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

THURSDAY, MAY 3, 2018

10:00 A.M.

Reported by: Rebecca Hudson

APPEARANCES

COMMITTEE MEMBERS

Sergio Aguilar-Gaxiola, MD, PhD

Rocco Cheng, PhD

Sarah de Guia, JD

Donnell Ewert, MPH

Lisa Folberg, MPP

Sandi Galvez, MSW

Virginia Hedrick, MPH

Carrie Johnson, PhD

Jo-Ann Julien, MEd

Manel Kappagoda, JD, MPH

Patricia Lee, PhD

Dexter Louie, MD, JD, MPA

Linda Wheaton, MURP, AICP

Michael Witte, MD

APPEARANCES

STATE OFFICIALS/STAFF

Karen Smith, MD, MPH, CDPH Director and State Public Health Officer

Dante Allen, Senior Communications Officer, OHE

Marina Castillo-Augusto, Chief, Community Development and Engagement Unit (CDEU), OHE

Maricela Cervantes, OHE intern

Noralee Cole, SSA, OHE

Rafael Colonna, Research Scientist I, OHE

Lianne Dillon, Policy Associate, HiAP, OHE

Dorette English, Health Specialist I, OHE

Cullen Fowler-Riggs, LGBTQ Population Lead, OHE

Carol Gomez, AGPA, OHE

Solange Gould, DrPH, MPH, Chief, Health Equity Policy and Planning (HEPP) Unit, OHE

Benjamin Hicks, Research Scientist I, OHE

Meredith Lee, Health Program Specialist I, HiAP, OHE

Laura Leonelli, Health Program Specialist I, CDEU, OHE

Meredith Milet, Research Scientist III, OHE

Dana Moore, OHE Assistant Deputy Director

Maureen Njmafa, CDEU, OHE

Tamu Nolfo, PhD, Senior Project Manager, OHE

Peter Oh, PhD, Chief, Health Research and Statistics Unit (HRSU), OHE

La Roux Pendleton, OHE Acting Deputy Director, CRDP Lead, CDEU, OHE

William Porter, Health Program Specialist I, CDEU, OHE

Edward Soto, MS, Health Program Specialist I, OHE

Daniel Woo, MPH, Health Program and Policy Specialist, OHE

ALSO PRESENT

Angelo Williams
California Black Health Network

INDEX

INDEX

PROCEEDINGS

10:10 a.m.

ACTING DEPUTY DIRECTOR PENDLETON: Good morning, everyone. We're going to go ahead and get started so if everybody can take their seats.

Operator?

THE OPERATOR: Yes?

ACTING DEPUTY DIRECTOR PENDLETON: Could you please start the meeting?

THE OPERATOR: I will transfer you in with music. When the music goes off, you'll be live. One moment, please.

ACTING DEPUTY DIRECTOR PENDLETON: Thank you.

(Teleconference transfer music played.)

ACTING DEPUTY DIRECTOR PENDLETON: Good morning, everyone.

(Greetings in unison.)

ACTING DEPUTY DIRECTOR PENDLETON: My name is La Roux Pendleton. I'm actually the Acting Deputy Director of the Office of Health Equity. I've seen some of these faces before so I just wanted to introduce myself in this new capacity. I'm still the Lead of the California Reducing Disparities Project.

Tamu could not be with us this morning so we're going to be making some changes to the agenda. We'll walk

you through those changes before we get started today.

I want to start with welcome and introductions. So, I want to go to my left here and we'll do a roll call for the people at the table.

OHE ASSISTANT DEPUTY DIRECTOR MOORE: Dana Moore, Assistant Deputy Director for the Office of Health Equity.

AC MEMBER EWERT: Donnell Ewert, member. I represent Shasta County Health and Human Services Agency.

AC MEMBER FOLBERG: Lisa Folberg.

AC MEMBER CHENG: Good morning. Rocco Cheng, psychologist.

AC MEMBER JOHNSON: Carrie Johnson, United American Indian Involvement.

AC MEMBER LEE: Patricia Lee, Department of Health Care Services.

AC MEMBER KAPPAGODA: Manel Kappagoda, ChangeLab Solutions.

AC MEMBER DE GUIA: Sarah de Guia, the California Pan-Ethnic Health Network.

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

AC MEMBER HEDRICK: Good morning. Virginia Hedrick, California Consortium for Urban Indian Health.

AC MEMBER AGUILAR-GAXIOLA: Good morning. Sergio

Aguilar-Gaxiola, UC Davis Center for Reducing Health Disparities.

AC MEMBER WITTE: Good morning. Dr. Mike Witte. I'm the Chief Medical Officer at the California Primary Care Association representing the Federally-Qualified Health Centers around the state.

AC MEMBER JULIEN: Good morning. Jo-Ann Julien, Office of Health Equity, Public Health Services, County of San Diego.

AC MEMBER LOUIE: Dexter Louie, a community physician, San Francisco.

CDPH DIRECTOR SMITH: Karen Smith, Director of the California Department of Public Health.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Hi.

Are there any members that have called in on the phone? Operator, is there a way to open up the phone lines?

(No audible response.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: All right. I'll keep moving.

So, I wanted to go over the agenda for today and we'll show those places where we've made some changes here. So, I'll be facilitating today's meeting in Tamu's absence.

And we are going to continue with the 10:40 presentation from the California Black Health Network. I

will be introducing our speaker during that time.

And I think what we'll do is we'll do from 11:45 to 12:45 -- that's the first change there for lunch. We can make that an hour, and then we're going to start again at 12:45 for the updates for the OHE units to create more time in case there's more questions and answers.

And then, we're going to go into the SWOT analysis later this afternoon.

And for the 3:30 time where we're planning for the September 16th meeting, we'll probably hold on that for a little while. We'll meet internally and have some discussions and then reach back out so that we can get your feedback in the planning for that next meeting but we probably won't do that today in person.

And so, those are the changes that we're going to make to the agenda today.

So, I wanted to go ahead and get approval or changes for the February 13, 2018, meeting minutes if everybody wants to take a moment to review those minutes and let me know if there are any changes or, if there are no changes, we can go through public comment and then approval of the minutes.

Rocco, you have a comment?

AC MEMBER CHENG: Yeah, page three. I think it's probably a typo on the first full paragraph "HOB" that

should probably be "a show on HBO."

OHE ACTING DEPUTY DIRECTOR PENDLETON: Okay. You said there's a typo on page three. Okay. Okay, HBO. Got it.

Does anyone else have any other changes for the minutes?

(No audible response.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: No? All right.

Any public comment about the minutes from the last meeting either in person or on the phone?

(No audible response.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: No? All right.

And so, we'll go through voting to approve the minutes. Does anyone make a motion?

AC MEMBER AGUILAR-GAXIOLA: So moved.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Second?

AC MEMBER CHENG: We don't need a second.

OHE ACTING DEPUTY DIRECTOR PENDLETON: I don't? Okay. Great. All right. So, the minutes for the February 13 meeting have been approved.

And then, we need to move to the approval of the minutes for the sustainability subcommittee from March 20. Any changes to those meeting minutes? If people need a

second, let me know.

AC MEMBER LOUIE: Dexter Louie. My question as to the subcommittee minutes, there was a comment about changing the bylaws and I pulled the bylaws and renewed it and I think it gives AC its specific goals and responsibilities and the fact that we are supposed to provide input to OHE to help them in their mission. But I also read in there that it's a legislative mandate, so a change in the bylaws may be difficult. Thank you.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Any other comments, changes to the subcommittee minutes?

(No audible response.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: If not, will someone make a motion to approve?

AC MEMBER JULIEN: So moved.

AC MEMBER AGUILAR-GAXIOLA: And I second that.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Okay.

Jo-Ann made a motion to approve and Sergio seconded that so those minutes are now approved.

Okay. And now we're going to go right into our elections for Chair and Vice Chair. So, I want to first start with Sarah de Guia, who has been nominated for the new Chair. If you want to provide a few words, Sarah, and then I'll had it over to Manel, and then we'll go through our process.

AC MEMBER DE GUIA: Thank you so much for the consideration and particularly for Lisa for the wonderful nomination at the last meeting. I just thought I would kind of point out some of you I know pretty well, others of you I'm still getting to know.

So, just a little bit about my background and kind of interest in this position. So, I do bring about 17 years of public policy experience in health equity. Early on, I began my career at the Mexican American Legal Defense and Education Fund looking at issues like language access, immigrants' rights, and women's health issues.

And then, Latino Issues Forum, where I also continued to look at the growing Latino community and really identified what are some of those policy issues that we can be moving forward for California.

I came across the California Pan Ethnic Health Network as we sponsored legislation at MALDEF and really appreciated the connection of the idea and the vision that CPEHN has, which is bringing together the similarities and the connections of communities of color in California who are now the majority of the population and really making sure that our policies and resources are dedicated and focused on the emerging majority of Californians.

And I, myself, am Mexican and of European or White background, and so, for me, it's really important to kind

of -- again, sort of find those similarities and differences as a biracial, bicultural woman.

So, I have great knowledge of the legislative, budgetary, and administrative processes and I have really -- we, as CPEHN and I myself, have really good relationships with policymakers across the state.

And so, I'm hoping to bring those connections and that knowledge to this body to help us think about -- as we envision the next five years of what the Office of Health Equity can and should be doing, that I think having that connection and having those -- that knowledge could be really important and influential to our work, as well.

And, as the Executive Director of CPEHN, I also bring a wealth of staff and the connections that we have as an organization up and down the state. So, we have connections to over 30 organizations that work really directly with communities and immigrants' rights, youth, reproductive justice - many different communities across the state.

And so, my hope is that, as we continue to grow as an Office and grow as the Advisory Committee as well, that we're really tapping into those networks and that expertise that we bring to help guide the vision of the Office of Health Equity.

And so, I'm hoping to be able to work with all of

you in order to really leverage those strengths and those connections to help our Director of Public Health and the new Director of the Office of Health Equity to really highlight those issues and make them a priority for the state of California.

So, thank you so much for your confidence.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Thank you, Sarah.

I want to invite Manel Kappagoda to make some remarks, as well.

AC MEMBER KAPPAGODA: Thank you very much.

So, like Sarah, I've been doing work in this field for many years. It's a little shocking when I think about it but twenty years. Twenty years ago, I graduated from law school and started working as an attorney at the San Francisco AIDS Foundation, and then moved over to doing legal services work at the East Bay Community Law Center in their Health Law Project.

I wanted to move into doing more systemic work looking at policy assistance and environment change, looking at the social determinants of health, so I went back and got a master's in public health, then moved over to the San Francisco Department of Public Health, where I worked on one of the first health impact assessments, the ENCHIA Project in the Mission District of San Francisco, and also worked at

the California Program on Access to Care with UCOP.

And all that led me to move to ChangeLab Solutions, where I've been for eleven years, focusing on a whole range of issues but all related to thinking about how we can address chronic disease, particularly in communities that suffer the greatest burdens related to chronic disease, using policy systems and environmental change.

So, that's my professional background. My personal background, like Sarah, is that I am also bicultural - South Asian and European background - and have also personally in my family dealt with physical and mental disabilities and differences that, I think, have given me a certain perspective on the work that we're all doing and the work that this Committee needs to do.

I'm really excited about the opportunity to have a leadership role on this Committee and think about how we can better support the work of the Office of Health Equity. My work at ChangeLab Solutions is national, and I think this Office is a real jewel nationally and needs -- the work of the Office needs to be elevated.

I do a lot of work at the moment with the CDC and with the Robert Wood Johnson Foundation, and I feel like those organizations need to know more about this Office and the work that's happening here, and this Committee needs to be doing everything we can to elevate the incredibly

valuable work that's happening. So, thank you.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Thank you.

Okay, now I'd like to open it up for any public comment before we get into our voting. So, I want to start to see if there's any public comments in the room.

(No audible response.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: Operator, can you open up the phonelines, please, to see if there are any comments on the phone?

THE OPERATOR: Yes.

If anyone has a public comment, please press Star 1 at this time. Star 1 if you have a public comment.

(No audible response.)

THE OPERATOR: No one has queued up.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Okay. Thank you.

THE OPERATOR: Yes, we do. We do have a public comment from the phone. Sandra Galvez, please go ahead.

AC MEMBER GALVEZ: Good morning, fellow Commissioners. I've been on since we started, I just wasn't able to announce myself.

I just wanted to say that I just wholeheartedly support both candidates for our Chair and Vice Chair. I've worked with both ladies in the past and think they would be wonderful in these roles. I just wanted to say that.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Thank you.

Are there any more public comments on the phone?

THE OPERATOR: There are no public comments on the phone at this time.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Okay. All right.

(CDPH Director Smith and OHE Acting Deputy Director Pendleton confer off mic.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: Operator, is it possible to have Sandi's line open for the entire meeting?

THE OPERATOR: Absolutely. In fact, I can open up -- the instructions are to request the Star 1 but do you want me to open up the entire conference?

OHE ACTING DEPUTY DIRECTOR PENDLETON: Just Sandi's line, if possible.

THE OPERATOR: Just Sandi's line? Okay. Will do. Thank you.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Okay.

Now we'll go into our voting process and I'm going to start with my right, here.

AC MEMBER LOUIE: Dexter Louie. I support the slate.

AC MEMBER JULIEN: I fully support and endorse and I think they're both great. I think they'll do a great job

and I'm looking forward to how it works out but I'm optimistic. I support.

AC MEMBER WITTE: Full support, as well. And I'm really excited about the fact that we're going to be having some -- obviously some experienced and really articulate leadership. Thank you, both.

AC MEMBER AGUILAR-GAXIOLA: I'm very grateful that both of you are willing to do it, as well. I'm very impressed with the work that you have done. I know the work, Sarah, very closely and it's great to have the leadership, so I totally endorse it.

AC MEMBER WHEATON: I support both, as well, and appreciate your time and commitment.

AC MEMBER LEE: Go girls.

(Laughter.)

AC MEMBER LEE: I also support both.

AC MEMBER JOHNSON: Yes. I support as well. Thank you.

AC MEMBER CHENG: I also support both nominations.

AC MEMBER FOLBERG: I support both nominations and really appreciate your willingness to be a part of this changing time at OHE.

AC MEMBER EWERT: Ditto. I'm very glad somebody's willing to step up and take the mantle.

OHE ACTING DEPUTY DIRECTOR PENDLETON: All right.

So, that was unanimous support both Sarah and Manel and welcome.

We look forward to working with you in this new capacity. And I've worked with Sarah on the CRDP and Manel in a previous life doing diabetes work, so I look forward to how we'll work together in, like Donnell said, this -- or I think maybe it was Lisa -- in this very changing time and transition that we're experiencing in OHE. So, thank you.

(Applause.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: Okay. We're running a little early on schedule here, so I will transition right now into presenting our next speaker. So, I'm going to take a few minutes to queue that up. So, thank you.

(CDPH Director Smith and OHE Acting Deputy Director Pendleton confer off mic.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: I'm actually going to make a quick change here. We're going to create some space for Dr. Smith to speak. So -- and, after that, then we'll go into the next presentation.

CDPH DIRECTOR SMITH: Sorry to disrupt the agenda, but I initially didn't think I was going to be able to be here at all so they scheduled around -- without me and now I'm able to be here but just for a little bit.

So, I did want to take the opportunity to just

kind of give you a non-update update --

(Laughter.)

CDPH DIRECTOR SMITH: -- in that there's not a whole lot to tell you in terms of things having moved. We are -- I'm -- and, actually, Tamu gave me some things she wants to be sure I talked to you about.

First, let me just talk about the Director of the Office -- the Deputy Director for the Office of Health Equity position. We're sort of -- we're in a position where we're taking -- people are interested and we're interested in hearing from them. We haven't posted the position yet because one of the things that I'm very interested in doing is having -- I think I mentioned last time - we're going to have a full-day retreat with staff.

And the intent of that is to bring everybody together to really talk about what people are currently working on and get their input on what direction should the Office move over the next five years and most especially during this transition year.

Also, to talk with the entire staff around the budget and what the realities of the budget are. And so (laughter), one of the things, too, is your plea for budget transparency. I share that plea. We are working really hard to -- the budget for health equity is a complicated one because it has a lot of different funding streams and staff

are doing a lot of different things. So, we're actually in the process of clarifying that right now.

And you heard her introduce yourself -- herself. Dana Moore is our new Assistant Deputy Director and, as in our other centers, the -- one of the primary roles of the Assistant Deputy Director is that administrative role. So, Dana has a lot of experience as an administrator and administrating complex budgets.

And so, we're much closer to having a better understanding of the budget. We're still tracking down a couple of things and then trying to tie it to actual activities. And, once we have that, we will share that. You have some of the data. You have, like, the numbers, and -- but it doesn't really tell the story of -- I -- you know, I find spreadsheets of numbers in a budget less than helpful because what I really want to know is what is the money doing, not so much what is the money. So, we're working on that.

And then, I really want to have staff have the first opportunity to talk about what they feel should happen with the Office. We will also, then, be talking to the Advisory Committee, whether we do it in the whole group or with your executive committee. I don't know; I'm agnostic on that. We want everybody's input.

After that, we really will be developing a --

whether it's a strategic plan or a vision or some combination thereof that will guide the development of things over -- I think it's very important for an entity like the Office of Health Equity to have a set of principles by which they function, an understanding of their mission, but then also priorities because everybody has an idea of what we should be doing. That's true of all 200-plus of our programs. Everybody knows exactly what we should be doing.

That's not always tied to what's realistic. One thing we absolutely should be doing is our statutory mandate. That's nonnegotiable. You have to carry out your statutory mandate, and so that will be kind of the piece at the top, but there are a lot of different ways to do that.

And, for me, an Office -- we have a -- as I said, we have over 200 programs. We run a lot of programmatic activities, we fund many more programmatic activities. There are very few places in the Department with an explicit mission to create policy - not to back into policy by what you pay for, which is kind of how it happens most of the time in reality, but to actually say our job is to think about high-level policy.

Equity is a such a foundational issue in health and in public health that I don't think we're -- this is my take and I'm going to be listening to everybody's input, but I don't think the -- that the Office is fully realizing its

potential to really have that policy discussion. It's a small Office; it will always be a small Office.

At least we have one, right? Texas has completely dismantled its Office of Minority Health and not put anything in its place, and there's been discussions at the federal level about whether we need one. California needs the Office of Health Equity and now it's about how do we take a small Office and maximize its impact.

And policy, for me, has always been one of -- and, I mean, you know, actually whether that's policy papers or, you know, really deep dives into certain policy areas. Recommendations are challenging when you're in the government, but we can absolutely do policy analysis that can then give our partners tools to use for their advocacy and that sort of thing. So, that's one of my most profound wishes for the Office is to mature into an Office that's actually providing substantive policy in areas of -- where we can get the biggest bang in terms of increasing equity.

So, that conversation will start with the staff, but then it will also include the members. I want to have some sense of where we're going with the Office before we bring in a new Director. And that doesn't mean we're not going to be recruiting, but knowing the direction that we're going to go is going to shape the person we're looking for because we want somebody who is really going to click with

where the staff wants to go, where the Advisory Committee wants us to go. And so, that -- it will play a role in that.

It's also not clear -- so, first of all, it's a governor's appointment and so it has to go through that appointment process, and the governor's office and the Agency are actually in the process right now. There's a lot of movement, as you can imagine - people leaving, et cetera, with the transition - and so they're having to prioritize across the Administration what positions they're going to appoint and which ones they're going to leave for the next governor. And that it's necessary to do it, and so we may or may not -- I don't know where we are on the list but we have work do anyway, so we'll see how all of that goes.

Obviously, I don't want to leave the Office without leadership, which is one of the reasons why I am as involved as I am, but also we have La Roux in the Acting position and now we have Dana, who can really help us, as well.

And so, we have a -- I think, a power team and, as you all know, we have amazing staff. So, the work continues and the work of creating that vision for where we're going next is already started but we're going to kind of take it to the next level.

Let's see. This is -- I'm going to read this

bullet point because I find it interesting: Assessing the role of the Advisory Council going forward, is there a need to move away from general discussions about health equity topics and increase focus on supporting the operations and budget of OHE?

So, I would say "yes" and "no." The discussions about health equity topics are great. If they turn into advice, that's even better. I have a lot of Advisory Committees; not many of them actually give advice. They're great because the conversations that you have, you know, are rich and meaningful and that in and of itself brings tremendous value.

But when it -- in terms of -- so, that's the "yes" part. The flipside of that, do we want you to provide more directions on operations and budget? The answer is I don't think that's necessarily your role. Many of you have organizations that -- for whom that may be a role, but for the Advisory Committee, what I want out of it is your expertise helping inform us in what we're doing.

I don't -- it would -- actually makes it harder for me if you're advocating for budget. That's a whole other world that kind of gets us in trouble potentially and -- but you -- I sort of think of you as the scientific advisory board for equity in the same way that we have one for tobacco, we have one for laboratory services, you're the

experts.

And so, we should be able to come to you with questions that are arising from people. We should be able to tap into your expertise if we are creating policy papers, et cetera.

