based in California. They were very, very
5 pleased with the work that the Office of Health Equity and
6 the Advisory Committee is doing. They pledged their support
7 and partnership, especially in the space of workforce
8 development and pipeline development. And that was a great
9 meeting that I was able to participate in last week.

10 And a few weeks ago, also here at Sierra Health
11 Foundation, I presented on a local, a regional forum on the
12 Affordable Care Act and how that is impacting the greater
13 Sacramento-Sierra region from a health equity standpoint and
14 how does the ACA converge with our ability to advance health
15 equity.

16 So those are just some examples, some highlights
17 across the board. There are many, many other activities
18 that we could -- I could spend much more time talking about.
19 But I am delighted that today you will have the opportunity
20 to learn about two critical areas that we are advancing in
21 the office of Health Equity. One is our climate in health
22 work. I am really delighted that Dr. Neil Maizlish is here
23 to present and share that information with you and also our
24 partners from CPEHN and our staff from the Community
25 Development and Engagement Unit is going to be able to share

1 more about our CRDP work.

2 And those two particular areas, it's important
3 that you get a better understanding, a comprehensive
4 understanding as we go into the afternoon and into tomorrow,
5 in seeing where are the convergence opportunities between
6 the statewide health equity plan to where we leverage
7 existing work around our mental health activities and our
8 climate and health activities that we haven't spent too much
9 time talking about.

10 So those are some just staffing updates, some
11 hearing updates, general Office of Health Equity updates
12 that I wanted to share with you. No presentation, didn't
13 want to do that to you again. Now we are eager to move
14 forward in getting strategic planning updates and the like
15 from Tamu. I really appreciate her thought, leadership and
16 partnership in helping to advance and accelerate our
17 strategic planning effort and appreciate the entire team's
18 contribution in those efforts. So with that said, if I
19 haven't missed anything I am going to hand the baton off
20 over to Tamu.

21 DR. NOLFO: I am going to see if I can do this
22 without the hand-held mic. Are we good? You can hear me?

23 (Affirmative responses.)

24 DR. NOLFO: Great. Great. So good morning. And
25 we did want to provide you with updates on what it is that

1 we have been doing, what we have been finding out, where we
2 are headed with all of this.

3 So when we started this meeting in March you were
4 all able to reflect on values that you would like to see
5 included in this plan and in this planning process and I
6 just wanted to spend one moment and reflect those back to
7 you.

8 So we have -- because I am very mindful of how we
9 have been building them into the plan.

10 So capacity building from many different parties.
11 Inclusiveness, sustainability. Gail, you said you are not
12 going to let us forget about the Valley.

13 Accountability. Consumers are the experts in
14 their own lives. A trauma-informed framework. Capacity
15 building. Community involvement, Equal opportunity for
16 everyone. Long-term sustainability. Effective outreach and
17 engagement. Engaging members, patients, families and
18 communities. Oh, you can't hear me?

19 It's too low. If I come closer can you hear me
20 now? I feel like I'm in a commercial. Can you hear me now?
21 It's better if I hold this? Is this better? If I move it
22 -- is that -- no, because now it's -- we have competing
23 interests. If I hold it too close then you get feedback.
24 This is good right here? Okay, I'll do my best just like
25 that. Let me know if that doesn't work for you. Okay.

1 So integration of health and mental health
2 concerns. Access to care, the importance of making sure
3 that we not only have services but providers. We have
4 follow-through with action and passionate engagement in our
5 dialogue.

6 So that is what you as advisory committee members
7 said you wanted in terms of values that show up in this plan
8 and in this planning process and that is what we are seeking
9 to accomplish.

10 So in terms of strategic planning process
11 developments. We incorporated -- you will recall that at
12 the March meeting, and I'm sorry that some of you weren't
13 here for the March meeting. We definitely missed you, we're
14 glad that you are here today. That we spent a good deal of
15 time working in small groups.

16 So the feedback that you came up with in those
17 small groups: You were responding to the strategic
18 framework. It was the first draft of the strategic
19 framework and you were responding to that. Looking at what
20 you saw as advantages and concerns and where we needed to
21 make modifications and additions and deletions, what you
22 wanted to prioritize, who you saw as potential partners.

23 And so all of that information was collected by
24 your facilitators, by Office of Health Equity staff who
25 typed that up for me. And I was able to try to make sense

1 of it and incorporate it as best I could into the next
2 version of the strategic framework.

3 So one of the things that you will notice is that
4 there were six strategic priority areas. I'm sorry, there
5 where five in the last version and now there are six. That
6 there was a little bit of confusion in the fifth one and it
7 just seemed to make sense to break it out into two and so
8 that's what we did. So now there are these six priority
9 areas as opposed to five.

10 We have been moving at quite a pace with this
11 planning process. And so it has been because it moves every
12 day, it changes every day. We have to have a lot of
13 flexibility with that. And so we have had multiple versions
14 of the strategic framework as we have gotten feedback from
15 the public, from you the advisory committee members, from
16 staff. And so we are trying to be as transparent as
17 possible with those versions and to put them out to you as
18 quickly as we can.

19 You know with Bagley-Keene that when we post
20 something online then that's what we distribute at the
21 meetings and so actually what you have is a version of the
22 plan that is 3.0. But after we posted that we actually got
23 more feedback and input to correct some things and there is
24 a version 3.1. And so that is not what you are looking at
25 unless you are looking online.

1 So we -- one of the things that we did, which was
2 very exciting, was to create a planning page on our website
3 since the last advisory committee meeting in March. So we
4 created a page, rather, specific to this planning effort
5 where we wanted to drive people to learn more about the
6 planning effort, to get information and updates about the
7 plan, and also to be able to access a survey, which I will
8 talk about in a moment. So on that planning page is the
9 most updated version of the plan. As I said, it's version
10 3.1 and it was just put up on Friday. And I actually want
11 to share with you some of what was updated from that version
12 because you don't have it in your print copy.

13 So one of the things that you will see is that
14 there is some narrative to go with the priority areas, the
15 strategic priorities, to provide a little bit more context
16 for what it is that we are trying to accomplish with those
17 strategic priorities. Why we felt like they were important
18 and they rose to the top as priorities and so how we intend
19 to move them forward.

20 So under Strategic Priority A there is some
21 updated language there about the Health Places Team in the
22 Office of Health Equity and so you can see that. That is
23 the final paragraph of the narrative in Strategic Priority
24 A. And I will read that to you:

25 "One important initiative of the Healthy

1 Places Team in the Office of Health Equity will be
2 to continue to build the Healthy Community
3 Indicators data and indicators project (HCI). The
4 goal of HCI is to enhance public health by
5 providing data, a standardized set of statistical
6 measures and tools that a broad array of sectors
7 can use for planning, healthy communities and
8 evaluating the impact of plans, projects, policy
9 and environmental changes on community health.
10 With funding from the Strategic Growth Council
11 (SGC), the HCI is a 2-year collaboration of the
12 California Department of Public Health and the
13 University of California, San Francisco to pilot
14 the creation and dissemination of indicators
15 linked to the Healthy Community framework. The
16 framework was developed by the SGC, which is the
17 Strategic Growth Council, Health in All Policies
18 Task Force, with extensive public discussion and
19 input from community stakeholders and public
20 health organizations. The Framework identifies 20
21 key attributes of a healthy community clustered in
22 five broad categories: 1) It meets basic needs of
23 all (housing, transportation, nutrition, health
24 care, livable communities and physical activity);
25 2) environmental quality and sustainability; 3)

1 adequate levels of economic and social
2 development; 4) health and social equity; and 5)
3 Social relationships that are supportive and
4 respectful. Indicators are associated with each
5 attribute and the goal is to present the data for
6 each indicator for local assessment and planning
7 down to the census tract or zip code wherever
8 possible. We will be diligent in seeking
9 opportunities to expand this pilot in order to
10 achieve our vision for high-quality, accessible
11 data that informs our policies and practices."

12 So once again, that language was updated from the
13 version that you have just to be as clear as possible. This
14 is a pilot that is underway and, as we've said, we are going
15 to continue to try to get funding. The resources that we
16 need to continue it into the future.

17 And then the other area that I want to call your
18 attention to is Strategic Priority B: Embed Health, Mental
19 Health and Equity into Institutional Policies and Practices
20 Across Non-Health Fields.

21 So once again what we updated was the language in
22 this area and I am going to read it to you because you don't
23 have it unless you're looking on line.

24 "In order to advance health and mental health
25 equity, our work will extend beyond the

1 traditional boundaries of public health and health
2 care to address the other factors that contribute
3 to overall health. These factors include
4 educational attainment, income, housing, safe
5 places and clean environments. Fortunately, this
6 work has begun with many willing partners and many
7 more will have the opportunity to engage. We
8 intend to identify the equity practices currently
9 being conducted across a spectrum of fields and
10 build upon them with both existing and new
11 partners."

12 "At the level of state government, exciting
13 work is being done with the Health in All Policies
14 (HiAP) Task Force created through the Governor's
15 Executive Order in 2010 and accountable to the
16 Strategic Growth Council. The Office of Health
17 Equity helps to staff the Task Force in
18 partnership with the Public Health Institute with
19 primary funding from the California Endowment.
20 This HiAP Task Force is specifically identified in
21 the statute that created the Office of Health
22 Equity (California Health and Safety Code Section
23 131019.5) naming it as a partner in the creation
24 of the statewide plan."

25 "We envision fostering a HiAP approach to

1 embed health equity criteria in decision-making,
2 grant programs, guidance documents and strategic
3 plans."

4 "A key area for dialogue and action that will
5 require the cooperation of interests across a
6 spectrum of fields is climate change. We can
7 anticipate the most profound consequences of
8 climate change to disproportionately impact the
9 state's most vulnerable populations. As such, we
10 intend to engage in partnerships to enhance
11 understanding of climate change and its impact on
12 the least of Californians. There are
13 opportunities through the Office of Health Equity
14 Climate and Health Team in the Office of Health
15 Equity to incorporate health equity into the
16 state's Climate Action Team, share data and tools,
17 and participate in cross-sector planning and
18 consultation."

19 I just wanted to give you those updates. This
20 narrative will continue to be updated in the final version.
21 If you have comments or recommendations about the language,
22 how to clarify, more that should be in, less that should be
23 in, that's all feedback that you can provide in your small
24 groups today. Or you also have the opportunity, quite
25 literally, to just mark up the copies that you have and hand

1 them back to me and I am more than happy to take it that way
2 as well. So that's an update on where we are with the
3 Framework

4 And as -- So as you see, we actually have named
5 our plan as well, California's Statewide Plan to Promote
6 Health and Mental Health Equity. And in naming our plan,
7 this also came out of lots of input that we got. And one of
8 the things that I know I heard in a number of discussions
9 starting back in January, possibly earlier than that, was
10 that there was some confusion around the strategic planning
11 that we are doing and the strategic planning that is taking
12 place within CRDP, the California Reducing Disparities
13 Project. And so the suggestion was made that we distinguish
14 the names and so that's one of the reasons why we came
15 across this plan. It's just to help people distinguish
16 between the two, between the two sets of planning efforts
17 that are happening.

18 So there were also some webinars to get the
19 information out broadly to the public to make sure that they
20 had an understanding of what we were doing; that we could
21 get feedback from them and incorporate that feedback into
22 the next versions of the plan.

23 On April 16th, Jahmal and I hosted a webinar. And
24 once again, as I said, all of this happened very quickly and
25 we actually were not able to put out the message that we

1 were having this webinar until just a few days before the
2 webinar and we still reached -- we actually exceeded the
3 capacity of what we could handle on the webinar. So we had
4 the technology to accommodate up to 200 participants and we
5 exceeded that capacity by a small amount. I want to say
6 there were about 14 or 16 people who were wait listed. And
7 so people got the word out and they wanted to participate
8 and they did participate in that webinar and the audio from
9 that webinar is available on our planning page.

10 But as Jahmal mentioned, there was also an
11 important conference that was going on with the local health
12 officers during the time of the webinar and so the local
13 health officers were not able to participate on the webinar.
14 And so we did a follow-up webinar just last Friday on May
15 9th so that we could accommodate the local health officers
16 as well as CHEAC. And someone is going to have to help me
17 with that acronym.

18 AC CO-CHAIR GÁLVEZ: County Health Executives
19 Association of California.

20 DR. NOLFO: I don't feel so bad that I am not the
21 only one who couldn't quit get that, okay.

22 So also for CHEAC and for the folks that were wait
23 listed for the first webinar, we also extended the
24 invitation to them, and I know that some of them were able
25 participate on May 9th. So that was a smaller webinar but

1 it was basically the same material that we went over. And
2 that webinar, including the graphics from that webinar, is
3 going to be posted on our planning page this week as well.
4 Okay. And that webinar also was extended to the California
5 MHSA multicultural coalition who had invited us to speak in
6 person. We weren't able to accommodate that as fully as we
7 wanted to.

8 We have done face-to-face and telephone meetings
9 with stakeholders and presentations at meetings that our
10 staff could logistically attend.

11 Jahmal and I also had a meeting with Yvonna
12 Cázares and with Dexter Louie, which was a fabulous meeting.
13 We were able to really talk about how to engage some of the
14 contacts that they have. And as a result of that we had
15 some phone meetings with the California School Boards
16 Association, the California school-Based Health Alliance and
17 the California Medical Association.

18 So there is some really exciting work that is
19 being done kind of behind the scenes in order to prime folks
20 for how they can be involved in this planning effort from
21 the ground up. And I told Dexter that I was actually just
22 going to turn it over for him for a moment so that he could
23 speak to those because it is such a wonderful example of how
24 the advisory committee can be used and is being used in this
25 planning effort.

1 AC MEMBER LOUIE: Thank you, Tamu. Dexter Louie.
2 It really goes to what Delphine was saying about this bi-
3 directional. Is how we on the advisory committee can reach
4 out and get other people involved in what we are doing. You
5 know, I was really pretty excited. So my experience has
6 been in education and medicine.

7 So I talked to some people I have met over the
8 years, Janus Norman is Senior Director at the California
9 Medical Association and he was very pleased to be brought in
10 at the front end of this, not at the back end. Because
11 physicians, when they get brought in at the back in, they
12 are not going to buy in. They just are not going to buy in.
13 And I think that's probably true of most of the people who
14 are expert in their fields, you know. That silo that they
15 have. We bring them in at the back end and you have not so
16 much buy-in.

17 And so from the education side, because I was on
18 the school board for so many years, I met people on the
19 school board, the California School Boards Association. And
20 it happens that Martin Gonzalez, fortunately for us, is
21 moving over to be Executive Director at the Institute for
22 Local Government. So all of a sudden our education went
23 into local government.

24 So our reach, I think, is going to be great but
25 getting them to buy in at the front end is really --

1 DR. NOLFO: Absolutely.

2 AC MEMBER LOUIE: Thank you.

3 DR. NOLFO: Absolutely. And so that's one of the
4 things that we are looking at. And even in your small group
5 work later on today, to help you identify, where do you have
6 reach? Where do you have connections that we need to be
7 engaging folks at this point so that they are in on the
8 front end, so that they are able to own this plan,
9 essentially.

10 So we have also had internal meetings with CDPH
11 leadership and management to get feedback and expand the
12 reach of the plan.

13 And I mentioned that we had an online survey. And
14 so we launched that survey on April 16. When I checked on
15 Friday we had exactly 100 responses in Survey Monkey. There
16 are also a number of responses that have come in outside of
17 Survey Monkey. And we had over 60 responses that had been
18 submitted by April 29, which is essentially when I
19 downloaded what was there and incorporated that feedback
20 into the update of the plan, 3.0 and now 3.1.

21 And there are two mandatory questions and there
22 are nearly 60 other that are optional. So some people went
23 through and they answered everything and gave us just
24 tremendous feedback throughout the entire plan. Others
25 were, you know, more choosy about what they wanted to give

1 feedback on. But we wanted to make it that way so that
2 people didn't feel like it was cumbersome. If it was too
3 much that they didn't have to answer everything, they could
4 answer as much or as little as they wanted to.

5 But the feedback was absolutely wonderful and I
6 wanted to just give you a little bit in terms of the
7 characteristics of those who did do the survey. And you
8 know who they are.

9 We asked them to indicate their geographical
10 representation, which they could do by zip code, county or
11 state or other. About 26 percent represented by zip code,
12 about 46 percent by county and almost 20 percent by state
13 and 8 percent by other. And when I look at -- and they we
14 asked them to specify what that was, what their zip code or
15 what their county was. It truly is all over the state and
16 so we have had really good geographical representation in
17 terms of who has gotten on and taken a look at the survey
18 and provided their feedback on the survey.

19 We also asked them to indicate their affiliation
20 with or representation of vulnerable community groups as
21 defined in the California Health and Safety Code. So we
22 have for women about 60 percent, for racial or ethnic groups
23 about 70 percent, low-income 77 percent. And so those are
24 the greatest numbers. Mental health condition, 58 percent.
25 Children, youth and young adult, 48 percent. LGBTQ, 48

1 percent. So those were the greatest numbers. And once
2 again, a number of people also went on to let us know which
3 community specifically that they were representing.

4 And then I just wanted to share with you that we
5 asked them to rate the challenges of the residents in the
6 geographic areas or populations for which they were
7 responding and these are what we have been calling the A-N
8 requirements. They are in the statute in terms of where we
9 need to be collecting data to understand where the
10 disparities are. So these are all of the areas that we are
11 building upon. So these are all the areas that we are
12 expanding upon in our data disparities report.

13 But when we ask people essentially to what extent
14 is this a high, medium or low challenge for the folks that
15 you are representing -- I'll give you the highest ones,
16 which were: income security, housing, ongoing discrimination
17 and minority stressors and accessible, affordable,
18 appropriate mental health services. And then kind of the
19 next tier from that we saw food security and nutrition,
20 health care, neighborhood safety and collective advocacy and
21 culturally appropriate and competent services.

22 And we went through and we asked folks to help us
23 in identifying priority areas, what they saw as their
24 highest priorities within the goals. And then to give us
25 the same kind of feedback that I spoke about that you did in

1 your small groups the last time around, what were the
2 advantages and what were their concerns and all of that. So
3 that was very helpful and there were some things that we
4 heard.

5 So one of the things that we heard was provide
6 narrative context for the priorities and goals. Now this
7 was always intended as we moved from kind of the skeleton of
8 the framework to the actual plan and the first draft of the
9 narrative is included, starting with that version 3.0. And
10 the narrative is more accurate in version 3.1, as I
11 mentioned, which was updated on May 9th. So we were able to
12 accommodate that request that people wanted some narrative.

13 Also that they wanted us to drill down on the
14 goals to make them smart, specific, measurable, achievable,
15 relevant and time bound.

16 So the drill-down on the goals will serve as an
17 implementation plan. And the implementation plan includes
18 those activities that we can reasonably identify and commit
19 to for each goal. Some of these activities will be
20 identified over the next two days by all of you and the
21 Office of Health Equity will incorporate those activities
22 along with activities the state can commit to with its
23 current resources to the development of this initial
24 implementation plan.

25 Now there was another piece of important feedback

1 that we got, which we knew was a part of this because of the
2 time line that we are on, right? And that was to take more
3 time to fully engage stakeholders and include their specific
4 population needs into the plan.

5 So the deadline to submit the strategic plan
6 should in no way be construed as the end of input from
7 stakeholders. Rather, the plan becomes a mechanism for
8 continued, ongoing engagement and participation. It's
9 actually built into Strategic Priority F, which is capacity
10 building for implementation of the strategic priorities.

11 So the strategic plan will be approved by July
12 1st, which means it begins making its way through the
13 state's administrative approval process by the end of May.
14 However, Strategic Priority F will guide us in engaging
15 stakeholders after that date. And in an effort to be
16 flexible and accommodate our desire to more fully engage
17 with stakeholders on the tactics the implementation plan
18 will be phased in.

19 So as previously mentioned, prior to July 1st the
20 Office of Health Equity will detail the implementation
21 activities that the state can commit to with the resources
22 and the partnerships currently available, including those
23 you will identify over the next two days, today and
24 tomorrow.

25 As with any plan, we will continue to build the

1 implementation plan as opportunities arise. So these
2 opportunities will come about as we sit down with partners
3 and get an understanding of what they can commit to with
4 their current resources or what resources we need to
5 identify in order for them to play a meaningful role. For
6 example, do they need interns or fellows, do they need
7 research support, do they need funding to augment staffing?
8 We can then look at this resource acquisition as part of the
9 implementation plan.

10 This will also allow us to respond to the feedback
11 that stakeholders want specific, underserved communities to
12 be included in the plan. So at the last advisory committee
13 meeting the members made it pretty clear that you wanted to
14 be global in how vulnerable communities are identified in
15 the plan. And as such we are including in the introduction
16 language about who is being served by this plan and it comes
17 from the statute that created the Office of Health Equity.

18 The strategic plan is designed to point us in the
19 right direction. The implementation plan is to ensure we
20 are doing all that is necessary to get to our destination.
21 That's where we are working in and on behalf of specific
22 communities really becomes crucial.

23 So for example, we have heard from a number of
24 communities, such as ethnic communities that may be more
25 vulnerable and require special attention, certain geographic

1 communities. That there should be special consideration
2 for, for example, boys and men of color or for women and
3 girls health. So this is what we are hearing, that there
4 are communities that have special needs and how are we
5 essentially going to get to those particular needs.

6 So I would like to share with you in particular
7 some of the feedback we have received about women and girls
8 health. The California Center for Research on Women and
9 Families took the time last year to survey nearly two dozen
10 women's health leaders from throughout the state and to
11 develop a set of recommendations to the newly formed Office
12 of Health Equity. I think one of those people that was
13 surveyed was Gail Newel who is on our committee now.

14 So recommendations are well-presented and
15 thorough, highlighting that a gender lens be applied at
16 multiple opportunities, including the Office of Health
17 Equity Advisory Committee, Office of Health Equity staffing,
18 the strategic plan, health-related research and consumer
19 engagement in education.

20 And this group, CCRWF, recommends that the
21 advisory committee should have a women's health
22 subcommittee. So whether the advisory committee decides to
23 heed this recommendation or not, we would certainly continue
24 our conversations with CCRWF and other women's health
25 advocates to identify how their expertise and partnership

1 could forward the implementation of the strategic plan.

2 Based on their initial feedback, there are
3 opportunities throughout the strategic priorities, for
4 example, related to data collection and analysis, landscape
5 assessment, planning within state departments and offices,
6 health care reform and workforce development. Which are all
7 included in the strategic plan and I highlight this feedback
8 as an example of how we are taking very seriously the
9 feedback we are receiving and carefully thinking through how
10 we integrate it into the unfolding implementation plan.

11 So those were the comments that I had prepared for
12 you to give you an idea of where we have been since the last
13 time that we met and where we see ourselves headed. Would
14 you like to open it up for discussion among the advisory
15 committee members and any public comment?

16 AC CO-CHAIR GÁLVEZ: Would anybody like to start a
17 discussion on what Tamu has presented?

18 While folks think about it I do want to ask a
19 question.

20 DR. NOLFO: Yes.

21 AC CO-CHAIR GÁLVEZ: When I was looking at the --
22 and by the way, this looks really great. I think this has
23 really moved a lot from our last meeting. Under Strategic
24 Priority A, I can't remember if it's mentioned elsewhere,
25 there is a mention of Annual Health Equity Summits,

1 capitalized.

2 DR. NOLFO: Yes.

3 AC CO-CHAIR GÁLVEZ: Are those existing events?

4 DR. NOLFO: We know, for example, that CPEHN does
5 health equity summits, there may be other organizations that
6 do them as well. So we had talked about doing our own and
7 then we looked at, well, if there are other organizations
8 that are doing them should we be capitalizing on those as
9 opposed to doing our own?

10 AC CO-CHAIR GÁLVEZ: I guess I would just -- I
11 think this should be not capitalized because it makes it
12 sound like it's a specific event that happens annually and I
13 think we're talking just about generally that there are lots
14 of different summits that occur.

15 DR. NOLFO: Right.

16 AC CO-CHAIR GÁLVEZ: Okay. Any other comments
17 from the committee before we open it up? Dexter.

18 AC MEMBER LOUIE: Thank you. Dexter Louie.

19 You know, I'd like to thank Jahmal and Tamu for
20 being so helpful. When I called these people that I knew
21 that I had relationships with over the years I said, would
22 you be interested in this? And either Tamu or Jahmal or
23 both would get on the email thread or get on a conference
24 call and really present this whole plan, this whole concept,
25 this whole vision so convincingly. I was even persuaded.

1 But they are very accessible. Once you make that outreach
2 they were really helpful to me and it was very timely.
3 Everybody we contacted we all met either in person or by
4 phone within two weeks. That's really moving it along.

5 And secondly I would like to mention, this women's
6 health. Did you talk to Leah Margolis? She did a study for
7 the California Medical Association Foundation about five
8 years ago and interviewed about 2,000 people including, at
9 that time - it may be more than five years ago - Maria
10 Shriver. You know, some of the real high-level people as
11 well as communities. She just did an extremely in-depth
12 interviewing. Unfortunately, that project did not move
13 along with the Foundation so that -- she would be probably
14 someone to communicate with, Leah Margolis. Thank you. And
15 Diane, do you have any comments on that? Because Diane
16 knows her.

17 AC MEMBER RAMOS: The CMA Foundation actually has
18 that report summary so we can get it.

19 DR. NOLFO: Which foundation?

20 AC MEMBER RAMOS: CMA, the California Medical
21 Association Foundation. And I could help facilitate to get
22 that for you.

23 DR. NOLFO: Thank you.

24 AC MEMBER PARKS: I would just like to give a
25 shout-out to Jahmal for his accessibility and talk a little

1 bit about the collaboration and partnership that we have
2 established with the directors of public health nursing.

3 So right off the bat, in terms of my involvement
4 with the advisory board committee and being so excited about
5 being here, I invited -- it was one engagement after the
6 next and I don't know if Jahmal was going to have enough
7 time but I was just so on fire about sharing what we are
8 doing here on the advisory committee.

9 I invited him to speak at the Association of State
10 and Territorial Health Officers Committee at the national
11 level, of which I am an affiliate through another nursing
12 organization and he was always available to be accessible to
13 that and spoke on a conference call.

14 And then we had a speaking engagement with the
15 directors of public health nursing in March. And
16 unfortunately I was ill and was not able to make the meeting
17 but Jahmal showed up and really shared a lot of information
18 regarding the plan and what we are doing.

19 And now he is scheduled to speak at the Maternal,
20 Child and Adolescent Health Directors, which is my other
21 hat, at the end of this month.

22 So other examples of our partnership and getting
23 the word out and letting everyone know what we are doing and
24 giving them the opportunity to be part of this plan.

25 AC CO-CHAIR GÁLVEZ: Yvonna.

1 AC MEMBER CÁZARES: I just want to echo Dexter's
2 comments and gratitude for Tamu and Jahmal for their
3 openness and we had a great meeting.

4 But mainly their openness to my idea of saying,
5 hey, there is an existing process that occurred and there
6 was a report released by the California Endowment on a
7 number of forums that they had in 14 communities across the
8 state in which they engaged 1600 parents, students,
9 residents, community members. And I felt like when I looked
10 at that report it really informed -- it can inform our
11 strategic plan in five of our priorities. I'm sending that
12 to you. I appreciate the openness. It was because I was
13 afraid but looking at the survey it wasn't accessible to a
14 lot of community members, especially youth and others that
15 don't really speak in the health-speak or edu-speak that we
16 are using. So I just really appreciate your openness to the
17 new ideas, thanks.

18 AC CO-CHAIR GÁLVEZ: Jahmal.

19 OHE DEPUTY DIRECTOR MILLER: I forgot to mention,
20 a couple of weeks ago to coincide with our effort to
21 optimize stakeholder engagement I presented to our
22 California Department of Public Health executive management
23 team. And as we -- you guys may recall that in the
24 Department there are over 200, roughly, different public
25 health programs. And one of the cross-cutting imperatives

1 of the California Department of Public Health, the strategic
2 map, is to achieve health equity in public health across
3 public health programs.

4 So after presenting the webinar presentation that
5 outlined the strategic priority draft they agreed to
6 collectively go back to their respective centers and offices
7 and units and divisions and to get feedback on what's
8 happening in CDPH and where do they see their ability to
9 plug in to this project from a public health perspective.
10 So that is really going to open up some opportunities to
11 tap into low-hanging fruit, whether it's from the tobacco
12 work, around the work that the office of AIDS is doing, our
13 Center for Environmental Health, Center for Family Health,
14 our WIC program, which is a third of the CDPH budget. So we
15 will be formally getting that feedback. And post-July 1, as
16 we are doing with all the other feedback we are getting,
17 around what's actionable, we'll look at how we can plug in
18 to existing efforts in CDPH to do their part, knowing that
19 other departments, agencies and offices throughout
20 government can contribute as well. So I forgot to mention
21 that.

22 AC CO-CHAIR GÁLVEZ: Delphine.

23 AC MEMBER BRODY: I want to echo many others'
24 words of praise for the openness of OHE staff, especially
25 Jahmal Miller and Dr. Nolfo, in the process of putting

1 together the statewide plan.

2 And I would say that overall although I greatly
3 appreciate the speed with which our feedback is -- the
4 feedback of both OHE advisory committee members and the
5 public is being incorporated, I would say that overall the
6 direction still needs to be strengthened with regard to the
7 long-term, ongoing participation of key stakeholders from
8 the community who are directly impacted by each specific
9 form of health inequity that we have become aware of.

10 And that goes for everything from access of health
11 care and timely health care and mental health care programs
12 to the climate change-type of work under Strategic Priority
13 B and the many different institutions and state departments
14 that we need to engage. The many different industries that
15 need to be engaged.

16 But in each instance the people with the least
17 resources who are most directly impacted need to be involved
18 early on. Thanks.

19 AC CO-CHAIR GÁLVEZ: Thank you, Delphine. Álvaro.

20 AC MEMBER GARZA: So Tamu or Jahmal maybe.

21 DR. NOLFO: Sure.

22 AC MEMBER GARZA: Because I am not sure if you
23 mentioned, you might have and maybe I missed it. I am
24 wondering to what extent have you reached out or had input
25 from non-health organizations, either in the webinars or the

1 Survey Monkey or in any other ways? Education,
2 transportation, that long list of non-health folks.

3 DR. NOLFO: Well, I can tell you how people
4 identified themselves. The very first question that we have
5 on the survey is: Check one or more affiliations and
6 identify each type of affiliation you've selected in the
7 text below. And so we have 3 percent that said they have no
8 affiliation, 32 percent that have governmental agency,
9 almost 51 percent nonprofit, 11.5 percent educational
10 institution, no business whatsoever, 4.9 percent civic or
11 volunteer organization, 16 percent health care institution,
12 3 percent philanthropic organization, 11.5 percent tribal
13 affiliation and 6.6 percent other. So that gives you some
14 idea of where we are at. Do you want to weigh in on this at
15 all, Jahmal?

16 OHE DEPUTY DIRECTOR MILLER: If either Connie or
17 Julie, I know we were coordinating at one time or another an
18 opportunity to share, and maybe with Linda as well, the
19 strategic plan with the task force. Did that happen or is
20 it underway?

21 DR. MITCHELL: Hello, I'm Connie Mitchell, I am
22 the Policy Unit Chief. One of the programs in my purview is
23 the Health in All Policies Task Force. And we did have a
24 meeting with the task force last week and we presented the
25 strategic plan to them. We specifically reviewed sections

1 that they were germane to the task force. We are ready with
2 some very specific language of how they might be able to
3 contribute when we get to that next step. So yes, it was
4 discussed.

5 AC CO-CHAIR GÁLVEZ: Jeremy.

6 AC MEMBER CANTOR: Thank you. So let me add my
7 voice to the praise for Jahmal and Tamu and your team for, I
8 think, both gathering and incorporating a lot of input in
9 the short time, it takes a really significant effort and I
10 see the document changing in really positive ways.

11 And I'm sorry, I missed the beginning of your
12 comments so if you covered this, apologies. But one thing
13 that I heard in talking to people who were looking at the
14 Survey Monkey and kind of reviewing the plan was, great
15 goals and super ambitious and it's going to take a lot of
16 work to sort out how to actually do these things. I'm
17 looking through and there's a lot of, you know, kind of
18 conduct assessments and landscape analyses and so forth.
19 And then there are things like, you know, I look at Strategy
20 B, goal 4 is: facilitate common understanding of health
21 equity and the social determinants of health between non-
22 health agencies and organizations. Well, that's a monster
23 task.

24 DR. NOLFO: Right.

25 AC MEMBER CANTOR: And I think what I heard from

1 people is that they wanted some sense of kind of, okay, so
2 how are we going to go from this to that, you know, and
3 where do I plug in, you know.

4 DR. NOLFO: Yes.

5 AC MEMBER CANTOR: So I'm just wondering if you
6 can talk a little bit about -- that's a -- you know, from my
7 perspective.

8 DR. NOLFO: Yes.

9 AC MEMBER CANTOR: For me to go back and say, here
10 is how we are thinking about it, here is how we are going to
11 start to really engage you in moving from this to the
12 implementation. So I'm sure you've talked about this so if
13 you could just say a little bit about that it would be
14 great.

15 DR. NOLFO: No, that's great, it actually gives me
16 an opportunity to talk about what you're doing in your small
17 groups over these two days.

18 So this implementation plan, when we talk about
19 the lowest hanging fruit it's what is it that we can do
20 within the Office of Health Equity, right? So we have staff
21 that we can -- and we have activities that can really help
22 to move forward some of these goals and so that's what we're
23 currently fleshing out.

24 When you look a little bit broader than that it
25 is, what else do we have going on within state government?

1 So when Jahmal talked about speaking with leadership and
2 management, what else is going on within state government
3 that we can really connect to. So we are looking at that,
4 we're having those conversations and looking at that.

5 Then there's you, the advisory committee members.
6 And so, you know, you have been selected in part because of
7 your connectivity and your influence in different areas and
8 your expertise. And so one of the things that we are going
9 to be asking you to do in your small groups is to look at
10 where do you see advancing particular goals? Where would
11 you be able to have some influence?

12 And whether that's tapping into your networks or
13 resources within your organization, whatever it is, that
14 that's what we want to call out. And so whether that's even
15 forwarding names of folks that we should be talking to, the
16 way that Dexter did, so that we can set up some meetings
17 with them and figure out how we can really kind of put the
18 pedal to the metal, that that's what we want to do.

19 And so that is the next step. The next step is
20 coming to you and saying, what are your thoughts on this?
21 How do you see this playing out?

22 AC CO-CHAIR GÁLVEZ: Linda, did you want to
23 comment from Health in All Policies?

24 AC MEMBER WHEATON: This is Linda Wheaton.
25 Regarding the non-health partners. I just want to again --

1 Jahmal also participated in our panel on our pending update
2 of the statewide housing plan and I noted that housing was
3 one of the second of the top challenges section that was up
4 in the survey. And so we look forward to engagement of --
5 we have obviously many common issues with statewide health,
6 housing issues and health disparities.

7 And I also might note that this week, for example,
8 I am also on the advisory committee for the California
9 freight Plan and so we are working at supporting mapping for
10 impact of community impact areas for air toxics from the
11 freight network in the state to position it for mitigation
12 funding eventually, hopefully, for federal support. So I
13 think there are many crossover realms in which those of us
14 who are involved in this work where we can make that
15 outreach.

16 AC CO-CHAIR GÁLVEZ: Thank you, Linda.
17 General Jeff.

18 AC MEMBER GENERAL JEFF: Thank you. General Jeff.
19 I guess I haven't been -- I apologize, I wasn't at the last
20 meeting. There's a lot going on in Skid Row where I am from
21 in Downtown Los Angeles and I basically have to have boots
22 on the ground dealing with what I have to do, just like -- I
23 apologize in advance, I will not be here tomorrow for the
24 very reason of that.

25 But looking at the overall document, I haven't

1 looked at this document since January and it has come a long
2 way. So I am so happy that it's getting -- it's starting to
3 take shape.

4 That said, just really glancing at it right now I
5 have tons and tons of concerns. But I will just --
6 hopefully I will be able to implement that later on in the
7 breakout session. But just off the top of my head, where I
8 see where it appears as though the document is pretty much
9 trying to attach to systems that are already in place.
10 Where it says strategic priority it talks about building and
11 strengthening the existing network. When we talk about
12 existing network, when I think about why this committee was
13 formed and the strategic plan was deemed necessary, was
14 because the solutions that are already in place aren't
15 working or weren't working.

16 So I was excited about being on this committee
17 because I felt like this is an opportunity for us to create
18 something fresh and new and exciting in detriment to the
19 world being of all the persons in this entire state of
20 California. And so when I see some of the strategic plans
21 that talk about embedding -- when you use words like
22 "embedding" that means to tap into something that's already
23 there.

24 Something that's a key priority of mine personally
25 is that I think that we definitely need to identify the most

1 vulnerable communities first and foremost. To let -- to
2 have specific target areas so that we can actually let our
3 fellow citizens in the entire state of California know that
4 we identify you, we notice that you need help and we're
5 coming.

6 There is nothing in here -- I mean, this is a lot
7 of wonderful words. But to say that we will get into
8 specifics later on down the road, that's not -- you know,
9 that's not helping people now. Where I am at in Skid Row,
10 it's the homeless capital of America. Not the homeless
11 capital of California but the homeless capital of America.
12 We need help now. There is nothing in this document that I
13 can take to my constituents and say, here it is, this is
14 what we have been working on and help is coming. My people
15 are going to look at this and say, this is hogwash. I know
16 it's in there eventually when we get to that end document
17 but we need to have something in there so the people that
18 are really in need can actually feel that the help is on the
19 way. That's all I have for right now, thank you.

20 OHE DEPUTY DIRECTOR MILLER: Jahmal and then
21 Álvaro.

22 OHE DEPUTY DIRECTOR MILLER: Thank you.
23 Appreciate that feedback, General Jeff. We actually spoke
24 to that -- and I think there is an opportunity to elevate
25 it, particularly -- not only in the strategic plan draft,

1 statewide plan draft, but also in the disparities report or
2 the demographic analyses that has a section on housing. And
3 some of the data points and statistics that we are looking
4 at are homelessness related, so there's going to be an
5 opportunity for us to elevate that in post-July 1 to really
6 identify where the specific opportunities are that are new
7 and fresh.

8 I feel comfortable about our ability to do the
9 new, to do the new and the fresh. And I think in the groups
10 if that information is shared we will make sure we make a
11 conscious effort to elevate that so that people don't think
12 that -- so that people don't think that we are only tapping
13 into existing resources that obviously don't exist for
14 vulnerable populations, whether they are geographically
15 isolated, unsheltered or the like. So I appreciate that
16 point and it's actually a point that I made at that
17 conference that Linda talked about.

18 I wanted to give three specific examples as to
19 kind of the direction that we will be able to go into when
20 we think about the actionable part of this plan, which is
21 where the strategic plan is really setting that direction
22 and that blueprint for us. And post-July 1 we can just go
23 in on what the specifics are, what we are actually going to
24 do to implement that plan.

25 And one connects back to this heavy lift that

1 Jeremy talked about. And prevention Institute actually came
2 up in a discussion I had with one of my colleagues in
3 quality improvement at CDPH because I talked with her about,
4 okay, if we want to -- one of the priorities talks about,
5 once again, embedding a health and equity lens across
6 government. Not just from a high up approach but intra to
7 government, like CDPH-DHCS.

8 So we talked about an opportunity for a Prevention
9 Institute that happens to have an expertise in building a
10 module in, you know, government or any organization on what
11 health equity looks like. So how do we train new staffers
12 on health equity and applying that to your work. That's an
13 illustration or an example. Not to say that we've committed
14 to that but to see where your organization can kind of fit
15 in to advancing some work, that's one example.

16 Another one, I was recently connected through one
17 of our mental health colleagues that Marina has worked
18 closely with, is our veterans. When we think about the many
19 negative dynamics that disproportionately impact our
20 veterans, whether it's race and ethnicity, mental health
21 conditions or the like, poverty. We have a huge opportunity
22 to call out and elevate addressing equity with respect to
23 our veterans. That's a huge opportunity for us there. I
24 already mentioned housing and homelessness.

25 Another one when we think about infrastructure and

1 resources, and I've talked with Robert Phillips and Chet
2 Hewitt here, about them partnering with us to bring national
3 and statewide philanthropic organizations together to share
4 this plan with them. So that not only are we looking to
5 federal and state resources to advance this work but giving
6 national, you know, organizations like Kellogg and Robert
7 Wood Johnson and statewide entities, the California
8 Endowment, California Wellness, an opportunity to look at
9 our statewide plan and say, okay, where can we plug in with
10 respect to our philanthropic priorities so that we are
11 diversifying kind of the funding and the resources to
12 advance this work?

13 So those are four kind of actionable areas and
14 examples that July 1 is really where the rubber is going to
15 meet the road. And that crystallized over the last few
16 weeks as far as this process and this balance between
17 getting so specific and tactical in the plan, versus getting
18 the plan done at the high level and then moving to that next
19 important step around what's actionable, what's
20 implementable.

21 And much of what's being shared right now is where
22 that heavy lifting is going to start that we can't do alone.
23 And that's where you're going to come in, you're going to
24 come in, everyone is going to come in as to where can we
25 plug in to your organization' existing efforts across the

1 state and that's why the collective impacted approach is so
2 important.

3 And that's why I'm encouraged. I know it's a
4 heavy lift. I'm not -- we e not going to do it by ourselves
5 and we in the room can't do it by ourselves. We've got to
6 be very resources. And if we look at it from that
7 perspective we can get there sooner than later. But I
8 wanted to use those four examples around how we fund this
9 fund this effort and how we do it, you know, by each taking
10 on a role and responsibility.

11 AC CO-CHAIR GÁLVEZ: Alvaro.

12 AC MEMBER GARZA: Álvaro. So I have a time frame
13 observation and question because I see Phase 1 and Phase 2
14 throughout and Phase 2 for the most part is just a
15 continuation of Phase 1. It's redundant. I don't know that
16 we need to --

17 DR. NOLFO: There's a lot of like assessment that
18 happens --

19 AC MEMBER GARZA: Yeah,

20 DR. NOLFO: -- in Phase 1, actually.

21 AC MEMBER GARZA: A few different things so that
22 might be important. But the question then is related to --
23 I think it was at our first meeting in September we were
24 talking about the strategic plan going for three or four
25 years at the most and then redoing it. So I see this as a

1 little different time frame. So much changes in one year,
2 two and three a lot more even.

3 DR. NOLFO: So there will be --

4 AC MEMBER GARZA: So that's a question about
5 continuation or really redoing a strategic plan in three or
6 four years.

7 DR. NOLFO: So the plan will be updated every two
8 years and so this is essentially the vision. It was trying
9 to capture what I heard coming out from this group around a
10 vision. So there was so much that couldn't be done in the
11 first couple of years, it wasn't realistic. But rather than
12 losing it I wanted to put it in as part of the vision so we
13 could see what we were trying to get to.

14 But you're absolutely right. I mean, when you do
15 strategic planning it is very hard to know what the
16 landscape is going to look like two or three years out. And
17 so the intention is that, yes, this plan will be updated in
18 two years. And we may want to keep a large portion of what
19 still remains or we may want to scrap a large portion of
20 what remains. So it's more of a vision beyond the two years
21 than anything else.

22 AC CO-CHAIR GÁLVEZ: Thank you. Did you not want
23 to speak, Willie?

24 AC MEMBER GRAHAM: Well I'm going to say one
25 thing; I am very encouraged. I was very disappointed that I

1 wasn't able to make it to the last meeting because I see so
2 much that has been given from each one of us to make things
3 so much better for all people in this community within the
4 state of California, being an example.

5 There were some things I was very much concerned
6 about. As a veteran injured during the Vietnam War, working
7 with men -- working with a lot of groups. There's a lot of
8 things that are very needed and necessary. But I learned
9 that there must be a starting point. There's got to be a
10 starting point and you add as you go along. We all are
11 dealing with different communities and things in partnership
12 but today my heart is very joyful because we are still
13 working hard to make it happen. And I found out that when
14 minds come together with the same determination, the same
15 goal, that it's always a positive outcome. It might not
16 always be exactly the way we want it but eventually we will
17 get there and the work will be done.

18 I went back and told a lot of people about the
19 resource center, using the resource center. The men's
20 group, the hero groups and a lot of veterans that I talk to.
21 I am very optimistic. And so I just want to thank you. I
22 want to thank Jahmal for coming and speaking at our church.
23 I just want to thank you all and keep encouraging us to keep
24 going forward. Keep bringing, as General did, the concerns.

25 I want us to be a voice that we feel like we can

1 express ourselves without someone looking down on us. Say
2 what you believe, say what you feel, don't hold back, we are
3 here as a partner. If we disagree we will disagree
4 respectfully. But we are here as one body to get the work
5 done and I am very joyful about it.

6 AC CO-CHAIR GÁLVEZ: Thank you, Willie, we missed
7 you.

8 Anyone else on the committee want to speak? Gail.

9 AC MEMBER NEWEL: Gail Newel. I want to echo what
10 General Jeff and Willie Graham have said. A theme that I
11 heard as well with my constituents in the Central Valley was
12 that much of the language in our documents is accessible to
13 many in need in California. And if there is any way that we
14 could perhaps prepare a more accessible language statement
15 of our mission and vision that is not in public health-speak
16 I think that would be really appreciated by the general
17 public.

18 DR. NOLFO: Gail, I would like to say, and Jahmal,
19 of course follow-up with me if you'd like. That that
20 actually has been our vision from the very beginning. And
21 so yes, our document is created for certain folks and it is
22 not the document that we would try to give to people who
23 don't work in this field or, you know, don't kind of live in
24 this world that we're in.

25 And so what we want to do is to actually create an

1 accompanying document that is very visual, that is very
2 accessible, that is very plain-speak about what does this
3 mean to you. You know, how can you be involved in this.
4 And so that has been the vision from the very beginning, and
5 as well to have like links on the website for those folks
6 who may want to go into our website and to see something
7 that may be a video presentation that's very, you know,
8 engaging and easy to understand. You know what I'm saying?
9 Yes, this is for a particular audience.

10 OHE DEPUTY DIRECTOR MILLER: And to that point, I
11 am eager to share with you once the graphic designer takes
12 the language and lays it out and then takes many of the bar
13 graphs and pie charts that we have shared and using info-
14 graphics and things of that nature that tell a story in a
15 less scientific way.

16 So we're trying to have that balance between,
17 okay, can the policy maker ingest and digest this
18 information easily and can the local, you know, principal of
19 a school that wants to, you know, address trauma and inform
20 care needs in their school, can they relate. So we are
21 trying to have that balance from an aesthetically pleasing
22 document that provides info-graphics.

23 And we are also considering once again leveraging
24 multimedia to actually use people to tell the story about
25 what's happening in the state of California. And that's the

1 advantage of different types of media, of the print media,
2 social media even. Different ways to share the story. So
3 we're taking that into consideration.

4 Once again just going back to that Willie
5 principle. That's always been top of mind. But we do
6 recognize the opportunity to just be less scientific in some
7 places and just make it plain, you know, and in more places
8 than not.

9 AC CO-CHAIR GÁLVEZ: Patricia.

10 AC MEMBER RYAN: Yes, I just wanted to advocate, I
11 guess, in however way we can do it to make it accessible by
12 language also because we have a very diverse state. And
13 even if you simplify whatever it is you're doing, if people
14 don't understand it they are not going to be able to
15 understand what we're saying. I know that's costly but.

16 DR. NOLFO: And we also are making the commitment
17 around translation of surveys in the future. That this one
18 was put together very quickly. But that's a miss to not be
19 able to translate the surveys as well.

20 AC CO-CHAIR GÁLVEZ: Hermia.

21 AC MEMBER PARKS: So I'm putting on my nursing
22 hat. It's always on. The way that I look at this document,
23 we have done our assessment, we've identified the needs and
24 now we are going to develop our individualized care plan.
25 And that care plan is going to engage our partners. In

1 nursing you cannot do a care plan without the patient's
2 involvement, the community involvement in terms of what they
3 see their needs are. So when I look at this I see this
4 says, the framework to then move forward to meet with our
5 individual partners and develop our individualized care plan
6 to address the needs of the community.

7 AC CO-CHAIR GÁLVEZ: Thank you. Anybody else from
8 the committee?

9 Okay, we have a couple of speakers that have put
10 forward cards. Pete Lafollette and Ricardo. Ricardo,
11 please -- Ricardo, if you could please line up so you're
12 ready to go as soon as Pete is done and please let's -- yes,
13 just right there. Pete will go first. Two minutes, Pete.
14 And we are opening the phone line to see if anyone else on
15 the phone would like to speak.

16 (Teleconference line was unmuted.)

17 MR. LAFOLLETTE: Thanks. Thanks, Sandi. I do
18 Mental Health Services Act stakeholder advocacy. Under the
19 components of reducing disparities, economic disparities,
20 including racial and ethnic.

21 At the beginning of this year I participated in a
22 Mental Health Services Oversight Commission meeting where
23 the chair spoke about last year's audit and how if things
24 did not change with the service act and comply with the
25 service act then these funds would disappear.

1 However, by the end of the self -- self -- health
2 policy item on the budget provision they were breaking into
3 a song of 99 bottles of beer on the wall. The office had
4 been commenting on their \$99 million established budget
5 annually.

6 What those numbers do not remedy is the conditions
7 of poverty and hopelessness for consumers in the underserved
8 with unmet needs that the Mental Health Services Act was
9 designed to address. As long as consumers continue not to
10 receive the opportunity, upward mobility, education, all of
11 these things that the services act was designed for,
12 including to increase the wellness and the health of
13 individuals and communities through taking action for social
14 change, strategies to restructure mental health systems to
15 be more recovery-oriented - and I do emphasize recovery -
16 and community-based to protect our civil and human rights to
17 be more accepting, inclusive and diverse organizations and
18 communities to maximize our individual and collective
19 strengths, potential and creativity to make wellness and
20 social justice a reality for all. All of these outcomes are
21 addressed in the reform -- should be addressed but are not
22 in the reform process.

23 Humanity cannot be lost in these policy
24 discussions, given the huge public expense for non-recovery
25 and disability, substance use and abuse, poor nutrition,

1 incarceration, hospitalization, institutionalization and a
2 long list of atrophies that as a public and a society we
3 simply must avoid in the future. Thanks.

4 AC CO-CHAIR GÁLVEZ: Thank you, Pete. Ricardo.

5 RICARDO: Good morning, everybody. I was trying
6 to get my partner Alberta to come up here but she refuses
7 but we do represent a special combination of social forces,
8 I might say.

9 We represent the micro- and the macro-elements
10 within community, the macro-element being the big picture.
11 What is the big picture? What does the big, interconnected
12 holistic picture look like? And Alberta represents the
13 multi-disciplinary coordination of these -- these elements.
14 So together, you know, we've got these bases covered.

15 And we kind of frame it under a Stanford review
16 for innovative social change project they call Collective
17 Impact. And I have to say that, you know, most people will
18 look at Collective Impact as just rhetoric but it's much,
19 much more, it's much more. It's a much more intensive
20 application of organizing, making collaborations, enforcing
21 accountability issues. Getting people to stay at the table.
22 And that is -- you know. They made a very special point of
23 saying, you have to get your community organizers, your idea
24 people, your conceptualizers, you have to get them at the
25 table and keep them at the table.

1 But I want to talk about -- a little bit about
2 what General Jeff was -- we had a conversation out in the
3 hall. This conversation is about how do we get resources,
4 you know. This money that seems to float around at the
5 grass tops sometimes, the grass mitt, how do we get those
6 resources down to grassroots people, you know? Because it
7 seems like, you know, I've been in the business for like 25
8 years of doing community work. And it always seems like
9 resources capacity gets absorbed in these middle lands.
10 They get lost and good programs get lost, good matrix get
11 lost. The community does not own its own data, you know,
12 and it's time we took charge of that, you know. We have to
13 be point specific on how we use data and how we apply them
14 to programs.

15 Also real quick. I'd just like to know if during
16 our strategic planning are we going to cover areas like
17 political networking, legal support systems? And I say
18 legal support systems because we have a shopping center that
19 is not responsive to the community. We have a public
20 housing sector, the only one in Marin County, that we would
21 like to change over to a land trust and using that to build
22 cheaper housing, affordable. Stop gentrification and keep
23 people in a social safety net that they can visibly feel and
24 touch on a day-to-day basis.

25 We also were thinking of making a recommendation

1 that came out of Maryland, Pennsylvania, New Jersey, where
2 they use a structure called Health Enterprise Zones. And
3 these are --

4 AC CO-CHAIR GÁLVEZ: You've gone way over time,
5 Ricardo, so please wrap it up.

6 RICARDO: Okay, okay, I'll wrap it up real quick.
7 But Health Enterprise Zones are zones used for the -- to
8 establish the relationship of private/public partnerships,
9 you know, to further the health interests of targeted
10 communities.

11 And with that I would like to say that anybody
12 that wants to talk about Collective Impact for lunch or
13 anything like that please, you know, grab me and, you know,
14 we'll break some bread. Thank you.

15 AC CO-CHAIR GÁLVEZ: Okay, we have one more
16 speaker, Nicki King.

17 DR. N. KING: Good morning. I can see the sign
18 and I am going to be very quick.

19 I am really encouraged by this plan. I think it
20 is a wonderful step to advancing a much more holistic agenda
21 to achieving health equity.

22 Having said that, I think there are two things
23 that it critically needs. When you think about health
24 disparities and health equity in the state, the California
25 Reducing Disparities Plan has focused most of its resources

1 on the quote/unquote "Big Five" and they are called out on
2 page six of the CRDP.

3 I would like to advance and want you to include in
4 your strategic plan the notion that equity cuts a lot of
5 different ways. You need to, I think, include specific
6 mention of the disability community, of immigrant
7 communities, of religious minority communities, of smaller
8 ethnic communities. Because they are also suffering from
9 problems associated with lack of access to health care.

10 Finally I think you really need to -- and this is
11 partially because I guess I'm an evaluator. But you need to
12 consider utilizing evaluation as a means to actually help
13 you achieve the things in Strategic Priority F. Most people
14 think about evaluation as a report card. As something that
15 comes in at the end to see how you did. I want you to
16 consider using evaluation as a formative process to help you
17 actually decide how you are meeting the things that are in
18 the individual goals. I think it's a much more boots on the
19 ground method of knowing where you need to correct before
20 you spend all the money and I'd like for you to think about
21 that. Thank you.

22 AC CO-CHAIR GÁLVEZ: Thank you.

23 Would anybody on the phone like to speak?

24 (No response, teleconference line muted.)

25 AC CO-CHAIR GÁLVEZ: Okay. So since we are done.

1 We are actually going to break for lunch a little early and
2 come back from lunch a little early to get more time in the
3 afternoon to -- just one minute, sorry. I didn't realize we
4 had gotten that close. Now we are down to one minute early
5 so forget that. So we are going to have lunch. Lunch is
6 provided for the advisory committee members in that room
7 down the hall and we look forward to seeing members of the
8 public at one o'clock. Thank you very much.

9 (Off the record at 11:59 a.m.)

10 (On the record at 1:13 p.m.)

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1 A F T E R N O O N S E S S I O N

2 AC CO-CHAIR GÁLVEZ: Okay. So our first item on
3 our agenda after lunch is going to be a presentation from
4 Dr. Neil Maizlish who will be talking about the Climate
5 Action Team of the Health Department.

6 And while he is setting up I just wanted to remind
7 folks, as I reminded you all before every presentation at
8 our last meeting, really be -- I know that all the
9 presentations are interesting and that it's an opportunity
10 to hear just in general what folks are doing, or what the
11 presenters are doing. But please try to focus the comments
12 and questions after the presentation on really how the
13 presentation can really inform our thinking around the
14 strategic plan. Thanks.

15 DR. MAIZLISH: Okay. So thank you very much. I
16 want to point out that the presentation itself may not have
17 gotten into your packet and Debbie has copies in case you'd
18 like to follow along that way as well.

19 Hi. My name is Neil Maizlish and I am in the
20 Office of Health Equity and I am one of the leads in the
21 Climate and Health Team at CDPH. And what I'd like to do to
22 start off with is really talk about what the message is
23 around climate change and health and health equity.

24 So I think folks have a pretty basic understanding
25 that climate change does represent a threat to our health.

1 But it also represents an incredible opportunity as well to
2 be able to leverage resources and strategies, especially
3 when it comes to our vulnerable communities because I think
4 people also have a sense that our vulnerable communities,
5 that are already vulnerable for many different factors,
6 climate change will amplify the threats that they already
7 sense and feel and exist in.

8 So I want to deliver this sort of dual message
9 that it is a threat and there are opportunities because
10 otherwise this tends to be a very depressing topic. And we
11 need to know that there really is hope and there are silver
12 linings to the climate and health and health equity issue.

13 So with that said I am going to talk a little bit
14 about -- before I do that why don't I ask folks individually
15 and perhaps with your own organization, how engaged on
16 climate change and health are you right now? Would you say
17 it's a lot, a little? I see some hands go up. How many say
18 their organizations/themselves a lot?

19 Okay, some activity. And let's say people who are
20 just starting to do that?

21 Okay. So it's a pretty diverse group of folks.
22 So what I am going to do is -- part of what I am going to do
23 today is present what the climate and health issues are and
24 health equity issues are around climate change, so what the
25 scientific issues are. Then we'll talk about what the state

1 is doing and then I'm going to talk a little bit about what
2 OHE is specifically doing. And again with that dual message
3 of opportunity and threat. So with that said let me move to
4 the next slide.

5 So I am going to start off with a couple of quotes
6 from opinion leaders and important documents.

7 From the standpoint of climate change, that they
8 can potentially have catastrophic impacts. it's an
9 existential threat to our lives and our communities. So
10 this comes from Georges Benjamin who is the Executive
11 Director of the American Public Health Association:

12 "Climate change is one of the most serious
13 public health threats facing our nation. Yet few
14 Americans are aware of the very real consequences
15 of climate change on the health of our
16 communities, our families and our children."

17 Climate change in California is one of the
18 governor's priorities. And this is a quote at a conference
19 that he gave on extreme weather a few years ago:

20 "It's time for courage, it's time for
21 creativity and it's time for boldness to tackle
22 climate change. The risk is real, the cost is
23 huge and growing, and therefore taking a sequence
24 of realistic steps just makes that sense, and
25 that's what we're going to do in California."

1 And as you will hear a little bit later, that is
2 what is happening in California.

3 The next quote is from the Human Health chapter of
4 the 3rd US National Climate Assessment that was actually
5 published last week on May 6th. And I am proud to say that
6 there were many contributions, scientific contributions,
7 from many scientists in California, including our own OHE
8 program. Some of the work that I have done was cited as
9 evidence around health code benefits. And I will talk a
10 little bit about the health code benefits a little bit later
11 on.

12 "Climate change will, absent other changes,
13 amplify some of the existing health threats the
14 nation now faces. Certain people and communities
15 are especially vulnerable, including children, the
16 elderly, the sick, the poor and some communities
17 of color."

18 So I think there is a recognition on the national,
19 state and local fronts that climate change represents a
20 health risk.

21 So what is climate change? Again, this is sort
22 of Climate Change 101. It's basically about the rising of
23 the earth's temperature due to the increased release of
24 greenhouse gases that's produced by the burning of fossil
25 fuels, whether that's from electric power generation,

1 whether it's our own cars, our heating, there's many
2 different sources. It also comes from deforestation and
3 certain agricultural practices and other things.

4 It's really about population growth globally and
5 our economic development model that is very much rooted in
6 burning fossil fuels and that's what's driving this process.
7 So as those greenhouse gases are emitted to the atmosphere
8 it creates sort of like a blanket that prevents heat from
9 getting -- from escaping and it's warming up the surface of
10 the earth, both the oceans and the land. And what it's
11 doing, it's beginning to create changes in the weather
12 cycles, whether it's in the oceans, in the atmosphere, on
13 land, so we are seeing these changes.

14 So some of the obvious things around heat. The
15 planet is warming. And what are some of the direct impacts
16 of that? Well it's rising heat, it's severe weather and the
17 intensification of certain kinds of air pollution. I think
18 we all know that the human body responds to heat in
19 different ways and that if there is too much heat and there
20 is not enough cooling hydration that there is actually heat
21 stress or even heat stroke and people can die from this. We
22 have had some relatable episodes of people dying actually in
23 the fields in California in the last decade where they were
24 overwhelmed by heat. We also had the heat wave in 2006 that
25 killed about 650 people and we'll talk a little bit about

1 that later.

2 In addition to heat we have severe weathers. The
3 high variability of intense storms with coastal flooding and
4 things like that. That can have a direct impact on
5 injuries, fatalities and disaster response.

6 With air pollution, as you heat up the atmosphere
7 things like ozone and particulate, fine particulate matter,
8 actually those concentrations can go up. So people who are
9 already vulnerable due to asthma or other kinds of
10 respiratory illnesses can have their conditions exacerbated
11 by heat waves and just rising temperature.

12 There's other impacts on people's health through
13 allergies. The plants can respond in a way to release more
14 allergens and that can have a direct impact on respiratory
15 effects.

16 We know that the climate has a huge impact on the
17 distribution of the insects and other kinds of vectors of
18 infectious disease and that the biogeography changes as our
19 climate changes. So the distribution of things like Lyme
20 disease or Hanta virus or other things like that, West Nile
21 virus, could be impacted by our changing climate in
22 California.

23 Water-borne diseases. Again, after intense
24 flooding it overruns water treatment systems and sometimes
25 there's water-borne outbreaks as well as other problems.

1 Our food and water supply are also at risk with
2 increasing climate change. In extreme situations in which
3 there's droughts, of course which California is suffering
4 from one right now. There could be disruptions in our food
5 supply. There could be price spikes that make food less
6 affordable to our vulnerable populations. So these are some
7 of the ways, the sort of indirect effects that climate
8 change can have an impact. It even in severe situations,
9 increase malnutrition and other kinds of things like that.

10 There is a big potential impact on mental health
11 and I am going to have a special slide just on that. But
12 it's just a call-out that the impacts of climate change, if
13 it's an intense, extreme event, can displace people, it can
14 threaten their families and it has huge mental health
15 overlays. It's something that is part and parcel of climate
16 change and we are very cognizant of those kinds of issues.