So, that's kind of my vision and we'll have conversations ongoing about what that really looks like and -- but in terms of supporting operations or the budget, there may be opportunities to that, but I don't think it's the primary function of the Advisory Committee. I'm always willing to converse further on that.

Understanding the Advisory Committee selection process and prioritizing filling some open positions. Well, I don't understand your selection process. In fact, I don't know anything about it except I read carefully the names that are put forward and all the materials that go with it and I have a very good sense of who all is on there.

So, what I'm usually looking for is people who kind of fill in gaps or bring balance as opposed to the same kind of background, et cetera. But, if it's in your bylaws, awesome. We're open to discussing any aspect of that that you're interested in and this is a good time. We don't have anybody who's really vested in a particular process.

There are certain rules around Advisory Committees, so we can do some investigation of that and then

share that and have a conversation based on what we can and can't do. I'm not aware of a lot that we can't do.

And then, the last one was standing meetings with key state staff, i.e. me or an appropriate deputy, for the subcommittee or select AC to promote and further the work of health equity. Well, I would assume it's always to promote and further the work of health equity.

But I'm happy to -- we do that with the California Conference of Local Health Officers, for example, which is an overarching advisory body for the Department. We're not entirely sure. So, the director -- the Deputy Director for the Office of Health Equity reports directly to me, to the Director of the Department, and that remains the same.

Operationally, I'm not sure where -- I don't have the bandwidth to actually oversee the full operations of the Office, so in order to be sure that it gets the attention it deserves, it will either be under the Chief Deputy, Susan Fanelli, who is awesome - so happy to have her in that position - and -- or the new assistant director.

And so, we have an assistant director vacancy, because when Claudia left, Susan was promoted to chief deputy, and now the assistant -- it's not really a promotion. They're kind of lateral. But we're kind of working through that, and to some extent it's going to depend on the who of the assistant director position, and

what -- which -- I mean, Susan is a huge proponent of -- the Office of Health Equity's been doing a lot of work on it. She has a pretty broad span of responsibility, as did Claudia.

And so, we're -- and we're doing some other reorganization. Whenever there's a vacancy, we always look to say, can we, like, increase operational efficiency in the Department? And one of the areas that we need to have more engagement with from the directorate is the Center for Health Care Quality, which is our licensing and certification in hospital-acquired infections program. It's about a third of the Department, and it hasn't gotten the attention that it should have, given its size and complexity, when it's just one of, you know, seven other major areas that is under the Chief Deputy.

And so, we're kind of trying to figure out how to right-size that. And that will give us the opportunity to also look at not just this Office but the Office of Public Affairs, for example. We have several offices that stay within the directorate, but we can move to make sure they're getting the right person and the right level of attention. So, more to follow on that.

So -- but the answer is absolutely yes in terms of standard meetings, and it would probably be with me and whoever is -- either the Chief Deputy or the Assistant

Director, depending on where we land.

So, other than that, I didn't have a lot to say except that I was going to say really amazing, wonderful things about Tamu, which I could still do, but you all know them already. And she's not here to hear them, sadly, but we're, like, having active conversations on how we can keep Tamu involved, not just here but she's -- she's got such value to the organization overall. Her unique combination of people skills and ability to get stuff done is not something I want to lose. She does want to take some time off, though, so we're respecting that rather than badgering her. We're trying to, anyway; it's a little hard. But -- so I don't know what that's going to look like, but we'll be moving on.

And so, other than that, I don't know how we're doing for time. I don't want to make you too late, but I could take a couple of questions if there's time.

AC MEMBER LOUIE: Thank you for your comments. And, you know, I agree with you on the part about the AC providing advice and input, but it should be based on what issues does OHE have? What questions arise from the staff? That's why I think the retreat is good. I may -- you know, I can't talk to anybody else here because that's a Bagley-Keene thing.

So, I have talked to Tamu about this. For

instance, the survey that was sent out was what do we as an Advisory Committee think are the priorities? Well, we don't have the data. I couldn't even do the survey, and I told her that. I asked her -- I said, well, what progress have we made in different parts of OHE? Didn't have that information. What impact do we have now or potential impact? What are the resources for this? Maybe I can answer -- as an Advisory Committee Member, answer that, but I couldn't. And last -- oh, what's doable, I mean, what can you actually do? Some things are impossible. Maybe it's budgetary.

So, the -- I think that -- having these presentations about what's happening, I'm getting the information now. If I had gotten that information like I got the minutes and the bylaws ahead of time, I had some real comments to make because that's something to look at, something to examine. So, you know, I think that we need to move to that where, if everybody gets information ahead of time and questions from OHE staff, maybe there's an answer out there.

CDPH DIRECTOR SMITH: I think that's exactly right. And that's kind of what I meant when I said that I see -- there's sort of two roles. One is you all should be telling us what you with -- in your level of expertise think our priorities -- sort of overarching priorities are

priority areas for the Office to be thinking about, as opposed to this program or that program or -- some of these programs -- they're almost all legacy programs and/or statutorily-mandated activities. Some of them may or may not belong in the Office of Health Equity, and so that's part of what we're going to be looking at.

So -- and if we do have questions, it's on us to bring you the questions and to do that ahead of time with all the information. So, if we have a question about, you know, does this project make sense? Or we're hearing X from, you know, people. It probably wouldn't be does this project make sense, but it would be more along the lines of we've gotten feedback that sounds like this about this project. We're considering that. And -- and/or you give us feedback on a project.

I mean, you're -- a lot of you are directly impacted by the work that we're doing, and so, if there's a challenge -- this happens a lot in other Advisory Committees. There's -- you know, someone brings up a challenge that they as a stakeholder are having, and that -- and it provides a richer opportunity for conversation than just your project officer, for example.

So, yeah, it was -- I didn't see the survey when it went out, but I probably would have had exactly the same reaction that you did. It was a -- it was a wonderful

opportunity to get input, but you also have, I think, different levels of understanding of the operational stuff about the Office. And I don't actually typically look to Advisory Committees for that level of input unless it's a very specific -- we don't know whether to go this way or that way; here are all the factors that we're considering. You know, help us think about this.

It also, I think, can set unrealistic expectations. I've had Advisory Committees where they decided they were going to tell the Department what to do, and that's kind of not advisory. And often it's -- you know, we might want badly to do that thing but can't for a variety of reasons. So, that's where your thing is -- like, what's actually doable is a really good question, so.

AC MEMBER EWERT: I'm also grateful for your comments today, and I do agree that the whole Advisory Committee role is sometimes confounding. I've got a few of my own in -- how to get good advice in a meaningful way is a challenge, and I think I agree with Dexter. If we have something presented to us and we're given choices of what -- which way to go, I think that's helpful.

I think -- and we've brought up policy issues in the past - quite often, actually - and the response from staff has been that the department can't engage in policy because of -- you know, the role of the administration

versus the Legislature and so forth, which has been a bit frustrating, I think. I think what -- there's got to be a way --

CDPH DIRECTOR SMITH: Oh, there's a way. There's definitely a way.

AC MEMBER EWERT: -- you know, to -- and to advise on that sort of thing, and I think policy is a big tool.

And California's got 39 million people and if -- you know, if we're really going to make a significant difference, it's going to have to be large on the one hand. And then, I think there's also an organizing principle, and I still would like to see the Office mobilize local health departments in some way.

So, I know that there's tons of internal change, as well, that can be done in your department, and I think that's fantastic. It's kind of hard for us to observe that.

CDPH DIRECTOR SMITH: It is.

AC MEMBER EWERT: I think that's -- those are, you know --

CDPH DIRECTOR SMITH: Yeah.

AC MEMBER EWERT: -- sort of -- and I know how that works. You know, you try to work with programs, get them to have a different perspective on equity and to approach things differently, and that's fantastic. It's a little hard to see that from the outside.

But I'd like to see, also, convenings where local departments are invited. You know, I've made the comment about funding at the last meeting, which you, you know, said isn't going to happen.

(Laughter.)

AC MEMBER EWERT: But, you know, I think --

CDPH DIRECTOR SMITH: Well, either, you know -- there could be something magical happen. I don't know.

AC MEMBER EWERT: Right. But I think that -- when -- like, what's happened now with the tobacco tax. There's just the oral health money and the expanded tobacco money that's been going down to local health departments. Change begins to happen because now there's financing, there's people hired, there's objectives, there's local work going on across the whole state, in a statewide manner.

I feel like we still need a statewide approach. It can't just be things emanating out of an Office in Sacramento to a few places. That isn't going to get us the change we need.

CDPH DIRECTOR SMITH: I agree with that.

AC MEMBER EWERT: It's got to be disseminated in a more comprehensive way, and I think local health departments want to do the work.

You know, it's a -- the most important paradigm in public health right now and -- but not every health

department has the tools and the people or the -- you know, the knowledge and background to really operationalize health equity work, and those of us who are engaged at some level want more health.

CDPH DIRECTOR SMITH: Right.

AC MEMBER EWERT: You know, more technical assistance, more ideas from other places.

So, I think, if there could be an annual conference that you all sponsor where people were -- could come and learn, and maybe there could be some recommendation about, you know, realignment allocation, you know, what a health department should spend on health equity, or approaches within the programs that already are funded by the state that could be implemented.

Also, if there could be objectives or -- you know, so a lot of times the state mandates certain programs or approaches in, like, tobacco -- the tobacco program. Health equity could be integrated into those so that the local health departments would be empowered that way to do the work. So, those are just a few suggestions.

CDPH DIRECTOR SMITH: Right. Thank you.

So, two things. One, on the local health department, that is exactly -- that is exactly where I think, in terms of operationalizing some advance in health equity in terms of practice. The local health departments

are our obvious opportunity to do that. We -- not just on equity, but also sort of the Health in All Policies work. So, I think that's one area where the Office really needs to step up. And we're starting to do it, but we need to do a lot more of it, being that expert -- in the same way that you're, as an expert, helping us, we should be the experts helping local health jurisdictions.

The second thing on policy is -- it's not that we can't do policy. Quite the opposite. What we can't do is tell the governor or the Legislature what to do. What you can do, though -- and -- is raise the profile of an issue by whether it's a white paper or an analysis of policy that's happening elsewhere, in a studiously, scientifically-accurate way that doesn't -- that gives a tool to people who are making policy in terms of whether it's statutory or otherwise. So -- and we do that a lot.

You know, we put out a paper on -- the Department put out - I wasn't there yet, but -- on e-cigarettes. That is nothing but a policy paper, but it doesn't make any recommendations. It says, here's the science, here's what's happening, here are the potential risks. And that's how you do policy when you're within an administration is you provide the information in a way that's accessible to the other policymakers who are in the business, frankly, of making statewide policy.

And that's what I would like to see the Office of Health Equity doing. Some of that work's starting to occur. We're looking at sort of the -- gender from the perspective of it being a spectrum rather than, you know, a dichotomy. And so, those are areas to dive into. The question is what are the priority areas? And that's where I think that -- one, we need to look at the expertise within the Office and say, do we have the right people? And be looking for -- that's -- knowing what we want to do in terms of that kind of engagement - is it, you know, development of policy papers or is it running programs?

It helps us -- helps guide us when we're hiring. So -- and really having an understanding of the skill sets of our staff, but also our partners, can help us hire the right people, get the right strengths within the Office. And that's why, for me, the absolute most highest priority right now is to figure out what we're doing, figuring out what we should be doing, and then charting the path to get there.

And policy is absolutely one of the highest priorities. So it isn't that we can't do it; it's just that we can't tell the Legislature or the governor what to do, or anyone else for that matter. But we can certainly provide information that's reliable and objective.

So, I think I'm going to have to give you back

your agenda. I'm sorry I have to go. It's budget time and, you know, the governor's office is calling. Literally.

OHE ACTING DEPUTY DIRECTOR PENDLETON: All right. So, thank you for your time, Dr. Smith. Sorry. We'll -- about the -- we won't be able to get to all the questions today.

We're going to transition into introducing Angelo. I'm going to do that.

(OHE Acting Deputy Director Pendleton moved over to the speaker podium.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: All right. I want to introduce Angelo Williams from the California Black Health Network. He's the deputy director there, and he will kind of walk through his own bio. He said he's been -- since I didn't have time to pull it up, but I wanted to welcome him.

I think Tamu and a couple of other OHE staff attended the conference on the Black Health Agenda, and Angelo's going to share some of what happened at that conference, and maybe we can have some discussion about how that relates to the work and the vision for OHE.

I want to introduce Angelo.

(Applause.)

DR. WILLIAMS: And I really want to thank the staff for inviting us. This is not the first time the

California Black Health Network has been here. Our executive director, Doretha Williams-Flournoy, of course, has been at these meetings. And so, this is really just me introducing myself to you, which is why I don't want to bore you with a PowerPoint or to have someone introduce my bio. I'm just Angelo.

And the reason why I want to start out with that is because, look, I'm an old-school community organizer, right? And that first-name basis thing is important because the work that we're doing is hyper-personal, right? Even when it, you know, lifts the level of policy in complexity, we cannot forget that we're talking about people, we're talking about lives, we're talking about core human empathy, right? And it's important to kind of touch bases on that.

So, by way of introduction, I just want to make a few comments about what we've been doing, what we're up to at the California Black Health Network, so it'll be relatively seamless, but you'll forgive the kind of flights of fancy that I may or may not engage myself in. So, again, my name is Angelo Williams. I want to mention something, again, because, true, I earned my doctorate at Sac State and also did master's work, but I started out at UC Davis and one of the folks that I went to school with is here, Dante, right?

And that's important because, you know, when we

were in college and we were having conversations about everything related to the African American community, health was really not one of those foremost, formidable things. There were issues, there were numbers, there were all the rest of that, but I think a part of, you know, looking at what's happening in the African American community is understanding what's happening generationally.

And what's happening generationally now is that there is a new generation of young people that have decided to make that nexus between health and everything. To ask African American organizations, both historic and new, to put health at the center - not an appendage, but at the center - of their existence and the center of their advocacy, right? If Black lives matter, then Black life matters. So, I want to mention that because that's the kind of contextual architecture that we're looking at in terms of the Black Health Network.

We started out by asking questions directly to the community about health. Many ways we could do that, right? We've got great organizations that have done it in the past, and they of course are a part of our conversation, but we decided to go through seven cities in the state of California, many of them predominantly African American, some of them newly African American - and this is an interesting thing to recognize. What I mean by that is of

course we understand how African Americans get to California and Chicago - it's the great migration, right?

But what is happening in California and has been happening since the late 80s is that African Americans have been moving back south and also up north, right? Our centers of population are different. Sacramento is really a case in point when you're looking at who the African Americans happen to be, right, and where they are in this state. One of the things we learned, going to those seven cities, is that there are new pockets of not only dynamism in the community but also political activity.

So, anybody know Perris, California? Show of hands - Perris?

(Show of hands.)

DR. WILLIAMS: Exactly. Right? Well, the only reason I know it is because my grandfather - he was a teamster, he was a truck driver, came from Mississippi. At, like, twenty-one, right, he decided, yep, that's enough of Mississippi, came out here, and he became a truck driver. Third-grade education, just a brilliant man because, you know, he bought, like, fourteen houses, and one of those houses, right, happened to be in Perris, California, when Perris was super-rural. Now, thirty years later, right, because the man's been dead, like -- maybe, like, twenty years. Thirty years later, there's a burgeoning African

American community in Perris.

The dynamics of that community -- the interesting pieces about that community as it relates to health is that the way that they're organizing around socio-political, cultural issues is through this question of health. So, they have meetings at this church -- a great church. It's -- and again, it's the -- like, a rural scene, so it's, like, a double-wide, but it's an actual church. And so, when you walk in, you're kind of expecting, you know, the things that happen in church. But, when you walk in, what are they doing? Healthy eating, yoga, exercise, screenings for diabetes. Do you see what I'm saying? Like, that's where the action is.

And so, there's a new form of activism within the African American community in some spots that links those two inextricably. I think that general insight is important for practitioners to think through, well, hey, how do we connect with the African American community? Well, we should probably think that the African American community has changed and obviously will change, right, because culture is kind of a social construct in and of itself.

So, when we went to these seven cities, the thing that was really important was we were trying to -- one, get to know, right? And we walked into -- of course, all the folks on our staff are African American, so, you know, we

have some bias we have to check at the door. Which is really important, particularly as health practitioners, right, to check that bias at the door, to say, I don't know what's going on, let me find out, right? It's the difference between induction and deduction. So, we walked in and said, hey, we know nothing about what's happening in these seven cities. Tell us what's happening.

And so, our first level of inquiry was really to listen. We had these town halls - some of them were over two days, some of them had a second day of advocacy training. And we found certain themes. And so, part of what we're doing right now with the Black Health Agenda -- which we view more as a long-term, generational kind of document that helps us to recognize what's present, new, and now within the Black community related to health, and also what are the issues that happen to be, right, in some sense over those seven cities in common, and what are the top four or five that we can tackle and work with our partners like CPEHN and others on strategy, right, and on advocacy and on public policy?

But I will tell you this. So, yes, there's like four top issues that we think are important, but our second level of due diligence is that now we're doing the work. We're working with some interns at USF. They're going through their master's program.

We're looking at the data and the literature and all of the connective tissue that combines the instinct of the community around what's going on and what to do and how to fix it, with the peer-reviewed journals, with all of the information and acronyms that everybody in this room knows. A part of what we're saying by doing that is it's not possible to solve these systemic problems without the community leading.

Now, here's the complication: sometimes the community is wrong. Sometimes the community is misinformed. Sometimes the community has got some bad advice and information. The beauty of that is, at first, our level of trust that the community understands something and that they have an insight beyond our insight, but also it gives us an opportunity to create a relationship where we can actually supply information to enhance, inform, and refine their thinking about whatever issue it is.

In public health, you know this: the relationship is the thing. And so, part of what we're really trying to do is to reinvigorate a long-term relationship and also work with partners in solidarity, right, that just so happen to be either in the health field or with communities that are connected to us in many different ways.

So, that's what we're up to, right? That's a part of what we're up to. We're going at it slow, and we're

trying to invite people in when we think that we're ready, because we don't want this to be a one-off. So, of course, along the way, different groups will come in invitations.

Dahir worked with us on the ground at the summit. He actually presented at the first town hall in Sacramento and was a part of the work that we did in workgroups. And also, just to mention CPEHN as well, we had our oral health workgroup, which was amazing. When you see this report, in terms of the level of interest and the level of focus that African Americans in those seven cities have on oral health, it will astound you only because that nexus, right, between, well, what is this issue related to health and how is it connected to my everyday lived experience? That is to say, we'll continue to invite different groups as we, you know, continue to get our report together. And, also, our hope is to be an influencer at every level.

So, the recommendations that will come out in the final Black Health Agenda Report are meant to be intersectional. What that means for us is that we've got recommendations for everybody, right? I mean, you know this. Health is really a proxy for many things - poverty, structural racism, white supremacy, all of the rest. And so, at the end of the day, what we're trying to do is influence the entire environment.

I want to make a -- just a couple of comments

about that last conversation, because it was beautiful and also just so dovetails into our conversation, so -- in addition to what I do at the Black Health Network, I teach sociology and sit on a couple of boards - advisory boards, yeah. I feel you.

(Laughter)

DR. WILLIAMS: The one reason why advisory boards are so difficult, right? And I'm just going to say this, take it with a grain of salt - I know we just met, but I'm about to dig into you real quick, so just -- I love you. Let me just say that first and foremost.

(Laughter.)

DR. WILLIAMS: You know, one of the places for the Advisory Board is the vision. It's the mission. It's the vision. It's the values. Because an Office of Health Equity in California and throughout the United States is needed now more than ever.

Just the concept, just the idea that there is an Office of Health Equity - what are we talking about, right? If you look at the -- you know this, the national spectrum, and you ask yourself questions about not where people think we are historically, right, but also with the ingrained issues related to the social construction of reality, that created segregation, that created white dominance that created white privilege. If you launch into

that, if you hurl into that a discussion about an Office of Health Equity, I've got to let you know that's revolutionary. I've got to let you know that's super-radical. It's the right thing to do, of course I'm going to say that, but also just you being ambassadors of this idea, having conversations with the platforms that you have, that softens the ground.

So, I'm always thinking about sociology, because that's what I teach and I enjoy the ideas around that. So, we live in a socially constructed world, but a socially constructed world is only transformed by those players and actors that tend to promote particular actions and conversations at the societal level.

So, one of the roles that you have - just talk about it. Talk about the idea of the Office of Health Equity every chance you get. Get a publicist, right, that just lines you up and all you have to say is, yeah, I'm such and such and so and I'm a doctor. I've got this background. I'm doing this health, and by the way, I sit on an Advisory Board for the Office of Health Equity. What is the Office of Health Equity, you say?

(Laughter.)

DR WILLIAMS: Just that conversation transforms the connective tissue, right, that not only lays bare the questions of the social determinants of health but the

social construction of society. Your job is to infect as many people as possible with the idea that the Office of Health Equity is not just ancillary. It's needed at an essential, core level within society. Equity is at that high level of value that, at the end of the day, if we don't have -- we've already seen what happens with inequitable societies.