17 And in severe cases, and you take Katrina as a
18 example. I don't know if folks have seen the map, the
19 national map of the Katrina Diaspora leaving their homes in
20 New Orleans and being displaced all over the country,
21 including in Sacramento and in San Francisco. So these have
22 wide-ranging effects. Because if you think about it, the
23 social fabric in which they existed got torn and of their
24 relationships and social networks that they relied on have
25 been disturbed. So these are some of the concerns in

1 general around climate change.

2 I wanted to do a special call-out on mental health
3 because many of the members of the advisory committee,
4 that's what they do full time.

5 So I just wanted to emphasize the nature of
6 extreme weather events having on mental health.
7 Unfortunately, we have a number of recent events, not just
8 Katrina but Hurricane Sandy in the mid-Atlantic and other
9 places. And even Irene, which is probably less-known to
10 people in California but in certain places in upper New
11 England and Vermont it had a devastating effect. A huge
12 amount of flooding that occurred that created displacement
13 and things like that. So you have a number of different
14 mental health outcomes.

15 Complicated grief reactions because of the loss
16 due to injury or death.

17 The actual displacement, whether it's temporary or
18 it could be long-standing as well.

19 Post-traumatic stress disorders are amplified by
20 these kinds of events in that there is just a recognition
21 that we are not talking about starting from scratch, there
22 already is a pre-existing level of mental health conditions
23 that make people vulnerable. And when these kinds of events
24 are overlaying they create exacerbations.

25 There's a whole other area that is basically

1 unknown right now where there is starting to be survey
2 research. Looking at the youth reaction, the future
3 generation, how they are perceiving climate change in their
4 world. And we are responsible for some of how that is going
5 to play out. So whether there is a generalized neuroses and
6 anxiety reactions about what our future is going to look
7 like, this is starting to be looked at in youth.

8 One thing I just wanted to point out is that it
9 appears, you know, in our discussions in state government
10 and also around the country, it seems like many social
11 service agencies are not as engaged as perhaps they would
12 like to be on this issue. Probably because they are just
13 struggling to deliver the services that they are trying to
14 do right now. So this is sort of a new area that that will
15 be asked -- they will have to get engaged because their
16 populations will be disproportionately impacted by this.

17 So I just wanted to -- part of our outreach in OHE
18 is talking to other states. I'll mention in particular a
19 Centers for Disease Control grant that we recently got where
20 we are in touch with many different states working on
21 preparing communities, trying to increase the resilience for
22 the impacts of climate change. And one of the folks we
23 talked to is from Vermont. And Irene was a severe storm
24 that caused a tremendous amount of flooding in Vermont. And
25 they are telling us that their social service agencies are

1 still dealing with the aftermath of Irene in terms of mental
2 health services provision, two and a half years after the
3 event. So this is just to emphasize that these things can
4 have long -- even a point event like an extreme event can
5 have years of impact.

6 I want to focus a little bit about vulnerable
7 communities. And this is not supposed to be a comprehensive
8 list but it illustrates some of the vulnerable communities,
9 whether it's based on age or gender, having preexisting
10 medical conditions or preexisting mental health conditions,
11 whether people have chronic diseases where they're taking
12 multiple medications, whether they're linguistically
13 isolated or socially isolated, whether they have mobility or
14 transportation limitations, whether they're low-income,
15 whether they're working outdoors, or it's race and
16 ethnicity. This a partial list of vulnerable populations.

17 And I think you can see that this is the same list
18 that is part of our legislation for OHE so it is very much
19 the same populations. And I want to address some of the
20 issues that General Jeff brought up earlier about trying to
21 identify those specific populations and how we at OHE might
22 be able to contribute to that, that discussion.

23 So I just wanted to emphasize again that climate
24 change is going to impact everybody but the most vulnerable
25 will be the ones to suffer the most. This map that you see

1 here of the southern part of LA County is an example of the
2 kind of vulnerability mapping that we are starting to do at
3 CDPH and in our OHE programs.

4 We understand that climate change is going to
5 magnify the existing health inequities that are rooted in
6 the social determinants of health. That's one of our
7 operating principles.

8 And this illustrates that. In LA County there's
9 going to be more African-Americans and Latinos that live in
10 high-risk areas. This map is actually showing several
11 different things, vulnerability to the heat, vulnerability
12 to wood fire smoke and to sea level rise. And red
13 represents higher levels of vulnerability, green represents
14 lower levels of vulnerability.

15 So you know LA, the County, you will see that the
16 center core, that's where the vulnerable populations are.
17 So this is just one of the techniques that we are starting
18 to use to elucidate where vulnerable populations are and to
19 put this information in the hands of people who then take
20 action to try to reduce the risks.

21 Another aspect of climate and health impacts is
22 the perception of the vulnerable populations themselves. So
23 there's been many public opinion polls that have been
24 conducted in California and nationally.

25 This particular poll is from the Public Policy

1 Institute of California that was done last year in June and
2 they're asking questions about do they perceive climate
3 change occurring now and who is perceiving this as a very
4 serious threat? So unlike other places in the United
5 States, there was a higher sensitivity to climate change
6 threats in California, where 79 percent of Californians are
7 saying that it's a very serious threat or somewhat serious
8 threat.

9 But when you break it down by race/ethnicity we
10 begin to see some really stark differences. The Latinos and
11 African-Americans share a higher recognition of that threat
12 where it's over two-thirds -- close to two-thirds of that
13 population say yes, it is a very serious threat; where you
14 see Asians and Whites perceiving it being a less serious or
15 immediate threat. This is sort of saying that there's some
16 populations that are already feeling vulnerable are getting
17 it because they perceive that this is going to be added to
18 their existing burden.

19 So I want to switch gears a little bit now and
20 talk sort of background, talk a little bit about what the
21 state of California is doing and then talk a little bit
22 about what OHE is doing specifically.

23 Because I am a public health person I tend to
24 divide up the world into primary prevention and secondary
25 and tertiary prevention. In that lingo it's, you know, if

1 you can eradicate smallpox, eradicate smallpox, then we
2 don't have to deal with the risk factor. That's primary
3 prevention. We've done that. We're trying to eliminate
4 polio and a bunch of other infectious diseases. But the
5 idea is, get rid of the risk factor so you don't even have
6 to worry about it.

7 If you can't do that there's other things that you
8 can do. You can immunize the population. You can take
9 other steps. If you can't absolutely prevent the exposure
10 to whatever the risk factor is you can try to do things to
11 minimize the damage.

12 So the scale of primary prevention to secondary
13 and third, we have that strategy in California. So the
14 language that is used, it's kind of geeky, it's not familiar
15 language, I'll try to explain it.

16 So when we talk about mitigation of greenhouse
17 gases in California, which is a state policy, we're talking
18 about preventing them from ever escaping the car, the car,
19 the smokestack, to begin with. That's really a primary
20 prevention strategy. So I'll talk about what are some of
21 the things that the state is doing.

22 So the state, again -- it's really several
23 governors' initiatives. It started in the Schwarzenegger
24 administration, it's continued in the Brown administration
25 to recognize that -- California is something like the 12th

1 largest emitter of greenhouse gases in the world. We have a
2 fair amount of generating the problem.

3 The state has mobilized and the governor has
4 mobilized and the legislature has mandated state agencies to
5 work together to try to reduce our carbon footprint. And
6 the state has inventoried its greenhouse gases, where it's
7 coming from. So we know where electrical generation --

8 We know that transportation actually is the
9 largest, single sector of greenhouse gas emission. On
10 average, every mile that you go you emit roughly a pound of
11 CO₂. So if your average driving is about 10,000 miles a
12 year that's 5 tons of greenhouse gases you, yourself may
13 have emitted. So when you multiply that by 35 million
14 people in California you can see that this is a big deal.
15 So the state is mobilizing to try to reduce our carbon
16 footprint through a number of different strategies.

17 One was creating a state agency level team of
18 which CDPH is a member. The coordination of housing and
19 transportation is key to our greenhouse gas emissions and
20 reductions. As I mentioned, about 38 percent of all our
21 greenhouse gases are emitted by automobiles, and a lot of
22 that is single occupancy cars trying to get to work in the
23 morning. There's hundreds of congested segments. So
24 something that might actually be a housing crisis, where
25 there's not enough affordable housing, becomes a

1 transportation crisis and contributes to that. So there's a
2 lot of dots to connect in this area and there's been
3 specific legislation that's trying to harmonize where people
4 live and where they work so that we can reduce our carbon
5 footprint that way.

6 I should just point out that there are scores of
7 local communities, not just a statewide effort or a state
8 agency effort. That there are scores of communities that on
9 their own have adopted climate action plans that are trying
10 to reduce their own carbon footprint in their own
11 communities. And it's really interesting because their
12 mantra is Economy, Environment and Equity. But I have to
13 say, in viewing many of these local plans, it's mostly about
14 economy and environment, not so much equity. So I think
15 there's a lot of opportunities there to figure out how that
16 works.

17 As I said, if you cannot reduce the risks entirely
18 then you have to begin to adapt. The result of decades
19 worth of accumulation of greenhouse gases in our atmosphere
20 does mean that there will be a certain amount of warming
21 even if we stop emitting carbon right now. There's sort of
22 a committed effect to what we have before. So we're going
23 to have to prepare for some of these changes and I'll talk a
24 little bit about our responses to this.

25 So I'm trying to highlight things that will focus

1 on our vulnerable communities. And there is legislation
2 through our overall climate reduction strategy. Part of it
3 is a market-based approach where you cap the amount of
4 emissions and then you can trade allowances to try to reduce
5 the overall amount of carbon that's emitted over time.

6 The state is now auctioning off these allowances
7 and getting revenue and there's a question of how to invest
8 that revenue. It's potentially hundreds of millions of
9 dollars. So legislation has been passed that requires the
10 state to come up with an investment plan and there is an
11 explicit earmarking of 25 percent of all the auction
12 proceeds to be spent for the benefit of disadvantaged
13 communities. And of that group, 10 percent of all the
14 action proceeds have to be spent in those communities
15 directly.

16 So this presents an opportunity, as I mentioned
17 before, to see how those investments might be invested.
18 What are the kind of projects that might benefit
19 communities. How we would even evaluate where they're
20 having the impact. And how communities will be engaged in
21 that process. So there are things that are happening around
22 climate and health that, again, represent opportunities.

23 Now I would like to switch gears and just focus a
24 little bit about what the Office of Health Equity is doing
25 particularly. And I just want to point out that some people

1 coming to this discussion about climate change and health
2 equity say, like what's the connection, how did it wind up
3 there?

4 I just want to point out that the Health in All
5 Policies Task Force and all the work that we are doing on
6 HiAP, the climate change activities and our Healthy
7 Community Indicators Project or our Healthy Places Team,
8 they all have overlapping core values. What they are, it's
9 about equity, it's about the social determinants of health
10 and multi-sector engagement. So that are some of the sort
11 of the core values that are embedded in all of our projects
12 and climate change represents another one of them. So I
13 just wanted to sort make that connection because some people
14 will say, climate change, what is that doing in the Office
15 of Health Equity, what does that have to do with it? It has
16 a lot to do with it. Again, mitigated by our vulnerable
17 populations.

18 So what we are trying to do -- what we are trying
19 to do in the Office of Health Equity is assess the climate
20 impacts on public health and vulnerable populations and try
21 to figure out those strategies which maximize co-benefits.
22 And I'll explain a little bit about that.

23 We want to provide training tools and metrics and
24 technical assistance to local health departments, local and
25 regional planning organizations and other folks on climate

1 and health.

2 And we were fortunate to get a Centers for Disease
3 Control grant recently that will allow us to build up our
4 capacity and that of local health departments to try to
5 create more resilient communities on this issue of adapting
6 to climate change.

7 So I just want to report out on some of our work,
8 especially around climate change and communications.
9 Because we believe that health plays a special role in
10 attracting people's interest. People are very naturally
11 responsive to their own health and the health of their
12 families and their communities. So using health as part of
13 the messaging becomes an important part of the overall
14 strategy. Not just for public health people but for non-
15 public health people too that they can bring this message
16 into their discussions.

17 So we have been conducting focus groups around the
18 state and it's Brooke Sommerfeldt and Kathy Dervin who are
19 leading the charge on this in our office. And we have
20 conducted focus groups exploring community health leaders'
21 knowledge and attitudes on climate change in public health.
22 So this was a series of focus groups we had over the summer
23 last year. And they were conducted in Northern, Central and
24 Southern California in English and Spanish. I'll share some
25 of the results with you.

1 First of all, this awareness of climate change.
2 Extreme weather. These are some of the things that are
3 being perceived already. The pollution and increased
4 vulnerability. These are the things that people are already
5 telling us that they are sensitive to. Here is a quote from
6 one of the participants:

7 "The extreme weather changes are hard when you
8 don't have the air conditioning, and we see asthma
9 and bronchitis and chronic illnesses. What's
10 going on is dangerous."

11 This is what people are perceiving.

12 Also concern about climate change. Not just that
13 it's occurring but about air pollution, the water supply,
14 violence and crime and public transportation.

15 "I am personally very concerned about these
16 disasters. I close my eyes and I see my children
17 in the future and I see me as an old woman in my
18 community and I don't think we will be able to
19 handle it."

20 So these are the very palpable feelings that
21 people are expressing around this issue.

22 I'll talk quickly about health co-benefits because
23 I think this is a part of the silver lining of climate
24 change, part of the opportunities. The idea that strategies
25 that can reduce our carbon footprint might have added health

1 benefits. I'll take the sort of an intuitive thing.
2 Everyone knows that physical activity is good for you. When
3 you couple that idea with what I said before that 38 percent
4 of the carbon emissions in California are in the
5 transportation sector. Well, if we could have a meaningful
6 mode shift from cars to biking and walking we could achieve
7 a couple of things, we'd reduce our carbon footprint with
8 that physical activity that's embedded in walking and
9 bicycling will have a tremendous impact.

10 So the question is, well how much? We know it's
11 sort of good of you to begin with but how much? So I have
12 been involved in a effort to actually quantify using
13 predictive models on how big the impact would be. And it
14 actually turns out to be a very significant impact. If we
15 could --

16 And this was based on a study done in the Bay
17 Area. But if we could bring the baseline in the Bay Area to
18 about 4.5 minutes per person per day, that's what people
19 walk and bike. If we could bring that up to the surgeon
20 general's recommendation, just roughly 20 minutes a day of
21 biking and walking or just physical activity, we would
22 reduce the amount of cardiovascular disease by about 15
23 percent. We'd reduce diabetes by 15 percent, depression,
24 dementia, many of the other conditions that are associated
25 with the lack of physical activity. We could have major

1 impacts.

2 Now I'm not saying that this is necessarily
3 realistic. To go from 4 minutes a day to 20 minutes a day
4 is a huge population change. But this is sort of saying
5 what the goal posts look like. That here is a potentially
6 large reward, it's just a question of what the strategies
7 are, what the investments are and things like that. So part
8 of this is alerting people to the benefits but also the
9 potential harms. Because you can see this red line in the
10 middle suggests that when you have a lot of new pedestrians
11 and bicyclists eventually in harm's way with motorized
12 vehicles those conflicts could result in increased injury.
13 So we are very sensitive to that as well. So that should
14 also be built into the strategy.

15 Now I'm going to quickly go through some of our
16 adaptation activities+ that the state has mobilized right
17 now to create a overall document to guide state agencies in
18 their activities. And public health is at the table with
19 the development of those strategies.

20 Some of them are based on what we do traditionally
21 around public health surveillance.

22 The idea that we have to build community
23 resilience.

24 Education outreach and community partnerships.

25 Improve preparedness and response. Our

1 traditional roles as emergency responders.

2 And identify those strategies that have co-
3 benefits and then promote policy changes.

4 The point of this list is not the list itself,
5 it's that embedded in each one there are -- there is a
6 dimension of health equity and how that plays out. I just
7 wanted to point that out.

8 Lastly I just wanted to point out that there are a
9 number of products that we have created in the realm of
10 working with urban planners and local government. We heard
11 earlier today about I guess folks that are now going to be
12 part -- I think it was you had mentioned about the ILG.
13 Well we have worked with the ILG on a climate action
14 planning guide where opportunities to improve urban planning
15 and think about the health impacts are embedded right in the
16 planning documents. So it's, again, to sensitize those non-
17 health sectors on what they are doing actually has a huge
18 impact on health.

19 As I mentioned, one of the things that we do is
20 provide guidance for other state agencies. And one of the
21 documents that we have created is an extreme heat guidance
22 that talks about not necessarily the medical response but
23 how we can cool our communities down through urban planning
24 design. How we can also improve our emergency response and
25 other kinds of things. And then, as I mentioned, the

1 safeguard in California is the state's official
2 documentation adaptation strategy.

3 So I hope I have given you hope and represented
4 the challenge, because it is a challenge. And that as we go
5 forward I think there are smart solutions and ways to
6 leverage what is a difficult hand that we have been dealt or
7 we've dealt ourselves around climate change. The ways that
8 we can see out of it. So thank you.

9 (Applause.)

10 DR. MAIZLISH: Questions? I'm going to be around.

11 AC CO-CHAIR GÁLVEZ: Thank you, Neil. Let's just
12 hold on and see, let's try to have at least a few minutes of
13 questions. José.

14 AC MEMBER OSEGUERA: I just had a quick question,
15 this is José Oseguera with the OAC. Just in regards to
16 slide number 6. There was a cluster of red in the middle of
17 Los Angeles. And was that attributable mostly to air
18 pollution or is that just an island of non-economic activity
19 where individuals are hopeless and don't have many resources
20 in that particular area?

21 DR. MAIZLISH: That's a combination of mostly
22 social vulnerability, so it will be things like poverty,
23 race/ethnicity, linguistic isolation. And it will also be
24 about aspects of the built environment where there is a lack
25 of trees and impervious surfaces, a lot of concrete where

1 there is urban heat island potential. So that's what that
2 red is about.

3 AC CO-CHAIR GÁLVEZ: Álvaro.

4 AC MEMBER GARZA: Thank you, a great review. I'm
5 trying to find if -- maybe you can comment on climate change
6 and agricultural changes, the impact on agriculture. And I
7 say that specifically because I see your slide 9, I think,
8 it mentioned the EnviroScreen by identifying disadvantaged
9 communities. And there's also a recent report by CDPH on
10 agricultural pesticide use near schools statewide. Well not
11 -- in the 15 major counties. But the big thing about equity
12 there is that Latino students are in proximity to this
13 agricultural pesticide use much more than others.

14 And I am thinking climate change may also impact
15 agricultural needs and therefore might they also impact
16 pesticide use and therefore there is more inequity there in
17 terms of these communities?

18 DR. MAIZLISH: Yes, you've hit it on the head. In
19 the Safeguarding California there is a specific chapter on
20 agriculture. And one of the things that is highlighted is
21 increase in pests and the potential for increased exposure
22 to pesticides. So that's one of several, several impacts.

23 The whole industry, agriculture industry in
24 California -- and the thing that's complicated is the inter-
25 dependency not just of what's grown in California, to what's

1 grown in California that's exported out of California and
2 inputs that come from outside of California that are
3 potentially impacted here as well.

4 So I can't go through all the -- it's crop-
5 specific. Some crops will do better up until a certain
6 point and then if the temperatures get too high they won't
7 be economically -- the yields will decrease to the point
8 where they won't be economically viable. And what the
9 agriculture establishment is talking about is crop switching
10 or substitution to other crops that will be more adapted to
11 those higher temperate regimes.

12 Certain industries like the premium wine industry
13 is very concerned right now because they don't see the
14 silver lining there. Warmer, warmer temperatures, nighttime
15 temperatures, will not allow a certain fruit to blossom and
16 develop properly so there's different -- you know, certain
17 stone fruits will do better, others won't. I'm not an
18 agriculture expert although I do have some background in
19 agriculture.

20 So there's going to be winners and losers in the
21 sense of which crops are going to do better or worse. But
22 humans are going to suffer because we know that the
23 temperature is going to be higher and that field workers are
24 going to be at risk, at greater risk. So all the OSHA
25 regulations that have recently been passed will have to have

1 heightened enforcement for those things so the workers won't
2 die in the fields or get sick. And I think -- is that it?

3 AC CO-CHAIR GÁLVEZ: Jeremy.

4 AC MEMBER CANTOR: Not yet. Thank you, Neil, for
5 this. A question sort of along the lines of the question
6 that José asked. I'm wondering -- So, you know, I think
7 this map is really compelling. This kind of data is really
8 helpful in -- and then that added piece that you just asked
9 -- you added about what the factors are that sort of lead to
10 those red areas. And I think the slide before this you have
11 a list about populations with particular vulnerability.

12 DR. MAIZLISH: Yes. Right.

13 AC MEMBER CANTOR: Although it sounds like this is
14 not exhaustive, because you then talked about islands.

15 DR. MAIZLISH: Right.

16 AC MEMBER CANTOR: So I'm wondering if you can
17 just talk a little bit more kind of our understanding of the
18 factors that create vulnerable communities and where that
19 fits.

20 DR. MAIZLISH: There's three axes that go into
21 these kinds of vulnerability indexes. One is the physical
22 threat, the environmental threat. So if we're talking about
23 sea level, obviously proximity to the ocean is part of that.
24 If it's heat it will be things like urban heat islands. If
25 it's wildfire smoke it's proximity to the sources or the

1 regional transport patterns. So that's one axis.

2 There's another axis which is about social
3 vulnerability. So it's about poverty, it's about race and
4 ethnicity. There's about six or seven other factors like
5 that. Elderly. Some of them are age-based, the very young,
6 the very old. There will be other factors such as social
7 isolation. Elderly living alone are one of those factors.
8 I can give you the whole list.

9 The third axis is what's called adaptive capacity.
10 That starts to get into what assets you might have that can
11 counteract those negative effects. So the things that we
12 started looking at, for heat it's really about cooling,
13 being able to cool yourself, and a lot of that is about
14 having access to air conditioning. But there is an
15 interaction there. Even if you have air conditioning but
16 you're afraid to turn on your air conditioner because the
17 bill is something you would never be able to afford, you
18 won't turn it on. So these very subtle interactions between
19 social vulnerability and the adaptive capacity.

20 So the other things like having access -- if it's
21 a situation of evacuation, having access to either a car, a
22 personal car, or to a public transit system that will get
23 you out of there in a hurry. So proximity to public
24 transportation that has a high frequency, a high headway
25 frequency, would be some of those kind of adaptive capacity

1 items.

2 So those are the ways that vulnerability tends to
3 be portrayed, the physical threat, the social vulnerability
4 and then what other adaptive capacity you may bring. I'm
5 simplifying because there's other dimensions too that have
6 to do with the governance of your community and social
7 cohesion that are also entered as factors in these models as
8 well.

9 AC MEMBER FOX: Yes, so that was what my follow-up
10 was going to be, whether those things fit under that
11 adaptive capacity. Because I know like those ideas of
12 resilience and social cohesion are often discussed as part
13 of the ability of communities to withstand these sorts of
14 changes.

15 DR. MAIZLISH: Yep. It's just that we have very
16 weak measures of those things. We tend to use things like
17 voter participation, some measure of civic engagement, which
18 probably is not the most - I don't know what the right word
19 is - sensitive predictor. But the alternative is to do
20 survey research to get additional information. We often
21 don't have that level of detail at those fine geographic
22 scales. At the higher scales, at the county scales we often
23 have some measure. the California Health Interview Survey
24 does collect that kind of information periodically.

25 I think Delphine had a question.

1 AC CO-CHAIR GÁLVEZ: General Jeff I think actually
2 was next, then Delphine.

3 AC MEMBER GARZA: Thank you. You know, this slide
4 number 6 -- General Jeff. Slide number 6 is so powerful.
5 It hits home to me, obviously, because that's my territory.
6 But when you talk about the most vulnerability in terms of
7 climate change, what we are doing in Skid Row is we are
8 planting more trees.

9 DR. MAIZLISH: Yeah.

10 AC MEMBER GARZA: And so we realize that -- you
11 know, obviously everybody in this room knows that there is a
12 natural ecological system between humans and trees where
13 humans breath in oxygen, breathe out carbon dioxide and
14 trees do the exact opposite, they breathe in carbon dioxide
15 and breathe out oxygen. And so also there's multiple
16 benefits as well with the homeless in Skid Rows, they can
17 actually use shade with the trees and it reduces the heat
18 amongst the concrete.

19 I am also on the Downtown Los Angeles Neighborhood
20 Council's Planning Department and what we have done is we
21 are in the process of urging the city of Los Angeles to
22 waive the tree variances. For those that don't know, if
23 there is a developer that's developing a property and
24 there's a -- they have to plant 100 trees but their plans
25 only account for 50 trees. They get a variance on the

1 remaining 50 trees and historically the city would waive
2 that. What we are asking the city to do is create a tree
3 bank and those remaining 50 trees will actually go into that
4 tree bank and so that a nearby community could actually get
5 the benefit from that tree and so on.

6 I wanted to pose to this committee, advisory
7 committee, that maybe we can put in the strategic plan, we
8 can actually create a statewide tree bank so that wherever
9 there is a development throughout the state of California
10 instead of giving -- allowing these developers to have a
11 variance on their trees, to actually put them in the tree
12 bank. And then any area throughout the state that needs
13 actual trees, that we could actually hold them accountable
14 to pay for that. I just wanted to make that point, thank
15 you.

16 DR. NOLFO: I think it's an excellent point.
17 Urban greening is one of the major strategies to cool down
18 our communities. And as General Jeff mentioned, it has
19 multiple benefits.

20 AC CO-CHAIR GÁLVEZ: Delphine. Actually, let me
21 -- can I just ask this in relation to the trees. You
22 mentioned you were working with ILG on a climate action
23 planning guide. Is something like that like a tree bank,
24 you know, to counteract variances, in there?

25 DR. MAIZLISH: What we did is ILG was one of our

1 reviewers for our climate action planning guide.

2 AC CO-CHAIR GÁLVEZ: Got it.

3 DR. MAIZLISH: So you can -- I didn't bring
4 copies. But if people want to see -- you know, it's on
5 our --

6 AC CO-CHAIR GÁLVEZ: But there isn't that idea of,
7 you know, of making sure that the net amount of trees is
8 still there for --

9 DR. MAIZLISH: Yes. So urban greening is one of
10 the strategies. Active transport is one of the major
11 strategies. So these are the kind of, you know, tangible
12 things that communities can do to develop in a way that is
13 more helpful.

14 AC CO-CHAIR GÁLVEZ: All right, thank you.
15 Delphine.

16 AC MEMBER BRODY: I just want to applaud you and
17 CDPH for this work. I think it is so urgent and so
18 important that you are doing it and you are exploring many
19 of the most important element -- aspects of it, in
20 California, so thank you.

21 In terms of the mental health aspects of climate
22 change. I would urge that that be prioritized for both
23 research and recommendations, particularly from people in
24 communities most impacted by climate change and its
25 concomitant mental health impacts. I think that is going to

1 be a critical piece for reducing mental health disparities
2 and inequities.

3 And I think when it comes to reducing greenhouse
4 gases that's absolutely the right direction we need to go
5 in. On the one hand I am glad to see that 25 percent of
6 SB 535 funds from cap and trade investment go to
7 disadvantaged communities but I don't think that's either
8 adequate or that the larger strategy is sustainable.

9 I am concerned because at over 20 years of
10 international climate change negotiations the US has come
11 under heavy criticism from countries that are most
12 vulnerable to climate change for the same strategy, the cap
13 and trade investment scheme, which I think is seen as a way
14 for the US to duck its responsibilities to actually reduce
15 its overall greenhouse gas emissions. And so more needs to
16 be done to actually reduce and not just cap and trade.

17 But I also hope that a larger amount can come out
18 of SB 535 directed to those populations disproportionately
19 impacted by climate change and more than 10 percent should
20 go into the particular populations directly.

21 And finally in terms of, in terms of walking and
22 bicycling instead of, instead of cars. As a method I
23 strongly, strongly support that. I am not just speaking as
24 a cyclist for 20 years who hasn't had a car in that time but
25 I am saying that if large cities everywhere took that route

1 and we simultaneously raised the bar for public transit and
2 paratransit for people with disabilities and elders then we
3 would see enormous benefits to the community. The air
4 quality reductions of greenhouse gases, much of the threat
5 could be averted, but we have to start acting much sooner
6 than maybe next year. Thanks.

7 AC CO-CHAIR GÁLVEZ: Thank you. Dexter.

8 AC MEMBER LOUIE: Hello; Dexter Louie.

9 I guess from the beginning of your presentation,
10 which I really enjoyed because it's overwhelming, is you
11 talked about fossil fuels and that seems to be the culprit.
12 Because I remember 50 years ago when I was in Italy they had
13 these little Fiats and gas was sky high. And you paid four
14 time what you paid in the US for a liter versus a gallon
15 here. The Fiats were running everywhere and the Vespas. So
16 if you look back historically, if you look at Europe versus
17 the US, haven't we gotten more than our share of fossil
18 fuels out there? How do you change that?

19 DR. MAIZLISH: Well, it's a multi-pronged
20 strategy. I mean, part of it is the redesign of the
21 combustion system of cars and that's happening. I mean, the
22 state has committed to have a million zero emission vehicles
23 on the road over time. Our fuel efficiency standards that
24 the Obama administration -- that's part of the overall
25 strategy. And that Fiat in Italy was probably getting, back

1 then, you know, 25, 30, you know, miles per gallon, where
2 here they were only getting 10 miles per gallon. So there's
3 many different aspects of the strategy.

4 California is committed to a energy portfolio that
5 is more green than, you know, other places. That up to a
6 third of our energy is going to be generated through non-
7 fossil fuel sources over time. So the state -- among many
8 states this state is tremendously committed to doing
9 something about the combustion of fossil fuels and reducing
10 that dependency.

11 So yeah, it'll take multiple strategies. It's not
12 just going to be about biking and walking, it's going to be,
13 as Delphine said, a public transportation system that is far
14 more accessible and affordable than it is now. It would
15 also be about re-engineering our transportation system as
16 well as other sectors too.

17 AC CO-CHAIR GÁLVEZ: Álvaro.

18 AC MEMBER GARZA: Just a comment on terms of
19 thinking about what you presented and translating to the
20 work for the strategic plan. And it's on slide 7, which --
21 it shows where we really need to talk about -- to which
22 audiences, if you will. Whites and Asians much more about
23 climate change and the inequitable distribution of the
24 effects on health, the impact that we'll be feeling. The
25 Latinos and African-Americans know it already, are getting

1 it, but we need to somehow all work with a whole lot more
2 people to getting that education and that awareness out
3 about climate change and inequities.

4 DR. MAIZLISH: By the way, this finding is fairly
5 consistent throughout the United States, not just -- you
6 know, it's been found a couple of times already in
7 California but it's also being reported elsewhere in the
8 United States.

9 AC CO-CHAIR GÁLVEZ: Yvonna.

10 AC MEMBER CÁZARES: I really enjoyed your
11 presentation. Right after college I went into a lot of
12 climate change and environmental justice work through that
13 health lens and I think what I learned the most is the tie-
14 in between mental health and climate change. I really
15 appreciated that slide, that was near to me. But I worked
16 on AB 32 implementation of the community empowerment
17 amendment and some of the other proceeding laws.

18 I was interested in knowing what is the follow-up,
19 what are the plans or the next steps for the communities
20 that you engaged in some of your surveys in those regions?
21 Are they going to be involved with decisions around where
22 that money now goes? Are you actively engaging them? Are
23 you aware of efforts that they are doing that?

24 DR. MAIZLISH: A couple of different parts of that
25 question. The California Department of Public Health is

1 actually not the lead agency on the disbursement of that
2 money so it's going to be through other agencies. There is
3 -- the ARB is the lead agency on the climate change, the
4 mitigation side. So this something you'll have to engage
5 those agencies with. I mean, we have a voice and
6 Dr. Chapman and our management has heard our concerns and
7 they are trying to bring that to other people because we
8 think there is a distinct public health role. And even
9 though public health is mentioned in the legislation, the
10 agency itself wasn't specifically called out.

11 And we think we have some expertise to lend to
12 that discussion. But I think it's going to be up to the
13 local communities to forcefully advocate for that money
14 going to their communities and how it's being spent. It
15 won't be a role that we necessarily will play.

16 AC CO-CHAIR GÁLVEZ: Anybody else from the
17 committee? Linda. Sorry, I thought that was still Yvonna's
18 card.

19 AC MEMBER WHEATON: Responding to that. So there
20 are a number of our state departments that are involved in
21 the proposal for the administration for the allocation of
22 cap and trade funds and I assure you that the involvement of
23 what we call "authentic community engagement." The SB 535
24 coalition, for example, and other coalitions have, you know,
25 made us very much aware of the need and the interest to do

1 so. So I think in speaking, for example, for the
2 sustainable communities implementation program as well as
3 the other programs, I think there is a very sincere
4 commitment for that engagement.

5 DR. MAIZLISH: Thank you, Linda.

6 AC CO-CHAIR GÁLVEZ: Jahmal.

7 OHE DEPUTY DIRECTOR MILLER: Just briefly. One of
8 the advantages of having this presentation and then followed
9 by the California Reducing disparities Project presentation
10 is that both of these teams and/or projects are having
11 influence on a national level. And we wanted to make sure
12 that you guys were aware of the phenomenal work that's
13 happening and in the office so I am really delighted that
14 you are learning about that.

15 But I wanted Connie Mitchell to briefly share why
16 Kathy Dervin, who actually is the lead for our climate and
17 health team, could not be here today to just speak to some
18 of the national work that is taking place out of our office.

19 DR. MITCHELL: Dr. Maizlish and Kathy Dervin kind
20 of head up our climate and health team and Kathy Dervin is
21 part of the governor's task force on climate change and
22 specifically addressing community health issues. This is
23 because our governor is participating in a White House
24 Council on climate change.

25 And then when Kathy became active in supporting

1 the governor's role she was asked by the White House to lead
2 the nation's community health team. So on behalf of
3 California she is now being responsible for this role. And
4 what she is actually -- the primary goal that she is doing
5 right now is to identify how the federal government can
6 assist us. What are the ways that the federal government
7 can assist state programs and state activities to do the
8 work that they need to do in their states around climate
9 change.

10 So I just wanted to acknowledge the work of not
11 only Dr. Maizlish but Kathy Dervin and that, just as Jahmal
12 said, that the ideas that we talk about here, they do --
13 they are going to resonate, they are going to multiply and
14 it's going to be part of our advice that we give to the
15 federal level.

16 AC CO-CHAIR GÁLVEZ: Okay, we have a couple --
17 actually, before you step down I wanted to thank you. Oh
18 wait, sorry. Diana.

19 AC MEMBER RAMOS: Along the climate change issue.
20 I just recently received -- I get all sorts of medical
21 updates but one that showed that there was an increase of
22 risk in stillbirth that was doubled in areas during the
23 Katrina Hurricane as well as Rita. So there is an increase,
24 you know. These are things that we don't even think about.
25 And they talked about the climate change issue and how we

1 are going to start to see a lot more of these stillbirths
2 perhaps in terms of in the future whenever we have any
3 catastrophic weather issues that come up. So I just wanted
4 to share that.

5 AC CO-CHAIR GÁLVEZ: Jahmal.

6 OHE DEPUTY DIRECTOR MILLER: And I also forgot to
7 add -- we'll do this -- we'll do this later. But I recently
8 met with my colleague who is a Deputy Director for the
9 Office of Emergency Preparedness. And we talked
10 specifically about, you know, some of the mental health
11 illustrations and examples of major climate change.
12 Illustrations that we're seeing take place in our country.

13 And we have an opportunity through that
14 conversation and through our interface with that office to
15 ensure that, you know, the populations that are already
16 disproportionately impacted or unserved prior to an
17 emergency are adequately resources and equipped in
18 preparation for some of these changes that we are talking
19 about. And I look forward to the future opportunities for
20 us to share that information with you all and also how we
21 can be a bit more explicit in how we pull that out of the
22 statewide plan around emergency preparedness as it relates
23 this topic today.

24 AC CO-CHAIR GÁLVEZ: Okay. So, Neil, I wanted --
25 I really wanted to thank you for the presentation and I --

1 it looks like it really was a good presentation for us to
2 all hear. I think that having been working on climate
3 change issues locally now for a couple of years it's -- I
4 mean, we're fabulous, we're very lucky in the state that we
5 have had a lot of leadership around creating really
6 monumental legislation that has helped put some things in
7 place.

8 But I think it's really up to us as public health
9 leaders at a local level to help make those things come into
10 reality. And what I have learned is that both for policy
11 makers and the general public, connecting climate change to
12 health, to human health, to what actually happens to people,
13 really resonates. And so I think it's really -- it's really
14 up to us to help carry that message and to keep informing
15 people and activating people to get more involved in this
16 issue at their local levels.

17 So we have two cards that I've received for
18 comments. One is Pete LaFollette, and so if you could make
19 your way. Theoretically you're supposed to be at the podium
20 even though that microphone doesn't even work very well.
21 And the next one is from Ricardo. So Ricardo, if you could
22 just start making your way that way too.

23 And please open the phone lines.

24 MR. LAFOLLETTE: This very timely discussion
25 reminds me of a story of the frog that is slowly but surely

1 being scalded to death and it dies when it's too late. I'd
2 like to thank the good doctor and wonder if you would
3 discuss or touch upon incentive programs. Recycling, make
4 recycling less marginalized and more mainstream so it's not
5 just people with carts behind their bicycles.

6 Have lifestyle choices, incentives for lifestyle
7 choices. Think globally, act locally. A regional and
8 centralized lifestyle versus decentralized.

9 The solution. I wonder if we really need to start
10 thinking in the broadest terms. Maybe in forming something
11 similar to the Army Corps of Engineers or what we saw after
12 the Depression in the Dust Bowl where broad segments of the
13 population started to address these problems. Because I
14 really believe that nothing less than altruistic response is
15 really going to make much of difference. And great things
16 can get done with altruism. The public recognition that we
17 are all in this together and we must find an incentive and
18 solution to this really pressing problem. Thanks.

19 AC CO-CHAIR GÁLVEZ: Thank you, Pete. Ricardo.

20 RICARDO: I'm going to take a chance here. This
21 is a kind of like a political question. As you know, as we
22 all know, there are those of a political persuasion who
23 would like to keep the flow of pollution flowing unabated
24 and whatnot. And they are using, you rationale, scientific
25 rationale such as the receding orbits of the moon, the solar

1 flares, vulcanization, periodic climate changes that occur 7
2 years, 11 years and one occurs every 7,000 years. Hence the
3 Sahara used to be a lush land. So they are using this.

4 And what I see is that we are in a war against
5 corporate America, nature and the conservative political
6 elements. Nature is going to take its course and it might
7 create climate changes anyway. But what I need to know is
8 -- some of these things are controllable, some are
9 uncontrollable. What can we do politically? What can the
10 average activist, you know, arm themself or to push back on
11 this systematized apathy that is coming at us from those
12 political persuasions. Are we looking at political
13 strategies here? Yes, sir.

14 DR. MAIZLISH: I would have to defer that to the
15 advisory committee. I can't -- in my position I can't talk
16 the political strategies.

17 RICARDO: I've got you.

18 DR. MAIZLISH: What I would point out, though, is
19 that there are people who are looking at the generation of
20 health inequity and the generation of climate inequities or
21 climate change. And there are frameworks that are being
22 developed that actually pair those two concepts together.
23 And I think there's been presentations by Dr. Linda Rudolph
24 who is has been presenting to show that -- I think
25 intuitively what you were saying is that what is causing

1 health inequity might actually be causing climate change.
2 and this is a framework that actually shows that.

3 What's useful about that framework, though. It
4 does show on the continuum down to the local level all the
5 way up to the policy levels, where the points of
6 intersection might be. Where local health departments or
7 community activities might weigh in on those issues. So I
8 would provide you with the framework and you can take a look
9 at that and talk to the people who are using that framework
10 as a way to help organize a strategy to work --

11 RICARDO: Well I'm more interested in the gravity
12 placed around some of this rhetoric, you know. It's
13 inaccurate and it's used for different causes. It's used
14 for political causes, you know, rather than for the
15 betterment, you know, of our environment. We've got to find
16 strategic ways to intercede and counteract, you know, that
17 push as much as we possibly can. So any clues that we have,
18 we are going to put into our, you know, our strategic matrix
19 and go about -- as best as we can go about using it, you
20 know, to do that type of push-back. Thank you.

21 AC CO-CHAIR GÁLVEZ: Thank you, Ricardo.

22 Anybody on the phone like to comment?

23 (No response, teleconference line muted.)

24 AC CO-CHAIR GÁLVEZ: Okay. I do want to let folks
25 know, if you are interested in the framework that Neil spoke

1 about, there is a webinar Wednesday morning that PHI is
2 putting on about the framework for climate change inequity
3 and health inequity. That's open to the public. So if
4 you'd look on PHI's website that webinar is happening on
5 Wednesday.

6 And actually this Friday there is going to be a
7 presentation at BARHII from the Environmental Health
8 Director from Los Angeles County talking about the strategy
9 that Los Angeles County Health Department has been putting
10 together to really integrate climate change into their work.
11 If anybody is interested in that let me know, that's this
12 Friday morning.

13 Okay, so the next thing on our agenda is a
14 presentation on the California Reducing Disparities Project.
15 Ellen Wu from our advisory committee, formerly from CPEHN --
16 I guess we are really behind schedule.

17 Do folks need a break or can we wait for the next
18 presentation for the break? Wait? Okay.

19 So Ellen Wu, formerly from CPEHN, and Robert
20 Cantú, still from CPEHN, will be presenting on the Reducing
21 Disparities Project.

22 AC MEMBER WU: I'm going to be, I'm going to be
23 quick. I was just asked to do a brief introduction before
24 Ruben goes into details about the strategic plan. I am
25 Ellen Wu, I am an advisory committee member, formerly at the

1 California Pan-Ethnic Health Network, Executive Director;
2 and as of April 1st, Executive Director of Urban Habitat.

3 A few years ago when the RFP came out for working
4 with the five population groups to develop a statewide
5 strategic plan, CPEHN looked at the requirements and really
6 was trying to figure out if we were the right organization
7 to do that. But because we are used to working multi-
8 culturally and creating a multicultural agenda with
9 different populations we thought it would be a good fit for
10 us. And that is the philosophy that we have gone into in
11 working with the five population groups to develop a
12 statewide plan. So while the organization is the author of
13 it, it came out of the five strategic plans of the five
14 different population groups. So it's a culmination of that.

15 I wanted to really quickly talk about it because I
16 know we have talked before about the interaction between the
17 Reducing Mental Health Disparities Strategic Plan and the
18 Office of Health Equity Strategic Plan. I see a couple of
19 definitely foundational principles for both plans that
20 really tie them together and I think can build off of each
21 other and create synergy.

22 The first is that it's very -- at the center of it
23 it's about equity and equity for vulnerable and
24 disadvantaged communities specifically. That we are trying
25 to address the social and environmental determinants of

1 health. And if we keep going back to income disparities and
2 education, quality education, access to quality education
3 and affordable housing, we know that all of those have co-
4 benefits to health and mental health and the well-being of
5 everyone.

6 And Neil mentioned this before. Social cohesion
7 is also, I think, at the center of this. You know, there
8 have been a lot of studies that show that people are much
9 healthier when they feel connected to their community.

10 And hopefully we can do something around the built
11 environment and the programming that we have to really build
12 that social cohesion.

13 That we really value community engagement. So
14 that's written in both the Mental Health Disparities Plan as
15 well as the Office of Health Equity's broader plan.

16 One area that I think can be strengthened a little
17 bit - I know we are going to get into the strategic plan
18 later - is just the state leadership position around these
19 issues. So I think the creating of the Office of Health
20 Equity to really focus on these issues is important but we
21 need the backing of the state leadership and the resources
22 that it takes to actually make these things happen. And,
23 you know, we talk about public/private partnership and this
24 community engagement to all come together to advance this,
25 but ultimately we do need the state to step forward and make

1 this a priority. So I hope that we really see more of that
2 element in both plans.

3 So I am going to hand it off to Ruben to actually
4 get into the details of the plan.

5 MR. CANTÚ: Thank you. So my name is Ruben Cantú
6 and I am the Program Director at -- is this close enough?
7 Program Director at the California Pan-Ethnic Health
8 Network. We have been working on this project now for about
9 three, four years. Since before it was a part of the
10 California Department of Public Health, back when there was
11 a California Department of Mental Health.

12 And there's a couple of folks in the room I just
13 wanted to quickly recognize who have been part of this
14 project as well that have been working on this with us for
15 the last four years. And I think Rocco stepped away from
16 the table but Rocco has been the Project Director for the
17 Asian/Pacific Islander portion of the Reducing Disparities
18 Project. And out in the audience we've got Dr. Nicki King
19 who is the co-lead of the African-American portion of this
20 project and Stacie Hiramoto and Noemi Castro who staff the
21 California MHSA Multicultural Coalition, which is another
22 component of this project I'll talk about in a little bit.

23 And then there are other folks around the table
24 that have been involved. I know Delphine is waving at me.
25 There have been other folks around the table that have been

1 part of the project as well in other capacities like
2 Delphine, José, Pat Ryan, who have been part of this project
3 from the very beginning as well.

4 So just to give you all a quick overview of what I
5 am going to be talking about. I am going to be talking a
6 little bit about the Reducing Disparities Project, kind of
7 where it comes from, what it is, what we have been doing and
8 a little bit about the strategic plan that we are
9 developing, that we have been developing for the last couple
10 of years.

11 I am not going to go into too much depth on the
12 strategic plan because I am not able to do that just yet.
13 The strategic plan is still in the process of being vetted
14 and reviewed and approved by the California Department of
15 health and Human Services. And once it has been approved
16 there it's kind of going through a secondary level of review
17 at the agency level. And once that happens we are going to
18 be able to release the plan for a 30 day public comment
19 period and then incorporate some of that feedback into the
20 final plan that we'll be -- that we'll be releasing later on
21 in the year.

22 So I think I don't have to go through this really
23 in-depth but just for background for folks who are not as
24 familiar with CPEHN. We have been around since 1992. We
25 were formed by these four racial/ethnic organizations in

1 California during an era of health care reform. That was
2 the year that the Clinton administration was trying to get
3 health care reform passed the first time -- the last time at
4 the national level. It was also during a time of a lot of
5 racial tension, particularly in Southern California with the
6 Rodney King trial and verdict and the riots.

7 And these four ethnic organizations came together
8 with the belief that by working together and having a
9 unified voice of multicultural health advocacy we could
10 achieve more than we could separately. And so they formed
11 CPEHN.

12 Our mission is to eliminate health disparities and
13 we do that through four primary activities, four major
14 areas. One is through advocating for cultural and
15 linguistic competency.

16 The other one is -- the second one is through
17 increasing access to health care.

18 The third one is to address the social and
19 environmental determinants of health. And we always get a
20 kick out of this slide. IF you can see it, it's people
21 getting on an escalator to go to the gym, which is kind of
22 funny.

23 And then the fourth is looking at data collection
24 and the analysis of data to help us identify and address
25 disparities.

1 So just to give you a little bit of background
2 about why this project was started and why it's important.
3 When we look at the number of -- when we look at the number
4 of communities of color in California we know that that's
5 about 60 percent of the population, so it's the vast
6 majority of the state.

7 So as part of this project we are looking at the
8 four major racial ethnic groups, African-Americans, Latinos,
9 Native Americans and Asian and Pacific-Islanders. And we
10 are also addressing the Lesbian, Gay, Bisexual, Transgender
11 and Questioning community; and that community there are no
12 mechanisms in place to actually count that population here
13 in the state.

14 So when we take 60 percent of communities of
15 color, add it to the uncounted LGBTQ communities in the
16 state we get a number that, you know, we can't define it but
17 we know that it's 60-percent-plus. And we know that these
18 populations are facing a lot of barriers to access to care
19 and they are also facing a disproportionate impact of mental
20 health issues and conditions.

21 So I list a couple here. You can look at them,
22 I'm not going to go through every single one. You can look
23 at them in the slide if you have -- you can also -- in the
24 packet of information you have there's a flyer for each of
25 the -- that lists each of the five populations, specific

1 reports that have been developed. And all of this
2 information is taken from those population reports. And I
3 know that you all have gotten links to those in the past and
4 you can use those to, you know, get a little bit more
5 information about, about the disparities that these groups
6 are facing.

7 So a little bit of background on the actual
8 Reducing Disparities Project itself. We started the project
9 in 2010. The overall goal of the project was to improve
10 access, quality of care and outcomes for racial, ethnic and
11 cultural communities. And by cultural communities we do
12 mean the addition of the LGBTQ population.

13 This project is the first of its kind in the
14 nation and it has gotten -- as Jahmal mentioned earlier, it
15 has gotten a lot of attention at the national level. Folks
16 that are part of this project have been asked to attend
17 meetings at the White House, to provide briefings on the
18 project. So folks are looking at this project from across
19 the country to see what we're doing and how it's going to
20 be, how it's going to be implemented. So it's the first of
21 it's kind in the country, it's a huge investment of public
22 funding to reduce mental health disparities. We can't
23 emphasize enough the importance of the project.

24 Like I mentioned, the project was targeted to
25 these five populations, African-American, Asian and Pacific

1 islander, Latino, LGBTQ and Native American,

2 There were three different -- and I'm lumping it
3 into three different components of this project. The first
4 one was for these five organizations that were selected to
5 develop population-specific reports for their communities in
6 those five targeted populations.

7 And these groups undertook a very immense,
8 thorough community engagement and stakeholder engagement
9 process to develop their population reports. They did focus
10 groups, they did interviews, they did surveys. I think all
11 in all at the end of the day, through those five groups they
12 reached tens of thousands of people across the state to get
13 information from them about the issues they are facing, the
14 barriers they are facing and what some of the success
15 stories they might have are.

16 The population reports identified some policy
17 solutions for addressing disparities in their communities,
18 they also tried to gather as much as they could some of
19 these promising practices in the communities that are
20 working. And by "promising practices" we are talking about
21 these community-driven, community-based projects that folks
22 are working on to try to reduce disparities.

23 These are not the things that we usually think
24 about when we think about mental health interventions and
25 projects, we're talking about things like community

1 gardening projects or Native American sweat lodges and other
2 kinds of activities like that that we wouldn't necessarily
3 think of as mental health interventions.

4 So these -- I can't emphasize enough, you know,
5 these five population reports have a wealth of information
6 on all of these kinds of -- on the kinds of activities that
7 are going on in the community, but also the solutions that
8 the community themselves have identified to try to reduce
9 disparities.

10 I forgot to mention earlier at the beginning of
11 this. This is all focused on prevention and early
12 intervention. So it's not focused on getting folks into
13 CARATs about preventing mental illness before it, before it
14 becomes serious.

15 The other two components. One of the other
16 components of this project was the development of a
17 statewide coalition, the California MHSA Multicultural
18 Coalition. Which was bringing together folks from those
19 five populations plus folks from other populations that were
20 not originally targeted as part of this reducing disparities
21 project. So we are talking about Muslim and Middle Eastern
22 communities, the deaf and hard of hearing community,
23 Armenian community. Other populations that weren't part of
24 the initial thrust of this project. Bringing all those
25 folks together to help develop statewide policy solutions

1 and to provide input on the implementation of statewide MHSA
2 activities.

3 And then the third component of this was to
4 develop this over-arching, comprehensive strategic plan to
5 reduce disparities and that's what the bulk of this
6 presentation is going to be about.

7 These are the -- these are just the logos for the
8 other organizations that were part of the Reducing
9 Disparities Project. So in addition to CPEHN, UC Davis
10 Center for Reducing Health Disparities took the lead on the
11 Latino Community, Native American Health Center focused on
12 the Native American Community, Pacific Clinics focused on
13 the API community, the African-American Health Institute of
14 San Bernardino County focused on the African-American
15 community and together Mental Health America of Northern
16 California and Equality California Institute focused on the
17 LGBTQ community, and then REMHDCO was the lead for the
18 statewide coalition.

19 So the strategic plan itself. Like Ellen
20 mentioned, it's kind of the synthesis of a lot of the
21 information that was in those five population reports. To
22 look at all of those, find the common themes, find the areas
23 of commonality and bring them all together into one over-
24 arching report for reducing disparities.

25 We wanted it to be this long range vision.

1 We went into this knowing that the strategic plan
2 was going to provide guidance for stuff that could happen
3 immediately but it was also going to be a longer range
4 vision to reducing disparities. Things that wouldn't
5 necessarily be able to happen overnight or within the next
6 couple of years.

7 So the strategic plan breaks it down by having
8 policy recommendations at the statewide level for reducing
9 disparities and then recommendations for what comes next.
10 What happens after we -- you know, after this portion of the
11 project. This is part of the first phase of the California
12 Reducing Disparities Project and then there is a second
13 phase, which I will talk about a little bit later.

14 So just to give you a little bit of information on
15 the strategic plan process. The five strategic planning
16 workgroups that focused on their individual populations,
17 they did the bulk of the work. I like to say that, you
18 know, I kind of had the easier job by coming in here and
19 taking all of the research and all of the information that
20 they had already gathered and synthesized and written about
21 and then I had the job of pulling that all together and try
22 to make it into one cohesive document.

23 We looked at those five reports. Some of them
24 were shorter reports, some of them were a little bit larger.
25 And they all were really rich documents full of these

1 recommendations to reducing disparities. We took all of
2 those recommendations, put them into this one huge grid that
3 was like 40 pages long and then we analyzed it to figure out
4 where are the -- what are the themes, which are the
5 recommendations that we see arising over and over again.

6 And then we had several sessions as a group of
7 project partners to prioritize those recommendations. So
8 several, several meetings where we would hash them, hash
9 this -- hash them apart in this discussion and come up with
10 a cohesive vision for what reducing disparities was going to
11 look like for us and for our communities.

12 And there are several times during the project
13 where we developed drafts of the strategic plan that's been
14 submitted to the Department for vetting. They've come back
15 with some structural recommendations. Not necessarily
16 changing the content of the plan but how we kind of present
17 the plan. We have made changes. We usually have to take
18 those changes back to the group of partners to make sure
19 that what we are changing actually still reflects the vision
20 of the community that helped to provide all of the input
21 into the development of the plan.

22 We also had a couple of points during the
23 development of the strategic plan, shared copies of the plan
24 with the folks that we actually call out for action, call
25 out for action in the plan itself, the folks that we list in

1 the recommendations, to say, this is what we are asking. Is
2 this accurate? Is this something that is actually within
3 your purview? And we've gotten some feedback from the folks
4 that we have shared it with and have had to make changes to
5 the plan as well.

6 But every time that we have made changes it has
7 been vetted with the entire group to make sure that it still
8 reflects that vision from the community. We don't want to
9 lose the fact that the strategic plan is -- it's really
10 authored by the community. There is nothing in the plan
11 that we are pulling out of the air, it's all stuff that
12 really does come from those population reports.

13 So the report itself, the strategic plan itself,
14 is broken up into a couple of different sections. We have
15 an Introduction and Background where we talk a little bit
16 about California, the public mental health system in the
17 state.

18 What disparities look like in the state.

19 We talk a little bit about some of the current
20 effort to reduce disparities in the state, because there are
21 some activities going on that are looking at disparities in
22 our populations and doing work in them. Everything from the
23 Mental Health Services Oversight and Accountability
24 Commission's Cultural and Linguistic Competency Committee,
25 the County Mental Health Directors Association Social

1 Justice and Cultural Competency Committee. There's projects
2 across the state that are already doing this work so we
3 wanted to provide a foundation of, this is the stuff that is
4 already happening and this is the stuff that we can do to
5 build upon that and continue to improve conditions for our
6 communities.

7 We talk a bit about current work that is being
8 done in the community to address disparities in these seven
9 key areas. These are the areas that kind of rose to the top
10 upon a review of the five population reports.

11 And then we actually get into the -- into the meat
12 of the plan, which is the Community Plan for Reducing
13 Disparities.

14 In analyzing all of the recommendations and all of
15 the content in the strategic plans we -- in the population
16 reports -- we identified 4 over-arching themes, 5 goals and
17 25 long-term strategies within the plan.

18 The four over-arching themes are the things that
19 we saw in each of the population reports. They were a
20 little bit different for some of the populations than for
21 others. For instance, when we talked about improving data
22 collection standards, that was something that was very
23 different for the Asian and Pacific Islander community where
24 the key issue there is disaggregating data so that we can
25 have a snapshot of what disparities look like for the

1 individual populations. And it was very different for the
2 LGBT community where they needed to actually be counted so
3 we can have a sense of what the disparities are.

4 But these are were the four over-arching themes
5 that we identified: cultural and linguistic competence,
6 capacity building. There was need at both the community
7 level for folks to be able t implement the kind of practices
8 that we're talking about in the plan but also capacity
9 building at the statewide level so that the state has the
10 capacity to work with community-based organizations better
11 than it has in the past. Data collection and then
12 addressing the social and environmental determinants of
13 health.

14 So these -- I am sharing with you all what the
15 goals are that we talk about in the strategic plan.

16 Goal 1 is to increase access to mental health
17 services for our populations. This includes things like
18 working on co-location of services, having more mental
19 health services in schools and having culturally and
20 linguistically appropriate outreach.

21 There were a couple of strategies that we
22 identified within these goals where we actually call out the
23 Office of Health Equity to do a couple of different things.
24 Under Goal 1 one of those is to help develop resource guides
25 to identify and facilitate access to services. So we are

1 asking in the strategic plan for the Legislature to fund the
2 Office of Health Equity to kind of take this on as a
3 project.

4 Goal 2: Improve the quality of mental health
5 services. This includes things like making sure that there
6 is a culturally and linguistically competent workforce and
7 linguistic access in services.

8 Goal 3: To build community strengths to increase
9 the capacity of and empower our communities. Those are
10 things like engaging the faith-based community. And that's
11 another one where we have asked the Office of Health Equity
12 to take the lead, asking the Legislature to fund the Office
13 of Health Equity to develop a consortium of faith-based
14 organizations and providers to help increase services.

15 Goal 4 is to develop, fund and demonstrate the
16 effectiveness of population-specific and tailored programs.
17 This is continuing the kind of research that folks did
18 through the -- did through the work of the five population
19 groups. We need to continue during that kind of research to
20 be able to identify the right kinds of interventions to have
21 for our communities.

22 And the last one is to continue to develop and
23 institutionalize local and statewide infrastructure to
24 support the -- to support this project past the end of this
25 phase of the project. We need to continue to identify

1 possibly other populations to look at in addition to the
2 five that were initially identified to continue doing the --
3 to continue doing this kind of research and identify --
4 identification of promising practices in the community.

5 So we also provide recommendations for the second
6 phase of this project. So once we have done all of this
7 research, done these population reports and developed a
8 strategic plan, the next phase of the project is to actually
9 work to implement those strategies that we have in the
10 strategic plan. But then also to put forth a four-year
11 pilot program to fund select interventions at the local
12 level to actually implement some of the projects that were
13 identified. Some of the promising practices that were
14 identified by each of the five population workgroups in
15 their, in their reports.

16 There is funding that is going to be available to
17 implement these projects; and not only implement them but
18 also evaluate them. One of the key parts of this project is
19 to be able to implement these promising practices but also
20 to see that they are working so that they can continue to be
21 funded in the future.

22 As part of this ice well we are also recommending
23 that there be technical assistance and capacity building for
24 those activities.

25 And also for the state to be able to work with

1 kind of the small grassroots organizations that are
2 identified in -- that are identified in the report that are
3 the ones that really are already doing the work in the
4 communities. Might not be funded to do that work and need
5 to be supported to continue doing those activities.

6 That is just a listing of the Appendices. We go
7 into a little bit more depth and detail in the report on
8 some of the disparities folks are facing, the projects that
9 people are already working on, implications of health care
10 reform and social and environmental issues impacting mental
11 health.

12 I was going to go a little bit into the
13 intersection with the OHE strategic plan. This is just a
14 listing of kind of the purposes of both of these plans. But
15 going into a little bit more detail here:

16 There is an overlap between the two plans in
17 certain places. Definitely with the "A", identifying and
18 dissemination actionable information. The SPWs, strategic
19 planning workgroups in those five populations have already
20 done a lot of the work of identifying a lot of the mental
21 health disparities and projects that are working and
22 strategies to reduce disparities in their populations.

23 There's a lot of overlap with embedding equity
24 into institutional policies and practices. One of the big
25 recommendations that comes out of our strategic plan is

1 enforcing class standards and other work to incorporate
2 cultural and linguistic competency into the work of -- into
3 the work of the state.

4 There's a lot of overlap under "E", around
5 incorporating more of a cultural and linguistically
6 competent workforce.

7 And there is definitely a lot of overlap with "F"
8 and building the capacity of communities to be active actors
9 in reducing disparities, both in the implementation of
10 projects to reduce disparities but also advocating at the
11 statewide level, evaluating the promising practices that we
12 have identified.

13 As I mentioned before, we are going to be having a
14 30 day public comment period once the strategic plan is
15 approved.

16 We are going to disseminate it widely, get it out
17 to folks. I'm sure everybody who is in this room is going
18 to get a copy of the strategic plan to review, to provide us
19 feedback. We know that there are things that might have
20 been left out of the strategic plan. It was very focused on
21 those five populations that we identified so we know that
22 there are other populations that might not be -- that might
23 not be reflected as much in the strategic plan. We want to
24 hear about that to be able to think about ways that we can
25 incorporate those perspectives into the strategic plan

1 better.

2 We are going to be doing some community forums.
3 We are going to be doing at least three community forums in
4 the state to get input into the strategic plan.

5 So we will be able to get input at these forums,
6 through email, through phone, if you want to mail us
7 comments. We are going to be open to everything to be able
8 to hear what you have to say about the strategic plan.

9 And just to wrap up, the timeline.

10 Once we get through with our 30 day public comment
11 period we will be releasing the final strategic plan.

12 There is then going to be a request for proposals
13 for the second phase of this project for folks who are going
14 to be able to actually implement and evaluate some of the
15 promising practices that are identified in the population
16 reports.

17 And then we'll go through that four year period
18 and see where we are after that.

19 So that's it. You can contact me if you would
20 like more information at any time. I'd be happy to talk to
21 anybody.

22 AC CO-CHAIR GÁLVEZ: Thank you, Ruben.

23 (Applause.)

24 AC CO-CHAIR GÁLVEZ: Jose, would you like to say
25 something?

1 AC MEMBER OSEGUERA: José Oseguera, Mental Health
2 Services Oversight and Accountability Commission.

3 Thank you for a fantastic presentation, Ruben. I
4 just have a clarification question in regards to your goal
5 number 4. Are these basically the community-based practices
6 that you are moving towards evidence-based?