So, I just want to say that - that a part of your role that is undisputed, no matter what you do, is that ambassador role. It's just the idea that you get out there. An example - I sit on the board for College Track. I've sat on that board for five years, and I pulled the remaining amounts of hair out of my head.

And, one day, the staff came in and said, you know what? You know what, they had a whole report, and buried under, like, you know, forty pages was this one insight. And the insight was we -- our commitment is different to students because, one, it's decades, right? It's from middle school, right, when they first interact with College Track, all the way to and through college. So, we had a quick conversation - that's the secret sauce. It's the ten-year commitment.

Now every single flyer has that ten-year commitment, because that's it. But my role, right, on the advisory board -- sure, I read the report and that was

interesting, but my ability to get out there and talk to people about this secret sauce -- I talked about that for three years straight.

Other organizations now are saying, well, what's our secret sauce? Should it be five? Should it be ten? Should it be fifteen? Look, this is the sleight of hand work of social change. Yes, the policy is important. Yes, we have to get that right. But, the influence at the level of hand-to-hand combat with convincing another person or providing with information that this is an important thing to do. More than that, the level of platform that you have because of your profile allows you to say simple things that transform people's perspective about everything.

All right, I'm going to say two more things and I'm going to sit down. So, a part of that vision, a part of that secret sauce idea for us is this idea of healthy Black people. We talked about this idea for a while. Is it healthy Black families? Is it healthy Black individuals? Who is it? But what we noticed, from an equity frame, is that healthy Black people includes individuals from the LGBTQIA community and includes those folks, particularly within our community, that have problems with those people. We decided to cast the largest possible net so that everybody fit, so this idea of healthy Black people, from a conceptual point of view, is important for us.

And then, the last thing I'll say is -- so -- yeah. So here's something, another one of those insights. You remember I told you about the insight, number one, in the African American community, we have to remember to step back from our bias. Culture is a consistent social change. It happens all the time. So, any kind of those preconceived notions about where Black people are and what they do - drop back, get some research, reformulate your ideas, right? That's one of our insights from going out. Perris, California, right, is our case in point, right? Thinking about how that -- the next is that -- that nexus between health and everything is a new way that Black folk are thinking about how to do advocacy as it relates to health --

The last thing I want to lay bare to you, and also ask you to think with us through it, because I love the fact that you're going through your five-year strategic plan, and of course we're looking at this twenty-year strategic plan, this agenda, so we obviously want to work with you, and we think that so many of the issues dovetail, so it's in -- it's exciting to recognize that you are in this thinking and strategizing process as well.

We looked at the numbers as it relates to African Americans and enrollment. ACA, Covered California - the numbers are down. The numbers are stagnant. We went to the

seven cities and asked those questions - hey, what's up with those numbers?

What was interesting is, we also -- in some of those places, we had some really great, you know, demographers and also people that had done this study and they said, no, the people that get Medi-Cal in particular, they love the service, they're enrolled, and all the rest, right?

But then, we looked at and heard from the community, no, Medi-Cal is the worst thing ever. I would never sign up for it. Why wouldn't you sign up for it? Is it an issue of proximity in terms of -- are the places where you can use this -- no, no, there they are. I know exactly where they are. In some places, is it an issue of the doctors? Kind of, but the doctors that I do meet with, they're fine. I'm okay with them. Right? Is it prescription drugs, right? Is it, you know, what -- is the high cost of that, or is there something going on in terms of affordability? No.

All seven cities - stigma. When African Americans pull out any kind of medical card related to, you know, state-sponsored medical care, there is a stigma in the use of that card. That stigma is attached to not only structural racism but this idea of white supremacy, and I'm not talking about the hoods and the sheets and all the rest

of that.

I'm talking about -- it's a very simple thing. It's actually -- there's a blamelessness to white supremacy. What I mean by that is, all right, here's a society that's socially constructed to, really, service these groups of people, so of course it's going to be a kind of choice environment for those folks because it's made for those folks. But, look, everything we've learned about behavioral economics tells us that, if we create choice environments for people, they will choose the service, they will choose the product.

So, our thinking around this question of why African Americans are not enrolling at numbers that we think they should - the bigger problem is one of the biggest problems for us to think about and solve. If you're looking for a big problem for the Advisory Board to attach to, if you're looking for an issue that you can direct staff, give me a report about it, some recommendations, how do you defeat the stigma related to structural racism, to white supremacy, to white privilege? How do you create choice environments for African Americans where they don't feel the stigma of their race when they use the card? How do we reengineer that so the card becomes a primer? Oh my God, I have got -- now here's the interesting part. We kind of did this with CalFresh, right?

CalFresh is something totally different. Trust me - I grew up on welfare. So, CalFresh is totally different. I don't even know what CalFresh is. CalFresh sounds cool, right?

(Laughter.)

DR. WILLIAMS: Oh, man, I've got to get my CalFresh! I've got to get some fresh vegetables and fruit. CalFresh. Well, what's fresh? The fruits and vegetables? Sounds good! That's what I'm talking about. It hasn't removed the stigma completely, but it does say you in the African American community - you are of value. Your health is important to us. Now, we don't just empathize with you; we are with you. At the appointment with the doctor, we're there to say, yeah, you're worth it. That's a big problem we would love to work with you on to think through, because it's not something that you can just snap your fingers and it disappears. And it also has to be balanced with society in general.

So, thank you for the opportunity to just get to know you. Again, just Angelo, and I hope to talk with you at different times, and maybe when we have lunch we can chat. And our doors are always open, and as we continue to kind of progress in building the Black Health Agenda, we really want to partner with you and work with you, get your insight and feedback. Thank you.

(Applause.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: Angelo, I didn't know if you wanted to remain for some questions? Angelo?

DR. WILLIAMS: Oh, sure.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Did you want to take a few questions?

DR. WILLIAMS: I was, like --

(Laughter.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: If folk in the room have tent cards, if you want to put those up? I see one down the way. If you can introduce yourself - I can't see that far.

Linda Wheaton, right?

AC MEMBER WHEATON: Linda Wheaton, from the Department of Housing and Community Development.

DR. WILLIAMS: Hello.

AC MEMBER WHEATON: What are the seven cities?

DR. WILLIAMS: Ah, yes. Sacramento, Fresno, Oakland, San Diego, San Bernardino, Perris, did I forget any, Larry?

OHE ACTING DEPUTY DIRECTOR PENDLETON: One, two, three, four, five, we have six.

(Larry speaking off mic.)

DR. WILLIAMS: He's lying. He knows all of them.

(Laughter.)

DR. WILLIAMS: Was that six?

OHE ACTING DEPUTY DIRECTOR PENDLETON: That was six.

DR. WILLIAMS: That was six? What was the other one?

(Larry speaking off mic.)

DR. WILLIAMS: Los Angeles. Do you see what I'm saying?

OHE ACTING DEPUTY DIRECTOR PENDLETON: You forgot L.A.?

DR. WILLIAMS: Oh, I don't know. No, how could I forget L.A.? Oh, I don't know. I had no idea about Los Angeles, get out of here. Those were the seven cities, yes.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Sarah?

AC MEMBER DE GUIA: Angelo, congratulations.

DR. WILLIAMS: Thank you.

AC MEMBER DE GUIA: Because that's really -- it's a huge undertaking -- the amount of effort it takes to, you know, get the word out, get folks there, make sure that you have, you know, really, like, a roomful of folks who are really willing to share their ideas and their thoughts and their experiences. And the trust factor, as you mentioned, is huge, right?

DR. WILLIAMS: Mm-hmm.

AC MEMBER DE GUIA: Being -- having folks actually be able to open up and share their thoughts and concerns. So, congratulations.

DR. WILLIAMS: Thank you.

AC MEMBER DE GUIA: And I'm really looking forward to the report. Thank you for including us.

Can you share a couple -- there's two questions that I have for you. One is, you know, are you ready to kind of share -- thank you so much for sharing the stigma around Medi-Cal.

DR. WILLIAMS: Yes.

AC MEMBER DE GUIA: That's huge. And, you know, thinking about ways to -- how can we do that? How can we change?

DR. WILLIAMS: Right.

AC MEMBER DE GUIA: And I think particularly show folks that Medi-Cal -- we want to change that system so that it really does say to people we value your health. So, those are -- that's a great insight. Are there others that you can kind of share with us today, would be my first question.

And the second questions is, as you were meeting with people around the state, what do you attribute to or what were some of the observations that you attribute to people making more of this connection around health?

DR. WILLIAMS: So, I'll start with the first one first. We're trying to triangulate the data, right? So, we've got this qualitative data - tons of it - from the community, and we're trying to make the match between the peer-reviewed literature, right, and then other sources, right, whether they be reports or -- you know, from health departments or other things, right, for historical kind of context and content.

So, the stigma is the one that we've -- we're 100 percent clear on, right? The triangle is there. So, I'm very hesitant to talk about any of the other ones because they feel more like anecdotes, whereas that one feels like, yep, if we're going to solve this problem, we've got to transform Medi-Cal in a totally different kind of way than we're thinking.

And I also think that's a staged process, right? I mean, all the bills that are out there that folks are supporting - 974 and 562 - all the rest of them - they're important because, you know, you can't build a structure that services African Americans without universal care. So, I mean, that's -- you know, we're cautious of looking for places and spaces to inject conversations about how we do this better.

I think that -- ask me your second question again.

AC MEMBER DE GUIA: Like, what do you attribute

that connection back to health?

DR. WILLIAMS: Do you know what? I'm going to tell you the truth. So, since 2012, every three months, there's a conversation about an African American young man or woman being murdered by the police, let alone, right, the -- just existential conversation of people being killed in communities, right?

I mean, we all know what the DOD says, right? People talk about Black on Black crime. There's no such thing as Black on Black crime. People -- murder is proximity. People kill people that are close to them. So, let's -- you know, that's the second level of conversation.

But the first level of conversation is people are -- I think we've seen this in Sacramento because I don't think Sacramento -- Sacramento hasn't seen this level of public -- first of all, I don't think it's seen this level of public anguish ever and it comes from all sectors, all groups, all communities, even if they're not marching.

The sense of public anguish is compounded, and I think that -- I'll be honest with you. From an emotional point of view, it comes from a deep sense of despair. And so, I think our conversations in the Black community around health and gun violence, right, have been going on for some time.

And this level of conversation around health and

gun violence has pushed people into the question of, well, can't we make this a matter of health, because I think it's the communities' perception of the idea of health. I also think, at the same time - at the same time - it's the migration patterns, right?

I think Black communities are reforming and reconnecting and reorganizing. And I think it's interesting because, again, I'm from South-Central L.A., when there was a South-Central L.A., right? (Laughter.) So, you know how far back that was.

But I think the migration patterns are reorganizing African American communities in a positive way because there's always this stratification between, you know, folks that are all of a particular class and status and those that are not.

And those that are not of that status, those are the ones that are moving. And I think they're attaching themselves to a particular kind of personal power. And I think they also recognize -- they're very astute historically about what has gone on before.

So, one of the comments from a practitioner in Perris was we have never pulled that lever. As we try to unpack these things, it's like, what does that mean? What lever are you talking about? And he said -- so, his comment was health is everything. Health is everywhere. There's

nothing not connected to health. If you don't have a job and you don't have health care, no health. If you get shot down in the street, right, and it's not a mental -- or it's not a health issue per se but the waves, right, of complication and conflict and anguish that comes creates a community health issue.

So, I think that it's really a crystalizing of the issues and an attempt to find that big lever. How do we talk about this in a unified way, A, to get people's attention but also, B, to actually make some progress? And I think that folks have seen progress related to ACA, they see it as, wait a minute, maybe that'll work. Maybe we should talk about health as it relates to all of our issues and maybe we can get some traction.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Jo-Ann, did you have a question?

AC MEMBER JULIEN: Yeah.

So, I also want to say thank you. I thought that was a great talk, as well as thank you for the efforts on the agenda. I have a number of questions but first I just want to ask you about timing.

DR. WILLIAMS: Yes.

AC MEMBER JULIEN: Because I feel like, in life and in government and in social change, timing is everything. And I'm just wondering if you could speak to

the timing and kind of what factors might need to align in order to really have the -- see change that I think we're all hungry for.

DR. WILLIAMS: Absolutely. I'll tell you - and you know this - time is our biggest adversary because everything that we want to do and that we should do, right, even the insights that we'll get form future iterations of conversations with the community. (Laughter.) It's almost like we need a time machine, because we need to go all the way out into time and then come back into this moment and implement it right now, right? This is really what -- if you ask me -- that's what we really need to do.

So, noting that - noting that, we are -- we're taking a longer eye not to extend what we think we need to do, but also to prioritize it and order it.

So, I'll answer your question, too, as we just had a meeting this week about a retreat, and we're going to invite certain folks and we want them to talk with us and work with us to look at -- Lumina did a great thing maybe back in the 19 -- or the late 1990s. And they had this 2020 idea, right? And Lumina focuses on higher education and they had a lot of things to say about what wasn't working, and they took, right, from the late 90s to 2020 not only to think through it but to order it, to prioritize it, to organize all of the people individually and organizations

that would be a part of that group.

And if you look at what's happening in higher education now, some of it's good, some of it's bad, but it's really organized and prioritized around, right, the student success issue, right? You can't -- you can't talk anywhere around higher education and not talk about student success. In the late 90s, we weren't talking about student success in higher education, not the way we're talking about it now. So, it's become ubiquitous. So, part of what we think -- that there's an order of operations, right? The one insight that we think is most important is that African American communities believe that health should be at the center of organizations focused on African American advocacy, right, and program service and all the rest of that.

So, our question is how do we do that? How do we start as an influencer having conversations to shift, right, not only bylaws but also programs of service? How do we shift that? So, we're looking at -- we're looking at, right now, our first iteration, right, of going out to the communities then coming back through advocacy. So, our first timeline is we're looking towards going back out into the community - probably in summer, more likely it'll be in fall - to talk to them about the legislation that has passed to see if that fits their needs, to attract more people to

the conversation and to gear back up, right, for more qualitative data.

We can't say we have a full agenda if we've gone out once. Right? So, our short-term task is to return to the community, and we peg that around the summer or fall. That's our first level of what's our timeline? That's as far as we're looking in terms of our short-term. And then, once we do our retreat, we'll have all kinds of long-term plans and what we think we can do.

AC MEMBER JULIEN: My second question was around -- and I've never heard someone say it, so I made a note. Sometimes the community is wrong.

DR. WILLIAMS: Yes.

AC MEMBER JULIEN: I've never heard anybody say that.

DR. WILLIAMS: Yes.

AC MEMBER JULIEN: So, then I said, oh, what -- what's he referring to? Like --

DR. WILLIAMS: Yes.

AC MEMBER JULIEN: And so, when you were listening, was there any one thing or couple of things that really were -- was surprising?

DR. WILLIAMS: I'll blame this on my grandmother. Sometimes, things are just wrong. And I don't mean from a moralistic point of view, like right or wrong,

life or death, or whatever the case may be. And I don't mean wrong like damned, right, or unintelligent or whatever the case may be. Have you ever heard the story of the Christmas ham?

AC MEMBER JULIEN: Christmas ham?

(Laughter.)

DR. WILLIAMS: Yeah, let me tell you the story of the Christmas ham. A mother, a daughter, and a grandmother are making a Christmas ham. The mom pulls out the pan, cuts both sides of the ham off, and puts it into the pan and puts it in the oven. The daughter turns to the mother and says, hey, why do we cut off both sides of the ham? She says, baby, it's tradition. She walks out of the room. The grandmother says to the mother, no, it's not tradition. The only reason I ever cut off both sides of the ham and put it in the pot is because we never had a pot big enough.

Now, far be it from me to say that tradition is wrong, but what I mean by wrong is there are certain levels of Christmas ham stories in the Black community around health, health access, health care that we can't dislodge by truth. We can't -- we -- see, this is what I'm saying. It's not right and wrong. We can't just say, no, it's not that way. That's never going to work.

Our level of relationship to understand the story and unpack that story helps us, but if we can unpack that

story, what we're unpacking is a core level of values that animate the activity and action of African Americans and their advocacy to other organizations and their information to organizations that could be of assistance, and to the building of their own organizations and strengthening their own organizations.

So, a part of it is really recognizing the tradition, understanding the tradition, really getting people to be open with us about, okay, tell me what that really is. Because, you know -- but -- you will hear explanations for things and you'll say to yourself, no, that couldn't be. But it is. And it's the truth.

And so, our ability to really kind of have those value-laden conversations to pull out, right, those ties, those metaphors, those connections with outside information -- because we're not looking to correct people. We're looking to make a bridge between what they know, feel, and think, right, the opportunities that abound, right, and then also the kind of strategy that gets us from point A to point B. Does that make sense?

AC MEMBER JULIEN: Yes, thank you.

DR. WILLIAMS: Okay.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Donnell, did you have a question?

AC MEMBER EWERT: I just want to thank you for

your work and for being here today. We do a lot of work with Adverse Childhood Experiences in my community, and we've adopted this new model, the two ACEs - with Adverse Community Experiences being a part of that, and part of that is trauma and part of that is stigma.

And there's other things -- discrimination, which I think the African American community has experienced in spades and, you know, it explains a lot of the difference in life expectancy and so forth.

So, I'm glad to hear you talk about stigma because I don't think there's any worse stigma than a stigma on you -- who you are. You know, we all have -- our communities have stigmas about behaviors, right? I mean, we want to stigmatize criminal behavior, for example, right?

But to stigmatize who we are is so wrong on so many levels, and that's -- pertains to the LGBT community, it pertains to this idea of race, as well. And, you know, I subscribe to National Geographic. I don't know if you've seen the issue that just came out on race --

DR. WILLIAMS: Yeah.

AC MEMBER EWERT: Which I read the entire -- that entire thing and I found it fascinating, especially the article about diversity within Africa. There is --

DR. WILLIAMS: Yes.

AC MEMBER EWERT: -- there is more diversity

within Africa, in the genome, than in the whole rest of the world.

DR. WILLIAMS: Yes.

AC MEMBER EWERT: And it's because only a small number of Africans left Africa, migrated out into the rest of the world. So there was much more -- there's more diversity within Africa.

And there was a -- you know, a two-page spread showing all -- faces of people from all over Africa, and you just look at these faces and these dramatic differences --

DR. WILLIAMS: Yes.

AC MEMBER EWERT: -- in facial structures. And I think the truth that we're all from Africa is important, and I think there's an education that needs to go on, you know, that we all came from Africa. In fact, white skin is a mutation of our original humanity. You know, how we first started. The mutation occurred in the north -- in the northern regions, you know, because we needed more vitamin D. And I think, also, that mutation is one base pair in a gene with 20,000 base pairs in the whole genome.

AC MEMBER EWERT: And I think this idea that we're different is -- been -- is a social construct, and one that's been reinforced in us, especially in the United States, for all these centuries and we've got to break it at that point. You know, we are not different.

AC MEMBER EWERT: We really aren't different. I mean, that difference is so minute. And so, I think that we need to start there with changing and saying we -- we're all the same. You know, to stigmatize people based on one of who they are is so -- is just so utterly ridiculous after you read that article. So, anyway, I just want to encourage you on that, and, you know, take that message out there. I just think we need more of that. But I -- the main question I wanted to ask --

DR. WILLIAMS: Sure.

AC MEMBER EWERT: -- is I come from a community where we're 87 percent white. And our African American community is less than 1 percent. The -- it -- we're very integrated in terms of residence. You know, so there is not really -- there once was a small African American community. The city, through some of its policymaking, broke it up and for -- which I think was wrong, but nevertheless it created more integration in the community. We probably have four or five African American churches, and we do have a mosque, I think, that has some African and African American people in it. But my question to you is, you know, Black Lives Matter, you know, started as a result of the police violence and so forth.

AC MEMBER EWERT: But I think it's a great thing for us to ponder as public health professionals, too, you

know. It'd be a great slogan for addressing inequities in health outcomes.

DR. WILLIAMS: That is. That's right.

AC MEMBER EWERT: And I think -- in my community, I think we've often said, you know, all -- our interventions raise all boats. You know, the communities are -- the ethnic communities are small. You know, we're -- and we have done outreach. We have staff that do outreach for those communities, but I'm just curious as to your take on this. You know, your trip with all -- kind of these large cities --

DR. WILLIAMS: Yes.

AC MEMBER EWERT: -- except for Perris - that have significantly large African American communities. What do you recommend for counties or communities that have small African American communities?

DR. WILLIAMS: Yes.

AC MEMBER EWERT: How is it for them different, you know, that they -- they don't have the same --

DR. WILLIAMS: Right.

AC MEMBER EWERT: -- the strength in numbers, say -- that we're -- for organizing purposes. Or for -- even for support. I think they've -- they do find each other through their various associations and so forth, but how do we as a community address the -- still the inequities and

the health outcome that we encounter? Some of that's hard to see in our small numbers, but it's -- are there, undoubtedly.

AC MEMBER EWERT: And we've been able to document some of them. But what -- just what are your thoughts on that as far as how do we work to improve health outcomes for --

DR. WILLIAMS: Yeah.

AC MEMBER EWERT: -- when the group is small within a community?