7 MR. CANTÚ: Yes, exactly. We want to make sure
8 that we take the -- as I said, the goal of the -- one of the
9 goals of the project was to identify these promising
10 practices out in the community that community organizations
11 are working on. These are the things that might not be
12 recognized as evidence-based practices. And we want to fund
13 some of those projects and evaluate them rigorously with
14 community-based participatory evaluation so that they can be
15 elevated to the level of evidence-based practices and then
16 they can be eligible for, you know, Medi-Cal reimbursement
17 and for funding from the federal government.

18 AC CO-CHAIR GÁLVEZ: Francis.

19 AC MEMBER LU: Just a simple question. It was
20 wonderful, thank you for that update. I was just checking
21 if you have a sense about when that 30 day comment period
22 might open? Just ballpark.

23 MR. CANTÚ: That actually might be -- I'm going to
24 throw this back out there. That actually might be a better
25 question for Jahmal. We are ever hopeful that it's going to

1 be sometime soon when the strategic plan will be approved to
2 go out for public comment. Or for Marina.

3 (Laughter.)

4 MR. CANTÚ: Or I can go back to answer it too if
5 nobody wants to --

6 OHE DEPUTY DIRECTOR MILLER: We are all partners
7 and friends. Marina can provide some comments on that. She
8 and our team have, you know, been very, very hands-on. We
9 just submitted our SAR, which is a Secretary Action Report,
10 to Secretary Dooley's office. And we have been working
11 closely with CDPH with briefing the agency to really prep
12 for an expedited approval process to get to that public
13 comment period. But I wanted Marina to add maybe some
14 context and color to that.

15 MS. AUGUSTO: So this has been a huge undertaking
16 in terms of the review process. Just remember that this
17 project is tied to \$60 million, 15 for the next four years
18 without regard to fiscal year. And so with that comes a lot
19 of scrutiny and just a thorough review process to ensure
20 that we have our bases covered.

21 In the strategic plan in draft number 1 and draft
22 number 2 we do call departments out for action and there are
23 many departments that fall under the Health and Human
24 Services purview and so with that we had to go through a
25 couple of layers of review by those departments, as Ruben

1 mentioned. So we are in our second phase of review.

2 We do have a briefing coming up soon to answer a
3 few questions as it relates to the recommendations. Once we
4 get the okay we will, and I think this was mentioned before,
5 we will go into our 30 day public review process. And we
6 are attaching three community forums so we hope that you can
7 join us during that time.

8 As far as the time line. Sometimes it takes, you
9 know, four to six weeks for our leadership to review above
10 our department. But sometimes depending on the priority,
11 and this has been a priority for the department, it could be
12 less than that. But that's our window.

13 AC CO-CHAIR GÁLVEZ: General Jeff.

14 AC MEMBER GENERAL JEFF: General Jeff. Ruben, a
15 great presentation. Thank you for the update on it.

16 In regards to Phase II. You mentioned that there
17 would be funding for -- funding like of the community
18 efforts. What do you anticipate, and if so, what
19 difficulties do you anticipate in funding grassroots
20 organizations?

21 MR. CANTÚ: That's a great question. So like
22 Marina mentioned, there's going -- it's a four-year pilot
23 project period. There's going to be \$15 million available
24 each year to be spread out amongst the five priority
25 populations. So at the end of the day it's not a lot of

1 money but we are really hoping to be able to use that money
2 wisely and do a lot with it.

3 We do know that a lot of the organizations that we
4 are hoping to get funded during that period are the kinds of
5 small, very grassroots organizations who might not have had
6 a lot of experience with state contracts or state grants and
7 they might not have had a lot of experience applying for
8 them and managing them and reporting on them.

9 So one of the things that we are hoping to have
10 and that we are recommending in the strategic plan is that
11 there is a very robust capacity building, technical
12 assistance component during the application period so that
13 folks who are applying for the funding have someplace to
14 call, somebody to talk to to help them develop their
15 proposals and walk them -- help them through that whole
16 process. You know, whether they might find a fiscal agent
17 or, you know, what have you.

18 And then we are also proposing that there be a
19 strong capacity building/technical assistance component
20 during the implementation of the projects as well so that
21 these folks know, you know, know that there is somebody that
22 they can reach out to help them if they have problems with
23 the, you know, financial management aspects of the grant,
24 for instance, of the evaluation of the project as well.

25 AC CO-CHAIR GÁLVEZ: Yvonna.

1 AC MEMBER CÁZARES: Hi Ruben. I wanted to say,
2 great presentation. Really excited about the work or just
3 the idea that you will be working with churches and faith
4 communities. I just can't imagine the power, you know.
5 Working with one pastor or lay leaders and saying, hey, we
6 are going to do a workshop on how to correctly fill out a
7 free and reduced, you know, lunch form, and the money that
8 that would bring to schools or -- or whatever form it is. I
9 mean, I just feel like empowering community members on that
10 level, reaching them where they are at, where they
11 congregate, is so important.

12 I am so glad that this type of work is bringing
13 those practices up. And it just really struck me. You
14 know, 85 percent of Mexican immigrants who need mental
15 health services remain untreated.

16 I know that in my experience working alongside my
17 dad doing a lot of community health fairs at churches or at
18 schools, you have a lot of immigrants, farm workers coming
19 out. And I don't remember seeing -- there's a lot of
20 physical health that's focused on, I don't remember seeing a
21 lot of mental health services being provided there. I mean,
22 that's a huge idea that we haven't even tapped yet, you
23 know. These health fairs, folks already know about them,
24 right?

25 So just great work. And I just wanted to relay to

1 you that the feedback that I have been getting from folks in
2 my circles and in communities is that this has actually been
3 a really great process that has really engaged community
4 members. So I just wanted to let you know that. That's
5 what I'm hearing, the word on the street.

6 MR. CANTÚ: It's always good to hear that and I'm
7 sure the other folks that are working on this project
8 they're --

9 AC CO-CHAIR GÁLVEZ: Delphine.

10 MR. CANTÚ: -- gratified to hear that. I know
11 that -- just really quickly. That the reason why there is
12 so much in the report about working with faith-based
13 communities, working with schools is because the community
14 members that we spoke to during the course of the project
15 are telling us that those are the places where they go.
16 And, you know, for a lot of our communities of color, when
17 you have an emotional problem, when you have something you
18 need to talk about the first person they turn to is their
19 pastor or their priest or, you know, their faith leader. So
20 we wanted to make sure that that was really strongly
21 incorporated in the plan.

22 AC MEMBER BRODY: Thank you. I want to follow up
23 on that comment. And thank you again, Ruben, for your hard
24 work on this as well as all the CRDP partners.

25 And I want to say that I agree with the last

1 comment that, in fact, this process has modeled a level of
2 meaningful community stakeholder engagement among the groups
3 that are most heavily impacted. Of course there is still
4 room for improvement there, more groups could have been
5 included more explicitly and could be called out better in
6 the population reports. Of course we'll have to go back and
7 fill in those gaps in the future.

8 In terms of Phase II implementation, the slide
9 that you have on that. I know the summary is -- could you
10 delve a little deeper into how stakeholders would be
11 meaningfully engaged in that level. Would there still be a
12 coalition like the MHSA Multicultural Coalition that
13 fulfills that role within that level of process and where
14 would the Office of Health Equity and its strategic plan
15 play into that?

16 MR. CANTÚ: Great questions. So we are
17 recommending in the strategic plan that the infrastructure
18 that we have already set up with this Reducing Disparities
19 Project continue during the implementation phase of the
20 strategic plan and the Phase II pilot program.

21 We are also recommending that there be a lot of, a
22 lot of emphasis placed on improving and kind of beefing up
23 the role of local mental health boards or similar entities
24 that can work -- that can incorporate more of the voices of
25 the impacted populations, the underserved populations that

1 we are targeting, so that they can be part of the process to
2 help provide input as local organizations are implementing
3 their promising practices and as they are being evaluated.
4 We want local community members to be involved in kind of
5 all phases of that so that they can see it through, see
6 these projects through their life span.

7 And I think there is a lot opportunity here for
8 overlap with the OHE strategic plan. Like I said, we have
9 already kind of developed this infrastructure. We've kind
10 of done all of this research and it's there for -- it's
11 there as a reference point for a lot of the work that is
12 being done by the OHE advisory committee in the strategic
13 plan that is being developed.

14 I think we can be used as a reference, we can be
15 used as a resource. I think anybody that has been a part of
16 this project would be willing to participate and to provide
17 you input as you are developing the strategic plan and as
18 you are trying to implement it, in terms of making
19 connections with some of the community engagement that we
20 have already developed as part of this project.

21 There are groups out there focused on each of the
22 five populations, in addition to the California MHSA
23 Coalition, that can serve as resources for getting out there
24 into the community and working with the community to try to
25 disseminate the OHE's strategic plan and to disseminate some

1 of the strategies that are in the plan, that are going to be
2 in the plan.

3 AC CO-CHAIR GÁLVEZ: Rocco.

4 AC CO-CHAIR CHENG: Ruben, thank you for the
5 presentation; and I just want to make a few comments as a
6 fellow grantee.

7 I want to start out by saying this is one of the
8 very transformational design efforts in engaging a diverse
9 community. Very grassroots, very bottom-up.

10 And starting from the OMS, Office of Multicultural
11 Services, they have originally a totally different design
12 that the community feels that it does not make sense and we
13 give them feedback. They gave a month or two, the window
14 for people to give feedback and then eventually changed the
15 design, so that's how we -- how they changed from one
16 grantee to seven different grantees.

17 Then in the process of getting the population
18 report. Ruben mentioned there's a lot of community
19 engagement. Even in the final draft each one of us, the
20 five strategic planning workgroups, gave a 30 day public
21 comment period. But after that we were asked to go take the
22 draft report on the road to at least three forums like our
23 API group, for example. Instead of three we did eight
24 community forums throughout the state. And that took the
25 course of a few months just to continue to get input and to

1 see that if we missed anything until we come up with the
2 final report.

3 I just wanted to send some acknowledgement to OMS
4 and currently OHE staff for their tremendous amount of
5 support and willingness and openness for their input and
6 then the effort. It is not any one but it is the entire
7 community giving a lot of input to come up with this
8 population report.

9 And of course Ruben did a great job putting the
10 five reports together for the strategic plan draft.

11 AC CO-CHAIR GÁLVEZ: Ruben, I had a kind of a dumb
12 question, not being part of the mental health world at all.

13 So you mention at the beginning that these plans
14 were around early prevention services. How does the mental
15 health -- or does the Mental Health Services Act address
16 once you actually need service, like chronically ill
17 services, how are disparities addressed through the MHSA?

18 MR. CANTÚ: And other people could probably answer
19 this question better than I can. The MHSA funds -- there's
20 a component of the MHSA funding that goes toward prevention
21 and early intervention funding. There is also a component
22 of it that goes toward workforce education and training. So
23 to improve the workforce. And then a big bulk of it
24 actually toward services for the severely mentally ill, for
25 those kinds of services. So it does address all three, all

1 three of those.

2 AC CO-CHAIR GÁLVEZ: And does that bulk that's for
3 services for the severely mentally ill, does that actually
4 have a disparities plan as well or looking at --

5 Pat, could you respond to that? Rocco says you
6 have that answer.

7 AC MEMBER RYAN: Yes, there are. There are
8 various requirements in different parts of the mental health
9 system. So there are federal requirements. The majority of
10 the funding that comes to the community mental health system
11 -- public mental health system comes from Medi-Cal. So that
12 is an area that needs attention and, you know, does have
13 requirements regarding cultural competency and other areas.
14 The federal government is looking at that.

15 The state in different parts of their regulations,
16 you know, have mention of and requirements for culturally
17 competent services.

18 There is also a cultural competence plan for
19 county mental health departments that is in the process of
20 being updated.

21 So it's addressed in various ways depending on the
22 funding source and, you know, which department is
23 responsible for what part of it. But you have to recognize
24 that most of the -- most, not all, of the funding that goes
25 to the public mental health system, including through

1 Prop 63 or the MHSA, has to comply with federal law to be
2 matchable because you have to be able to maximize your
3 resources through the federal government.

4 So it's a complex system that people who are
5 interested in addressing all of these issues should pay
6 attention to all of the above, not just the prevention and
7 early intervention part of it.

8 AC CO-CHAIR GÁLVEZ: All right, thank you, Pat.

9 Are there any other questions or comments related
10 to this presentation from the committee?

11 Okay, so we have four speakers from the public
12 that would like to comment. And if the phone line is even
13 on if we could turn it, if we could open it to see if
14 anybody on the phone would like to comment.

15 (Teleconference line was unmuted.)

16 AC CO-CHAIR GÁLVEZ: So the first speaker is Pete
17 Lafollette, second is Stacie Hiramoto, third is Steve Leoni
18 and fourth is Kate Karpilow. So if you could, if folks
19 could please line up on the chairs over there to be ready to
20 present. And a two minute limit, please. You're on, Pete.

21 MR. LAFOLLETTE: Okay, thanks. The California
22 State Auditor, the Mental Health Illness Policy Organization
23 and others, including Rose King, she is the original MHSA
24 author, have documented the Mental Health Services Act
25 funding are not reaching the most seriously ill, they are

1 reaching only 5 percent.

2 A principal party set out to generate success
3 story statistics by serving only 5 percent of the public
4 mental illness clients and only new clients and new
5 programs. The calculated purpose of excluding all
6 underserved clients in the existing system was to generate
7 deceptive statistics that are irrelevant and accrue insult
8 to consumers and their family and friends suffering from the
9 tragedy of untreated, serious mental illness and the despair
10 leading to increased suicide and incarceration.

11 On a personal note, I find it such a tangled web
12 and so much collusion I still don't quite understand how
13 they get away with it and how it's done, as state employees,
14 lobbyists, oversight commissioners agree that they would get
15 better performance data by serving new clients in new
16 programs.

17 The strategy also produces a bonanza of new grants
18 for Rusty Selix's clients such as the Mental Health
19 Association and contract providers and the California
20 Institute of Mental Health, the premier grant consumer and
21 producer of conferences, training, reports of unknown
22 utility and employer of legions of consultants and the
23 proper special interest connections. The major grants to
24 conduct programs from which there are minimal audience of
25 questionable benefits from these grants. Entrepreneurs of

1 every conceivable service for stakeholders and unwanted
2 stakeholders for -- and resulting in unwanted and unknown
3 products get aboard this same gravy train.

4 And once again, it's of such of enormous
5 proportion it's actually called the \$10 billion bait and
6 switch. And I still don't quite understand how they are
7 getting away with it but I know from personal experience
8 that it's very real and it's very much happening.

9 MS. HIRAMOTO: Good afternoon. My name is Stacie
10 Hiramoto, I am the Director of REMHDCO, the Racial and
11 Ethnic Mental Health Disparities Coalition. I believe this
12 is the first time I am addressing this honorable body and i
13 want to congratulate you for the work you've done already,
14 it's very impressive. I staff with my other coworkers the
15 CMMC, the California MHSA Multicultural Coalition, so I know
16 what a tremendous job it is to be on a coalition and also to
17 staff it.

18 Rocco Cheng took away my thunder. He, I think,
19 gave kudos where I wanted to. To everyone such as Ruben and
20 CPEHN for putting together and facilitating this.

21 And also the Office of Health Equity, formerly the
22 staff from OMS, the Office of Multicultural Services. They
23 are really to be commended for being a model of how to
24 engage the community and I just wish that more government
25 offices would do as they have done with this project. It's

1 just been tremendous working with them.

2 But I wanted to, I wanted to invite all of you.
3 There is an open invitation to attend the CMMC meetings.
4 They are still taking place every three months. The next
5 one is Thursday, June 19th. And in conjunction with that
6 meeting we will probably be having a class training open to
7 the public. So if you call me or go on our website we will
8 have more information on that. But again, particularly
9 everyone at this body is welcome.

10 And the other thing is I wanted to mention that if
11 you would like to support the CRDP please come to the OAC
12 meeting on Thursday, May 22nd. There will be an item and we
13 could use your support at that meeting.

14 And again, don't forget that the CMMC not only
15 encompasses the five populations in those reports but other
16 populations such as Middle Eastern, other religious groups
17 and the deaf and hard of hearing and others. So thank you.

18 MR. LEONI: Hello, folks, hi. My name is Steve
19 Leoni. I'm a mental health client and I have been an
20 advocate for mental health services for the last 25 years.
21 I am fairly well-known in the mental health community though
22 not necessarily here, for those of you who are not part of
23 that community.

24 I wanted to address something that's a little
25 awkward perhaps but those of you who know me know that I am

1 a strong proponent of cultural competence and reduction of
2 disparities in racial/ethnic groups, et cetera. But I want
3 to point out that clients, mental health clients are a
4 community of their own.

5 They are -- thank you, Delphine. We have our own
6 set of discrimination against us. And I'd like to make the
7 point that in terms of the broader health equity, which is
8 the purview of this group today. That while this California
9 Reducing Disparities Project is long overdue, it's wonderful
10 work they are doing, actually working on practical means of
11 reducing disparity, your job would be only half done if you
12 don't do that because mental health consumers as a whole are
13 dying 25 years before their time.

14 And basically I'll address this a little bit later
15 but I don't want to tread on it too much on this but
16 basically just like the deaf community, the mental health
17 community is made up of many different ethnicities and
18 races. There may be some variations but the commonality of
19 a community, actually it's been called client culture, is
20 that that you band together in the face of discrimination.
21 And we have had that experience.

22 And there are multiple barriers to our health.
23 There are socioeconomic determinants. We are locked in low-
24 income, many of us. The list goes on. And if you only have
25 equality with the so-called mainstream mental health

1 community, your job is only half done in terms of health
2 equity. You need to go further. And I'm hoping that this
3 strategic plan will allow for that broader viewpoint. Thank
4 you.

5 RICARDO: I'm hearing that whisper back over
6 there, Ricardo, you've only got two minutes.

7 I want to share with you these three quick tools
8 that we are using. One is called the functioning scale, and
9 Alberta will tell you a little bit more about that if you
10 want. And that tracks families in crisis through a
11 continuum to a state of self-sustaining wellness and to
12 include, you know, things like prevention and protective
13 factors, and we're working on that.

14 The second piece is what we call the DCW, which is
15 a designed communications work team prior to the collective
16 impact piece.

17 And what I want to see is three hours a day for
18 four days a week for six weeks of a team of people getting
19 together to do all of the background work that needs to be
20 done, collecting the data, there are many things. About 60
21 pieces that have to go into a master plan. This master plan
22 will generate progress indicators which we can then forward
23 up to the state and we can see what we are doing.

24 The other piece, the last piece is the -- this is
25 a matrix that we've created. And in this matrix we talk

1 about what are the health determinants. This column tells
2 if it satisfies the state requirement and where it's listed
3 in the state records. The organizations that are doing the
4 actual work to address those particular health determinants
5 and do we have a narrative on it. Like I have here, "not
6 yet" and some remarks.

7 The object is to create a narrative so we can
8 develop the progress indicators. And that way hopefully we
9 can eliminate, visibly eliminate, you know, health
10 disparities and build equity at the same time. Thank you.

11 DR. KARPILOW: Hi everyone, Kate Karpilow,
12 California Center for Research on Women and Families.

13 I want to start by saying that I think the CRDP is
14 one of the most important efforts that has ever been
15 undertaken in the mental health field to address communities
16 that are long overlooked and are the future of California.
17 I want to underscore that point.

18 Saying that, as you know, my organization, my
19 partners, we have a serious concern that those communities
20 are made up of many sub-communities including men and women
21 and boys and girls and there are distinct mental health
22 profiles for those groups. And as a consequence not only do
23 you have different conditions that are gender-linked but you
24 also have promising and proven practices which are gender-
25 linked.

1 If we begin to put public dollars into programs
2 that we are not linking to gender in a systematic and
3 strategic way then we are potentially not researching and
4 understanding not only the causes of mental health
5 conditions but the practices that will improve them. So
6 you've heard this argument from me before.

7 But I want to end with a question directed to
8 Ruben, again underscoring the importance of this, which is:
9 I didn't hear men and women, I didn't hear gender in
10 anything else other than LGBTQ. And I would like to ask, is
11 this concern not based in the same reality that I share?
12 And if it is something that we do share commonly and I think
13 we do, how can we correct this train which is 20 engines
14 being pulled, has so much force behind it, to actually in
15 the strategic plan for the themes, the goals and the
16 strategies, begin to explore the conditions and the research
17 and the practices that we need to understand from a gender
18 perspective? So I end with that question, thank you very
19 much.

20 MR. MITRY: A question on the phone, please.

21 AC CO-CHAIR GÁLVEZ: Go ahead.

22 MR. MITRY: This is Raja Mitry, I'm a member of
23 the CMMC.

24 Ruben, I notice that one of the beginning slides
25 on CPEHN's health disparities page where it asks in the box

1 about demographic information, what's the person's race. A
2 person like me could mark White but that wouldn't identify
3 me being of Middle Eastern Arab background. I hope CPEHN
4 and others will consider having a place to gather distinct
5 heritages, Arab as well as others who similarly fall in a
6 racial category as White. Otherwise health disparities will
7 continue within our unrecognized ethnic communities without
8 this appropriate data.

9 I have a question. Would you be able to please
10 clarify what constitutes a community of color? Might one
11 make a distinction between people of Arab descent along the
12 Eastern Mediterranean such as Lebanese, Palestinian, Syrian,
13 and those of darker color from Arabic-speaking countries on
14 the African continent, for example Sudan, when it comes to
15 be considered a community of color? Who besides the obvious
16 race and what criteria are there to designate a community as
17 being one of color?

18 MR. CANTÚ: I'm going to address your question,
19 Raja, and Kate's also, really quickly. So Raja first.

20 For this project, for the Reducing Disparities
21 Project, we have followed the guidance of the project, which
22 targeted those four populations. But one of the things that
23 we are doing in the strategic plan that we have -- that we
24 have put forward as one of our recommendations is that we
25 need to continue doing this kind of research and we need to

1 continue doing this kind of research specifically on some of
2 those populations that were not included in those five
3 targeted groups, African-American, Latino, Native American,
4 Asian/Pacific Islander and LGBTQ.

5 And we specifically called out some of the Arab
6 populations, also Armenian population, deaf and hard of
7 hearing, so that we can continue to do the kind of research
8 that we have been doing and focus on some of these
9 populations that were left out of the first phase of the
10 project. So there is a hope that maybe at some point there
11 will be some additional funding that we can be able to
12 continue doing, doing this and focus on some of those
13 populations that haven't been the focus of this research.

14 And so for Kate's question. I am really looking
15 forward to having a more in-depth conversation with you.
16 You know, we can start the conversation now and continue it
17 when the strategic plan actually comes out for public
18 comment, to figure out where some of those places we can
19 include that gender lens in the strategic plan.

20 The other thing that I want to point out is when
21 the RFP for Phase II comes out, that is going to be open to
22 folks to, you know, if there are specific projects that want
23 to apply for funding to focus on African-American women or
24 Latina women, you know, we -- I think -- I don't want to
25 speak for the state but I would personally welcome those

1 kinds of projects to submit proposals to get funded to
2 continue to implement some of those promising practices out
3 there that are working with women. So that they can get
4 funded and then they can get evaluated to continue doing
5 that kind of work.

6 MR. MITRY: Very good, thank you.

7 (Teleconference line was muted.)

8 AC CO-CHAIR GÁLVEZ: Linda.

9 AC MEMBER WHEATON: A quick question on follow-up
10 to Kate's -- to your response to Kate's question. Did the
11 gender issue not come up in all the outreach that you did?

12 MR. CANTÚ: It's actually been a while since I've
13 gone through and read all of the five population reports to
14 remember what was specifically called out in them in regards
15 to the gender, the gender lens, and I can't recall off the
16 top of my head how much of that was a focus in those
17 population reports. When we wrote the report we focused
18 mainly on the racial, ethnic and other cultural community
19 lens in writing the report.

20 OHE DEPUTY DIRECTOR MILLER: This is Jahmal from
21 the Office of Health Equity. It would be helpful, I know we
22 don't want to prolong the hour too much so we can
23 transition, but maybe to hear from maybe like Rocco and
24 Dr. King, you know, who they both had, you know, in-depth
25 experience with their strategic planning workgroups.

1 I am confident that with respect to how we are
2 talking about the gender lens being reflected and
3 integrated, that that may not necessarily in a structural
4 way have happened. But I'd be interested too in hearing
5 from them just based on the process how, you know, from one
6 strategic planning workgroup to another, gender, you know,
7 boys, men, girls, women, how that was discussed, and to some
8 extent in some reports, integrated. That would be great
9 context to have from kind of the experts, if you will.

10 AC CO-CHAIR CHENG: Well, thank you. In the
11 process of our collecting data and information from the
12 community we are mindful that in certain cultures, because
13 of the gender differences and power differential, the
14 information may up differently. So in some of our focus
15 groups we purposefully make it single gender. For example,
16 Southeast Asian, sometimes if you have a mixed gender group
17 in a focus group we learned that many female members tend
18 not to speak up or their comment will be overshadowed by
19 males. So we have several focus groups that conducted like
20 that way so we are able to be able to hear their comment and
21 their needs, their perception of disparity. They were
22 actually, instead of being overshadowed by the other gender.
23 So that's why we, in our approach, what we do. Nicki.

24 DR. KING: Nicki King, UC Davis and African
25 American Health Institute, the African-American strategic

1 planning workgroup.

2 In our report we specifically did call out women,
3 men. We gave them -- we asked specifically in each case how
4 many of them perceived whether women had more issues related
5 to mental illness than men. I mean, we asked each
6 individual group that. The data is absolutely fascinating.
7 And what the consensus was, was that women had different,
8 African-American women had different mental health issues
9 than men. So we actually did that.

10 And we also had some separate groups with
11 transition age youth. That is, youth from the ages of let's
12 say 18 to 25, approximately. And as a result of that we are
13 doing a project now with CalMHSA that is focusing on the
14 specific needs of young, African-American men who in many
15 instances receive their mental health treatment not at all
16 or by the criminal justice system.

17 AC CO-CHAIR GÁLVEZ: Thank you both.

18 Okay, so if we don't have any more comments we are
19 going to take a -- sorry, Dexter.

20 AC MEMBER LOUIE: Sandi, actually like you --
21 Dexter Louie. I don't have much of a mental health
22 background and so much of this is new to me. But it seems
23 to me that when you're talking about prevention and early
24 intervention the same, many of the same problems arise
25 because of the socioeconomic issues, social determinants,

1 whether it's physical health or mental health. And in
2 Asians it's largely depression because they're a different
3 culture, they're immigrants, they don't have a lot of money.
4 Whereas the second and third generations, they do much
5 better. So again you get to the social determinants part.

6 So how do you divide \$6 million into care today
7 for 5 percent versus all mental health issues and going
8 upstream? In other words, how do you apportion downstream
9 and upstream?

10 MR. CANTÚ: Again I don't want to speak for the
11 state or anything. It's going to be very difficult to try
12 to balance it out. We are really talking about a drop in
13 the bucket in terms of the funding that is going to be
14 available to implement this project at the end of the day.
15 And it's really going to be about looking at the projects
16 that are out there and which ones that we think are going to
17 be -- that are going to work best for the population. It's
18 going to have to be a mix of different -- a mix of different
19 types of interventions and promising practices to really
20 have an impact on those populations. It's going to be a
21 wide range of things.

22 And we also know that a lot of the issues that
23 folks identified through the community stakeholder and
24 engagement process that the population workgroups undertook,
25 a lot of the issues that they identified are issues that are

1 not going to be able to be addressed through the -- through
2 the Phase II of this project.

3 A lot of the issues of, you know, institutional
4 racism and a lot of the issues around housing and education,
5 they're issues that we are not going to be able to address
6 with \$60 million over four years or even \$60 billion over
7 four years. We know that those are the things that are
8 going to be the long range strategies that we are going to
9 be having to work on past the -- you know, past the four
10 years of this pilot program. So it really is a drop in the
11 bucket but it is a way to get things started and get people
12 to start thinking about ways that we can be supporting these
13 projects over the years.

14 AC CO-CHAIR CHENG: I just wanted to clarify that
15 my understanding that the purpose of CRDP is traditionally
16 there are a few groups that have been marginalized and have
17 more significant disadvantage or not being able to utilize
18 the mental health system or use it properly and so that's
19 where this funding, CRDP, came about.

20 And part of the report is to -- for at a time, at
21 a certain time we come up with our observation of the scan
22 of what's the current state of disparity that we observe and
23 give some recommendations. But the Phase II is to come up
24 with some strategies or programs that have some promising
25 elements in there to give them some opportunity and resource

1 so they could validate some quote/unquote scientific or
2 culturally appropriate evidence that these interventions are
3 also valid compared to the traditionally used evidence-based
4 practices. That's the main charge of CRDP.

5 In terms of public policy or upstream, there is --
6 there is a strategic plan and it is probably -- we are
7 hoping that with this strategic plan that the state and
8 other funding streams will consider what we -- our
9 observation and our recommendation and use that to leverage
10 the system change.

11 As Jahmal mentioned a couple -- last meeting that
12 CRDP project, even though it's \$60 million, is one percent,
13 less than one percent of the entire Mental Health Services
14 Act dollar. So if this is our observation with some
15 recommendation, maybe there is an opportunity that counties
16 and the system could incorporate and consider these
17 principles and incorporate it in some change. And then to
18 address, address either the current utilization of the
19 services with a more severe mentally ill population. Is
20 there a change, is there improvement of reducing disparity
21 or of going to a more diverse community, something like
22 that. That is our hope.

23 But the charge for Phase II of CRDP is very
24 specific. And we are not involved in the design of the
25 Phase II RFP so we actually don't know what Phase II will

1 look like at this point.

2 AC CO-CHAIR GÁLVEZ: Thank you, Rocco. General
3 Jeff.

4 AC MEMBER GENERAL JEFF: General Jeff. In using
5 simple math let's say there's 300 million people in the
6 United States of America. I don't know what the population
7 is in California but just for the sake of the conversation
8 let's say there's 30 million people, 10 percent of the
9 overall population.

10 So with the CRDP, there's \$60 million there, that
11 basically equates to \$2 per person. If you focus just on
12 minorities, so meaning that I guess no funding would go to
13 whites. So let's say there's \$3 per person. That means \$3
14 per person. That's not enough funding to accomplish too
15 much of anything. So if Ruben is saying that, you know, \$60
16 million or \$60 billion is not enough, where does the \$60
17 million number come from and why is it -- I don't know. Is
18 it just me or does it seem like minorities are left to fight
19 over crumbs.

20 AC CO-CHAIR GÁLVEZ: Pat.

21 AC MEMBER RYAN: Yeah, I just wanted to remind
22 everybody that the vast majority of the MHSA funding goes
23 directly to counties. That there are, you know, the
24 language of the Act itself requires counties to address
25 unserved and underserved populations. There is a prevention

1 and early intervention part of the Act, there are general
2 services, workforce education and training. There are
3 different components to address different things.

4 The funding, there's -- 20 percent of the total
5 funding is required to go to prevention and early
6 intervention, so counties have to be working in those areas.
7 The \$60 million that was identified was really to fund pilot
8 programs, to help to provide infrastructure and training to
9 those unfunded but promising practices that are existing in
10 the communities that are actually reaching people better so
11 that we can learn from them. So that if they are -- if we
12 do identify good and promising and effective practices the
13 counties are going to want to incorporate some of those
14 findings in their overall funding. There's about \$1.6
15 billion that are raised every year, on average, from the
16 Mental Health Services Act. So it's not that these things
17 aren't being addressed in other ways. This is really going
18 to help identify some promising and effective practices;
19 that if they work people are going to want to fund and
20 continue into the future.

21 AC CO-CHAIR GÁLVEZ: Thank you, Pat.

22 Willie.

23 AC MEMBER GRAHAM: I remember when the First 5
24 first came out and I was one of the commissioners giving out
25 the money. You better come, bring proposals, grants and all

1 that. And we were trying to make sure that we created an
2 environment for people representing the community who didn't
3 know how to write grants but had good ideas that were
4 already making a difference. Could come to the table and
5 say, I have a good idea. I don't have all that stuff but I
6 can make a difference because this is what I've been doing.
7 And we encouraged that.

8 We have gotten to a point many years later where
9 there's a lot of good ideas in the community, I know, but
10 they don't know how to write grants, they don't know how to
11 get the money. And then when they try to get organizations
12 to put together some real good grant classes, not a one-day
13 class, it takes a while to learn, it doesn't happen. It is
14 a discussion, we talk about it but it doesn't happen.

15 There's a lot of good programs out there that
16 people are doing on their own but they don't have a voice.
17 They come, they say something, people listen to it and say
18 it's a good idea. What we should try to do is create
19 incentives for those people who already are working hard in
20 the community, already making a difference in the community,
21 to get some of this money, these resources to make a
22 difference.

23 They're already out there. But they are being
24 pushed way back but still expected to do so much more. The
25 grandmother who now her daughter done left and left her five

1 kids and she's got to deal with that reality. And she's got
2 to try to get Medicare. I mean, there's a lot of stuff out
3 in the community that maybe a lot of us don't know.

4 Down in the community the church is a good place.
5 But not just the church but a lot of them are good places
6 out there. You have to bring these information forums to
7 those real places out there. You might have to go to a park
8 and put a tent up and say, you've got a tent in this park,
9 everybody come to have a voice. That's the only way we're
10 going to make a difference. If we don't start doing those
11 things in ten years -- We are making a difference in some
12 way. But we've got to make a major difference if we're
13 going to turn this boat around. And we've got to get back
14 to those people out there who are really going all out to
15 make a difference.

16 How are we going to do that? We've got to give
17 them an opportunity to get some funds. It's all about
18 getting some funds. They have ideas but ideas cannot go in
19 the world and get you some funds. And they don't know how
20 to write grants. They don't know nothing about grants. But
21 they do know how to tell you what they'd like to do.

22 So maybe there should be a grant that is based
23 upon me being able to communicate verbally my idea and then
24 have a panel to listen to it and then put it in writing.
25 Everybody can -- just like everybody can take a test. But

1 some people can take a test -- when it comes down to
2 speaking out, saying what the answer is. I always had a
3 problem taking tests putting it on paper. But if you ask
4 me, that's where we are.

5 So if we can come up with some way that they can
6 come freely and say, I have this good idea, Patricia, and
7 let me tell you what it is, let me tell you what it is. I'm
8 not calling your name. Let me tell you what it is. And
9 then you say, and then you can say, you know, ma'am, you do
10 have a good idea. And you have been doing this for four or
11 five years and you have these people that would come with
12 you and say, you have touched my life, have turned my life
13 around.

14 I'll share this and then I'll give the mic to
15 someone else. Many, many years ago I was at a camp booster
16 banquet and it was all senior highs. And they asked me to
17 go to Sierra Pines to speak. And all these big, beautiful
18 trees, they were so beautiful. And I took my keys out of my
19 pocket and I said, how many of you senior highs believe I
20 can throw my keys through that big tree? They looked at me
21 like I was silly. Through a tree, key through the tree?

22 I wanted to start them thinking because they were
23 getting ready to go to college. Some of them feel like they
24 can't make it to college, they can't make it. And so I
25 said, on the count of three I'm going to throw my keys,

1 let's see it go through the tree. One, two, three. I threw
2 the keys. Guess what happened? It didn't go through the
3 tree. But what it did is set up the idea that I used, the
4 reason why you said it couldn't go through the tree, because
5 you're already looking at the giant and you said, no way it
6 could happen.

7 It was about three years later in Vallejo,
8 California that this little blonde girl, her mother and her
9 sister started saying, Reverend Graham, Reverend Graham. I
10 looked back and said, these blonde people calling my name.
11 I started speeding up, why are they calling my name? They
12 caught up with me. The young lady said, you remember when
13 you were at Sierra Pines and you talked about the key? She
14 said, I was thinking about I could not make it going to
15 college. She said, guess what, I'm a second year in college
16 now.

17 That's what I'm saying here. People have, they
18 have a voice, they want to do something. But we've got to
19 find a way. If we are going to make a difference we've got
20 to find a way to, guess what, get those in the community to
21 the table and say, this is a good idea. How we're going to
22 do that? Like we do everything, teamwork. Putting our mind
23 together, be creative and get that voice out there. That's
24 all I want to say.

25 AC CO-CHAIR GÁLVEZ: Thank you, Willie.

1 Okay, I think we are going to close this part of
2 the agenda. I am going to pass the mic to Tamu. We are
3 going to take a break after she gives us directions about
4 what we are going to do after the break.

5 DR. NOLFO: Thank you. I'll be quick because I
6 know everybody wants a break.

7 So we have some time for you to talk in small
8 groups, about an hour or so. And tomorrow is actually all
9 small groups, we don't have any presentations tomorrow. The
10 presentations today have been great and we wanted them so
11 that they could help to fuel our discussions in the small
12 groups. But tomorrow it is all small groups so we will play
13 with the agenda and the times however we need to. But I
14 wanted to tell you what you're doing in your small groups.

15 First off you are going to have five small groups.
16 And w should have an opportunity between this afternoon and
17 tomorrow for you to participate in each one of them. And in
18 the different small groups you will be looking at the
19 different priority areas. There are six priority areas but
20 the last two are being collapsed down into one group. Okay?

21 So if we do this right and we have enough time
22 then everyone will be able to have some input into each one.
23 And the public is also welcome to join the group that they
24 would like to be in. So there are a couple of things that
25 we would like for you to accomplish in the groups.

1 So the first item to accomplish is to identify
2 benchmarks or indicators of success for the strategic
3 priority. And you will have a facilitator that will help
4 you go into that and think that through a little bit more.

5 And then the second item to accomplish is to
6 identify the specific areas where advisory committee members
7 and members of the public can contribute to advancing the
8 strategic priority.

9 So it looks like we should be able to put about
10 four people in each group. Is Diana still here? Did she
11 just step away or -- she left for the day?

12 Okay. So one group may only have three. Is Ellen
13 still here also? She is. You are, okay.

14 So if I could get you to just count off one
15 through five as we go around the table that would be great.

16 AC MEMBER GENERAL JEFF: One.

17 AC MEMBER GRAHAM: Two.

18 AC MEMBER LU: Three.

19 AC MEMBER PARKS: Four.

20 AC MEMBER LOUIE: Five.

21 AC MEMBER FOX: One.

22 AC CO-CHAIR CHENG: Two.

23 AC CO-CHAIR GÁLVEZ: Three.

24 AC MEMBER BRODY: Four.

25 AC MEMBER OSEGUERA: Five.

1 AC MEMBER DERBY: One.

2 AC MEMBER OGAN: Two.

3 AC MEMBER CÁZARES: Three.

4 AC MEMBER WHEATON: Four.

5 AC MEMBER NEWEL: Five.

6 AC MEMBER GARZA: One.

7 AC MEMBER RYAN: Two.

8 AC MEMBER CANTOR: Three.

9 AC MEMBER WU: Four.

10 DR. NOLFO: Four, okay, perfect. And so what we
11 are going to do is we will have Group 1 here, Group 2 here,
12 Group 3 here, Group 4 in the room where the advisory
13 committee members had lunch and Group 5 is around the
14 corner. And we will show you where -- what is the name of
15 that group?

16 SPEAKER: It's a secret room.

17 DR. NOLFO: It's the secret room. It's the board
18 room that's around the corner. So we can show you where
19 that is.

20 Yvonna, you have a question?

21 AC MEMBER CÁZARES (Off mic): Just two things.
22 Could you put them on a presentation or just give them to us
23 again (inaudible).

24 DR. NOLFO: I can't put them on the presentation
25 but I can tell you the first one looking at benchmarks for

1 the plan and the second one is looking at how can you help
2 to advance the priority that you're looking at. So those
3 are essentially the two instructions.

4 And there is kind of this question about what it
5 is that we are doing with the implementation, right? And
6 the implementation is a bit of a rollout that is happening
7 in some ways overlapping the strategic plan and in some ways
8 after we submit the strategic plan. And so I wanted to help
9 to clarify that a little bit, right.

10 So we have the strategic plan, which we are
11 absolutely going to have signed off by July 1st. Included
12 in that strategic plan we will also have some implementation
13 planning that we feel fairly confident that we can commit to
14 based on the resources that we have within the Office of
15 Health Equity, within CDPH, California Department of Public
16 Health, and other kinds of initial commitments that we are
17 able to secure from the advisory committee and potentially
18 members from the public as well.

19 They don't have to be hard and fast commitments
20 but essentially to be able to tell the Legislature, this is
21 how we are looking at being able to unroll this plan and
22 actually put some action into this plan. So that they can
23 have some confidence in where this is going. And where the
24 public can have some confidence and you can have some
25 confidence in where this is going.

1 However, we also are seeing that this plan, this
2 implementation plan, is being phased in because we want to
3 be able to allow some additional time post-July 1 to have
4 those deep and rich conversations that still need to happen
5 around engaging partners.

6 Do you see where we are going with this? Any
7 questions before we move on?

8 The public, you are welcome to come to any one
9 that you want. So if there is a particular strategic
10 priority that you would like to be a part of that
11 conversation it's going to be A, B, C, D is the next room
12 over, E and F are around the corner in the board room.

13 Okay? So get your snack, take care of your
14 business and in 10 minutes -- and what we'll do is we'll
15 back here at quarter to 5:00; 4:45 we'll meet back in here.

16 (Off the record at 3:44 p.m.)

17 (On the record at 4:53 p.m.)

18 DR. NOLFO: Thank you for rejoining us. Just a
19 few more minutes left in our work day.

20 I hope you can appreciate the flexible schedule or
21 agenda for the meetings that we have. We do have to lay
22 them out to provide us with some kind of guidance for what
23 we think we are doing but we also do try to be flexible as
24 well so that if you want more time to have discussion
25 following a presentation or if there is more public comment

1 or whatnot that we can kind of bend with that.

2 So today we thought that we were going to have
3 more time with the small groups in the afternoon but we had
4 less time. Which is fine because we have plenty of time
5 tomorrow in the small groups.

6 So tomorrow you will be reconvening with the group
7 that you were in this afternoon to finish up the work that
8 you had with that group and we'll see how many more groups
9 you can be a part of. And so we'll kind of see how the day
10 goes, if we're okay with that. You may be able to sit in on
11 all of them or you may be able to sit in on a few of them.
12 Okay?

13 So with that I just want to turn it back over to
14 Sandi, do you have --

15 AC CO-CHAIR GÁLVEZ: Does anybody from the
16 committee want to make any brief comments about the process
17 so far? If not, we do have at least one member of the
18 public that wants to make a comment. And I don't know what
19 time it is. Okay, so we have six minutes. Does anyone from
20 the committee want to say anything? Francis.

21 AC MEMBER LU: I agree with what Tamu had to say.
22 At least in my small group we had a very productive
23 discussion but we only got through two of the goals. So I
24 think that if we could stay in our same group at least for
25 the next session or so I think we'd get more by staying

1 rather than rotating, it just seems to me.

2 AC CO-CHAIR GÁLVEZ: Any other comments from the
3 committee?

4 Okay, we have one public speaker, Steve Leoni, who
5 would like to speak.

6 And please open the phone line so we can see if
7 anyone on the phone wants to make comments.

8 (Teleconference line unmuted.)

9 AC CO-CHAIR GÁLVEZ: You have two minutes, Steve.

10 MR. LEONI: Yes, thank you. Somebody give me the
11 signs or something, I don't see anybody up here. Thank you.
12 This thing is working? I guess it is, okay.

13 Again, Steve Leoni, client and advocate. I kind
14 of wanted to continue what I was saying earlier, kind of a
15 little maybe mini-presentation about the issue of the
16 inequities around clients. And a couple of things I want to
17 talk about.

18 One is that there's a lot of stigma and
19 discrimination and that extends to the health care field.
20 And when you go in to see a doctor you don't always get
21 listened to. You say "I'm a mental health client" and they
22 don't always really take what you're saying seriously. I
23 know I was in a position that I went someplace and they
24 checked out some things that they had read that mental
25 health clients typically have and when I started asking them

1 about the complaint I originally came in for they told they
2 didn't have time. And that's very, very poor circumstances.

3 Also some of the training going on. I have a
4 friend of mine who is an advocate in Los Angeles that guest-
5 lectured at a class of health care administrators in college
6 and they were still studying -- their textbook indicated
7 that schizophrenia had a uniform downward course and cited a
8 19th century psychiatrist by the name of Kraepelin. And that
9 is very outdated information. The entirety of mental health
10 in California is predicated on recovery now and certainly in
11 public mental health.

12 I was talking to a nurse in the practice I use and
13 they said, well we don't accommodate the concerns of mental
14 health clients too much because that might be enabling them.
15 And that word "enabling" comes from the old psychodynamic
16 era, which has been largely abandoned for the last two
17 decades by most of the field.

18 So outdated training, outdated ideas, you know,
19 serve as barriers to people.

20 As I repeat, the mental health community, the
21 client community is dying 25 years before its time, on the
22 average.

23 So some of that has to do also with that we live
24 in poverty. If you are not on benefits even in employment
25 you tend to have lower paying jobs. There's a lot of

1 discrimination out there about that. And that puts you --
2 to talk about the social determinants of health, that puts
3 you right at the bottom of that scale.

4 And you are also -- because of discrimination you
5 are also very, very isolated. And I am being told that it's
6 time to go so I'll leave it at that and hope I can
7 contribute more later.

8 AC CO-CHAIR GÁLVEZ: Thank you, Steve. Any other
9 comments from the public?

10 Okay. Well, I don't want to delay us from going.
11 I know some people won't be here tomorrow. I know some
12 folks won't be here tomorrow so I just want to wish you all
13 safe travels if you are traveling tonight.

14 And good luck if you are advocating tomorrow,
15 because I know some folks are doing that tomorrow.

16 So with that I will adjourn the meeting.

17 (Thereupon, the meeting of the OHE Advisory
18 Committee adjourned at 4:58 p.m., to continue
19 May 13, 2014 at 9:00 a.m.)

20 --oOo--

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I, John Cota, an Electronic Reporter, do hereby certify that I am a disinterested person herein; that I recorded the foregoing California Department of Public Health, Office of Health Equity Advisory Committee meeting; that it was thereafter transcribed.

I further certify that I am not of counsel or attorney for any of the parties to said meeting, nor in any way interested in the outcome of said matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 27th day of May, 2014.

JOHN COTA

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May 27, 2014

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH EQUITY

MEETING OF THE
OFFICE OF HEALTH EQUITY (OHE)
ADVISORY COMMITTEE

SIERRA HEALTH FOUNDATION
1321 GARDEN HIGHWAY
SACRAMENTO, CALIFORNIA

VOLUME II OF II

TUESDAY, MAY 13, 2014

9:00 A.M.

Reported by: John Cota

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Delphine Brody

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Yvonna Cázares

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Tamu Nolfo, PhD

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Also Present

Lilyane Glamben
ONTRACK Program Resources

Steve Leoni

Domenica Giovannini

Laurel Benhamida, PhD
Racial and Ethnic Mental Health Disparities Coalition
(REMHDCO) Steering Committee
and Muslim American Society-Social Services Foundation

Nicki King, PhD
University of California, Davis

INDEX

	<u>Page</u>
Convene Meeting and Welcome Agenda Review Logistics	219
Strategic Plan Small Group Discussions (Continued from Day 1)	221
Breakout	242
Afternoon Session	243
Strategic Plan Report Out of Small Groups	246
Group A	248
Group B	249
Group C	251
Group D	258
Group E & F	262
Committee Discussion	264
Public Comment	
Nicki King	277
Steve Leoni	278
Domenica Giovannini	279
Laurel Benhamida	280
Next Steps	283
Public Comment Period	
Lilyane Glamben	286
Public Comment for Items Not on the Agenda	
Laurel Benhamida	287
Closing Comments and Adjournment	288
Certificate of Reporter and Transcriber	290

1 AC CO-CHAIR GÁLVEZ: Okay.

2 DR. NOLFO: Do you want to start?

3 AC MEMBER JOHNSON: Sure. Carrie Johnson.

4 AC MEMBER GRAHAM: Willie Graham.

5 AC MEMBER AGUILAR-GAXIOLA: Sergio Aguilar-

6 Gaxiola.

7 AC MEMBER LU: Francis Lu.

8 AC MEMBER PARKS: Hermia Parks.

9 AC MEMBER LOUIE: Dexter Louie.

10 AC MEMBER FOX: Aaron Fox.

11 AC CO-CHAIR GÁLVEZ: Sandi Gálvez.

12 AC MEMBER OSEGUERA: José Oseguera.

13 AC MEMBER BRODY: Delphine Brody.

14 AC MEMBER DERBY: Kathleen Derby.

15 AC MEMBER OGAN: Teresa Ogan.

16 AC MEMBER CÁZARES: Yvonna Cázares.

17 AC MEMBER WHEATON: Linda Wheaton.

18 AC MEMBER NEWEL: Gail Newel.

19 AC MEMBER RYAN: Patricia Ryan.

20 AC MEMBER CANTOR: Jeremy Cantor.

21 AC MEMBER WU: Ellen Wu.

22 DR. NOLFO: Great, thank you. And good morning to

23 everyone. It's nice to have you back and some new faces who

24 weren't able to be with us yesterday. I hope that you

25 enjoyed your time in your small groups yesterday; you're

1 definitely going to have time to be back in them again
2 today.

3 I wanted to share with you just a little bit. One
4 is, in your small groups there are a couple of things that
5 we are trying to accomplish. So one of them is to look at
6 benchmarks. And I know that there was a lot of discussion
7 in your groups yesterday about what exactly are we talking
8 about with benchmarks.

9 You know, with strategic planning there is quite a
10 bit of art and science kind of combined and so we can do
11 this however we want. Essentially what makes sense for us
12 to do. And it may look different from one small group to
13 the next, which is fine.

14 But really what we are looking at is when we --
15 when we determine our success, when we determine our
16 progress, what is that based on?

17 So we have this end goal where we are looking at
18 decreasing disparities. And it's going to take us a little
19 bit of time to be able to do that, right? That's the long-
20 term goal is to be able to decrease or eliminate these
21 disparities.

22 And what we think is that we have the right mix of
23 strategies and goals to get us to that point.

24 Now if we were to come back and report on -- let
25 me back up one second. What we are going to have as part of

1 the report and plan that gets signed off on July 1st is a
2 number of these indicators, where we currently stand. So
3 where do we currently stand around income and housing and
4 early childhood development, right. So we are going to have
5 kind of this baseline of where we are with our disparities.

6 And we will be reporting on where we are with
7 those disparities every two years. Whether or not we're
8 able to make significant progress in moving the needle on
9 those disparities in the next two years, I don't know,
10 because I think that it took a long time to get us to this
11 point of having these disparities and I think it's going to
12 take us some time to get us out of that as well.

13 So it's not just looking at how these disparities
14 have been reduced in two years but it's looking at our
15 strategies and our goals and the progress that we are making
16 on them. It's not a one-to-one relationship that you do
17 this one particular goal and it reduces the disparities in
18 this way. It's really the combination and the culmination
19 of all of these goals coming together.

20 And so what we want to know is, how are we
21 progressing with our strategy. Because if we are
22 progressing with our strategy then we are ultimately getting
23 ourselves to the point where we'll be able to reduce those
24 disparities. And we can eliminate those disparities, which
25 would be wonderful, right?

1 So it's kind of like looking at it like a logic
2 model. And this is the end point but are we along the way?
3 And so that's what we are looking at in terms of our
4 benchmarks is where are we along the way with our strategies
5 and with our goals. And how would we determine success
6 along the way.

7 So when we come back here and we have these
8 meetings, you know, you can start out -- when we have this
9 meeting five years from now what do we want to be able to
10 say that we have done? What we feel really good about in
11 terms of our accomplishments when we look at those
12 strategies and those goals? Right? So what's realistic,
13 what's feasible? But what can we really be proud about to
14 say, this is what we accomplished.

15 And then to back it up, right? So we're backing
16 it up four years, we're backing it up three years, two
17 years, one year.

18 So however it is that you get to that in your
19 small groups to be able to have what it is that we want to
20 hang our hat on as we are moving along. So we can check in
21 and say, are we on the right path? Are we okay with this or
22 do we need to adjust a little bit? But something for us to
23 know where we are moving towards.

24 And that's what we are looking at. Does that make
25 sense or are there any questions about that at this point?

1 It doesn't have to be specific in terms of numbers, it
2 doesn't have to be, you know -- what am I saying? Like you
3 don't have to necessarily say that we are going to do five
4 forums a year, although it could be. But it could be, when
5 we do our forums this is the outcome that we want to see.
6 When we do our forums we want to see that 1,000 people have
7 been connected within a learning community that we have
8 online. So you get to kind of decide what it looks like in
9 terms of your measures of success.

10 Are there any questions about that? Yes, Linda.

11 AC MEMBER WHEATON: I guess precisely because the
12 disparities are so daunting that the term "success" seems to
13 me problematic to use in a two year period. And would it
14 not be more realistic to think of it as what would
15 constitute progress?

16 DR. NOLFO: Yes, you can absolutely say that, yes.

17 AC MEMBER WHEATON: Because you don't want people
18 to be overwhelmed --

19 DR. NOLFO: Yes.

20 AC MEMBER WHEATON: -- by how am I going to do
21 that. We are not ending anything in two years.

22 DR. NOLFO: That's exactly right.

23 AC MEMBER WHEATON: So i think really getting to
24 what would constitute progress that is beyond an activity is
25 the real challenging part.

1 DR. NOLFO: Yes, yes. I would agree with you.
2 And so that's why we have the day to think about it.

3 So the other thing that we talked about yesterday,
4 kind of your -- the second task for you to achieve in your
5 small groups is what is it that you bring to the table?
6 What is it that you can do to help move along these
7 strategies and goals? And that could be the connections
8 that you have, you know. It could be anything that you can
9 imagine that you can muster to help move this along. And so
10 that's what we want to know, you know.

11 If there are certain initiatives that you are
12 aware of that you can help make some inroads into and to
13 leverage to essentially up-level and move more into the
14 alignment of what we are trying to achieve with our
15 strategies and goals then we want to know that. We want to
16 have synergy with a lot of the efforts that are happening,
17 not just in the state but some that are happening nationally
18 as well. And you're the brain trust; so that's what we want
19 to bring to bear in this process.

20 So those are the two things that we would like to
21 accomplish in these small groups. And I know that we just
22 started out, we just had a little bit of time yesterday
23 afternoon. The facilitators have asked that you have
24 another hour and a half this morning to stay in those
25 groups. We'll kind of be checking in and seeing how you're

1 doing in those groups. We have some new people that we'll
2 put into groups.

3 The public, you're welcome to go into any groups
4 that you'd like.

5 So we'll move you during the day into other groups
6 as well so that you are not just focused on a single
7 priority area but that you have the opportunity to move into
8 some other priority areas and give input into those as well.
9 And then we'll check in with each other at the end of the
10 day. And as Sandi said, and we'll leave time also to talk
11 about what would you like the future meetings to look like,
12 when do you think they should be.

13 So are there any questions? Yes.

14 AC MEMBER CANTOR: Thank you. On that second
15 point. I understand the desire to get commitments from this
16 group and obviously there is a huge amount of expertise
17 around the table. I also realize that on most of these
18 issues we are not the totality of organizations or experts
19 that might weigh in or could be, you know, influential/
20 impactful on them. So is that an appropriate thing for us
21 to talk about in our small groups are key other players or
22 do you want -- or is that sort of a next phase after this
23 initial discussion?

24 DR. NOLFO: That would be wonderful for you to
25 talk about key other players.

1 AC MEMBER CANTOR: Okay.

2 DR. NOLFO: Absolutely.

3 AC MEMBER WU: So in our small group yesterday we
4 also talked about the state's role in providing leadership
5 or resources or capacity to this. And I think that's
6 actually, I feel, like an essential element that is missing
7 from the plan. So I don't know if we could fold that, if
8 it's appropriate to fold that in or ask it as a separate
9 question.

10 DR. NOLFO: And so the state's role is definitely
11 going to be there and that's part of what we are fleshing
12 out as well is essentially what's our ability around
13 implementation. And so we kind of went back and forth a
14 little bit in terms of how we were writing up the plan and
15 how prominent of a piece we wanted to make that. So when
16 you kind of look back at other versions of it you can see
17 that.

18 And so one of the reasons why we chose to not
19 highlight at the goal level what it is that the state is
20 doing is because we wanted to make the goals as inclusive as
21 possible for everyone to be able to see themselves in them.
22 So that it wouldn't just be, oh, the state is handling that,
23 the state is taking care of that. Because the reality is
24 that there are many opportunities above and beyond what the
25 state can do with each one of the goals to move them

1 forward, to advance them. And so that was kind of our fear
2 is that if we wrote it in that way that people would not be
3 able to see their place at the table, they would not be able
4 to see additional possibilities.

5 But we are fleshing out within each of these goal
6 areas where it is that the state can provide leadership,
7 where the state can take on some of the advancement of the
8 goals. You don't have it with you today but it's within the
9 areas that we have been talking about around the units that
10 we have. So it's within, you know, what CRDP is doing, the
11 California Reducing Disparities Project; it's within what's
12 happening in our policy unit; it's within what's happening
13 in our statistics unit; around with the being able to manage
14 the data and to disaggregate the data and make the data more
15 readily available. so those are some of the key areas where
16 we have the capacity within the Office of Health Equity.

17 And what we are doing also is a scan within the
18 California Department of Public Health to see well what else
19 is going on within our department that makes sense around
20 advancing these goals. So we are just in that process. We
21 weren't quite ready to put it out to the group today or for
22 you guys to have at this point in this meeting. But know
23 that it's happening.

24 Jahmal, do you want to say anything else about,
25 about this piece, the state essentially providing leadership

1 on the plan? I think Ellen is looking at in terms of
2 knowing what the state is doing, what the state's leadership
3 is that it may help in terms of knowing how other partners
4 can fall into place.

5 Is that -- did I get that right, Ellen? How it
6 makes sense for the other partners to fall into place?

7 AC MEMBER WU: I think there is an internal
8 process of the state's role but there is also -- I mean, you
9 can see it. No, you can't see it because it's not released.
10 But the CRDP plan is a community-driven plan that really
11 holds the state accountable, all the different departments
12 that touch mental health. And I don't know if -- Rocco is
13 not here -- if Sergio wants to talk about it. So from the
14 external stakeholders' perspective, how they see the state's
15 role. And that piece is missing from this plan.

16 So there's the internal assessment, this is what
17 we currently have the capacity to do and how we can do it.
18 But then from the stakeholder perspective, holding the state
19 accountable for their leadership role in pushing this issue
20 and making it a priority.

21 OHE DEPUTY DIRECTOR MILLER: So there are two
22 comments I can make in response to that. And we talked
23 about it actually yesterday at our debriefing.

24 One of the opportunity areas that is in one of the
25 strategic priorities is that aside from like Health in All

1 Policies and the task force members that we have at the
2 table to where we can kind of articulate to what extent
3 those task force members are doing health and equity-related
4 work in those respective agencies, departments and offices,
5 and aside from our inter-agency agreement with respect to
6 DHCS and then obviously the office being in CDPH,

7 We can to some degree articulate what those
8 entities are doing from a low hanging fruit perspective,
9 existing work that impacts our ability to eliminate
10 disparities in the state of California. But on a much
11 broader scale, and it's somewhere in the plan, we literally
12 have to do some more groundwork to explicitly identify that
13 it aligns with the decisions and policies that government
14 institutions can make to institutionalize our ability to
15 achieve health and mental health equity in the state of
16 California.

17 We have to do some kind of -- some groundwork to
18 really be able to assess just what is going on. Right now
19 we can't even really say that as far as what is -- what is
20 the state doing as a whole. And it's built into the plan,
21 our ability to go out to either have the capacity to do that
22 as an Office of Health Equity and/or partner with an outside
23 entity that can evaluate across our state partners, what
24 work is being done. Where can we put our hooks into this
25 existing work to advance our health equity agenda. I can't

1 articulate that comprehensively right now. And that's kind
2 of the sprint versus the marathon approach of just doing
3 this groundwork to just know where do we stand with respect
4 to state government as an institution and then build upon
5 that foundation.

6 And I don't think, unless there has been a report
7 or an assessment or an evaluation that's been done before, I
8 really don't think that exists.

9 So we're building it in increments. So we share
10 the strategic plan with the executive management team with
11 CDPH. Right now we don't even know of those 200 programs,
12 which of those programs are doing this work already. So
13 even right at home we're starting to build at home. We need
14 to do the same thing with DHCS to just get an idea. And
15 that will inform our next steps versus getting ahead.

16 So that's an opportunity area that you've stated,
17 Ellen, and it's something that we just have to, we have to
18 do. That way we can provide that informed response and a
19 strategic approach that we just -- we don't have right now.

20 And lastly, I think that we just look at what are
21 the strengths of government. What do we bring to the table
22 that allows us to have an impact on the strategic plan? And
23 that's policy making, that's mobilizing, you know, federal,
24 state resources to the communities that need these resources
25 the most.

1 That's our ability to work with partners like the
2 Department of General Services who is responsible for our
3 procurement practices to ensure that small businesses,
4 minority owned businesses, women owned businesses are able
5 to get contracts that allow them to stimulate local
6 economies. Because local, you know, communities that are
7 healthy are economically strong. So there is a systemic way
8 that we have to do it to engage these partners.

9 But mobilizing the resources, creating policy
10 affecting those decisions are the strengths that government
11 brings. And we are a powerful convener. To be able to say
12 that this is what this plan is going to be and it inspires
13 people to get on board with moving this plan forward. So
14 hopefully that helps.

15 AC MEMBER AGUILAR-GAXIOLA: Yes. I think that
16 what -- a few of the things that I was going to say you
17 addressed them, Jahmal. The strategic plan is shaping up
18 very nicely. It's, you know, a relatively easy read and
19 understandable for the regular folks.

20 But I think that one of the big, big challenges as
21 you look at the different strategic priorities in the plans,
22 Phase I and Phase II, that one of the biggest challenges
23 that we are going to have is the resources to implement
24 them. And it is still unclear to me what is the state
25 commitment to those resources.

1 And I can tell very clearly all the incredible
2 activity that you and your team, your office, and
3 Dr. Chapman's commitment to start looking for federal as
4 well as -- I mean, anywhere that you can possibly get
5 resources for these purposes. But it would be -- it would
6 be important, I think, in terms of implementation to have a
7 sense of what is the procurement, what is the commitment
8 here.