DR. WILLIAMS: Yeah. Well, so, great question and I think that, number one, that's part of what the Black Health Agenda is attempting to aggregate. And in that aggregated fashion, we're going to come up with large solutions and some of them probably won't fit the Perris's and the small communities and so we have to work on that. That's really important, number one, to be specific.

I think the other thing, too, is that -- to recognize that the level of agency within any human community, right, is extremely important to the level of agency and license to think through. What I mean by that is, if you want to bring Black people together, bring Black people together. (Laughter.)

And that seems, like, overly simplistic, but part of what that means is go to not just the community leaders

but the young people and the rest and simply assert to them, hey, I'd love to be a part of a conversation when we talk about some of those pressing issues that you think are important. Allow the community to lead first, right?

I mean, that's one of the key issues around Black Lives Matter, right? Black Lives Matter is completely disaggregated, they're self-starters, they're not -- you know, it's not a -- it's not even a federation. It's people using the structure, and that's why a Black Life Matters is so important and could be a rallying cry for many people looking at the nexus between African Americans and health because one of the reasons why people show up at BLM is because they are attracted to this very simple idea -- it's quasi-ironic but it's also a statement of, yeah, Black lives do matter. It's a question, right, you know, and a statement at the same time.

But your first level of inquiry really is having conversations with people and asking them, hey, how do we configure? How do we connect? Also, at the same time, right -- so you've got to work on the building, the agency, and license of individuals within the community by suggesting that, hey, if you led a conversation around this, we would be there to resource you on whatever you need. Tell us what you need. Tell us what you think is important - start there.

On the other side, it's deep integration, meaning, at the rest of the community, conversations around health and all the rest of that triple your efforts to invite African Americans to that conversation. Because what will happen, right, inside of those larger conversations -- but it's got to be triple the effort because what happens, of course, is that the stigma -- well, I'm going to be the only Black person in the room, right? Well, I'm not representative of the whole African American community, so why did you invite me? Right?

You have to -- that's why you've got to go out three times. (Laughter.) And the third time, if you show up, most folks are like, okay, my God, first of all, stop bugging me. Yeah, I'll come to whatever you want me to come to.

But integrating that voice and those perspectives actually creates solidarity and it creates coalitions because what we find -- and I love that you started out, right, with talking about, you know, just the genome and adaptation and all the rest of that.

Well, we find out, when we put people in the room, there's going to be a least one issue of solidarity. At least one. That in those spaces, that radical solidarity - I care about and know the numbers and know the issues in your community because I want you to know the same thing in

mine - that core solidarity, that's what creates true community movement over time.

So, you've got to be in a -- and it already seems like you are just ambidextrous, right? Do the individual kind of coaching, focusing, encouraging, and at the same time, look, everybody shows up. We desperately need you here.

And making sure that the conversation leads itself to comparative numbers. Being clear about it up front. We've got four different ethnic groups here, we all suffer from this one thing, can we get together and work on this one thing? Right? Because, once people start working on something, the solidarity builds in action and movement. So, those are my meager suggestions to you.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Manel?

AC MEMBER KAPPAGODA: Thank you for taking the time to come and talk with us today.

DR. WILLIAMS: Sure.

AC MEMBER KAPPAGODA: I think we all really appreciate it. I have a question for you and then just a note for you. You mentioned that you were on a couple of advisory boards. I just want to flag for you that we have some open positions on this Advisory Board --

(Laughter.)

AC MEMBER KAPPAGODA: -- that you might want to

think about.

DR. WILLIAMS: You just want me to go completely bald, don't you?

(Laughter.)

DR. WILLIAMS: I mean, I've lost all, you know, volume. It's just terrible.

AC MEMBER KAPPAGODA: It wouldn't be like that.

DR. WILLIAMS: I'm kidding.

AC MEMBER KAPPAGODA: It would not be like that.

DR. WILLIAMS: (Laughter.) I'm joking.

AC MEMBER KAPPAGODA: But you talked about how our role as Advisory Committee Members is to be an ambassador for the Office of Health Equity and kind of lift up that idea.

DR. WILLIAMS: Yes.

AC MEMBER KAPPAGODA: And I'd love it if you could give us your elevator speech for why an Office of Health Equity is needed and how you would frame that to people who may not be persuaded.

DR. WILLIAMS: (Laughter.) So, I've got two elevator speeches, right? One is my Black radical elevator speech and one is my I live in an open community speech. I'm going to give you my Black radical speech first.

Come on. The Office of Health Equity is needed and required because we live in a society based upon white

supremacy and segregation. And so, one quick example related to that, right? It's not just race, it's also gender and it's focused on the question of heart disease.

For many years, we studied the cadavers of men. And so, everything we knew about heart disease, including the symptoms, were focused on male symptoms. Women died in droves because we decided that we were going to focus on one myopic view from a medical model point of view, right, about who gets the disease, how they get it, what their symptoms are.

People die when equity is not enforced as not an appendage but a core principle. We caught up with that. We now understand that women will come into the emergency room, right, and in fact they'll say, you know what? I've got a stomach ache and back pain. And we won't just send them home like they did during the 50s and the 60s and then they die because they have a heart attack.

What will happen is, because we've reformed ourselves, because it's a society, we put equity at the core of it, what happens is that the attendant says, oh, wait a minute. That's a symptom of heart disease. Maybe something's happening with you. Let's hold you over.

If we'd done that already as it relates to gender, what more can we do related to race and ethnicity? The Office of Health Equity is at the forefront of reminding

people, right, of putting the pressure on society to say equity saves lives. That's what I'd say.

Oh, my Black radical speech is my same -- is the same.

(Laughter.)

DR. WILLIAMS: Because that's what you're going to get, so don't be upset.

OHE ACTING DEPUTY DIRECTOR PENDLETON: I think we have --

DR. WILLIAMS: That was fun for me. Thank you. This is the best setup ever. We've got to go on the road together, you and me.

(Laughter.)

DR. WILLIAMS: We gotta do it. We gotta do it.

OHE ACTING DEPUTY DIRECTOR PENDLETON: I think we have a question from Michael.

DR. WILLIAMS: Sure.

AC MEMBER WITTE: Thanks again.

DR. WILLIAMS: Thank you.

AC MEMBER WITTE: I love your thinking.

DR. WILLIAMS: Thank you.

AC MEMBER WITTE: And I know there's a lot more that we could hear, for sure. It's pretty wonderful. I was reading an article this morning in the Journal of American Medical Association about looking at the Second Amendment.

And one of the things that was in there was that the most common cause of death in African Americans between 15 and 34 is gun violence.

DR. WILLIAMS: Absolutely.

AC MEMBER WITTE: And I wonder if you can see, with the Never Again Movement, there's an opportunity here timing-wise to be able to unify this Never Again Movement, which is multiethnic but also looking at the African American and the white supremacy issues that (indiscernible).

DR. WILLIAMS: Absolutely. That's the nail on the head right there. I think -- I mean, you all know. You've watched the footage of the students from Parkland and their level of understanding around white privilege and, you know, bringing other folks to the table.

So, I think that, A, there -- this is the generational opportunity and we have to be a part of that. This is, like, another role for ambassadors. See, we get to say things, right -- you know, not irresponsible things but we get to say things like that and we get to suggest things like that. We get to ask questions like that and those questions get into the societal ether.

They attract people. They attract different people. Someone hears what you said and they're saying, oh, wait a minute. Well, maybe we can do a study on that, and

the study bolsters, right, the validity of the claim, and the claim then becomes something. Oh my God, maybe we can make some policy or a program, whatever the case may be.

But I think the beauty of your observation and the observation of that study is -- see, this is the toll of white supremacy. What I mean by that is that, when I went to school in South Central L.A. between ’83 and ’86, man, I’d see, like, four or five drive-bys right on my front lawn - going to school with kids shot down dead.

But back then all of the conversation -- and Time Magazine actually did it and our wonderous elected officials who called those young men super predators. In fact, what was happening is the same thing that happened at Columbine, it’s the same thing that happened at any other case -- at any other situation where it didn’t involve Black people.

But, when it involves Black people, the tendency is to think there is a pathology within the Black community. Lottie Guinier did a great book called *The Miner’s Canary,* right, and she talks about this idea of race as an indicator. Instead of looking at what’s happening in ethnic communities, marginalized communities, communities of color as pathological, we tend to or should, according to her, look at them as that’s the harbinger, that’s what’s coming next.

So, in ’83, we can see Columbine in ’99, if -- if

we had the courage to say, where did these kids get these guns? You could say all these Black guys are out there doing their thing with the guns, but then you can ask -- oh, my God, these kids are, like, 16, 17, or 18 years old. Where in the world are they getting guns? Because the guns are part of the issue.

Now violence is a deeper issue, you know, and there are situations related to community mental health in every community that need to be dealt with - and social isolation and issues around toxic masculinity. Absolutely. All those are there. But it's that proximity to that gun that created that scourge in South Central between '83 and '86 that showed up again in Columbine, that showed up again in Parkland.

So, yeah. It should be number -- one of the number one issues and we should be the folks looking at it and helping people to see it from an equity lens. Because this is our problem. I'll say this and stop talking. (Laughter.) I know you're not aware that I could stop talking, I know.

(Laughter.)

DR. WILLIAMS: But, if the equity lens that allows you and anyone else to see, oh, my God, there's a connection there - that's what we're missing. What we're missing is a viral equity lens. A pair of glasses for every human being

to see, wait a minute, there's something that, A, connects us together as a people, as one. And then also connects us to, wait a minute, you're having a problem in this particular issue? This could become a larger societal problem so why don't we marshal the resources to focus on that?

That's the job of an Advisory Committee is to take those entangled issues and say, you know what? Let's take a -- let's take an examination of that and see what we can do. And, if we take that examination in California and we really look at, right, the lives of other individuals, right, from farm workers, to the homeless, to African Americans, to single moms -- if we tend to, like, focus our energy on those folks that we think are the least of these, man, we have the possibility of a future for our state. So, really, we have no other choice. We have to do that in order to survive and that's how we should think about it and that's how we should talk about it.

OHE ACTING DEPUTY DIRECTOR PENDLETON: All right. I want to thank Angelo.

(Applause.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: So, Tamu, are you ready to be loved on a little bit?

DR. NOLFO: I would love that.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Okay.

(Laughter.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: So, we're going to transition into honoring Tamu right before lunch. So, I want to just kick that off. Again, this is La Roux Pendleton, for those of you on the phone.

So, very early, I would say, in this year, I've been feeling a strong sense of an energy around the Office's transition. You know, it's -- it started with the transition of Dante, who is here today.

Hi, Dante. Our Senior Communications Officer.

(Applause.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: And so, I am in Sister Circle. It's an emotional emancipation circle. It's kind of one of our seed-ups. We don't fund it but it's something that I wanted to be involved in for my own healing process.

So, in January, in that meeting, there was this individual sense of transition amongst ourselves and there was this communal sense. So, it's just been around me.

So, we've seen the transition of our visionary, Jahmal Miller. Like I say, Dante's transition. I didn't realize there was actually -- what the transition was going to be in my life, but here I am. So, there was that transition that was just there and now we're living and experiencing what some of that stuff, that energy was that

at least I've been feeling for a while.

And now, today, we're here to praise, celebrate, and show gratitude towards Tamu as she will be, you know, transitioning out but maybe transitioning back in later. But we just want to honor where we are today and just to show that gratitude to Tamu.

And I'll invite some OHE staff to come up after I give some just quick regards and remarks and also the AC Members and anybody else who wants to show some gratitude towards Tamu.

So, Tamu, I just wanted to say, the first time that I actually heard you speak, I probably had been working at OHE for a while, but, you know, we're always crossing paths doing different things. So, the first time I actually heard you speak was at the CCLHO Conference - I think we were in Claremont, California. Somewhere in Southern California.

And it was at that time that I heard you talk about your mother. I heard you talk about your childhood. And it's very -- kind of in alignment with what we're talking about today with stigma. When I heard you say those words about your childhood and your mother, for me, it made it okay to let go of some of the shame that I felt as a child growing up in adverse circumstances. So, it made me be able to let some of that go because you showed the

courage to share your life and to share that that was okay and that builds strength and resilience and all of those things.

I'm so sorry. So, yeah, in that moment, you know, I carried that with me. I got to get back to my talking points. I have thoughts and then, you know, I've got to get them out.

(Laughter.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: And so, what I also realized in that moment, Tamu, is that why you're here is the reason why a lot of us are here - because we have lived experience with certain things. So, you know, Tamu has been -- I haven't had the opportunity to have a lot of time with you, Tamu, because you're always on the go. You know, talking about Portrait of Promise, operationalizing all the goals within, making connections to help bring -- add meat and bring vision to that document.

So, I just wanted to share those words and to say thank you, Tamu, for everything that you've done for OHE in the last four years, four and a half years that you've been with the Office. So, thank you.

(Applause.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: So, I want to open it up. I think a few of the chiefs -- I think, Solange, you had some words that you wanted to share, so I

wanted to invite you up and welcome you up.

DR. GOULD: Hi, Tamu.

DR. NOLFO: Hi, Solange.

DR. GOULD: You know, you have accomplished so much for the Office of Health Equity in your time here and supported so many of others across the state in their racial and health equity work. And we could go on and on about that, and maybe we should, but I'm incredible -- incredibly grateful that, before I got here, you went through the arduous process of birthing and delivering the Portrait of Promise, which I understand was a daily cold sweat. You also helped lead and form this group from its -- almost its inception. And you've supported all of our work from top to bottom in the Office of Health Equity.

But it's funny, because just a few days ago, I was speaking with one of our partners in the Housing and Community Development Agency, and they were talking about that they were at your first racial equity training series for HCD.

And she said that you were able to bring a whole room of people along on the concept of implicit bias in institutional processes and racial equity, and that it was your loving facilitation skills that allowed for this very difficult conversation to happen within the safe container that you created. And that is the kind of work that is not

from books. It's from your heart, that you have that magic, that you can do that.

And this -- to me, that story is really exemplary of who you are and why you are able to do this work and why you will continue to do this work with us, in partnership with us. You have epic energy and enthusiasm and creativity. You have epic bravery and positivity. And all of that allows you to be the exceptional change-maker that you are.

And I also carry with me a very difficult talk that I gave at CDPH in the beginning of my time here, and you sat in the very front and you just beamed at me. And it was -- it was like you were holding me up, and that positivity that you bring to your everyday encounters, no matter whether they're daily cold sweats of moving something through the state - you bring that love beam, and so thank you. Thank you for that.

DR. NOLFO: Thank you, Solange.

(Applause.)

DR. NOLFO: So sweet.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Marina, did you want to come up and share some thoughts?

MS. CASTILLO-AUGUSTO: Good afternoon, everybody.

So, Tamu, I didn't write anything, but what I have I'm going to say from my heart. And, before I got into this

work and this space of health equity and, you know, mental health disparities and whatnot, I had heard of you. So, in my twenty year plus career in this work, you know, there are the legends.

(Laughter.)

MS. CASTILLO-AUGUSTO: The edge-walkers, I call them. And those are like Rachel Guererro and Sergio and, you know, for me, you fall in that category.

And so, I had always heard about you and seen you, but never had worked with you. And so, when you came on board at OHE, not only was I elated to just kind of have a mentor, one that I've never had in -- you know, in my work in terms of working at a state department.

So, you were that for me. You were my sounding-board. You come to the table with such grace, integrity, and honesty and I echo in terms of being able to really engage difficult conversations in this space. And whether there's disagreements or not, we find a middle ground through you. And so, that was very instrumental and integral in building this Office.

And so, I thank you for taking OHE on the road. Many of our communities don't have efforts and don't have the means to come to meetings like this, or even participate at tables where their voices are heard. And so, you took OHE on the road and you gave us a presence and you helped

build our credibility.

And I'm forever appreciative for you also taking on the CRDP. When we were all with our heads in the sand trying to lift that project, you were out there keeping that project and that initiative at the forefront of people's conversations. So, thank you very much.

(Applause.)

DR. NOLFO: Thank you, Marina.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Yes. Peter.

DR. OH: Hello. Peter Oh with the Health Research and Statistics Unit.

And, Tamu, I met you in the end of -- late September last year when I first started here, and I was quite nervous, you know, to get started in this really renowned Office. And, despite my long experience at CDPH, I really felt like I was, you know, wading into new territory, and I was very fortunate to have you as my office neighbor.

And so, I wanted to thank you personally and on behalf of the rest of the HRSU team for being such a gracious advocate for health equity, really congenial, and a real enabling presence to our whole team. And I want to thank you especially for the time you took in the last several months of our intense work to update the legislative reports, for providing an update to the Portrait of Promise,

which you -- which is -- which you birthed with such great care and dedication. So, I hope that our efforts are worthy of kind of the -- you know, the claim that you've staked to that document, that ongoing and living document, going forward.

I also wanted to thank you for helping precept graduate students. I know last year you helped precept along with Dulce -- a group of UC Berkeley students do a health equity project, so that's another example of your role, your great, enthusiastic role in kind of helping build a pipeline of future health equity experts.

And, lastly, I wanted to just say that -- just -- I really appreciate your -- just your spirit, your generous spirit and one of the best things that I hear in the Office - we share a wall -- we shared a wall, and one of the best things in the Office to hear is Tamu's really unique and boisterous laugh. And there it is.

(Laughter.)

DR. OH: Yeah. And this -- I just wanted to say that that's just a great thing to hear in that kind of, you know, bland office setting, so I appreciate that.

(Laughter.)

DR. OH: Sorry. I wasn't -- I didn't mean to, you know, listen in or eavesdrop by any means, but I definitely heard that laughter and I will miss that. And I also want

to finish by saying that, at the December meeting here in this room, I've never seen an Advisory Committee have a dance-out, which you led so enthusiastically.

(Laughter.)

DR. OH: There was dancing going on right here, and so that's -- again just speaks to your great enthusiastic spirit. So, you will be missed and we hope that our collaboration continues in some way, shape, or form. Thank you.

(Applause.)

DR. NOLFO: Thanks, Peter.

OHE ACTING DEPUTY DIRECTOR PENDLETON: I want to open it up to anyone else who would like to share some remarks about Tamu.

MR. ALLEN: Thank you. I feel like I've been gone long enough that maybe I have to introduce myself.

(Laughter.)

MR. ALLEN: I'm Dante Allen, and Tamu and I had the sheer pleasure and joy of being a little dual personality when we approached our work. We were both employees of the Sierra Health Foundation and made our way to the Office of Health Equity as, quote-unquote, contractors.

And there was an -- there was a very -- what seemed like, you know, two very conflicting cultures of how

we operated. And so -- and I was always of the mindset of if -- it was very difficult for me to switch back and forth, that code switch that you hear about so often, and it was often very difficult for me.

And I went to Tamu and said, whatever you can do to keep me from having to jump back and forth, I would greatly appreciate it. And as courageous as Tamu can be, she took that head-on. And it -- I mean, it was a great experience on both sides. The deepest difficulty was being able to switch back and forth.

But I have to say, and I will couch this by saying it will sound a little pejorative as I say it, but if you listen to me for a little bit, you'll get what I'm saying is -- Tamu is a walking contradiction.

(Laughter.)

MR. ALLEN: And I say that because of everything about her, which you see on the surface, and when you get to know her better, it challenges all of your preconceived notions of what it means to be the person that she is.

When I first met her and listened to her talk, and she told me a little bit about herself, that she grew up in Compton, that she has a mother who is a superstar, for lack of a better phrase, that she is this family woman and she does a Black girls' run and she does -- she has -- in addition to her work, which is a personal passion, she also

has about eight or nine other personal passions that she follows. And even in this diminutive frame, she carries such power wherever she goes.

And yet, it's so heartfelt when she talks to you and connects with you. There's no sense of, well, I need to be in charge and that means that I need to have an iron fist or anything. She carries her power in her ability to connect to people. And I guarantee you that I would not have been able to do the work that I did for the three and a half years within the Office of Health Equity if I didn't have Tamu as a partner, as a work wife, as --

(Laughter.)

MR. ALLEN: -- as the person who really taught me -- I came from a world that was very centered around health care, and when I looked at -- when I looked at what we call inequities, I would have called them disparities and felt like there had to be a health care solution to those disparities. And Tamu really helped open my mind to what it was that we were addressing.

And so, I feel like everything that -- any great idea that I ever had about communicating health equity had to have started with a conversation with Tamu, and so I am enormously thankful for you. I love you. And now I don't have to steal you to come and work with me. You can come on your own.

(Laughter and applause.)

DR. NOLFO: I love you, too, Dante.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Would anyone else like to make some remarks?

Yes?

AC MEMBER WHEATON: Well, I would like to echo a lot of what people have said but especially, I think, Tamu, in my tenure here on the Advisory Committee, you have been kind of the constant, the guiding light, kind of, and created, as people have noted, just a very welcoming space and I think modeled for us what we can all do -- we all need to do and can do in making headway in this field with very positive influence, adjusting to -- I mean, you know, some of the conditions that we have to work under are very constraining and limiting but you've modeled a great way to go. Thank you.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Sarah, then Sergio.

AC MEMBER DE GUIA: So, Tamu, thank you -- this is Sarah. Thank you just so very much for everything that you've done for the Office. When I think of the Office, I think you hold a lot of the logistics and the coordination in your mind, but it's really your heart that you bring to the table.

I always feel so supported in terms of just when

we have a discussion about what are we going to do next and how are we going to grow this and how do we really take what we're learning and make it, you know, so different and unique for the whole nation, you're there. Your thoughts are always there.

And just everything -- the way in which you put your touch and your flair, it's like nobody else can do that except for you. So, that's the thing that I'm going to miss the most is just thinking about that, you know, and maybe all of us can sort of support each other in thinking about what would Tamu do?

(Laughter.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: Sergio?

AC MEMBER AGUILAR-GAXIOLA: Tamu, it's in a blink of an eye since I met you, and we met when the Office of Health Equity still was an idea that many of us advocated for the Office.

DR. NOLFO: Right.

AC MEMBER AGUILAR-GAXIOLA: And you were consistent in your presence and your support. And consistently since I met you, I didn't see the cold sweats. I saw the warm smiles and how you ushered the creation, the release, and the dissemination of the Portrait of Promise, which, you know, is not a small feat. This -- pulling us all in, you know, creating something that is very

much a roadmap for good.

And since I met you, I -- there are several qualities that come to mind that I have seen firsthand. You know, your openness. You always were available for discussions. Your passion, your commitment, your connecting not only people but thoughts, you know?

You took us on the road to where people are. When we went to Marin, for example, you know, that was, in my opinion, a very good example of taking us out of our comfort zone because it's not easy to get to Marin and coming back.

(Laughter.)

AC MEMBER AGUILAR-GAXIOLA: But, you know, it was absolutely worth it. And you brought folks to talk to the Advisory Committee that I thought was very much needed and continues to be needed.

So, I -- and I know about your mom, as well, and I think that Dante put it very, very beautifully, and I know her accomplishments and the incredible (indiscernible) that you have and that you have incorporated them in who you are.

So, I have also seen how you have -- you know, through blogs and through emails and conversations, the impact that you are having not only in the state but nationally, as well. I have been very pleased to see that you are conversing with national leaders. That is very gratifying to see that.

So, I'm already missing you.

(Laughter.)

AC MEMBER AGUILAR-GAXIOLA: But I trust that we will continue to be in touch.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Thank you.

Dexter?

AC MEMBER LOUIE: Hi, Tamu. (Laughter.)

DR. NOLFO: Hi, Dexter.

AC MEMBER LOUIE: I remember when this all started four and a half years ago. You know, I've been going to some night classes for seniors and it's all about creation. And so, here you have created something from nothing. All right, the first few meetings of creating the Portrait of Promise was -- that was a huge task. And I just can't believe you got it done.

But, secondly - and, you know, this is more -- I'm sort of the in-house skeptic and, when I call Tamu, she actually picks up.

(Laughter.)

AC MEMBER LOUIE: And, if she doesn't pick up, she actually calls me back and she knows I've got a complaint.

(Laughter.)

AC MEMBER LOUIE: So, thank you so much. Thank you so much for all you've done.

DR. NOLFO: Thank you.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Thank you.

Manel?

AC MEMBER KAPPAGODA: Tamu -- I'll keep it short. I just want to say thank you so much for all of the support that you provided to the Committee but you provided to me to kind of onboard and understand what the heck is going on --

(Laughter.)

AC MEMBER KAPPAGODA: -- with the Advisory Committee. And I feel like I have learned a great deal watching you work - your combination of strength and warmth and humor and your ability to push things forward very firmly but leave people feeling good is really special and inspirational. So, thank you.

DR. NOLFO: Thank you.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Rocco?

AC MEMBER CHENG: Yes. I want to echo a lot of what people have been saying and just want to remind us where we were before you came versus what happened after you came.

We were struggling, trying to define who we are as a group. And that was how the initial struggle we had. And, after you came, you were -- you formed a very good team with Jahmal and trying to -- I think it's a yeoman's job trying to herd this group.

(Laughter.)

AC MEMBER CHENG: And you're very effective, very communicative, very positive, and very supportive. So, I just admire your people skill as well as how you communicate the effectiveness of your getting things done and get -- the plan got approved so quickly. And then -- so I just -- a lot of appreciation and a lot of admiration towards you.

Good luck and thank you.

DR. NOLFO: Thank you, Rocco.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Thank you.

Lisa?

AC MEMBER FOLBERG: I first met Tamu in New Orleans at the American Public Health Association meeting. I remember when she walked in there was this sort of buzz and I thought who is this mythical, magical Tamu?

(Laughter.)

AC MEMBER FOLBERG: And getting to know her and the work that, Tamu, you have done in the last couple of years with the Office of Health Equity, I think my original impression was correct - you're absolutely mythical and magical and extraordinary and we will really miss you. Thank you.

DR. NOLFO: Thank you, Lisa.

OHE ACTING DEPUTY DIRECTOR PENDLETON: All right. So, Tamu, here is a card for you on behalf of the

Advisory Committee. I want you to get this. And there's cake for us in a minute, but thank you so much, Tamu.

(Applause.)

DR. NOLFO: Whoo. I'm going to grab one of these.

AC MEMBER GALVEZ: Hi, all. This is Sandi on the phone.

DR. NOLFO: Who is that?

(AC Members respond.)

DR. NOLFO: Sandi?

AC MEMBER GALVEZ: Yes.

DR. NOLFO: Sandi. Speak.

AC MEMBER GALVEZ. Hi. So sorry I couldn't be there in person. I just -- you know, I mean, it's a hard act to follow everything that's already been said. But, I mean, I met you at our first or second meeting and, you know, it was our first session and we were trying to get the Strategic Plan started and it didn't go very well.

And, luckily, Jahmal had the foresight to snatch you up when he met you and to bring you on to help establish the Office and the role of this Committee and how this Committee and the Office would work together. And, as has already been said, we couldn't have done it without you. And, as Chair and, in particular, as the inaugural chair, I relied on you greatly.

And I just want to thank you for being a good

partner to me as the Chair, for your dedication to the work, your attention to detail both the big and small, you helping to make the meetings seem seamless, and also, of course, your laugh and the staff that I've had the chance to see behind the scenes probably more than others on the Committee. You know, as one sassy woman to another, I always appreciate that.

And just, you know, I'm going to miss you and you've been an integral part of this Office and this Committee; however, I am encouraged by Karen's words about trying to way to -- to find a way to keep you in the mix. So, I'm hoping that this is just a chance for us to show appreciation today but it won't be the last time. Thanks.

DR. NOLFO: Thank you, Sandi. I appreciate that. Wow.

So, I didn't hear Dr. Smith's words so I guess we'll see how the future plays out.

Wow. Thank you for letting me have some time this morning. I had a really rough morning. I got some bad news when I pulled into the parking lot this morning. So, my husband came and picked me up and I went home and I sat in my backyard and called all my family members and cried a lot.

And when I said to my Aunt Shellie, you know, I'm supposed to be at the Statewide Advisory Committee today,

not only facilitating it but they're doing this, like, honoring and goodbye at lunchtime. And she said, you've got to be there for that. And she was right. It's meant a lot for me to be here.

It's meant so much to me to hear from all of you today. I just want you to know how it's received. I'm really taking it in and I'm so grateful for it.

And I have to tell you I know for a fact that I couldn't have been doing this work if it weren't for all of you - that I feel like I got powered up by all of you but I got inspired by all of you. (Laughter.) That, you know, I would look at the very tough things that you were doing in all of the various ways that you were doing them and I would think, well, if they're doing that, I can certainly do my piece.

And so, I think that that's really what this movement is all about - that we jump in together, we link arms, we go with our passions, we go with our hearts, we take ourselves all together with it - you know, this big wave. And I feel like that's been one of the most exciting things about this is really being at the crest of the wave of this health and mental health equity movement.

You know, we are creating it. We are defining it and it is huge. And so, we, by all means, have not seen the impact of it but the impact is coming. And that means that

our kids' generation and our grandkids' generation is going to look very different than what we've seen up to this point. And that's so exciting to me. That's so heartwarming to me. And I can't imagine a better way to spend my time and talents and I definitely can't imagine that I would have wanted to spend the last four years with anyone other than the folks in this room right here.

So, thank you so much. Let's go enjoy some lunch and have some cake.

(Applause.)

MS. COLE: Operator, this is Noralee. We're breaking for lunch.

(Off the record at 12:19 p.m.)

AFTERNOON SESSION

1:14 p.m.

DR. OH: Should I go ahead and get started, Tamu?

DR. NOLFO: Please do.

DR. OH: Okay.

DR. NOLFO: Oh, could you please open the phone lines, operator, if they're not open?

(No audible response.)

OHE ACTING DEPUTY DIRECTOR PENDLETON: Can you say it again, Tamu?

DR. NOLFO: Operator?

OHE ACTING DEPUTY DIRECTOR PENDLETON: Operator? Would you please open the phone lines?

THE OPERATOR: I am here.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Can you open the phone lines?

THE OPERATOR: Yes. Do you want the whole conference fully interactive?

OHE ACTING DEPUTY DIRECTOR PENDLETON: No. I just want us -- we're going to get started with our afternoon presentations.

THE OPERATOR: Okay. We're ready to go.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Thank you.

THE OPERATOR: Anyone that's dialed in has a muted line. They can -- if they need to make a public comment,

dial 1.

DR. OH: Welcome back from lunch, everybody. My name is Peter Oh. I'm the current Chief of the Health Research and Statistics Unit, also known as HRSU - you've heard that many times since September. I've been here since September of 2017. I'm mindful of the fact that we only have -- the three unit chiefs have 45 minutes to present, so I'll only take up my 15 minutes and hopefully not more than that.

(Laughter.)

DR. OH: I just wanted to start by -- to give you a sense of the scale of my unit, the team that I work with. We're currently a small team of only four research scientists, including myself, who are fully located in the unit.

We're in the process of hiring on -- backfilling for one position that became vacant in December. We're trying to get that done soon.

(Dr. Oh and staff member confer off mic.)

DR. OH: So, that's five positions fully located in the unit, and I also help supervise two additional research scientists who work in other units in OHE. So, we're basically a basketball-team sized unit in HRSU.

(Laughter.)

DR. OH: So, given the short amount of time, I'll

focus in the next 15 minutes on only our two largest projects that my team worked on intensive for the -- in the last several months, namely the Legislative Report, which we're calling an Update on the Portrait of Promise, and just a brief update on the Healthy Communities Data and Indicators Project, the HCI. I will not have time to address the numerous workshops, collaborations, consultations, committees, and ad hoc data analyses that my staff have worked on in addition to these big-ticket items shown on this slide.

So, to set the stage on my brief comments on the Legislative Report, recall that our legislative mandate requires us to conduct demographic analyses on health and mental health disparities no -- at least every two years, reporting data on the underlying conditions that contribute to health and well-being. And these underlying conditions that are listed in the legislation as a 14 set of categories, letters A through N. So, our alphabet of health equity in California, so to speak.

So, our ABCs go like this: A is for income security, B is for food security and nutrition, C is for child development and education, and so on all the way through letter N, which is for accessible, affordable, and appropriate mental health services - just to set the stage for what categories we need to report on in the Legislative

Report.

So, some brief specifications for -- about the Legislative Report that my team has been working on. So, it's due for publication on July 1st of this year, both in the form of a hardcopy to be filed with the actual Legislature, as well as an electronic version posted on the CDPH website, hopefully up by no later than July 1st. Just earlier this week, we submitted this report for CDPH approval and eventually, hopefully, gaining Health and Human Services Agency approval before it then is released.

So, primarily, in the third bullet -- in the fourth bullet point here, I want to emphasize that this is -- this update on the Portrait of Promise is primarily a refresh of the Demographic Report portion, using more recent data on the "(A)-(N)" factors. So, it's that middle portion of the Portrait of Promise that kind of gives the -- provides the evidence base for all the underlying factors -- health -- social determinants of health, in order words.

So, in the next few slides, I'm going to share with you a couple of highlights just in the interest of time -- some excerpts from the Executive Summary, specifically, of the report, highlighting what the data tell us about the magnitude of the social determinants of health in our state.

Please note that, because this report is under

review -- that the material that you're about to preview is subject to change and may be slightly different from the final form.

So, let's get straight into some of the excerpts from the Executive Summary. So, this slide shows some summary statements that we've put in our draft. Summary statements on poverty, income inequality, food insecurity, and education, followed in subsequent slides, which I'll talk about, too, as I discuss them, by a few samples of the accompanying charts that are -- that show up -- that appear in the Legislative Report.

So, onto poverty. So, nationally, while California's official poverty ranking among the 50 states is improved from 14th to 18th, high cost of living translates into the highest poverty rate in the fifty states, according to the Supplemental Poverty Measure, which takes into account cost of living, noncash benefits, taxes, and other costs.

The second bullet point - income inequality persists, especially among the families headed by single mothers. Fully 38 percent of such households are below the federal poverty level, compared to 11 percent of married couple households. And that's exemplified in this graphic.

And so, these are summary statements in the Legislative Report accompanied by a series of figures. We

have about thirty of these figures that we've updated in the current Legislative Report.

And this shows, on the right side there, the 38 percent of female households with children and 38 percent of those households are below the federal poverty level compared to just 11 percent of married couple households.

The third point - food insecurity in California has decreased from 15.6 percent of households to 11.8 percent of households in the most recent set of available data in 2014-2016. That's based on USDA data. However, communities of color continue to be disproportionately affected, and two out of every five low-income adults in California are unable to afford enough food.

And this graphic drives home that point that 40 percent of -- more than 40 percent of low-income adults in California continue to be unable to afford enough food for their households.

And fourthly, disparities by racial and ethnic group persist in childhood education indicators such as reading level. Higher proportions of Asian and White third-graders are reading at or above -- oh, sorry -- at above or near standard compared with African American, American Indian, and Latino students. And that is captured in this slide number ten. And these data are from the California

Department of Education.

Going on to a couple more highlights from the Legislative Report addressing the -- addressing summary statements on the housing cost burdens, the environmental factors of -- factor of pollution burdens, as well as health insurance coverage. So, in the first bullet here we find -- we report in this Legislative Report update that higher percentages of African American and Latino households are housing cost-burdened. In other words, they have to spend over 30 percent of their monthly income on housing compared to other racial/ethnic groups. And that's exemplified by this graph in slide twelve.

Moving on to pollution burdens using some data from the CalEPA and the Office of Environmental Health Hazard Assessment, the CalEnviroScreen 3.0 2017 data, we see that the pollution burdens continue to be highest in regions such as the Central Valley, where Latinos and other racial and ethnic minorities make up a large proportion of the population.

And that's shown here in this pair of maps where the map at the top is shown using a red color map. It depicts higher burdens with increasing intensive color. Note that the swath of darker red in the Central Valley.

And the map at the bottom is a blue color map that depicts percentages of the Latino and other non-White

populations in California counties. And note the concentration of racial and ethnic minorities in the -- along the Central Valley area and some of the urban areas in Southern California.

And then, lastly, despite overall improvements in health insurance coverage, disparities by racial/ethnic group persist. The uninsured rate among Latinos dropped from 28 percent in 2012 to 17 percent in the latest year of data available of 2016, but remained substantially higher than the rate among Whites, which is 10 percent in 2017.

So, that was just a very brief run through just in the interest of time of a snapshot of the -- what -- the contents of the Legislative Report.

While the Legislative Report is an important and mandated venue for OHE to report on indicators of health disparities, I also wanted to give a very brief update on HRSU's flagship product, where we display data on the social determinants of health in a maybe more accessible and more dynamic way in addition to the Legislative Report, which is more of a -- little bit of a static document and where we show data not only at the state and county level, as the Legislative Report focuses on, but also where data are available, where we show data at the city and census tract level to really show kind of place-based community-level burdens of health disparities.

Thank you, Tamu, for that time reminder.

So, I'm talking about the Healthy Communities Indicators Project Data -- the Health Communities Data and Indicators Project, the HCI, as we know it. So, this link -- I think I've shown this at a previous meeting. I encourage you to explore this -- the HCI data -- the website yourself or ask other data-minded folks in your agencies to really give this a critical look. We like to receive feedback on how we're doing with this set of projects and how we can make it better.

So, just as a reminder, the HCI goals are to provide a standardized set of indicators of health disparities and social determinants of health. And what we're really trying to strive for is to become a very useful surveillance tool to monitor the social determinants of health over time and to become also sort of a resource for feeding into the Legislative Report. For future editions of the Legislative Report, perhaps if more data or more relevant data than maybe to the perhaps somewhat limited format of the Legislative Report provides currently.

So, the basis of the HCI is the Healthy Communities Framework, which -- with which you are -- many of you are familiar. That's from our partners at the Strategic Growth Council and Health in All Policies Taskforce. Some of you are here in the audience

representing those groups. And the HCI divides -- is divided into -- the indicators are divided into the first broad domains that you see here that I won't repeat.

But I just wanted to give you a quick -- I know I only have about two minutes left. A quick orientation into what the HCI actually contains:

First, we post narratives of the -- the actual indicators describing what the indicators are, what they measure, the rationale behind measuring that particular indicator, as well as technical information that allows users of the data to really make the best use and to understand the data.

We provide the actual datasets on our website in Excel format.

And then, the third and fourth points are perhaps the most kind of engaging ones:

The third point here for data -- for indicators for which data are available, we provide Tableau data visualizations, dashboards, where we show maps and stratifications by race/ethnicity and other relevant factors, rankings of and comparisons between geographies that the user can choose, as well as some basic visualizations of changes over time on a specific indicator.

And then we also go a little bit further. We provide ESRI Story Maps - this is a GIS product that CDPH

supports - where we offer the user to dynamically zoom down on very small geographies all the way down to the census tract level on some of these indicators where data are available.

We also provide Open Data tables, which is the Agency effort to kind of provide transparency in accessibility to data.

Just really quickly, this is a dashboard of what our -- one of our Tableau indicators looks like for the educational attainment indicator, for example. You can see that you can do a county ranking visually, you can stratify by race/ethnicity in the upper right of this slide, and where, as necessary, we provide other stratifications. In this case, nativity in the bottom right.

If you click on -- if you select one of the counties, then you can dig deeper into -- down to the city level for a lot of these indicators. So, that's what makes this a really dynamic product.

And, again, the ESRI Story Map that I indicated earlier allows you to really take a really close look down to the census track level on some of these indicators to really bring home differences at the -- place-based differences in our indicators.

So, I just want to just orient you back to the -- kind of the power of the HCI and just give you an update

that -- in late 2017, we updated a number of indicators that you see listed here.

We are currently -- one of our staff members left the Office of Health Equity in December who was really kind of a driving force behind this -- kind of our progress. It has impacted it somewhat, but we've tried to plow ahead and we have the poverty rate and housing cost burden indicators nearing completion in the next few weeks and months. And, later in 2018, we are planning to complete a couple of indicators, namely health insurance coverage and violent crime rate.

So, just a quick snapshot on what my staff have been refocusing on in the last couple of months. If you -- I wanted to acknowledge my staff as well as Tamu, who guided us through the Legislative Report progress, as well as my unit colleagues, who provided the updated information in the Legislative Report.

And, if you have any questions, please feel free to contact me at the information here.

(Applause.)

DR. NOLFO: Thank you, Peter. I appreciate that.

And so, Solange, are you coming up next?

DR. GOULD: Yeah.

DR. NOLFO: So, we're doing these snapshots of where the units are with their work, in part because it came

out on the last Sustainability Subcommittee call and at the last meeting that we had here in February that it's hard for the Advisory Committee to even weigh in and provide direction to OHE, if you're not really aware of the work of OHE. And so, we thought we should probably make it a standing meeting agenda item that you do get some updates on the work that's underway.

And so, I turn it over to Dr. Solange Gould.

DR. GOULD: Good morning. It's great to see everyone. I'm presenting on the accomplishments of the Health Equity Policy and Planning Unit, or HEPP, since we last presented our 2017 accomplishments to you in December and want to give a big shout out to the HEPP staff that are on the screen here and also in the room. If you could raise your hand and wave them in the air so people know who you are.

(Show of hands.)

DR. GOULD: I think it's important for people to know whose staff -- who is actually doing this work that I'm representing.

(Applause.)

DR. GOULD: So, I'm going to start with the Climate Change and Health Equity Program's work of the past four months, and I want to say, one of my jobs is to message this in a way that you guys understand that climate change

work is very squarely health equity work.

All of us are being affected by climate change right now, but some of us are most likely to be harmed. The populations who are already facing the worst socioeconomic and living conditions and existing health inequities are being hurt first and worst by climate change and have the most to gain when we improve social determinants of health through our climate change policies.

And so, because of that, the work that this team does includes in everything stronger language on labor and workforce development, stronger language on anti-displacement, community engagement, public health data, and tools in the middle of all that work. So, through this work, we are really improving the social determinants of health.