9 I have seen other plans, you know, in 30 years
10 that I have been working on disparities, national, state and
11 other places, that just become, you know, nice plans and not
12 much has happened to them because of resources primarily.

13 And I think that the point that Ellen made about,
14 you know, having the stakeholders looking from the out, in,
15 the outside in, is also of critical importance. And that is
16 -- I agree with you, Ellen, that that is the case with the
17 CRDP. You know, that with grassroots there is a lot of
18 expectations built across the state in the diverse
19 communities looking at the Department of Public Health and
20 specifically the Office of Health Equity as to, you know,
21 how that needle is moving forward.

22 I think that it is in our best interest to
23 identify and differentiate the low hanging fruit versus the
24 high altitude fruit and see, you know, what are the quick
25 wins that we can possibly have that don't require too many

1 resources. So there is traction that we can be shown to
2 inspire, you know, and to leverage potential resources that
3 can be -- can be allocated for this.

4 OHE DEPUTY DIRECTOR MILLER: The plan, I'm very
5 confident that post-July 1 the plan is going to position us
6 to really prep for the next legislative session to become
7 very active in the setting of the budget for the next
8 legislative session. And we will be able to spend, you
9 know, the summer months identifying what human and financial
10 resources we need to advance this work.

11 And just as this office was created through
12 stakeholder engagement and through leadership at CDPH and
13 across government, I think we will have an opportunity as an
14 advisory committee, as a staff, to literally go through this
15 process. And maybe it's maybe having an expert come in to
16 one of our future meetings and really walk us through the
17 political process of how we just get things done. Because
18 when we talk about really going to bat for ourselves to
19 build up our human capital and our financial resources. The
20 legislative process that I'm getting acclimated through,
21 That's how we do it, budget change proposals.

22 As these private foundations, we're going to
23 ultimately establish what I would call a brain trust of
24 private foundation leadership and philanthropy. Show them
25 the strategic plan, allow them to plug in with what aligns

1 with their impact investing, you know, priorities.

2 But also we'll do the same thing with respect to
3 state government. And it's going to require all of us to
4 just be engaged, to be at these Assembly and Senate budget
5 committee hearings to advocate on behalf of what it is that
6 we need. And that's how we get things done, that's how we
7 secure the resources that we need.

8 I think -- well I know we have the support of our
9 leadership. There are some existing resources that we can
10 tap into right now financially that we don't have to go
11 through the process to secure. But when we start talking
12 about \$2 million, \$3 million, \$4 million, \$10 million,
13 that's going to require a collective, you know, policy
14 strategy that can be driven by our colleagues internally.

15 But it opens up an opportunity for our advisory
16 committee members to get involved with the process, to go to
17 these hearings where we speak and we testify at these
18 hearings. Where you guys will be right there alongside with
19 us stating your support for why these committees should
20 pass, you know, these legislative initiatives and proposals.
21 And that's how we are going to get things done.

22 The last comment. I think I mentioned it at the
23 last meeting. Dr. Chapman and the executive management team
24 at CDPH decided that for the next legislative cycle all of
25 the policies or legislative proposals that come out of CDPH

1 at the core of them, even when they cut across all of the
2 programs, at the core of them is going to be health equity.
3 So we have gone through a list of over 80 proposals that
4 were submitted by our leadership to prioritize what our top
5 20 are going to be. So they're on board, our leadership is
6 on board.

7 So we are going to need our stakeholders like you
8 to be right alongside with us. So in the next legislative
9 cycle when we go to bat to get the resources we need the
10 voices, we need the people. And that's how we get resources
11 to get things done.

12 AC MEMBER PARKS: Hermia Parks. One of the things
13 I've noticed, which is a fairly common thread within each of
14 our priorities, and forgive me if I may have overlooked this
15 Tamu and Jahmal, but part of looking at our goals is also
16 monitoring and evaluating the effectiveness of the
17 activities. And I don't see that listed as a goal, that we
18 will evaluate and monitor health equity activities for its
19 effectiveness. Because we can come together and talk about
20 those goals and activities but there's got to be a way that
21 we are going to evaluate and monitor those activities to see
22 whether or not they are effective.

23 DR. NOLFO: I would, I would agree with you. And I
24 am hoping that that's part of what comes out of this is what
25 do we see as effective. Do you see what I'm saying? What

1 would we place as progress? What would we place as success
2 so that we have something to know whether or not we are
3 being effective or not. Because in some of them it's not so
4 clear cut. So that's part of the conversation that we want
5 to have in the small groups is what would you see as
6 effective so that we can monitor it. But yes, to call it
7 out explicitly as a goal, yes, absolutely.

8 AC MEMBER LOUIE: Dexter Louie. Two points. One
9 is, Tamu, I did ask you both yesterday and today after
10 reading this about what are you going to do with all the
11 input and you reminded me, this is a draft. There's a lot
12 of changes and we can actually edit in committee or groups,
13 in the groups, and then you will take that into account for
14 the next version.

15 Secondly is, Jeremy, when you're talking about
16 partners is that -- when I talked to the CMA as a partner
17 because, you know, they're interested in medicine but that's
18 only 10 percent of health care, the other 90 percent is what
19 we're talking about. Is that I really had to have them buy
20 in on this being a worthwhile project to partner with. And
21 it's what is in their interest, that type of thing.

22 So this is broad-based. It's to bring everybody
23 on board that you can think of. Some whom won't come. The
24 education people, you know, what's in their interest? Well,
25 they talk about STAR testing and achievement and graduation

1 rates, but of course without the basic health care thing.
2 They're not going to buy in unless we make it palatable to
3 them and show value to them.

4 (Teleconference message was heard.)

5 AC MEMBER LOUIE: So it's just bringing everybody
6 on board but providing them with this broad-based inclusive
7 way of trying to address something that everybody is
8 frustrated about. We all know, we talk to each other all
9 the time. We're totally frustrated. So anyway, it's a
10 start. Thank you.

11 AC CO-CHAIR GÁLVEZ: So if the -- Álvaro.

12 AC MEMBER GARZA: Yes, thanks. Álvaro. And so
13 the discussion is raising some thoughts in me and that's
14 around maybe we need clarity in following up on Ellen's
15 comments. We have some but it's not clear to us in terms of
16 clarity in the roles and responsibilities of the OHE itself.
17 And I haven't checked the website so I apologize if it's
18 there. But clarity like a one pager on roles and
19 responsibilities of the OHE. And clearly most of that is
20 going to be and is in the law that set up the OHE and
21 therefore in the Health and Safety Code.

22 But I would -- my suggestion and recommendation
23 would be along the lines that you can translate that into
24 and put it in a format of the essential public health
25 services. So that the OHE, regarding everything of Health

1 Equity, does the assessment, the policy development, the
2 mobilizing, the -- there's ten essential services, right?
3 Evaluation and so on. And that would play very well into
4 the CDPH accreditation process as well.

5 So just a suggestion. And it could be a one pager
6 or so but roles and responsibilities of basically what we
7 do, what we don't do. I've been on other advisory
8 committees and that has worked very, very well. So when it
9 goes to the public, you know, the public says, what the heck
10 do you do? Well, this is what we do, this is what we don't
11 do. And you do most everything about health equity, of
12 course you have limitations. And our roles and
13 responsibilities are much clearer because it's in here, we
14 have our bylaws and so on. But it seems to be unclear as to
15 what the OHE's is.

16 AC CO-CHAIR GÁLVEZ: I think that would fit in
17 nicely with this introduction piece so it actually -- you
18 know, this does go into describing the Office of Health
19 Equity and the different units. And I think, you know,
20 adding something here specifically about the responsibility
21 of the office in relation to the strategic plan. I mean, in
22 the last version we had, or two versions ago or something,
23 we had where we had the little asterisks for the things that
24 were directly, that the office would be directly responsible
25 for implementing.

1 And I think, you know, highlighting that. That,
2 you know, that that's how throughout the rest of this plan
3 it will be highlighted in this opening section would be
4 good. And then reminding folks of that once they get to
5 that part of the -- because it's going to be a big, fat
6 report. And I guess the strategic plan is the last thing in
7 the report. Once they get to that again, once again making
8 sure that that's clear. That things that are asterisks or
9 marked in some other way, are the clear responsibilities of
10 the office.

11 DR. NOLFO: Willie, did you want to speak?

12 AC MEMBER GRAHAM: (Shook head.)

13 DR. NOLFO: Anything else? Okay, Jahmal.

14 OHE DEPUTY DIRECTOR MILLER: If there is a section
15 or a goal in there that just seems too ambiguous or it
16 doesn't even really seem relevant, if it needs to be pulled,
17 if wordsmithing it doesn't help to make more sense of it,
18 that's okay too. If it's not, you know, something that
19 really is a must have if you will, especially given that
20 it's a pretty robust and lengthy kind of strategic plan. So
21 if there is something in there that doesn't make sense and
22 we kind of pound through it and beat it up a bit more and it
23 still doesn't make -- if it doesn't make sense even if we
24 wordsmith it, we can pull it or we can just de-prioritize
25 and bump it out and bicycle rack it until the next go-

1 around. It wouldn't hurt if we, you know, just pull some
2 things out of it if we feel the need to do it.

3 DR. NOLFO: Or as Hermia said, maybe there is
4 something that is really missing that needs to go in and so
5 to note that as well.

6 So I am going to leave you with two quotes before
7 I send you off. So this first one is:

8 "The important thing is that when you come to
9 understand something you act on it, no matter how
10 small that act is. Eventually it will take you
11 where you need to go."

12 That is Sister Helen Prejean. And here is another
13 quote for you, if I can get my technology to cooperate.

14 "Normally, when you challenge the
15 conventional wisdom that the current economic and
16 political system is the only possible one, the
17 first reaction you are likely to get is a demand
18 for a detailed, architectural blueprint of how an
19 alternative system would work, down to the nature
20 of its financial instruments, energy supplies and
21 policies of sewer maintenance. Next, you are
22 likely to be asked for a detailed program of how
23 the system will be brought into existence.

24 Historically, this is ridiculous. When has social
25 change ever happened according to someone's

1 blueprint?"

2 And that is by David Graeber who was very
3 instrumental in starting the Occupy movement.

4 And I just put those out there because I know that
5 this planning process is incredibly important but to have
6 some perspective on it as well. That really what we're
7 talking about is social change. So this is a starting point
8 and we are going to move on it.

9 And so with that if I could have you go into the
10 groups that you were in yesterday. For the couple of people
11 that were not here yesterday, if you could just stay where
12 you are and we'll place you in the groups where you're
13 needed if that's okay. For an hour and a half. Thank you.

14 (Off the record at 9:48 a.m.)

15 (On the record at 1:10 p.m.)

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1 A F T E R N O O N S E S S I O N

2 AC CO-CHAIR GÁLVEZ: Okay. So I am going to pass
3 it to Tamu to give us further instructions.

4 DR. NOLFO: Okay. I just wanted to check in
5 really quick and see how we're doing with the morning
6 sessions. Were there any big questions that came up that
7 you'd like for me to try to address at this point? We're in
8 good shape? Okay.

9 So what we are going to do is you are going to
10 have the opportunity to go into another priority area and to
11 build on the work of the group before you. But what we
12 would like for you to do is to first hear about that work
13 from that group. You know, from the group.

14 So this is what I'd like to have happen is that if
15 you were in this room, so if you were in Groups 1, 2 or 3,
16 or A, B or C, then what we'll do is we'll have you start
17 over here at A and kind of hear what it is for just about
18 five minutes, kind of the high points of what came out of
19 Group A. And then we'll go over to Group B and hear the
20 high points from Group B and then go over to C and hear the
21 high points from Group C.

22 And what you'll do then is you'll go into a new
23 group to be able to build on that work that was done. And
24 so if you were in A you can move to B, if you were in B you
25 can move to C, like that. If you were in C actually I'd

1 like for you to move to A. So you're going to stay in this
2 room with the other two groups.

3 So we had one that was Group 4 that was Priority
4 D, we had one that was Group 5 which was Priorities E and F.
5 We'll start out in Group D so -- what is the room right off
6 the hallway here? The lunchroom right off the hallway here.
7 So where Group D was and we'll take about five minutes for
8 Group 5, which was E and F, to be able to hear the high
9 points, about five minutes worth of the high points that
10 came out of that group.

11 You guys can then go around the corner to the
12 board room and the folks that were in Group D can hear about
13 the high points that came out of E and F and then you guys
14 can swap. Okay? So if you were in D you're going to go
15 into E and F, if you were in E and F you're going to go into
16 D. That was clear to me, was that clear to you? Clear as
17 mud?

18 And for the public, you can -- the public, you can
19 listen in wherever your interested in listening in. So if
20 there is a priority area that you would like to give input
21 into, because we are going to keep you in these groups.
22 We're going to see about how long it makes sense for you to
23 stay in your new groups. It may be 45 minutes, it may be an
24 hour. We're anticipating that it won't be as long as the
25 first groups because the first groups did a lot of the

1 initial work and so you're kind of building on, capitalizing
2 on what they have already done, right? And then so we'll
3 check in and see about how long it makes sense for you to be
4 in those groups together.

5 But if you're a member of the public and you'd
6 like to stay in one of those groups, you'd like to
7 contribute, the places are going to be the same and you can
8 see where they are. So A is here, B is here, C is here, D
9 is off of the hallway here and E and F are around the corner
10 in the board room.

11 Lilyane, you look confused. I'm going --

12 MS. GLAMBEN: So it's not like the report out,
13 like everyone is going to stay in the room and we get to
14 hear what folks have been working on.

15 DR. NOLFO: No, no, no, we are not doing a big
16 report out at this point. We are going to give the groups
17 some more time --

18 MS. GLAMBEN: Okay.

19 DR. NOLFO: -- to give some more input into the
20 priorities before we do a big report out.

21 MS. GLAMBEN: But that's still going to happen?

22 DR. NOLFO: But that's still going to happen, yes.

23 MS. GLAMBEN: Okay.

24 DR. NOLFO: Later on in the afternoon.

25 MS. GLAMBEN: Around what time?

1 DR. NOLFO: So --

2 MS. GLAMBEN: Around what time did you say?

3 DR. NOLFO: I would say that that's probably going
4 to happen about 3:15, 3:30. Yes? Because what I was
5 getting from Sandi is that the conversation is a little bit
6 richer when you have the opportunity to do some of the
7 reporting out during the sessions and to hear directly from
8 the people who were in the groups doing that one-on-one kind
9 of reporting out.

10 So if that makes sense to you then we are going to
11 start over here. If you were in this room in A, B or C we
12 are going to convene over here for the first few minutes so
13 that A can give you the highlights of what they came up
14 with, okay? If you were in the other two rooms start in D.
15 Thank you.

16 (Off the record at 1:15 p.m.)

17 (On the record at 3:54 p.m.)

18 DR. NOLFO: You guys have been working hard all
19 day but you are now in the home stretch. And so what we
20 would like to do is some report-outs.

21 Fortunately, you should have gotten acclimated, if
22 I'm doing my math right, with four out of the five areas
23 already.

24 AC MEMBER: Three.

25 DR. NOLFO: Really, you only got three. Well the

1 people in here went to three and then another one. Four,
2 yes. The people who were in this room got four. Oh, some
3 got -- sorry. Okay.

4 So you haven't gotten everything and so this is an
5 opportunity to kind of tie it all together. But since you
6 have already had an opportunity to hear quite a bit in most
7 of the strategic areas, priorities, then we don't need to go
8 into a lot of depth, we just need to kind of give the
9 highlights.

10 And so if we can have Group A. Who was the
11 facilitator for Group A who would like to give us some of
12 the highlights? Great. Do you have a microphone or do you
13 need one? So this is Group A, this is Julia.

14 MS. CAPLAN: Great.

15 DR. NOLFO: Julia?

16 MS. CAPLAN: Oh, Julia Caplan.

17 DR. NOLFO: Thank you. If you can introduce
18 yourselves before you start speaking.

19 MS. CAPLAN: Okay, great.

20 DR. NOLFO: And I just wanted to say to the group,
21 to all of you here, that the process that we are going to go
22 through back in our office is that the facilitators will
23 type up the notes for me so that I have them to integrate
24 into this final version. Okay.

25 MS. CAPLAN: Great. So you just want kind of

1 high-level.

2 Our topic was to identify and disseminate
3 actionable information on inequities and disparities. As we
4 worked through the goals in our area we realized that really
5 they fell into three over-arching areas.

6 So the first was really about data, and
7 particularly thinking about both what roles the Office of
8 Health Equity can play in identifying data sources and
9 making it easier for people in communities to even know what
10 is out there and what are kind of high quality, vetted data
11 sources, legitimate that they can trust and use.

12 And then in addition, a recommendation around
13 really identifying gaps in data. And a big piece of that,
14 one idea for actually this group, the advisory committee to
15 form a subgroup to explore what the gaps are and make
16 recommendations.

17 The second big area was around communications.
18 And we had stuff in ours creating briefs and creating a
19 website but we didn't have anything about creating an
20 overall strategic -- not a strategic plan but a
21 communications plan. And so we added that there should
22 really be an overall communications plan that comes out of
23 this body, for what that's going to look like, and the
24 website and briefs can be a piece of that.

25 And then the third was around building a network

1 of people who are doing work to promote health equity. And
2 that can include participating in summits, representing OHE
3 out in the world. Identifying, you know, kind of really
4 supporting the relationship building among people doing this
5 work.

6 Does anybody want to add to A? Great.

7 DR. NOLFO: I really appreciated how your group
8 managed to break down those three areas to help us better
9 identify what was really happening within that priority
10 area.

11 So we are going to move on to B, okay, thank you.
12 Meredith, will you introduce yourself.

13 MS. LEE: Meredith Lee, Health in All Policies.

14 So we were Group B and B is around embedding
15 health, mental health and equity into institutional policies
16 and practices across non-traditional health partner
17 agencies.

18 And so one of, I think, the first things to talk
19 about is the fact that we started out with non-health
20 fields. And there was a general consensus amongst the
21 groups that came through that non-health fields, especially
22 for those of us who have been working with the non-
23 traditional partners, that we have been spending the last
24 few years trying to get them to think that their jobs are
25 health-related, and so to now tell them that they are no

1 longer health-related is stepping backwards. So either
2 health allies or non-traditional health partners is what we
3 were thinking.

4 And so Strategic Priority B really is focused at
5 the government level, so state agencies. And so the goals.
6 Similar to Group A we also categorized our goals, thanks to
7 some of the thinking from Álvaro. In terms of the first
8 category would be policies and practices. And we put Goal 1
9 and Goal 2, which are conducting a landscape analysis about
10 equity practices and then also using a Health in All
11 Policies approach to embed health equity criteria in
12 decision-making grants, programs, guidance documents and
13 strategic plans.

14 And it was -- we wanted to just also note that the
15 Health in All Policies Task Force met last week and agreed
16 that Goal area 2 is something that they have already been
17 working on for four years and it's something that they are
18 going to continue to work on. And they agreed to commit to
19 working to embed health and equity criteria into at least
20 five plans, guidelines, guidance documents. So that was one
21 thing that they have already committed to.

22 And then in terms of the second category, that we
23 really felt like this section was divided into was around
24 communication. So Goal 4 was around facilitate common
25 understanding of health equity and the social determinants

1 of health. And so really we felt like this builds on
2 Priority A in the communication field. Talking about
3 communication but actually thinking about some fee the next
4 steps, whether that's training with four other agencies,
5 identifying champions who can maybe become Train the
6 Trainers and do the trainings within their own agencies.

7 So I think those are some of the big, big take-
8 aways from this group. Anything that anybody in my group
9 would like to add? Questions?

10 DR. NOLFO: Okay, thank you, Meredith.

11 So for Group C, who is doing the report out for
12 Group C?

13 MS. AUGUSTO: So I'm Marina Augusto and I had the
14 pleasure of leading Group C. There was a lot of lively
15 discussion. And our priority area was really about
16 embedding equity into institutional policies and practices
17 across the health field.

18 So right off the bat there was some discussion
19 around a glossary of terms or definition of health field.
20 As you recall, in some of our previous meetings there was
21 this discussion about health, if it's inclusive of mental
22 health. So we had some discussion about adding a paragraph
23 to the beginning of our strategic priority area or into the
24 glossary of terms that really explains why OHE is choosing
25 to use health and mental health separately because sometimes

1 mental health is not addressed when health is referenced.
2 And so that was what we identified early on just to give
3 clarity.

4 Also we did have a listing of potential partners
5 and we added to the list that was provided to us by adding
6 the Department of Aging, the Mental Health Directors
7 Association and a few other community-based organizations.

8 Under our Goal number 1, which is really about the
9 assessment piece, conduct assessment of health and mental
10 health equity practices throughout state departments and
11 state-funded programs in the health field. Sandi addressed
12 early on some of the, you know, operationalizing or
13 activities associated with that.

14 I think one of the things that came up for the
15 following groups is really working with people to addressing
16 challenges that their departments are having so that the
17 office or the work of this advisory committee could really
18 prioritize how technical assistance and further support to
19 the departments could be offered to them. So I thought that
20 -- and really in a candid way so that it provides an
21 opportunity for that.

22 In addition to that another outcome that was
23 listed for Goal 1 is assessment is completed. And Debbie,
24 you're going to help me out with your writing here. Been
25 developed. Gaps are identified. So again going back to the

1 assessments. This was an interesting dialogue as well of
2 doing assessments as far as gathering the baseline
3 information to help inform and prioritize the work ahead.

4 It also spoke to an assessment internally, which
5 Jahmal addressed early on, about assessing within the
6 Department of Public Health, what's going on in terms of
7 health equity activities.

8 I thought what was also interesting is that we
9 were really focused on state departments under the
10 California Health and Human Services agency but then really
11 wanted to expand that. And that was pretty much, you know,
12 in agreement with the rest of the groups that were in our
13 working groups.

14 I think -- I believe Sandi addressed this but the
15 importance under Goal 2 of having buy-in from leadership.
16 So we talked about the need for the buy-in. Having a
17 meeting with the leadership up top and then also including
18 line staff of different representation from the departments
19 to begin the discussion.

20 I think I was asked the question twice about "Does
21 the OHE meet with other departments, you know, coming
22 together in a platform to talk about these issues?" And we
23 really don't have a platform for that, so that really gave
24 an opportunity through this discussion to, how can we begin
25 integrating? When we talked about integration this would be

1 a good spot for us to do that.

2 But really having that letter from Agency or Dr.
3 Chapman or Toby Douglas saying they are on board because it
4 demonstrates commitment. We talked about executive orders
5 and how other policies are developed from that and so, you
6 know, maybe in the future looking at that. But again, the
7 assessment piece was just the beginning.

8 And then moving to Goal number 3. This was an
9 area that our first group said okay, let's just hand this
10 over to Tamu. But then, you know, we did have some experts
11 come through. And one of the things that we talked about in
12 terms of CLAS is that there is not enough information and
13 knowledge base around CLAS. And so that was partly going to
14 be part of Christina Perez's presentation today, to talk
15 about the enhanced CLAS standards and how those standards
16 are critical to this work. It's a logic model that builds
17 upon resources, training and many of the areas that you all
18 are talking about.

19 So one of the things that Group number 2 really
20 talked about was the importance of an educational component,
21 an educational strategy to not only educate internal staff
22 but also the general public on CLAS standards. And how the
23 standards really speak to a lot of language access issues,
24 linguistic capability. But then the next step to that is
25 the resources that are needed for that to happen. But to at

1 least begin the training and discussion dialogue around
2 that. Did I miss anything on that?

3 I thought there was one other component of the
4 CLAS that you talked about. Oh, it was something that
5 Álvaro mentioned and that was really that oftentimes when
6 people speak of CLAS they look at the CLAS standards and
7 they go, oh my gosh, you have to do all these things and
8 whatnot. But really, that if we could just take, even if we
9 took a portion of what the CLAS concepts or use this as a
10 guide, would be helpful. The CLAS standards were developed
11 for the health field but mental health has incorporated CLAS
12 and substance use disorder folks -- the substance use field
13 is now using CLAS as well and so taking a look at that.

14 And then also encouraging folks or providing
15 information to go on the Office of Minority Health at the
16 national level to look at the blueprint for guidance on
17 that.

18 Moving to goal number 4. I don't -- let me just
19 double-check. I don't think there were any recommendations
20 for goal number 4 from the other two groups.

21 And then goal number 5 was really about climate as
22 kind of a separate action or activity. And our last group
23 really recommended that climate should not be separate, it
24 should be inclusive throughout the strategic priorities
25 because of the impacts that it has overall.

1 And I wanted to go back to goal number 4. There
2 was a recommendation to maximize opportunities for data
3 collection by engaging and having discussions with Covered
4 California as an entity but then the plans are Medi-Cal
5 managed care. Because we will have access to new data that
6 we have never had before, so the importance of really
7 looking at that. And we can look at what populations are
8 utilizing the ACA and which are not.

9 My group have any other comments? Debbie, any
10 more to add? Okay, thank you.

11 DR. NOLFO: Marina, the little bit that I sat in
12 on your group, you had talked about a couple of workgroups
13 that potentially you wanted to recommend forming. You want
14 to say something about those couple of workgroups?

15 MS. AUGUSTO: So Sandi addressed the workgroups
16 during her first report-out. But under Goal 2 was really
17 the development of a workgroup to begin that platform or the
18 level of discussion around the departments coming together.
19 Bringing together mental health, bringing together climate,
20 bringing together, you know, our health advocacy partners to
21 begin the dialogue around our work. And, you know, just
22 coming up with ideas on how we can impact change and
23 prioritize.

24 The other workgroup was related to -- I believe --
25 yes. So the ACA Opportunities convened a support or a

1 summit to explore expanded coverage to be co-led by OHE and
2 DHCS involving Covered California and explore feasibility
3 strategies. And that again ties into data collection
4 components with Covered California.

5 The other thing I'd like to add, we didn't get a
6 whole lot of discussion, is that we do have an inter-agency
7 agreement with Department of Health Care Services and so we
8 do have these pockets of meetings that happen in terms of a
9 data workgroup. So beginning discussions around that and
10 expanding that and also we do meet with DHCS monthly on --
11 they have a new division called Mental Health Substance Use
12 Disorder Division. And so just making connections through
13 that level as well.

14 One more, sorry. Sorry, I lied. There was also
15 just some recommendations that we should talk with Group A
16 as far as the communication outreach plan so that we can
17 incorporate in that communication plan efforts and awareness
18 on CLAS.

19 And there was also another area, I believe in a
20 discussion around a clearinghouse, that we should also have
21 discussion with Group B and Group A based on website
22 development for the strategic plan, I believe, and also --
23 so the clearinghouse.

24 And then also there was another, a separate
25 discussion about buy-in from leadership. Group B has

1 started a conversation around the same topic, around the
2 buy-in from leadership, and so we should connect the dots on
3 those.

4 DR. NOLFO: You guys were working hard.

5 Who is reporting out for Group D?

6 MS. KNIFONG: I am, Kimberly Knifong. I'll spell
7 that for you later.

8 So I had the pleasure to work with a lot of folks
9 around Priority D, which had to do with empowering
10 communities in equity and disparity reduction initiatives.

11 So I am just going to point out some of the really
12 high-level -- I will not do the justice that Marina did for
13 her group because she has all these prompts.

14 I think if you add up everyone's sheets, that's
15 how many we produced. I'm not kidding. It was a prolific,
16 articulate group. And poor Eugenio and Karen, their fingers
17 are probably hurting from copying all that down.

18 So I won't do it justice but I'll just share with
19 you, we only got to Phase I goals. And that was, you know,
20 pretty good of us to be able to drill down to what would
21 like we were moving in the right direction for this
22 priority.

23 So there are three goals written in Phase I and
24 the group wants -- most of the group spoke to adding a
25 couple more. So I am going to read what's in here and I am

1 going to speak to the additions they had.

2 There are some language changes too. So I'm going
3 to read what's here but just know the languages will be
4 changed, probably because it was too subjective. Like
5 "measures of success." What's success to you might be
6 different for me and communities really need to define that.

7 One of the added goals was we need to have
8 community engagement all along, within these goals and
9 within implementation. Design, implementation, evaluation.
10 All the components of a program or initiative and have
11 meaningful community engagement. So there is another
12 subjective word. We really walked through, what does it
13 mean to have "meaningful engagement?" It's not an event,
14 it's a process, so just holding one event is not going to do
15 it but -- so those measures of success, if you will, or, you
16 know, how would we know we're making progress? Look
17 different in terms of how we defined "meaningful
18 engagement."

19 So our first goal said to do an environmental scan
20 of what is out there in the community to address social
21 determinants of health. And in that discussion folks
22 thought, you know, what are you going to do with the scan.
23 We really need to share it and -- a hub, I think we called
24 it a health equity hub on the web. So we pointed back to
25 another priority and I think Marina's group brought up

1 additional information to put in a hub or "a clearinghouse"
2 I think was the term you used.

3 So the hub would help to bring siloed communities
4 or those that are doing work. For example, somebody brought
5 up work with transitional age youth. And being able to know
6 what is going on with all the programs in the nearby
7 community or within the community. Because sometimes they
8 don't even know who is doing what. So that would be helpful
9 for just that purpose. But there's many more purposes I
10 don't really have time to walk through but we'll share them
11 in the notes with leadership.

12 The second one is exploring the opportunities for
13 what initiatives to A, maybe start or initiate if that's
14 needed, if there is a total gap, or to add dollars to or
15 resources to because there's already programs in the
16 community working on things and important things. So what
17 can we do to leverage that and add to it?

18 And then Goal 3 was to -- it says mobilize
19 resources but it's speaking to how do we invest our
20 resources. And I think that was one of the language
21 changes. So how do we invest it?

22 And Goal 4 was embedding community engagement into
23 all levels.

24 And then Goal 5 was measure and monitor this in
25 kind of a quality improvement framework. So you can tweak

1 as you go. Because sometimes what we do, we think we are
2 reducing a disparity but we are actually perpetuating it.
3 So just a continuous quality improvement with the community
4 at the table, really talking about that together.

5 So that's a really high level. There was a lot of
6 talk about replicating. For example, California Reducing
7 Disparities targets five communities right now; how can we
8 replicate to go beyond the five one day?

9 And we talked about language changes. And there
10 was one more -- and Karen, please jump in if I missed
11 anything. I think that's it.

12 MS. BEN-MOSHE: I was going to say, I think the one
13 key change was to number 2, which talks about initiating new
14 initiatives and that there's a lot of work going on on the
15 ground. And the importance of not always starting something
16 new when there are existing things that can be leveraged.

17 MS. KNIFONG: Does any of the group who added to
18 this, the many sheets on the wall in the other room, do you
19 want to add anything else while we're here? Let me put a
20 microphone to you.

21 MS. GLAMBEN: Lilyane Glamben, ONTRACK Program
22 Resources. Just leadership development of community.

23 MS. KNIFONG: So that would look like when you
24 operationalize that out further. We talked about leveling
25 and how often. Just to be an advocate or be at the table

1 and make meaningful recommendation, you don't even know how
2 to move forward. For example, urban planning apparently is
3 very complex. Knowing the rules and regulations for that
4 locality. But how can you be at the table advocating for
5 your community if you aren't even aware or educated on those
6 rules and processes. Is that a fair way to say it? So
7 raising emerging leaders and growing our own.