When California climate change bills pass into law, this team works with implementing agencies to make sure that health and equity are integrated throughout the implementation. So, in the past four months, we have given input on language and metrics, and technical assistance to the agencies that implement these bills, including:

AB 617, which is a bill that will increase community air monitoring in environmental justice communities;

SB 150, which focuses on greenhouse gas reductions

through transportation planning;

SB 350, which seeks to remove barriers for low-income communities to access clean energy and transportation;

SB 375, which sets greenhouse gas reduction targets for Metropolitan Planning Organizations through land use and transportation planning; and

AB 32. We continued to implement AB 32, which is our state's original comprehensive climate change legislation for achieving greenhouse gas reduction.

(Dr. Gould and Dr. Nolfo confer off mic.)

DR. GOULD: Stand in the middle? Okay. Thank you.

All right. Is that better?

(Negative responses.)

DR. GOULD: Not better?

You may -- okay, I'm just going to keep going.

(Laughter.)

DR. GOULD: I'm just going to keep going. If you can't hear me, go like that. (Hand signal demonstrated.)

You may have also heard that Governor Jerry Brown and Michael Bloomberg and others are holding a Global Climate Action Summit here in California in September that will bring together leaders from all sectors to showcase climate action taking place around the world, and to help

sub-nationals like cities, states, business, hospital systems, and universities really step up their commitments to reduce greenhouse gases under the Perris agreement. And our staff has been on the planning committee for the summit, with a focus on elevating health equity, economic development, and improving living conditions as central to global climate change agreement work.

Can you hear me now? I feel like I'm going in and out but I don't know if it's my inner ear.

(Affirmative responses.)

DR. GOULD: All right.

Our staff were also asked by the Governor's Office of Planning and Research to facilitate the development of a climate justice checklist for state agencies to integrate climate adaptation and prioritize vulnerable communities in all of the state's planning and investments, per Executive Order B-30-15.

So, we facilitated a group of governmental and non-governmental climate justice stakeholders to develop written guidance to help state agencies' staff identify communities facing inequities, reach out to them and engage them in decision-making, and shape state investment and infrastructure plans in ways that provide additional resources, such as funding, facilities, services, training, jobs, the goods for people facing inequities.

And this guidance was recently released. I really advise you to download it and take a look at it because I think, no matter what planning process you're in the middle of, it's an excellent, excellent equity checklist.

And, at the request of OPR, we produced an analysis of the likely health and equity impacts of automated vehicles in California. We have the draft report now and are revising it, along with developing a checklist of health equity considerations for policymakers around autonomous vehicles, which are literally rolling out as we speak.

We have also partnered with RAMP, Contra Costa County Public Health, and low-income energy efficiency providers to pilot a project that links Contra Costa residents with health conditions that are related to housing and environmental quality to energy efficiency and weatherization services.

And, based on this experience, we're also hoping to release this year a guidance document for public health practitioners on what it takes to really engage with weatherization services to promote health benefits, especially for vulnerable populations that are accessing public health services.

And we're working on a variety of strategies and policies at the state and local level to increase community

resilience to the impacts of climate change.

So, we have the California Building Resilience Against Climate Effects (or CalBRACE) Project, which provides resources and technical assistance for the state and local health departments and other stakeholders to build capacity to enhance health equity and resilience in their climate change adaptation planning and implementation.

And last year we released a Climate Change and Health Report for each county in California. And these reports provide a snapshot of the predicted climate change impacts up to 2100, as well as data on health, demographic, and social vulnerabilities to help local jurisdictions understand their local impacts and begin planning around them.

And these reports, we're excited to say, are also being used in several state planning processes and several state grant guidelines.

And we're about to release customized climate vulnerability assessment reports for eleven California counties, which give more detailed descriptions of indicators of climate change and health vulnerabilities, including maps and graphs.

CalBRACE is also developing an online adaptation toolkit - sort of a one-stop shop, which is a collection of resources to assist Local Health Departments to incorporate

climate adaptation planning into their public health.

And the staff facilitates regular meetings of a Community of Practice, where local health departments can share resources and get technical assistance from our staff and each other. CalBRACE regularly gives technical assistance to local health departments, non-governmentals, and state agency stakeholders, including to Tulare, San Diego, and Napa Counties in the last four months, and to Tribal partners.

We developed a set of indicators for assessing climate change and health vulnerability, which we call the CCHVIs, and in recent months we've been working on new ways to visualize these indicators, or the CCHVIZ.

We also worked with the Public Health Alliance of Southern California to put them into the Healthy Places Index, or the HPI, which you may know about. It's a tool that looks at social determinants of health at the census tract level for all of California.

And the CCHVIs are part of the newly launched HPI as decision support layers that can be visualized along with the HPI health equity index.

So, we're also developing, as I said, our own visualization platform where users can look at climate change and health indicators by state, by county, and even compare two climate vulnerability indicators to see which

locations are high in multiple vulnerabilities.

And, as we've talked about with you before, we've developed the public health chapter of the state's adaptation plan, Safeguarding California. It's now been released. We hope you will download it and look at that, as well.

And last, our program now sits on the technical advisory committee for OPR's Integrated Climate Adaptation and Resiliency Program, where we advise them on integrating health equity into their guidance and provide data tools and resources to their climate adaptation clearinghouse website.

Our research scientists are busy, involved in a number of ongoing climate change research projects, as well. We're working with the Air Resources Board on developing methods for measuring the health impacts of greenhouse gas mitigation measures in the Scoping Plan and Climate Change Investment Programs in the state. And we've also given input to ARB's Triennial Research Plan.

We sit on the Strategic Growth Council's Climate Change Research Program Steering Committee, which directs $11 million in research funding, and we are advising others in the development of tools, such as the California Heat Assessment.

So, I showed you this slide in December, but since then I wanted to tell you there's been a little bit of an

update because we've evaluated which of the program -- these are all grant programs. And we decided that, in order to direct resources and funding to places and people experiencing poor health outcomes, our unit staff should work with partner agencies to integrate health and equity language, approaches, and tools and to grant guidelines.

So, listed on the screen are all of the grant guidelines that we successfully integrated health equity language into this year, which in total directs -- helps direct $1 billion in state funding.

And on the right, what's new is the language that got in - the kind of practices and tools that can really help direct state funding to health equity communities.

And, as Angelo said, in public health the relationship is the thing, and so we also have a number of stakeholders that we nurse long-term relationships with so that we can learn from them and partner with them. We have given numerous presentations on the intersection of climate change and health to environmental justice and climate justice organizations to tribal partners to local health departments to academic institutions, the Federal Reserve Bank of San Francisco, et cetera. I'm not going to go into all the details about that.

And, finally, we also work with CDPH to assist and encourage other CDPH programs to integrate climate change

into their work. We've given webinars, organized a workshop for CDPH staff to learn about things, given input to Let's Get Healthy California, and collaborated with the other CDPH programs listed here.

Now I'm going into the work of the past four months for the Health in All Policies Program. And, as you know, the HiAP staff was previously all housed in OHE, and since then, the PHI staff, some of whom are here and can raise their hands --

(Show of hands.)

DR. GOULD: -- yay - were moved to the Strategic Growth Council. However, we all continue to work as one Health in All Policies program. But for today, I am just going to report out on the work supported by the CDPH HiAP staff but encourage you to get on their mailing list if you are not already to receive regular full-program updates.

So, our Health in All Policies work is usually formulated into cross-departmental action plans, which are voluntary scopes of work that last around three years. And we have continued to make progress on our Parks and Urban Canopy -- Tree Canopy Action Plan in the past four months. Real incredible work.

The goal of that action plan is that priority communities will benefit from optimized access to tree canopy, open space, and parks and maintenance of these

essential community spaces. And priority communities are defined as those with low access to parks, tree canopy, and open space and burdened by poverty and health inequities.

Staff are supporting the Government Operations Agency and others to propose an update to California Green Building Standards Code to recommend tree planting in school parking lots to reduce urban heat islands. And we've been working with a number of agencies and departments on supporting K-12 schools and tree-planting efforts to cool schools that need them the most.

Finally, staff are partnering with the Nutrition Education Obesity Prevention Branch and State Parks to launch the Active Parks, Healthy People Pilot Project. We are hoping to finalize site selection and a project evaluation plan for a pilot project in Los Angeles, Fresno, and Stanislaus counties that would increase programming in six parks to promote physical activity, safety, and community resilience in SNAP-Ed eligible communities. And we've already seeing the results of that kind of relationship-building between state and local parks and public health staff.

HiAP staff are in the process of collecting input for a new Healthy Transportation Action Plan. As you know, over the last eight years, there's been incredible progress on -- in the area of active transportation, partly through

the Health in All Policies Task Force Active Transportation Action Plan.

And we're now seeing more intersectoral collaboration on transportation at all levels of government on active transportation. But there are really some gaps still that we hope to address. So, going forward, we're really hoping to look at -- especially in the upcoming administration change, we'd like to focus on key high-level strategies to elevate healthy and equitable transportation.

In really key areas, such as the focus on transit and why public transit is if a health equity investment, creating more state supports to support MPOs in reducing vehicles miles traveled and support intersectoral collaboration and embedding health equity into grant guidelines.

We've also been supporting Equity in Government Practices Action Plan, primarily through the launch of the Capital Cohort Government Alliance on Race and Equity, or GARE. This GARE cohort has over 150 people from 18 departments and agencies going through the learning and doing work that CDPH went through 3 years ago, but in a cohort with only other state agencies and departments.

And listed are our training sessions for the cohort to date and for June, as well as a speaker series that we hosted with John Powell on the role of government in

addressing institutional racism.

Here's a listing of the Capital Cohort GARE teams, which I will let you read on your own. It's an exciting and impressive endeavor that we're in the beginning of.

And 2018 is our third year working in CDPH on our Racial and Health Equity Initiative. The first year was our GARE cohort learning year where we wrote our long-term Action Plan. The second year was about building buy-in at all levels, from executive leadership to mid-level to line staff.

And we held a number of trainings for staff on racial/equity 101 and several webinars. We created our working infrastructure and we created and disseminated a racial and health equity survey to all 4000 CDPH staff to measure our baseline so that we can assess our progress on our -- in this work over time.

This is our first year of having our infrastructure in place, which I'll show you next and it's my last slide. I promise. And focusing on implementation. So, we're focusing right now on normalizing the conversation around racial/equity in government, but you can see that we are also planning to focus on hiring, recruitment, education, training and capacities, and communications.

And I think it's -- I wanted to share our Racial

and Health Equity Initiative structure, so that you can see that there is now a Steering Committee, the box at the top, who is tasked with advising and giving direction to the initiative, and a workgroup who are 17 staff from across the Department, who are tasked with implementing various parts of the action plan. And the deep work of the action plan will probably happen in the subgroups in the blue boxes.

Like I said, this work on CDPH racial and health equity is really just getting underway and we would love to come back to this group periodically and share updates as the work rolls out.

We have -- there are a number of things we could update you on in future meetings - all staff equity survey results, race and gender pay analysis that we recently completed with an intern's help, and communication tools. And we'd love to talk about stakeholder engagement in this work. So, for example, how do we best ensure transparency and accountability, but also how to get input on this work, and how do we best support, align, and collaborate with the local GARES - the local racial/equity initiatives that are really a movement right now in California? What should and could CDPH's role be in supporting this local racial/equity work?

So, I'm well out of time. I can tell by Tamu's signals, but I wanted to encourage you to talk with all of

the staff. Please be in touch with us and we can talk anytime by phone or email.

(Applause.)

DR. NOLFO: And you did just fine on time. Thank you, Solange.

Marina, are you coming up?

(No audible response)

DR. NOLFO: Great. Marina Augusto, who heads up the Community Development and Engagement Unit.

AC MEMBER DE GUIA: Tamu, just a quick question in between while we're changing slides.

DR. NOLFO: Yes. Sure.

AC MEMBER DE GUIA: Will we have a chance to ask staff a couple of questions?

DR. NOLFO: We didn't build it into the agenda that way, but we certainly could. And so, if after this presentation we want to take 10 or 15 minutes in order to have that discussion with staff, we can. Sure.

MS. CASTILLO-AUGUSTO: Okay. Good afternoon, everybody. Stay awake with me here.

(Laughter.)

MS. CASTILLO-AUGUSTO: Anyway, I'm glad to be here with you all. I'm not always here but it's a pleasure to come here and report to you about the work that our Office is doing - in particular, the Community Development and

Engagement Unit.

I've been the Chief of the unit since the beginnings of the Office of Health Equity. So, I'm very humbled to serve in this role for many reasons. I don't take my job and the efforts that we do - engaging internally and externally - lightly. We hold a huge responsibility in our Office to ensure that community members get access to our Office and for a number of good reasons.

I'd like to just give you a little bit of background, and I'm going to try to make mine brief, because I also invited one of my staff today, Maureen Njmafa, who works with our African American community-based organizations under the umbrella of the CRDP, because we want to highlight a few -- two of the projects that we're working with and the work that they're doing within the community.

So, CDEU, the Community Development and Engagement Unit, is made up of 12.5 staff. I say five because Rafael is under HRSU, but he is an integral part of our team overseeing the evaluation component of one of our major initiatives that you've heard of before, the California Reducing Disparities Project.

We are primarily funded with Mental Health Services Act dollars. So, I say that because a lot of the work that we engage in has to be tied to the mandate. And

so, that has created a really good partnership with the Office of Health Equity because mental health has always kind of been an afterthought. And so, being in this Office and being in this Department has really elevated kind of our connectivity of looking at whole health care. And this is something that our former leader, Jahmal, and others around this table are really committed to in terms of having this conversation.

The other thing I wanted to mention is that, within my unit, our four staff who serve as the administrative team for the entire Office of Health Equity -- and Kimberly Knifong, Carol, Noralee, Leah - those are the folks that really support you in your endeavor of being part of this Advisory Committee.

The vision of my unit is about creating a public mental health system that is more inclusive, that is culturally and linguistically responsive, that, you know, is able to retain people in systems of care, and this doesn't always happen for a lot of the communities that we work with.

So, in addition to working with county mental health departments, we make a concerted effort to highlight projects at the local level through community-based organizations and other agencies that could really support community wellness and addressing mental health care needs.

Our primary role and responsibility is to engage with diverse communities. Sure, at the Department level, we engage in-house. We try to make every effort to embed that health equity lens that we're all talking about, but we also have a job to reach across departments, and we also have a job to work at the local and regional level. And so, most of the responsibility of my staff is the engagement piece with the underserved communities and vulnerable populations, and, again, that's by a number of activities and events that I will be highlighting.

But we also serve as liaisons and connectors to the Department. So, if there's a stakeholder group who is interested in coming to meet with our leadership, we help instruct them. Like, just don't come and talk about your issue, but come and -- come to the table with some asks. What is the Department going to do about it? Who can we get to loan us some resources? What are you going to do to help us elevate this concern? And so, we very -- we truly -- very much try to be concrete in our efforts in providing that technical assistance.

The other thing we do, as far as high-touch contract management and technical assistance, is we've brought in forty-one contracts, and you'll learn a little bit more about that momentarily. We also infuse ourselves with program design and implementation.

All my team can't be here today. A good majority are. This picture is just a picture of the team that helps me do what I do every day and makes it feel sometimes effortless. They are very much -- I call them fearless leaders and the dream team, because where I've hit roadblocks and where we all get frustrated in this work, they speak the unspoken, they go to tables, and they go to bat for the communities in which they're representing, and you'll hear more about their work.

But they work looking at bill analysis - I think, here recently, there were about ten mental health bills that we take a look at and we watch or we provide a primary analysis on and give our input. They serve on review teams, help make funding recommendations. We lend ourselves to provide workforce input as far as behavioral health, and so the efforts of this team really has to be highlighted.

The next slide really gives some brief highlights and overviews. We engage with academic institutions, primarily UC Davis, Sac State, and some of the community colleges, and that's sometimes in efforts of bringing mentors and interns into our unit. We bring at least six to eight interns a year into our unit and grow emerging leaders.

We also -- any time there's development of a center or CSUS is looking at the development of a public

health master's program, we participate and meet with representatives and participate on these committees. We're also very much involved in Mental Health Matters Day and anything happening over at the capitol to provide resources and information.

Internally, as far as the Health Equity Speaker Series, we are currently working on promoting a gender lens curriculum and training for both outside and inside stakeholders through the Let's Get Healthy California Innovation Conference that is coming next week. We also try to highlight and showcase many of our projects. One of the main areas that we're very much interested in CDEU is -- something that I highlighted in December is tribal engagement. So, working at a very high level with Agency to expand and learn more about what that looks like and how we could do a better job in that.

We have involvement in the Government Alliance on Racial Equity training, workforce equity, and community engagement that I will soon be participating in on a panel. This year -- and this is an area that I want to highlight because one of the things that I would really like to do is become more involved in your interest in the work that we do in terms of being out in the field.

This year, under the CRDP, we're launching site visits, so of the forty-one contracts and grantees that we

oversee who are growing community-defined promising practices -- we were -- we will be out across the state visiting these programs.

If any of you are interested in the -- and -- in the various regions that we are going to, to participate and come learn about what the Mixteco group is doing within the Guayacan community in Oxnard, or if you're interested in look -- learning more about the Sweet Potato Project out of Fresno and how they're growing enterprise and raising mental health, or coming to Humboldt to visit some of our rural partners who are providing services -- mental health services to Native American communities - please reach out to us by way of Tamu or of our leadership, and we will see what we can do to make that happen so that you could see our work on the ground.

We also are very instrumental in submitting abstracts to highlight our work in monitoring and oversight. One of our major initiatives is the California Reducing Disparities. I want to give a shout-out to Sarah, even though she's out of the room. I had been reporting probably for the last year at this Advisory Committee meeting about this strategic plan on reducing mental health disparities that couldn't get approval because of its -- it's community-authored, and it's very difficult to get a community-authored report out of any state department. So,

I'm happy to report that it was finally approved, and Sarah was --

(Applause.)

MS. CASTILLO-AUGUSTO: Yay! (Laughter.) Go spread the word! Sarah and her team at CPEHN did a fabulous job at holding a conference. I think it was April 10 --

(Applause.)

MS. CASTILLO-AUGUSTO: (Laughter.) I'm raving about you and you're out of the room.

But -- so -- had over two hundred plus participants in L.A. where they disseminated the report and highlighted recommendations in this report. She had some big, heavy hitters, leaders in the field who spent their whole day at this conference, engaging with the attendees. Why I bring up this illustration here is because CRDP Phase I, with this approval of the report, is now kind of like closed and packaged and nicely put away. Now we're in the throes of CRDP Phase II, and that goes until 2022. And I'm not going to get into the weeds on that project because that's a whole other presentation of itself and most of you are pretty familiar with that.

So, again, here is the CRDP Strategic Plan. We have a link on our website. Please peruse it. We're hoping to bring copies, if they're not already here, and disseminate it to the AC. But very good stuff.

Thank you, Sarah, for all your hard work and patience with us.

Now, I show this picture because it's very inspiring to me and it just warms my heart. This is our cohort for CRDP Phase II. This is our major initiative in CDEU. I would say the vast majority -- 85 if not more of the folks in this picture belonging to the different community-based organizations across the five populations have never been funded by a state government before.

So, it's a huge endeavor for our Office but a huge endeavor for them, learning our processes and procedures and whatnot, and we're still very enthusiastic and just happy that we were able to fund forty-one projects with Mental Health Services Act dollars by way of Prevention and Early Intervention.

Again, we're not covering all the state. We cover about eighteen state -- I mean, counties and some cross over to satellite, and so these are the areas in which we will be site visiting. So, if we're in your area, you know, I can share a calendar of our upcoming site visits. If we're in your area and you would like to come and meet with some of the project staff and learn about the resources, I highly encourage you to do so.

The final component of the CRDP Phase II is an education outreach and awareness consultant that we're going

to be making an intent to offer. We issued that solicitation and this project is really telling -- it's really about telling these compelling stories. So, we're growing evidence and we're -- we'll be presenting, hopefully, in the near future on data -- outcome data from our evaluation under the CRDP.

But an added component to that is that we want to hear the compelling stories of the projects and the people and the testimonials that this project is really impacting. And we feel, together with the data and the compelling storytelling, that this project could be really elevated to much higher levels than what it is.

Remember, this project is a demonstration project. The money goes away. There is no guarantee that these projects will continue. And so, this is also part of our effort of sustainability. So, this consultant will not only be serving as -- trying to get our media, but we'll be training many of our CPOs on media training, media consulting, development of collateral material, and highlighting the effort of the CRDP nationwide and statewide.

At this time, I'd like to call Maureen up. We want to showcase two of our pilot projects under the African American cohort. And I hope you enjoy the presentation, and we're here to answer any questions if you --

MS. NJMAFA: Hello, everyone. Again, my name is Maureen Njmafa. I'm the Contract Manager on the California Reducing Disparities Project. I oversee seven of the grants under the CRDP African American hub. So, we decided that it will be a great thing, while we're talking about the great happenings in the CRDP, to highlight two of the projects.

So, I have -- the first one will be for the Sweet Potato Project, and this is located in Fresno County. And --

(The video began to play for a few seconds.)

MS. CASTILLO-AUGUSTO: Anytime you want.