8 Thank you. Anything else? Thank you.

9 AC CO-CHAIR GÁLVEZ: Fantastic.

10 And we have the E and F group.

11 MS. SISSON: Amy Sisson from the Office of Health
12 Equity. We had eight goals between Strategic Priorities E
13 and F. E relates to infrastructure and F is around capacity
14 for implementation of the strategic plan itself. I just
15 want to make five key points of our highest, like most major
16 changes suggested by the groups that rotated through.

17 First of all on E-3. The group -- this relates to
18 monitoring other plans and seeking opportunities to increase
19 California's role in those plans. We felt like this was too
20 passive and that it should be around seeking to adopt the
21 models that arise from these other communities, whether at
22 the national level or from other states.

23 And we also wanted to add a goal to make this a
24 two-way communication street so it's not just about learning
25 about the models in other states but that we would be

1 sharing information on what's happening in California
2 through our implementation of our own plan.

3 The second key point relates to Goal 4 under E
4 around the health equity zones. A lot of folks didn't
5 understand what we meant by health equity zones and didn't
6 know enough about them, for whether they are a promising
7 enough practice to be implemented. And so I think everyone
8 wanted to take a step back and really hopefully reword the
9 goal to captures the concept of doing place-based work to
10 address health equity but necessarily to call them health
11 equity zones.

12 The third area is moving on to F around
13 implementation capacity. The first goal is around ongoing
14 engagement and accountability regarding the strategic plan.

15 The accountability piece, folks really felt like
16 there is an evaluation role. And so either to emphasize
17 evaluation in the language or to add a separate goal around
18 evaluating implementation of the plan itself.

19 Next relates to F-2, the goal around utilizing
20 fellows and interns in the implementation of the plan.
21 Wanted to make sure that we aren't assuming that there is
22 going to be a ready supply of interns who are stepping in,
23 like from the college level, to do this health equity work
24 and really thinking about moving upstream and developing
25 this pipeline even sooner.

1 And also incorporating folks who are in these
2 disadvantaged/impacted communities. Developing them,
3 getting them into higher education so that they can become
4 part of the workforce that is addressing health inequities
5 because they are actually very highly qualified. They know
6 these communities, they understand the sources of these
7 disparities and they can be part of the solution.

8 And then finally under the last goal under F.
9 This is Goal 4 related to partnerships. The original
10 language relates to identifying and fostering partnerships.
11 And we really felt like the identification process is
12 already underway and really what we need is to develop a
13 process for how to engage these partners. And so just kind
14 of thinking about how we are going to do it as opposed to
15 just doing it. So process-oriented as opposed to outcome.

16 And I think that's it. I didn't invite the group
17 members to add anything since I tried to make a very high
18 level summary.

19 DR. NOLFO: Thank you. And so I am actually going
20 to turn the mic back to you, Sandi.

21 AC CO-CHAIR GÁLVEZ: I wanted to share with you --
22 so one of the things that we kept kind of hearing, and
23 certainly in the report-back I think it was repeated I think
24 pretty much from every group, there's a lot of overlap. A
25 lot of like, this group relates to that group, that Goal 1

1 here relates to Goal B over there, whatever.

2 And so a few of us attempted to make an elegant
3 solution for what we saw as, you know, some overlapping and
4 maybe disjointed order of the way the current plan is put
5 together. So I wanted to share that with you. Not as a
6 "this is the final" or anything like that, as a way to
7 encourage dialogue and see what you all thought about it.
8 So let me -- can I get one of those little things to tack it
9 up? It goes like this.

10 Jeremy, please, can we get some help?

11 He's part of the diverse groups that we needed to
12 have on this advisory Committee.

13 (Laughter.)

14 AC MEMBER CANTOR: That's right.

15 AC CO-CHAIR GÁLVEZ: It's like we need a talk
16 person.

17 AC MEMBER CANTOR: Tall people.

18 AC CO-CHAIR GÁLVEZ: Okay. So I'm looking at the
19 strategies that were -- sorry, what are the A, B and Cs?
20 They're strategic --

21 DR. NOLFO: Strategic priorities.

22 AC CO-CHAIR GÁLVEZ: Strategic Priorities. We saw
23 that a few of them seemed to be kind of over-arching kinds
24 of strategies. So, for example the one that is currently A
25 seemed to be about the strategy of data and communication.

1 Strategy E and F were about infrastructure and
2 capacity building and resources and that sort of thing.

3 And then Strategy B, C and D seemed to be -- and
4 that's where we saw a lot of overlap from the others in B, C
5 and D. Seemed to be about targeted efforts at different
6 groups. So one group being health practitioners, one group
7 being what we now in discussion decided "health partners"
8 might be a good term and the other group being communities.

9 And so we wanted to suggest a different way of
10 organizing the current plan. It wouldn't be throwing
11 anything away that's in the plan, it's just kind of figuring
12 out a different way to organize and we think it might be a
13 little more simple.

14 So just to walk you through. There would be three
15 different kind of groups that would be targeted with
16 efforts, one the health field, one the health partners and
17 one, communities.

18 And types of strategies would be data evaluation.
19 Actually I'm thinking assessment. Hearing the report-backs
20 now I would put assessment here. One would be communication
21 strategies, one would be around capacity building
22 strategies, one would be around sustainability around
23 resources and people and partnerships. And then one -- and
24 this we weren't sure whether this should be separate or fit
25 in somewhere else, would be identifying promising practices.

1 Those are some of the things that we saw, especially in -- I
2 don't remember if it was E or F but in some of those we had
3 identifying promising practices and policies.

4 So for example let's take the creation of the
5 website. That might be -- and this just says "overall." So
6 the creation of the website might be an overall
7 communication strategy for any group. But then, I don't
8 know, the creation of certain training materials. I can't
9 actually remember the wording but it's in the specific
10 strategies. You know, depending on if it's -- for which
11 group it would fit in different groups.

12 I don't know if I'm making any sense. I just kind
13 of wanted to put this out there for discussion. Because
14 this is one of the problems we have been hearing all day is
15 that people are feeling there's a lot of overlap and it's
16 not as clear as it could be. So I just wanted to invite
17 discussion about this. Pat.

18 AC MEMBER RYAN: I think it makes a lot of sense.
19 We were noticing, I was noticing the same thing as we were
20 traveling from group to group. I don't know if it should
21 replace what we have, I don't know that it shouldn't, but as
22 long as you include all of the points it sure makes it a lot
23 easier to figure out what we're talking about, I think.
24 Talk about, you know, you show the different sectors, you
25 show all the things that need to be done. Most of them are

1 cross-cutting across the different goals or policy areas,
2 priorities. So I just think it's a good idea.

3 AC CO-CHAIR GÁLVEZ: Any other ideas or thoughts
4 about this? Aaron.

5 Could we get a couple other mics out here so that
6 we could, you know, facilitate discussion quickly.

7 AC MEMBER FOX: I mean, I would say this is an
8 easier way to go about breaking down the different sort of
9 categories and goals. And I think this definitely was a
10 good start and got us thinking more about how to simplify
11 this. And clearly from -- I was in Group A and I think that
12 our facilitator did a really good job of identifying, you
13 know. Clearly there's like two or three themes here that
14 can be parsed out and easily understood so I would
15 definitely think that this is a good way of proceeding. I
16 think everyone understands what those mean. Whereas in this
17 they were a little more complicated and a little more
18 complex. So, you know, anything that's more understandable
19 I think is always better and simpler so I definitely think
20 this is a good way to proceed.

21 AC CO-CHAIR GÁLVEZ: Dexter.

22 AC MEMBER LOUIE: Like Aaron I agree. I think
23 reorganizing it because of the overlap, putting it in this
24 type of matrix certainly makes it clearer for the reader.
25 Otherwise you're reading the same thing but you are not

1 remembering, did I read that someplace else? How does that
2 apply? So, you know, this really makes it easy. And some
3 things will go all the way across your target audiences.

4 The second thing I wanted to mention was I brought
5 this up -- so I will bring it up. Is that, you know, part
6 of our charge in our new bylaws that we just adopted was
7 that AC Members, we'll we're close to adopting it, Aaron.
8 We're almost there, Aaron, we're close, we're close.

9 (Laughter.)

10 AC CO-CHAIR GÁLVEZ: I want it to take five
11 minutes at our next meeting.

12 AC MEMBER LOUIE: But one of the -- it's in here
13 under one of the sections at the beginning of the
14 responsibilities of AC Members, and that is to identify
15 partners. And so I have given Tamu and Jahmal some names
16 and organizations just to get a rolling start. Because when
17 July 1st comes we are not here. In fact, when we leave here
18 we're not. You know, you kind of shut down after two days
19 of this. So unless you're going to think about this all the
20 way home and keep thinking about it and communicating then
21 we'll double your pay.

22 (Laughter.)

23 AC MEMBER LOUIE: That's it. But anyway, what
24 happens at these meetings, you spend two days here, you
25 leave and you're numb and you don't think about it for

1 another two months. Well, in order for staff here at OHE to
2 get a rolling start as of July 1st we need to give them
3 partners to talk to. Anyway, that's my request is that
4 everyone list five.

5 AC CO-CHAIR GÁLVEZ: Francis.

6 AC MEMBER LU: Yes. I would concur with the
7 comments. I made this comment earlier in the our small
8 group. I think all the work that we have been doing here,
9 hopefully, you know, will really be able to be fit into this
10 template and that the action-oriented strategic priority,
11 you know, language can be preserved. I think it's -- so I
12 think this is an elegant way of organizing this information.

13 AC CO-CHAIR GÁLVEZ: Delphine.

14 AC MEMBER BRODY: Yes. Thank you for your efforts
15 to streamline and alleviate duplication.

16 I am just wondering where we would fit in
17 Strategic Priority D in this picture, empowering communities
18 in inequity and disparity reduction initiatives. Do you see
19 that as being folded into --

20 AC CO-CHAIR GÁLVEZ: I would see it as capacity
21 building --

22 AC MEMBER BRODY: Capacity building.

23 AC CO-CHAIR GÁLVEZ: -- in communities..

24 AC MEMBER BRODY: Okay. Okay, yes. Potentially
25 parts of it could be -- you know, specific things could be

1 put here and here but primarily I think if it's around
2 empowering them it's around capacity.

3 AC MEMBER BRODY: Yes, yes, I agree.

4 AC CO-CHAIR GÁLVEZ: And actually leadership
5 development. That was mentioned as something that was not
6 specifically called out, could be added and put here as a
7 specific activity.

8 AC MEMBER BRODY: Thank you. And I also wanted to
9 voice my support for creating a subcommittee to work on an
10 item within what was -- has been Strategic Priority A, to
11 really look at where the gaps in the data are right now so
12 that we can ensure that those are covered in the plan.

13 AC CO-CHAIR GÁLVEZ: Would anybody else -- Álvaro.

14 AC MEMBER GARZA: I agree. I like the framework
15 and particularly to send it out to the public, the general
16 public who would have a very hard time trying to make sense
17 of the way we have it right now.

18 So the question is, are we suggesting changing the
19 strategic priorities to those 1, 2, 3, 4, 5 that we have
20 here in stead of the 6 that we have here?

21 AC CO-CHAIR GÁLVEZ: I think so. I mean, it's not
22 like the word would be "data." I mean, we would probably
23 use very similar language to what's there --

24 AC MEMBER GARZA: Yes, right.

25 AC CO-CHAIR GÁLVEZ: -- but it's just reorganizing

1 the information that we currently have to fit a simpler
2 framework.

3 AC MEMBER GARZA: So the strategic priorities
4 would be -- Assessment is A. What is the next one?
5 Communication is Strategic Priority B, and so on.

6 AC CO-CHAIR GÁLVEZ: Yes.

7 AC MEMBER GARZA: Okay. I'm liking it, yes.

8 AC CO-CHAIR GÁLVEZ: And whether or not
9 Identifying Promising Practices and Policies stays out
10 separate or maybe becomes part of capacity building or data
11 assessment, you know. I would -- I mean, I would recommend
12 -- I wanted to have a discussion to see if you guys more or
13 less like the idea of trying to reorganize it. This is
14 going to be a starting place and then giving, you know, the
15 permission then for staff to keep playing with it to build
16 it out. But that in concept we could agree with moving in
17 this direction. Pat.

18 AC MEMBER RYAN: Yes, I was just going to say, I
19 mean, I really like the idea. I think we should assume that
20 staff when they are putting this together will not drop
21 anything that is important that people have agreed on. But
22 that we rely on you -- not you -- you to -- gosh, my brain
23 is dead. Collapse those things that are, you know, similar
24 to each other so that we eliminate duplication but that we
25 don't lose all of the points that people have agreed to

1 today.

2 DR. NOLFO: And I just want to say thank you,
3 because I have also been kind of trying to figure out how to
4 make this a little bit more visual and I haven't had a
5 chance to kind of play with it yet. But I guess what I'm
6 thinking is that this is like an addendum to what we have so
7 that we can make this the graphic representation of what we
8 have and we could essentially reference priority goals. So
9 you would have, you know, A-1 at one place and B-2 in
10 another. So that you could look at it and you could see
11 where if you wanted to go into more depth to see the goal
12 completely written out and more of a narrative about it you
13 can go and do that. But from a visual perspective you can
14 just kind of see where it lands on the map.

15 AC CO-CHAIR GÁLVEZ: I think I see it differently.
16 Because I think that could be confusing. I would -- I mean,
17 I'm thinking that there might be a visual representation
18 right at the beginning that would clearly outline it like
19 this and maybe -- but then the actual when it's more spelled
20 out. It would be whatever nice words around Data Assessment
21 and Evaluation and then now there would be goals for the
22 health field, goals for the health partners, goals for
23 communities. And then on the next one that that would
24 become A and then the B page would then be Communication
25 Strategies and then it would have goals for health

1 practitioners, goals for health partners and goals for
2 communities. And just that the grid would match the
3 language. I just think otherwise it could be confusing to
4 have two different, two different visual ways of saying it
5 and different lettering and wording.

6 I do want to get the community in but I just want
7 to know if there was any other committee comments? Hermia.

8 AC MEMBER PARKS: So just to clarify. Under the
9 subheadings that we have we will then identify each of the
10 current priorities and list them under these new
11 subcategories? Okay.

12 AC CO-CHAIR GÁLVEZ: And/or goals.

13 AC MEMBER PARKS: Okay.

14 AC CO-CHAIR GÁLVEZ: Yes. Linda.

15 AC MEMBER WHEATON: This is Linda Wheaton. Can
16 you clarify the distinction between the sustainability
17 category and the others?

18 AC CO-CHAIR GÁLVEZ: Sure. So sustainability
19 would capture the language that we had in the different
20 priorities around resources, financial resources, and then
21 people, so we had workforce development and interns. We
22 also had -- I can't -- and I don't remember, sorry, it's
23 been a long day. I don't remember if it was an addition, I
24 think, to E and F around this necessity for partnerships.
25 Maybe it was a different one, I'm sorry, I don't remember.

1 But there was a suggestion around really focusing on
2 building partnerships. I see that as a resource. So those
3 are like the -- in the sustainability type issues.

4 Versus promising practices, there were things
5 around the health equity zones, the national -- help me.
6 The national plan. The National Prevention Plan, is that
7 what it's called. And I think there might have been some
8 other specific practices that, you know, that were mentioned
9 and then some others suggested in the last two days.

10 So I am personally not sure whether this needs to
11 be a separate category or feed under the other ones but I
12 noticed that it was in there in a few different places so
13 that's why I stuck it out.

14 The other one that I just forgot that I wanted to
15 mention was also around institutionalization. So capacity
16 building things around training and technical assistance but
17 maybe about the embedding language in funding streams, which
18 was in at least three different priority areas. You know,
19 we have to figure out whether it's a sustainability effort
20 or whether it's a capacity building effort. I would leave
21 it up to the best minds out in staff to figure that out.
22 But the institutionalization ones needs to figure out where
23 it would go in here. Jeremy.

24 AC MEMBER CANTOR: Thank you. A couple of things.
25 Just I wanted to kind of weigh in on the dialogue with you,

1 Sandi, in terms of kind of the extent to which this is a
2 modification versus just kind of taking what we have. You
3 know, I really want the staff to feel comfortable
4 considering we're sort of, you know, reorganizing what we
5 have pretty fundamentally or substantially here. And that
6 because I think there is this issue of these strategy
7 elements popping up in multiple different places and I think
8 there is a real need to group them together. I think that
9 will really strengthen our approach.

10 That said, I think it could totally make sense to
11 have this as a visual cover and then have deeper explanation
12 but just so long as it's kind of organized in the same way.
13 So just to reiterate that.

14 Just one point I made; I don't want to get deep
15 into the practices and policies but I actually think it's
16 important to call that one out. I feel like it's one of the
17 -- it should be one of the things that we keep kind of at
18 the forefront of our thinking is how are these things being
19 institutionalized? And so -- although I could see how that
20 might fit in with capacity building, I think capacity
21 building is really, for the most part focused on people, and
22 policy and practice is really sort of focused on changing
23 institutions in a fundamental way. So, you know. I mean,
24 it could maybe fit under sustainability but I really, you
25 know, at least at first glance, like that as an element.

1 The one other thing I think just to clarify for
2 folks is that there -- it's organized in Phase I and II
3 right now and that's something for staff to sort of figure
4 out how that fits in here in terms of kind of thinking of
5 Phase I as the low hanging fruit, the immediate
6 opportunities and then the longer term and how that kind of
7 works into this grid. It may be that there's kind of -- you
8 know, they're color coded, there's two boxes in each area,
9 one that's Phase I and Phase II. But that idea I think we
10 wanted to preserve in developing this.

11 AC CO-CHAIR GÁLVEZ: Yes, thank you for reminding
12 me, I forgot about that part.

13 Okay. If there aren't any further comments I'd
14 like to get public feedback on, you know, and your
15 suggestions and being okay with moving forward with the
16 reordering of the current content. If anybody would like to
17 provide feedback.

18 DR. N. KING: Do I have to stand up?

19 AC CO-CHAIR GÁLVEZ: I'm doing the executive
20 decision; no, you can stay right there.

21 (Laughter.)

22 DR. N. KING: Thank you. Nicki King.

23 I actually want to encourage you to -- if you want
24 to use the matrix I think it's a good thing. Particularly
25 for operationalizing it and for seeing where you've got

1 overlaps and where you've got potential conflicts. I think
2 it's a -- I think it's a great tool. But I want to
3 encourage you for your formal strategic plan to keep a
4 narrative focus because most of the people who look for
5 strategic plan kinds of things are going to be looking for
6 narrative and the explanation that goes with narrative. So
7 this may be a great way to make it real, make it happen,
8 move forward and tell how you're going to move forward, but
9 I don't want you to lose the strong narrative aspects that
10 you've got down here now.

11 AC CO-CHAIR GÁLVEZ: And I'm sorry if that wasn't
12 clear. The intent was definitely to keep the narrative, it
13 was just to reorganize the narrative in a different way so,
14 you know. What is currently Strategic Priority A would
15 change. It wouldn't be whatever it is now, it would be
16 something around data assessment and evaluation and then the
17 goals would change and be reflective of this and so on and
18 so forth. But the narrative would still be there. It's
19 just reorganizing all the information so that it's a simpler
20 way of thinking about it.

21 Would anybody else like to provide feedback?

22 MR. LEONI: Hi, Steve Leoni here. And I was lucky
23 enough to be in the group where some of this was thought
24 out. It's a great idea. And I think by making the
25 narrative a little more comprehensible and condensed like

1 that you will actually -- it will be easier for people to
2 read this document, which is what you want. You want people
3 to be not afraid of it or not get lost after the second page
4 because there's all this repetition and where was I. I hate
5 that. I mean, I noticed that as I was looking at it it was
6 like, wait a minute, I'm going over and over and back and
7 forth and around. I think this makes it more succinct and
8 kind of lays out a roadmap, if you were, as for the
9 narrative. It's great.

10 AC CO-CHAIR GÁLVEZ: Anybody else?

11 MS. GIOVANNINI: Domenica Giovannini. And I want
12 to agree. I know that the communication piece came up quite
13 a bit in a lot of different areas and for me that is an
14 over-arching stand along objective that needs to be
15 addressed throughout the entire strategic planning process
16 is how the information is going to be communicated and
17 packaged to communities and how that is all going to happen.
18 So I kind of like this setup a little bit better because
19 again I think communication is like its own over-arching,
20 necessary strategic direction.

21 MS. BENHAMIDA: I just have a question.

22 AC CO-CHAIR GÁLVEZ: Would you identify yourself.

23 MS. BENHAMIDA: Laurel Benhamida, REMHDCO Steering
24 Committee and Muslim American Society-Social Services
25 Foundation.

1 A survey was issued after the webinar that you
2 have, it's due today. And that either -- as you said, the
3 whole thing or comments. But how does this change here
4 impact the validity of that survey and the process of
5 getting engagement from people who aren't here today? I
6 mean, this is a huge, diverse state.

7 AC CO-CHAIR GÁLVEZ: Tamu, do you want to answer
8 that or do you want me to answer it?

9 DR. NOLFO: I guess I would say that it doesn't
10 change because we are not actually changing the content, we
11 are just reorganizing it in a way that it can be more user-
12 friendly. So that's what we are asking people in the survey
13 to comment on is essentially the content. Does it seem like
14 we're headed in the right direction, are there goals that
15 you feel like are missing or, you know, that are there that
16 shouldn't be there, that kind of thing.

17 And so I think -- I feel pretty confident that I
18 can use the information that people are providing either in
19 the survey or letters that they are writing or emails that
20 they are writing, to incorporate into this final version.

21 DR. BENHAMIDA: My mind moves slow as I become
22 older and older and so I need a long time to absorb,
23 although I love this kind of layout. And there are people
24 here whose minds work faster and they're saying good. I
25 think maybe the way the survey went out it was difficult for

1 organizations with little capacity to slog their way through
2 and that's why it was good that you said, you don't have to
3 do the whole thing. Although maybe that message could have
4 been stronger from the beginning. But this might be
5 something that later could be also, once you have it tweaked
6 and refined, that might be helpful for people in terms of
7 understanding what the process -- what turn the process is
8 taking.

9 DR. NOLFO: I just want a point of clarification.
10 Are you saying that it would be good if we put it out for
11 additional public comment in a survey?

12 DR. BENHAMIDA: Well you might get more
13 information from people who just couldn't make your
14 timelines with the complexity and the, you know, sort of
15 academese or mental haalthese of the -- so.

16 DR. NOLFO: So the reality is that I am going to
17 need to incorporate all of this feedback within the next two
18 weeks in order to make it up the approval process that it
19 needs to go through in order for us to stay in compliance
20 with the code that created this office. So if that doesn't
21 happen within the next couple of weeks then we are going to
22 run into some problems and so that's why today is the
23 deadline for the feedback.

24 But what we recognized was that, you know, this
25 was a short-ish time period to do strategic planning. The

1 implementation is going to roll out. And so we are going to
2 start with what can we commit to. The low hanging fruit
3 around implementation. And so -- oh, I'm sorry, I need to
4 wrap it up.

5 But in terms of being able to further engage
6 stakeholders around what stakeholders would like to see in
7 the implementation plan, we have some time to do that. And
8 so yes, we can definitely issue additional surveys and have
9 other forums, have meetings, that kind of thing, in order to
10 really get that kind of rich conversation that we need to
11 have with the stakeholders.

12 AC CO-CHAIR GÁLVEZ: Is there any more community
13 feedback about this specifically because we need to -- we're
14 going to lose quorum in a minute and we need to take a vote
15 before we lose people. So if there is no more feedback --
16 any feedback?

17 And please fill out speaker cards. So staff, if
18 you could give speaker cards to all the folks that spoke.
19 We need to make sure we have their names properly in the
20 record.

21 So would someone like to make a motion?

22 AC MEMBER OSEGUERA: I move to move forward with
23 the modifications that have been suggested for the strategic
24 plan.

25 AC CO-CHAIR GÁLVEZ: All those in favor please

1 raise your hands.

2 (Show of hands.)

3 AC CO-CHAIR GÁLVEZ: Any opposed?

4 Okay, motion carries. So for those of you that
5 have to go, safe travels. Thank you so much for your input.

6 And I really want to reiterate to the public, this
7 has been a very quickly moving process. I think for the
8 next strategic plan it will be a lot more inclusive, a lot
9 more comfortable for all of us, AC members included. So
10 thank you for bearing with us and thank you all for
11 participating and bearing with it as well. Bye, you guys.

12 So just quickly. So the things that I would love
13 to try to have quick conversations about before we go are,
14 one, the process for getting -- what is going to be the
15 remaining process for getting any more feedback once any
16 final changes are done and if there is such and then a
17 little opportunity to talk about our next meeting.

18 DR. NOLFO: So Sandi was just asking around
19 additional feedback or input. And fortunately we have reams
20 and reams of it. And so it will be synthesized and we will
21 make sense of it and have the version that we begin to move
22 through our approvals process within the next couple of
23 weeks.

24 AC CO-CHAIR GÁLVEZ: Okay, question for staff.
25 Has there been thought given already to when the next

1 meeting of this group will be or is that far off in the
2 horizon?

3 DR. NOLFO: That is completely up to your
4 discretion.

5 AC CO-CHAIR GÁLVEZ: Okay.

6 DR. NOLFO: To give us some feedback on.

7 AC CO-CHAIR GÁLVEZ: I personally would feel that
8 no sooner than September would be appropriate since given
9 that July 1 is when the plan is due, August, probably a lot
10 of people are out. I mean, I think September or October
11 would be the most appropriate time.

12 I did want to give folks a chance to talk a little
13 bit about what you might want to see happen in our upcoming
14 meetings, if there's any presentations you would really like
15 to have. How you would like to structure our upcoming
16 meetings together. In our remaining time together today.
17 Dexter. Francis, sorry.

18 AC MEMBER LU: I think, obviously, just the plan
19 is going to come out in July for public comment, right, for
20 30 days, or no? Okay. Okay. So no public commentary to be
21 reviewed and so on. Okay, got it.

22 AC CO-CHAIR GÁLVEZ: Any other thoughts? Álvaro.

23 AC MEMBER GARZA: Yes. My suggestion is if we're
24 meeting -- I think I heard you say September or October. So
25 closer to like two months before to put out an email to all

1 of us about agenda items and building the agenda around that
2 time. I think it's kind of too early right now to do it in
3 my, in my view.

4 AC CO-CHAIR GÁLVEZ: Okay. I agree. Just if
5 there are some thoughts we should start moving on I just
6 wanted to give you the chance. Patricia. Patricia.

7 AC MEMBER RYAN: I mean, the only thing that comes
8 to mind, I agree with Álvaro, is maybe start to prioritize
9 some of the work that we can participate in advising the
10 department on. You know, after the plan is out really take
11 a look at the plan and is there any additional help, are
12 there subcommittees that we can put together to help
13 facilitate the follow-through on the plan.

14 AC CO-CHAIR GÁLVEZ: Anyone else like to suggest
15 anything?

16 Would anyone like to make any final comments about
17 anything related to this process together? Francis?

18 AC MEMBER LU: In terms of the meeting scheduling
19 process. I'm just -- I'm just wondering if there is any
20 possibility that once it's determined within the OHE as to
21 dates that are possible there, would it be possible to send
22 out a Doodle poll to get our input as opposed to the dates
23 just being -- whatever Debra has been doing. Getting input
24 from people about our availability is helpful, whether that
25 be a Doodle poll or some other mechanism. I think we should

1 try to optimize the number of people here for obvious
2 reasons.

3 AC CO-CHAIR GÁLVEZ: I believe that that's been
4 the process. At least, you know, a long-range Doodle poll
5 was done. But I think having a focused Doodle poll for like
6 the upcoming meeting in September or October, as soon as
7 possible to get that poll out would be helpful.

8 Any other comments? Mr. Miller, I will have you
9 be last. Would anybody else like to make comments?

10 Would anybody from the public like to make any
11 final comments?

12 MS. GLAMBEN: Lilyane Glamben from ONTRACK Program
13 Resources. I had the delight of missing your morning
14 session because I was at the Mental Health Matters event. I
15 just want to encourage if at all possible, ways in which the
16 committee can somehow integrate these kinds of incredible
17 opportunities. It was very consumer driven and it was
18 inspiring, invigorating. And those kinds of opportunities
19 for stakeholder engagement, you know, are just worth their
20 weight in gold.

21 AC CO-CHAIR GÁLVEZ: Yes, thank you. And we
22 apologize for the overlap. We unfortunately didn't find out
23 about the event until after this meeting was scheduled and
24 we were not able to reschedule it. We did not want to try
25 to have both -- people not have to choose one or the other,

1 including AC members.

2 Anybody else from the public want to make any
3 comments about anything?

4 MS. D. KING: I'd like to make a comment about
5 what Lily said. The advisory committee, when I ask for your
6 blackout dates, it would be very, very helpful if there are
7 annual meetings, quarterly meetings, big events that you
8 know of, because we don't know everything that's going on
9 around the state that impacts you. So please provide me
10 with those things and I can calendar them, yearly,
11 quarterly, monthly. Whatever those big issues are that you
12 need to be at please let me know. Thank you.

13 AC CO-CHAIR GÁLVEZ: Yes.

14 DR. BENHAMIDA: And I spoke with Debbie about this
15 earlier but it's a chance to say it again. This is a
16 wonderful venue but I would like to see going forward after
17 the summer, meetings in community-based locations.

18 AC CO-CHAIR GÁLVEZ: Can you say more about what
19 that means?

20 DR. BENHAMIDA: To me it means the Croation
21 Cultural Center in Sacramento; it means Salaam, which has,
22 you know, high-tech lecture halls, which is for the Muslim
23 community. It might mean a Sikh gurdwara. It means getting
24 people out of these places and into places where people are
25 that are experiencing disparities.

1 AC CO-CHAIR GÁLVEZ: All right, thank you.

2 Any other comments before I pass it to Jahmal?

3 Okay, Jahmal, you're on.

4 OHE DEPUTY DIRECTOR MILLER: Keep it brief because
5 I know it's time to go. I just once again thank our
6 advisory committee members for being so flexible and just
7 committing in eight months, to me, four times for two days.
8 That's a huge sacrifice. And I really appreciate the time
9 and your flexibility in really addressing this tight
10 timeline that we are up against. But I am really excited
11 about just what has evolved and what we are -- the
12 information that we have to work with to take back to the
13 office and to really refine it.

14 And even though we won't be meeting until, you
15 know, the end of the summer, we are going to continuously
16 engage with you as individual advisory committee members.
17 You know, pulling you in with respect to some of the
18 activities we are going to have going on in the latter part
19 of the spring and across the summer.

20 My tentative date around the hearing that I have
21 going before the Senate Rules Committee, I'll keep you all
22 posted on that. And any other opportunities for you guys to
23 be, to be involved. So I really appreciate the hard work.
24 And this is an important time in our history in California
25 and this plan positions us to do great things.

CERTIFICATE OF REPORTER

I, John Cota, an Electronic Reporter, do hereby certify that I am a disinterested person herein; that I recorded the foregoing California Department of Public Health, Office of Health Equity Advisory Committee meeting; that it was thereafter transcribed.

I further certify that I am not of counsel or attorney for any of the parties to said meeting, nor in any way interested in the outcome of said matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 27th day of May, 2014.

JOHN COTA

CERTIFICATE OF TRANSCRIBER

I certify that the foregoing is a correct transcript, to the best of my ability, from the electronic sound recording of the proceedings in the above-entitled matter.

May 27, 2014

RAMONA COTA, CERT**478