MS. NJMAFA: Yeah.

(Laughter.)

MS. NJMAFA: Okay. The Sweet Potato Project is located in Fresno County and serves youth from twelve to fifteen. The main focus here is to -- Fresno County has a very high rate of gang involvement, substance use, and dropout from school. Their grades are -- these kids over there, their grades are really below the state level.

So, the goal for this project is to try to reduce the dropout in school and gang involvement and try to create some way where kids can go there after school to build their -- improve their self-worth and self-esteem and teach them also entrepreneur -- it is -- to make sweet potatoes that they sell in the community. They do baked goods and

just to -- just life skills that they can use instead of going after gang involvement and other stuff.

So, we're going to start with the Sweet Potato Project. We have a video here just to show the kids.

(A video clip was shown.)

MS. NJMAFA: Thank you. I want to also highlight that the Sweet Potato Project, besides from the -- as you can tell, the kids said they were improving their entrepreneurial skills. They also receive mental health services from local mentors --

(Feedback and talking over the teleconference line.)

THE OPERATOR: Sorry.

MS. NJMAFA: -- just to improve their -- be aware of health and also mental health work. So, besides them learning how to become little business owners, they're also helping their -- I mean, improving their mental health. So, that's a good thing. And the one highlight I also want to say is that the Sweet Potato Project just got a huge award from the Fresno Unified School District. They're going to be a major vendor to the entire Fresno Unified School District.

MS. CASTILLO-AUGUSTO: Can you believe that?

MS. NJMAFA: Meaning that all these sweet potatoes that the kids plant, they'll be able to supply it year-round

to all of the Fresno schools. That -- we're talking about a hundred plus thousand kids over there. So, that's a huge deal. All thanks to the CRDP project.

(Applause.)

MS. NJMAFA: Yeah. While Laura is doing the IT work, we're going to go next to the Village Project. This is located in Monterey County. And the Village Project basically serves kids from kindergarten through fourth grade.

Again, their main goal here is to reduce -- a lot of these kids come in with anxiety, depression, and PTSD. And so, their goal there is to help to reduce and improve their mental wellbeing. So, last -- about two weeks ago, the Sweet Potato Project -- the executive directors, Mel and Regina Mason - those are the co-founders. They --

MS. CASTILLO-AUGUSTO: (Off mic.)

MS. NJMAFA: Yeah. They were recognized by their local -- just for the good work they do. Their organization will be ten years coming May 11 that they've been working in the community, so they are just excited, just for the good work that they've been doing, just improving the health and mental wellbeing of these kids from kindergarten through fourth grade.

So, we're just going to watch a little video. I don't --

(A video clip was shown.)

MS. CASTILLO-AUGUSTO: We've got a fifteen-minute video --

MS. NJMAFA: It's fifteen.

MS. CASTILLO-AUGUSTO: Yeah.

(Laughter.)

MS. NJMAFA: We're not going to --

MS. CASTILLO-AUGUSTO: And it's a very compelling story, but we're not going to be able to cover it all.

MS. NJMAFA: Right.

MS. CASTILLO-AUGUSTO: So --

MS. NJMAFA: But the main focus here, as I said, for the Village Project is that they work with these kids and they just -- all the kids there are basically from age --

MS. CASTILLO-AUGUSTO: (Off mic.)

MS. NJMAFA: Yeah. Most of the kids there are from kindergarten through fourth grade, and the great news is that most of these kids come there with very -- from horrible backgrounds who suffer from PTSD, anxiety, depression, and Mel and Regina are there.

All they have -- they are -- licensed clinical social workers have been working with these kids to help improve their mental health. So, (indiscernible), I'm -- I will be heading over to Monterey County to celebrate their

ten-year anniversary about the great work they're doing in Monterey next Friday.

And Jahmal is going to be the keynote speaker. I just thought about that.

MS. CASTILLO-AUGUSTO: Really?

MS. NJMAFA: Yes. Yes.

MS. CASTILLO-AUGUSTO: Wow.

MS. NJMAFA: Yes.

MS. CASTILLO-AUGUSTO: Nice.

DR. NOLFO: Okay. Well, thank you to the Community Development and Engagement Unit for enlightening us on what is happening in your unit.

(Applause.)

DR. NOLFO: Sarah, you had asked whether you could ask a question or two to staff?

OHE MEMBER DE GUIA: Yeah. I just wanted to -- I think -- Solange, the last time I think you presented -- there was a discussion around some positions that were open at the HiAP office. And so, I just wanted to see kind of, again, you know, talking a little bit about transitions and some of the great work that you all were doing. If we could get a little bit of an update on that staffing?

DR. NOLFO: Do you want to go up front?

DR. GOULD: This may be a group effort. So, we do still have two vacant positions in our unit. There, I

think, are five vacant positions total in the Office. And we are still in the process of recruitment. We have opened up the lists and posted the positions that you may have already seen online. And we're still in the process of recruiting right now.

And do you want to speak to this? Should I give you the -- here you go.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Yeah. I think, in light of a lot of the things that Dr. Smith mentioned this morning in terms of us really needing to look at the strategic planning and the internal OHE infrastructure, we're still looking to fill those positions, but we might want to -- and we're probably going to go into the strategic planning process first because you heard a lot about making sure that, one, we prioritize our work, and then, two, we find the right people to implement that work.

So, this will be OHE's first strategic planning, I think, that we've done as an Office since our existence. So, we want to be just very mindful of the work that we're currently doing to look to see there's any shifts or tweaks we need to make in terms of priority and then making sure we find the right people to fit all of the things that come out of our strategic planning process.

AC MEMBER DE GUIA: So, just kind of on that note, I wanted to --

DR. NOLFO: We need to give you a microphone.

AC MEMBER DE GUIA: So, one of the things that I reflected on this morning, too, that Dr. Smith mentioned is that one of the kind of primary inputs would be listening to staff and kind of what are the needs and what are some of the goals?

And so, I just really want -- what I had meant to say earlier I didn't have a chance to say to Dr. Smith, but I wanted to just mention it here at the -- in the meeting for the minutes is that I do -- I feel like it is really important that we listen to staff and have a good sense of what are the needs, what are the -- where are they feeling the pressure in terms of the demands.

Clearly, we're doing a lot of -- they're doing a lot of work across different departments and cultivating those relationships and that trust in order to make sure that they can do the work that they need and influence the policies that they want to influence.

So, just as kind of a note as you go forward and think about the strategic planning, I just really wanted to put that emphasis on. I think listening to staff is great. And then, also to us, you know, hopefully is we can be kind of involved in that process, too.

OHE ACTING DEPUTY DIRECTOR PENDLETON: Thank you, Sarah. Absolutely. And this strategic planning has

actually morphed, too. It will be an all-staff strategic planning retreat that we're going to do, which is different than the initial kind of concept of what was going to happen. So, we're hoping to get as much OHE representation as we can from the staff.

DR. NOLFO: Do you have a question, Manel?

AC MEMBER KAPPAGODA: I have a quick question.

DR. NOLFO: Go ahead.

AC MEMBER KAPPAGODA: It's kind of a question and a comment. So, one of the things that Dr. Smith said this morning, I think, if I heard her correctly is -- I think she said she wants to move the Office towards focusing on policy. And what I take from these presentations is there's a lot of work happening on guiding policy already in the Office. So, I wish we'd had a chance to kind of dig in with her a little bit more.

But one of the things that I think would be really helpful for us is when -- Peter, when you're talking about the great data work that's happening and the analysis that's happening, then just for the Advisory Committee I think it would be really helpful to kind of have you walk us through also how that is being used to drive recommendations to different state departments around policy.

I was getting that kind of reading between the lines of the presentation but I think just being explicit

about that. Obviously, you're not trying to tell other agencies what to do, but you're trying to make sure they are developing evidence-based policy and just kind of making those connections would be really helpful. Thanks.

DR. NOLFO: Thank you.

I have Rocco and Donnell and Sergio.

AC MEMBER CHENG: Thank you.

I just appreciated the update for the three units. Just a quick suggestion on some of the terminology being used. I hear the term ethnic minority being used. I think, in the state of California, we may want to consider using diverse community instead of ethnic minority because now there is no ethnic minority in California.

And the second thing is now I saw a chart of -- on education and then indicating that Asian has a very high education attainment and I think that's a myth because, if we look at the overall Asian as a group -- one group, then, yes, you do get that conclusion.

However, I would -- whenever the -- when the data is not available, I would suggest that you should caution the audience that there's a huge diversity within the Asian community. Some of the APS Asian community such as Southeast Asian - they are the poorest and then they have the lowest education attainment.

So, when we make a presentation like that, I would

say -- when the data is not disaggregated or when data is not available, I would really caution the audience and then put that out there so people would have some understanding and don't just assume that Asians are doing very well. Thank you.

DR. NOLFO: Thank you so much, Rocco. And I actually had made a note that I wanted to announce to you all that -- something that came out of the CRDP Annual Conference last fall was that we wanted to have more stakeholder engagement in how we're doing data analysis -- data collection and analysis.

And so, we've have a couple of think tanks. We had one that was focused on LGBTQ data and we're having another one that's coming up on Asian/Pacific Islander data and that is on May 21st from 12:30 to 1:30. It's completely open to the public. It'll be held by phone.

And so, I'll make sure that a notice goes out to all of the Advisory Committee Members. We have a lot of people signed up for it. We've had tremendous interest in this particular think tank, and so I think that what you had to say, Rocco, really resonates with folks. Thank you.

Donnell?

AC MEMBER EWERT: Thank you.

Thanks for those presentations. I think that was a great overview of some of the big projects in the Office.

So, you know, we heard about the data, we heard about the Health in All Policies and then the reducing disparities with the Mental Health Services Act money, and I guess I'm -- my question is, is there a unit dedicated to a more general approach to health equity?

Like, who is -- who is tasked with then influencing the rest of the Department of Public Health in all the other programs to be looking through a health equity lens? And who's looking at all the other health issues that -- around the state for which there are disparities by -- in diverse communities and gender and sexual orientation and so forth?

Because I know there's these -- certain projects are mandated by legislation or funding but, in this more general sense, who is doing all of that?

DR. NOLFO: Solange, do you want to speak to any of the work that's happening in your unit to do that? Although, obviously, the unit does not have enough capacity -- staffing capacity to do what's -- what Donnell was asking.

DR. GOULD: Yeah.

I think that's a really excellent question that we are also asking ourselves. Clearly, there's a need to increase to capacity to work on health equity inside CDPH, across data departments, at the local level, with non-

governmentals, health equity needs to be infused in everything.

And so, we are also trying to figure out how to respond to all the requests that are coming at us. Some of -- you know, we've spoken to people in this room and provided technical assistance to people in this room, but we don't, as you said, have the capacity to serve 58 counites, 700 small governments, and all of our partners, but we should. It's a really important role.

So, in the HEPP Unit, we have taken on some of that work. So, we've provided health equity trainings to CDPH last summer -- health equity and racial equity trainings to CDPH staff. We have taken on the approach -- Dahir is helping with pulling together resources for locals who are looking to start the health equity work. Some of the requests we get are from locals that are way far advanced. You know, Alameda County has contacted us for help on health equity work, and then we have requests from people who are like, I want to begin. Where do I even begin? I'm in a rural, conservative county.

So, in the range of requests, we're starting by -- instead of doing, which will certainly overtax our ability to provide, we're trying to put together a technical assistance and resource toolkit so that we can at least point people to the best sets of resources that we know of,

help them -- you know, direct them so that they can start to do some self-education, and then continue to work with them.

And then, I will say, even though we don't have a unit that is, like, the health equity unit, we all do it. Everyone in the Office of Health Equity advances health equity capacity with others.

We are also -- in all of the work that you heard described, we are educating our partners and building their capacity to do health equity work. So, I could speak to an example, and I'm sure Marina and Peter could speak to other examples of when we first started working with our transportation partners - they were like you are out of your lane. This is not -- we don't do health equity work. And now, their core mission of Caltrans has health language in it.

And so, we feel that, you know, a lot of the work you described we didn't say explicitly, like, this is building health equity capacity at the state, but, in fact, we're seeing progress where health is now in the center of so many of other people's work that we have worked with.

DR. NOLFO: Thank you.

Sergio and I also see Dexter and if there are any comments from the public, and then we'll move on to the SWOT Analysis.

AC MEMBER AGUILAR-GAXIOLA: Yeah. Well, it is

great that we had these three presentations and the updates. You know, I think that this is exactly what this Advisory Committee is -- you know, is hoping to hear. I certainly do. And I think that coming out of CDPH is great work.

Solange, I really appreciated what you presented. It is like health equity in all policies. You know, it's like putting health equity in the water across many different sectors. And it's -- it is great to see those efforts. I would love to see what outcomes would come out of that, then.

The other thing that didn't -- that I notice is that the -- one of the matrices that you provided -- one of the tables you -- in the measures, you included in every single row, community engagement, as well, along with other indicators. You had community engagement so permeating across all the specific projects that were included in that table. So, that's also great to hear.

Peter, that's great that you provided that update. I'm looking forward to seeing that report and to see the progress that has been made in the indicators and the update from the indicators. But I was going to -- I don't know if you have on your radar this California Healthy Places Index.

This is a tool that health professionals and

communities can use to explore and address the health of California communities. This is developed by the Public Health Alliance of Southern California and the Virginia Commonwealth University Center on Society and Health and provides kind of an overall score for each community and offers the Bell Data to identify areas with the greatest potential for impact. So, I think that is worth looking at it - talking about healthy communities to have scores that -- and indicators that can help us get there.

My final comment is, Marina, it's great to see the (laughter) -- that report out, you know, is a protracted pregnancy.

(Laughter.)

AC MEMBER AGUILAR-GAXIOLA: But it's great to see it. And, Sarah, it's in a great, you know, paper. The quality looks terrific. So, I'm very pleased to see that out now, and thank you for organizing the fantastic meeting that happened.

But I want to just share with all of you that the level of complexity of the second phase of the California Reducing Disparities Project -- I don't know if it dawns on you, but Marina talked about 41 entities across the state that they have to oversee and supervise and provide site visits.

This is one of the most complex studies that I'm

aware of nationwide and internationally, for that matter. And to be able -- to see that as part of the community engagement unit that you lead, it's just a really, really awesome undertaking, and I want to thank you certainly as the leader, certainly La Roux, that you are overseeing the CRDP. And the team, you know, many of whom are here for this incredible work - very time-consuming but also very rewarding, you know, with an incredible promise to be, you know, a flagship for California and the nation, quite frankly.

So, I think that it is incumbent upon us to be ambassadors about that as well, and I would encourage you to take a look at it because I think that this is really solid, thoughtful, and potentially impact -- very impactful work, unique in many respects.

DR. NOLFO: Thank you so much, Sergio. Would you mind passing the mic down to Dexter?

AC MEMBER LOUIE: Dexter Louie. Again, I'm the in-house skeptic.

(Laughter.)

AC MEMBER LOUIE: And so, you know I've learned something from a school superintendent that I worked with for ten years. He was from Redding - White area, 1 percent Black, you said, high Medi-Cal population, and what he taught me was - and he was a White guy (laughter) -- what he

taught me was, Dexter, you can do anything, you just can't do everything. And, you know, that's what I hope the retreat gets us to.

The other thing I learned from him -- he used to say this: Dexter, I'd like to pick your brains. Have you ever heard that comment? I'd like to pick your brains? Well, I sort of thought that was my role here in AC is that what are your issues, what are your problems that I might be able to solve? Maybe not. Maybe I've had experience. Maybe I've had a bad experience.

But maybe you should pick my brains and everyone else's around here because Peter, who has done a lot of data, where do you want to put all your -- where do you want to put your money? What's your priority?

DR. NOLFO: I feel like you're throwing me a grapefruit right now.

AC MEMBER LOUIE: So.

DR. NOLFO: Are we ready to go onto the SWOT Analysis?

AC MEMBER LOUIE: Yeah.

(Laughter.)

AC MEMBER LOUIE: We're getting there. We are moving that direction because, again, I'm going to spend six hours here.

DR. NOLFO: That's right.

AC MEMBER LOUIE: I want to get something out of it, but I want to give something.

DR. NOLFO: Exactly.

So, I'm going to ask, are there any members of the public that wanted to weigh in on this? We didn't set up this section to do the discussion and public comment but, since we did have some discussion, I just want to see if there were any members of the public that wanted to weigh in.

Operator, would you open the lines to see if there is anyone on the line that wanted to weigh in on this particular segment of the agenda?

THE OPERATOR: Thank you.

Anyone in the -- on the phone, press Star 1, Star 1 if you would like to public comment.

No one has queued up for any comments.

DR. NOLFO: Thank you. I appreciate it.

Then, we are going to move onto the SWOT Analysis and it's based exactly on what Dexter just said, which is that you can't do everything. You may want to do everything, but you can't do everything. And so, fortunately, you guys are such a wonderful brain trust.

And so, this came out of the Sustainability Subcommittee meeting that we had in March and that we wanted to do a SWOT Analysis here at this meeting. So, that's a

strengths, weaknesses, opportunities, and threats. And Jo-Ann was -- thankfully stepped up to kind of be my thought partner on this exercise, so she's passing out some materials now that she and I have been working on.

Now, a SWOT Analysis -- the strengths and weaknesses part is normally looking internally. Within your organization, what are the strengths that weaknesses -- what are the strengths that you really want to capitalize on and what is your -- what is it that you're able to do uniquely or special?

And then, your weaknesses are -- you know, let's just be honest with ourselves, what is it that we're not so great at or where we really shouldn't go into that space because we don't have a lot of influence or expertise of whatever it may be?

So, that's the S and W part. The O and T is more external. The opportunities are what's happening outside of the organization? What's happening in the external environment that we may be able to ride the crest of a wave on - that there may be a window that we want to go through?

And what are the threats? What are the things out there that we really don't want to be blindsided by and that we need to take into account in our planning because they could mow us down?

So, what Jo-Ann said to me the other day was it

doesn't really make sense to do the S and W here at this meeting because the Advisory Committee doesn't necessarily know the strengths and weaknesses of the Office, but that should be left primarily up to the staff to do during the retreat that we will be doing within the next couple of months.

I thought that made a lot of sense and so to put the O and T, the opportunities and threats really here at play with the Advisory Committee.

So, we put together this worksheet for you and have kind of some exercises, a three-step process, that we're going to go through at a little bit of a clip because, as is wont to happen with our Advisory Committee meetings, we're a little bit overtime.

But would you like to say anything at this point, Jo-Ann?

AC MEMBER JULIEN: You're doing great so far.

DR. NOLFO: No?

Okay. So, what you have in front of you is this worksheet, and on the front page what we would like for you to do is to spend a few minutes listing what you might see as external factors, events, and trends. And so, I've put an example there for you.

As an example, increase power building to address the traumas and policies adversely impacting the African

American community - that that is something that we can see across our county. We can see it across our state. We can see it at the local level.

And so, what are some of the opportunities for health and mental health equity that might arise from that trend that we're seeing? Momentum and agendas set by a wide range of African American organizations and movements; public opinion and policymakers' increased sensitivity to the need for changes in law enforcement, incarceration, education, housing, business, and other systems. Even the U.S. Department of the Treasury has certified California's 879 nominated census tracts as Qualified Opportunity Zones.

These are all external to the Office of Health Equity, to CDPH, but they're opportunities that we may be able to somehow seize upon

Threats to health and mental health equity. We have profit-driven incarceration policies, explicit and implicit institutional and personal bias, the widening racial wealth gap, widespread residential and school segregation.

So, that's just kind of an example that I came up with, and what we would love is for you to spend a few minutes thinking about what some other factors might be and opportunities and threats that go with them. So, why don't you do that now and then we'll come back together and we'll

share out some of those are that you come up with.

And, if members of the audience would like to participate in this exercise as well, you're more than welcome to do so. I think we have 25 copies.

If you're on the phone and you're listening in, we would love to get your input on this, as well.

THE OPERATOR: Star 1, if you'd care to comment.

(No audible response.)

(AC MEMBERS worked on page one of the worksheet.)

DR. NOLFO: Why don't we take just a few more minutes and then we'll come back together and share some of what we have?

(AC MEMBERS continued to work on page one of the worksheet.)

DR. NOLFO: Remember that you're just doing the first page right now.

So, I'm going to ask that we do this: maybe we'll start down there with you, Linda. Take the mic in front of Manel and, if you could talk about one of the things that you have listed?

AC MEMBER WHEATON: For the first column - factors, events, and trends - I have growing income disparities. Is that what you meant?

DR. NOLFO: Yeah, so you have growing income disparities as the trend?

AC MEMBER WHEATON: Yes.

DR. NOLFO: And what are the opportunities in this -- and the threats that you see for health and mental health equity?

AC MEMBER WHEATON: I have that it's actually an election year, so it's an opportunity to identify candidates with positions who would be supportive of dress -- of addressing those issues. And threats to health and mental health equity - I have increased or unaffordable health care and the lack of health care access.

DR. NOLFO: Sarah, do you want to share one of the trends that you've got?

AC MEMBER DE GUIA: Let me just get one. Sorry. (Laughter.) So, I'll pick one that I think -- well, I would just want to ditto what Angelo said this morning around the youth movement and how the youth movement kind of is getting those intersections and really lifting them up, and, like, what more can we actually do to support them --

DR. NOLFO: Right.

AC MEMBER DE GUIA: -- so that, number one, they don't burn out, but number two, I think putting our voices behind something like that could -- it also could be -- we could leverage that -- their movement, right, and their energy in ways that maybe we don't have as much energy. So, just to kind of, like, ditto what he was saying earlier.

But I wanted to lift up in this particular area -- in oral health, there's a -- like, a national oral health movement that's actually putting health equity very much at the center of their work, who has brought in speakers and facilitators to help people come along in the discussion around race, ethnicity, immigration, LGBTQ -- like, really looking at that focus around equity, and how can we be more at the center of that?

And so, I think, are those models that we could replicate here in our space, in our capacity? And kind of looking at that as a potential model of how they've -- really bringing in social justice -- a social justice lens to the work that they're -- in every aspect of the work that they're doing.

I have more, but I'll just stop there.

(Laughter.)

AC MEMBER KAPPAGODA: So, I just learned about this, that the federal budget doubles the budget for the Community Development Block Grant program at -- which means that states are get -- state agencies that deal with child care and community -- and the child -- did I say Community Development Block Grant? I meant Child Care Development Block Grant, sorry.

The Child Care Development Block Grant is being -- the budget for that is being doubled -- is being -- it's a

huge increase and very surprising, given the trend of -- at the federal level for many of the other programs that we care about.

So, right now, state agencies that deal with child care are writing their state plans around how they're going to use this big influx of funding. And so, there may be an opportunity there for this Office to influence the language in those plans. And I don't know what the threats to health and mental health equity are, but as this was a Trump Administration initiative, there's probably something in there, but I don't know what it is.

(Laughter.)

AC MEMBER JOHNSON: Okay. Well, I kind of stole what you put down, but I switched --

DR. NOLFO: (Laughter.) Okay.

AC MEMBER JOHNSON: -- one thing - increase power-building to address the traumas of policies adversely impacting American Indian or Alaskan Native communities. I think some of the opportunities that we're seeing -- like, America -- a lot of urban and rural organizations and our tribes are really starting to use a lot of our traditions and culture to heal from traumas. And I think the CRDP Project is a great opportunity.

Some of the threats are the historical trauma cycle that we see that's so much impacting our families, and

stigma and racism.

DR. NOLFO: Thank you.

AC MEMBER CHENG: I'm not sure if I understand this practice. What I have put down is that what I observe is a lot of the immigrations -- immigrants go through immigration stress and historical trauma, especially experienced by a refuge population. And I would like to see more of discussion in that area in our -- as we look at what's possible out there and also in our discussion here.

Some opportunities, such as an educational campaign on something that's very basic, such as knowing the signs -- the five signs, and then to -- and something to demystify mental health stigma. And also establish standards for material translation, because a lot of our translations may be going through Google translation and it doesn't make sense to the target community.

And another opportunity, like what Carrie was saying, I see that -- CRDP as one of the opportunities to really look in -- to help us look into that.

Threats - I see that a lot of the materials do not necessarily reflect the community that it's attempted to target. For example, the verbiage, the language used may not be appropriate. Or sometimes an image or photo or lack of photo of their own community --

DR. NOLFO: Right.

AC MEMBER CHENG: -- may make people -- like, this is not about me. This is about something -- someone else.

And then, the other threat I see is that sometimes it's very convenient to transplant some intervention, some material from different ethnic or cultural groups without going through the culture translation - that totally missed the boat. It doesn't make sense to the target community. I see these two are the major threats.

DR. NOLFO: Thank you.

AC MEMBER EWERT: Just have one?

DR. NOLFO: Just one.

AC MEMBER EWERT: Okay.

One thing that's affecting rural parts of California is a grant from SAMHSA the DHCS got to expand medically-assisted treatment for substance -- for opiate dependency disorders, and there are many -- very rural parts of California really have no -- medically-assisted treatment to speak of - Suboxone or methadone. So, this grant is creating hub-and-spoke systems all throughout the rural parts of California. And so, that's an opportunity to increase equity of that particular health service in rural areas.

DR. NOLFO: Any threats that you see?

AC MEMBER EWERT: Well --

DR. NOLFO: Associated with that?

AC MEMBER EWERT: If it gets implemented right, I don't see threats.

(Laughter.)

AC MEMBER EWERT: If there's threats, it --

DR. NOLFO: Yes.

AC MEMBER EWERT: -- won't happen or be done properly.

DR. NOLFO: Yes.

Dexter?

AC MEMBER LOUIE: Dexter Louie. I guess I'm the education advocate here. So, you know, it's like a broken record. I think education is really important because it goes to all the socioeconomic factors that we've discussed - in particular, the growing education gap. And so, education is, of course, what leads to workforce and income issues.

So, you know, in the matrix, I thought about, you know, where do we want to have impact? What's the potential impact? I think education is very big, preschool in particular, because it's a critical step to closing the education gap. In other words, if you're not reading at grade level in third grade, you're done. You never catch up.

So, what are the opportunities? Well, California is the 47th in education funding. And we used to be number five or ten, somewhere in there. And so, this should be an

opportunity -- it should be a priority for the next generation of patients or whatever you -- workforce.

What are the threats? California budget, Prop 13, the Legislature, and the governor.

AC MEMBER JULIEN: All right. So, I think -- I don't know if it's because I sit next to Dexter, but I also -- as we were having similar thoughts, but education, I felt -- also, I'm an advocate for education, like yourself. I feel like, increasingly, there's not just an education divide, but I see that there's a technological complexity, there's a legal complexity, and there's people that just seem to be moving in one track where they're understanding those things, and then other people that are getting left behind, and that really makes me nervous. When I saw the numbers today with kids at 46 percent in third grade, reaching at or above level, that's -- we're going to be here twenty years. That's not just a now problem.

DR. NOLFO: Right.

AC MEMBER JULIEN: And so, I feel like we need to have a sense of urgency about -- where, like, our hair's on fire, because it's going to be on -- it already -- it's something that just needs to be addressed. And I know that there's lots of social determinants, but, for me, I think that's the biggest one where I just see it plugs into so many other issues, and it's not okay to see those kinds of

numbers and go, okay, and then on to the next thing. Because, for me, I'm like, oh, my gosh, that that's so -- that's an issue and I do want to see us do something about education.

I feel that the cost of living and cost for basic human needs seems to be something that's going up with no end in sight. Housing prices are -- I don't even have to tell you how ridiculous it is to get an apartment and what that costs for regular people. And I feel that we have to do something as a state to help mitigate some of that. That's eating into people's budgets for food.

DR. NOLFO: Right.

AC MEMBER JULIEN: For pharmaceutical drugs that they might need. People have to decide - am I going to put my kid through any sports or not, because I can't afford it because I'm paying rent, which is twice what I really want to be paying. So, I think housing and education - we have to do something about these trends, and we'll have huge impacts and those are opportunities.

I think, also, there's a trend towards this lack of civility online and in public discourse that's fueling deep-rooted sentiments and aggregating -- or aggravating wedges between groups of people. I feel like teens are a good example where they're sort of bearing the burden of having to navigate in worlds we never had to deal with.

Being a teenager's hard enough as it is, but now they're 24-7 exposed to these abuses online of people being completely uncivilized, and I feel like it's too much to ask of children to have to navigate those kinds of things. So, I'd like to see maybe the tech industry brought to the table with some creative solutions, maybe some funding, because we're seeing teen suicide rates skyrocketing.

DR. NOLFO: I think you're jumping into kind of solutions, but what do you see as the opportunities around the education gap or the housing crisis? What are, like, some of the opportunities that you see and what are some of the threats that you see there?

AC MEMBER JULIEN: So, I have here -- those are the three factors, events, trends were the costs of living, the growing divide, and then the civility issue. Those were the factors, trends. I see those as threats to public health. I see those as threats to wellbeing and mental health. I don't see them as opportunities, so I couldn't really -- I was kind of in that mode of, like, the sky is falling, and so it's really hard to see them as -- oh!

DR. NOLFO: (Laughter.)

AC MEMBER JULIEN: But in here, this crisis, there's something great about it. Because I wasn't -- I couldn't do that. So, what I did for you was I just put together general opportunities in terms of the time that

we're in. And they -- and some of them have been mentioned.

So, we know there's a new governor coming. It's a great opportunity. I feel like California is well-positioned to be a leader in some of these areas, and the extent to which we can be a beacon of light for the rest of the country could have national implications, so I think -- let's not forget that. That we -- what we do here will be seen by other people, and I think that is an opportunity in and of itself, just because we're California.

We can do things here that I think other people can't. I feel like we could bill ourselves as an inclusion state and then try to live up to that, so it becomes an aspiration that we fully embody that, and then we kind of bring people along in that. I think the tech industry being here is an opportunity because they can come with solutions and ideas, and I feel like we might want to engage with them.

So, those were kind of some of the -- and I think there's a couple of movements happening with -- well, there's a number of movements happening, but I think we need to leverage the ones that we can clearly see are moving - so the kids reacting to gun violence, the MeToo movement -- there's a number of people that are just saying, like, enough is enough on certain fronts, and I feel like putting energy behind those things and rallying people together -- I

think we're capitalizing on an opportunity. But those are more general statements for opportunities.

DR. NOLFO: Okay.

AC MEMBER JULIEN: And that's -- but I -- that's how I wrote it.

DR. NOLFO: Thank you, Jo-Ann.

Mike?

AC MEMBER WITTE: So, I'll be echoing some of the things that we've heard here, but one of the things that rises to the top for me is how we're communicating. I think there's -- and what I -- the way I put it in here is the accelerating -- the acceleration, really, of the internet and social media access, and we're seeing it now writ large with all the stuff going on with Facebook, et cetera, and the dangers there.

But, in terms of health care, the personalization of how we can actually meet people where they need to be met, how they need to be met, with whom they need care is really accelerating with respect to points of service. That doesn't have to be necessarily a face-to-face. I think there are certainly organizations - Kaiser is an example of this - where how -- where there are many different ways to provide service to people that doesn't necessarily mean a face-to-face contact, because we have so many other ways of being able to communicate.

And this is also communication with each other. One of the big opportunities I've seen writ large is crowdsourcing information. That is taking -- where, particularly in our area that I work in with -- where we all work in, really, with vulnerable populations, the safety net where there's decreased access to, say, specialty care.

There are now many tools -- the Human Diagnosis Project is one of them that I know about where there are actually many, many -- 7,000 doctors internationally that signed up to be able to make themselves available to give information to someone like myself in, let's say, a clinic out in the boonies, to give me information that is real high-level, high-quality information regarding a problem I might have, and this is backed up by machine intelligence, which is increasing in terms of the way that it actually can provide us more accurate, valuable information with better data.

So, all those things are really great. And then, on the other end, of course, there are privacy threats that are huge. And there's also the big-time threat of decreased face-to-face contact and more isolation and tribalism. I think those are things that are always a real risk with these different kinds of tools that are -- have great value, but also threats to us.

DR. NOLFO: Thank you. So, we wanted to be able

to do that as sort of some context-setting around the goals. You know, we talk a lot about Portrait of Promise. At the last meeting, I went through the survey results that I had gotten from those of you who participated in that SurveyMonkey that I put out around kind of prioritizing the goals within Portrait of Promise.

Of course, there are, like, thirty-one of them and it's a bit overwhelming and daunting, and really one of the things that came out of that conversation at our last meeting was that the way that the strategy was written was that we would lead off with assessment, because it was really important for us to have a better understanding of the problems and the possibilities, and that that would flow more into communication, how are we communicating, getting on the same page around the problems and the possibilities. And then, ultimately, we're looking at infrastructure, which is how do we change and bolster our institutions to effectively act on our behalf?

And that we had -- so, we have a lot of goals in that last infrastructure strategy of Portrait of Promise, and some of them we've sort of waded into, some of them we haven't, some of them we actual -- actually have staffing to do. You know, some of the projects that you hear us talking about - CRDP and climate change and HiAP and whatnot. So, some of those are really just kind of baked into the

Portrait of Promise.

But then, we have some of these goals that really are more aspirational in nature. And so, we may be doing them as we're able to, but we really don't necessarily have the resources to go after them.

Those were the goals that, for the most part, I wanted to put in front of you today, because I wanted to get from you if we are able to essentially lead and have the funding follow. What does that look like, as opposed to kind of going in the direction of the funding?

And it is altogether possible that these goals that we came up with together a few years ago are no longer relevant, that, you know, we can sort of put them to the side because, you know, they don't have the same kind of meaning now that they did then, and we should know that. Or, that it's like, no, they're just as relevant now, maybe even more relevant now, than they were a few years ago, and so we really should be doing everything we can to go very strongly after them.

So, I have sort of taken the spirit of the goals, those that seemed to rise to the top as much as possible in that survey that we did during the last -- or in preparation for the last meeting. So, I've taken the ten that I -- out of the infrastructure strategy that really did seem to have the most resonance for folks and have sort of paraphrased

them here.

And we want to ask you to rank them on the third page, but before you do that, you have this opportunity under additional specific goals that, if you feel like these aren't the right goals, you know, to choose from among these ten -- if you feel like there are other goals that may have surfaced during the conversation that we've been having, thinking about the opportunities and threats, to go ahead and put those down so that those can be considered, as well.

So, they should be specific enough that we can do something about them as an Office, that we can actually get some traction around them. But, I love the language that Jo-Ann uses - that they can be bold and audacious, as well, so don't let that stop you.

So, take a moment and read through the ten goals that are here. Like I said, if you feel like there are additional goals that are not really represented in this ten that you feel strongly that we should be going after, go ahead and list those on your page. I did bring some copies of Portrait of Promise just in case folks actually want to refer back to the actual language of the goals and kind of what we wrote and said about them.

I'll give you a few minutes to look this over. Feel free to ask questions if you have questions.

(AC Members reviewed page two of the worksheet.)

DR. NOLFO: And before we move on to the third page, the ranking page, I'm going to ask - if you did add a goal or two on page two, would you share it with the group? Because other folks may want to include that in the goals that they're ranking. So, I'll give you a moment to jot down if you are in fact adding a goal or a couple of goals.

(AC Members worked on page two of the worksheet.)

DR. NOLFO: So, Mike, I'm going to start on your end. Did you add any goals? Can you use the mic, please?

AC MEMBER WITTE: Oh, sure. No, I haven't, but I've -- well, let me put it this way. I think, within these goals that I saw here --

DR. NOLFO: Yes?

AC MEMBER WITTE: -- it seemed like these had -- even though my own wording might be a little bit different, but I think the rest is some of the goals that I think are prioritizable. (Laughter.)

DR. NOLFO: Okay. Good. All right.

AC MEMBER WITTE: For Office -- for us. For the Office of Health Equity AC. So.

DR. NOLFO: Okay. Okay. So, did you add any goals to yours, Jo-Ann?

AC MEMBER JULIEN: Yes.

AC MEMBER WITTE: Can we hear you -- what goals

you added?

AC MEMBER JULIEN: Well, I have -- I have this idea that someone -- and it could be the Office of Health Equity or it could be someone with us in partnership, but I would love to see a series of strategies or agendas - for example, a children's health agenda, an African American health agenda that cuts across and includes the big-picture stuff. Because I get we have a -- we have a diabetes program for somebody here.

DR. NOLFO: Right.

AC MEMBER JULIEN: But, for me, unless we have a strategy with an agenda that includes those systemic, big-picture, big-ticket items --

DR. NOLFO: Right.

AC MEMBER JULIEN: -- we're just going to be doing these little tweets all the time. So, I'd like to see a series of strategies for women's health, children's health, African American, where you can bundle in all the great work that's happening currently.

DR. NOLFO: Mm-hmm. Yeah.

AC MEMBER JULIEN: We're not saying nothing's being done.

DR. NOLFO: Yeah.

AC MEMBER JULIEN: There's just -- everything has a home in the broader agenda. And there's funding, and the

funding rolls out to counties and to communities and to people who need it, and we can -- by cutting across these different ways, I feel that we're going to get at a lot of these issues. Thank you.

DR. NOLFO: I'm a little bit sad that I wasn't here to present my -- I actually presented -- I put together a bunch of stuff on that for this morning, but it didn't happen. Sorry.

AC MEMBER JULIEN: Okay.

DR. NOLFO: But I was thinking maybe I would just send it out to you guys, so. Okay. And you had more?

AC MEMBER JULIEN: I just started writing that one. I could probably come up with more, but I will hand in my sheet at the end.

DR. NOLFO: Okay. That sounds good.

Dexter, did you add any goals?

AC MEMBER LOUIE: Dexter Louie. I did not, because what you listed here in -- I tend to be a lumper rather than the splitter.

(Laughter.)

AC MEMBER LOUIE: Lump -- you lump them nicely --

DR. NOLFO: Yes.

AC MEMBER LOUIE: -- because it covers just about everything.

DR. NOLFO: Good. Okay.

Did you list any new goals, Donnell?

AC MEMBER EWERT: I did.

DR. NOLFO: Oh, here you go.

AC MEMBER EWERT: Let's see here. Well, I listed a couple that I mentioned earlier - convene local health departments and a health equity conference. You could partner with CHIAC (phonetic) and CCLHO on that. Seek grants from The California Endowment to expand staffing. These are kind of objectives, maybe. Partner with local economic development corporations to use the 879 qualified opportunity zones to promote job growth in disadvantaged communities that -- maybe that's part of the IC 2.6.

DR. NOLFO: I put that under the health equity zone, maybe.

AC MEMBER EWERT: Yeah, maybe. Yeah.

DR. NOLFO: Okay.

AC MEMBER EWERT: Collaborate with education partners, such as Department of Education and community college chancellors' office, to address some equity and educational outcomes. I just wanted to mention that, with the new education dashboard the district's required to use now, they actually have to break down the data by student group.

And this is a revolutionary thing for school districts, and, like, in my county, for example, there's six

areas. I can't tell you what they are exactly, if they have to break down all the data, but I know -- I mean, one thing that's been identified is chronic absenteeism -- or that's one thing they have to look at. And in our community, there's a very significant problem with the Native American community in that -- in chronic absenteeism. And chronic absenteeism various dramatically by grade, and it's actually quite high in the very early days - kindergarten and first grade, which probably contributes to not being able to read by the time you're in third grade.

DR. NOLFO: Yeah.

AC MEMBER EWERT: And a lot of the times it's chaotic families, families with a single parent, with transportation problems, et cetera. So, there's huge opportunities right now with that.

And the other thing is that community colleges now are offering the first -- the California Promise - first year of community college for free. So, what does that mean for communities -- low-income communities?

And then, finally, consider policy responses to the federal tax policy, which really is a disaster. It's a catastrophe for equity. You know, dramatically shifting wealth in our country, even more to the one percent. You -- what can we do in California to address that, since, you know, a lot of Californians are benefiting?

DR. NOLFO: Mm-hmm. Thank you.

Carrie? You did not have any.

Manel, did you add any?

AC MEMBER KAPPAGODA: Yeah, I added -- along the lines of embedding the health and mental health equity goals in funding allocation, I added one that was embed health and mental health equity language in legislative language and agency policy, which I think may be happening, but I think that that is a role that this Office could play. And then, I thought just bullet one and bullet four were more or less the same thing, so just in terms of being a lumper, not a splitter, I would lump those two.

DR. NOLFO: Okay.

AC MEMBER DE GUIA: Two that I centered on, and I just -- I ditto Jo-Ann's around kind of developing an informed agenda across different populations, so sort of identifying what are those similarities. I'm probably not going to say this great but prioritize the root causes of inequities related to economic development and through supporting family and child education and economic development. So, in other words, I think it's important to focus on the child, but I don't think you can ignore the situation of the parents and families as a part of that challenge.

So, in supporting the child, you may also look at

child care subsidies in order to make sure that the mom has an opportunity to accept -- or the mom or dad. And then, the second one is a little bit building off of IHF 1 -- the top -- the bullet on the top in the second column on the right-hand side.

So, yes, it's important to respond to equity considerations and the ACA, but I also think it's an opportunity to, as you're -- to embed public health and health equity into the health care delivery system. So, how can we not only build on the ACA but also make sure that we're bridging across to the public health sector, and really embedding that, those social determinants of health, into the expansion of the ACA, as well?

DR. NOLFO: And that may be there with the second one, as well, under that support health care institutions to partner with health allies, but I think that that was part of the intention in that one.

AC MEMBER WHEATON: I thought that, in general, there should -- would -- there should be specific focus on leveraging youth activism in these areas. I think it relates to some of the educational and the other input. I don't know for -- like, this is the next page or not, but I thought then an opportunity on -- for IHP 2.4 would be for training and TA for housing providers with the new SB 2 homeless funds. That would be a lot of money going out to

communities and for supportive housing.

DR. NOLFO: So, thank you.

With that, then, if you flip the page over and give us in ranking -- so, number one, if there was one goal that the Office of Health Equity was going to throw itself behind, assuming that we could get the funding or the capacity or the political will or whatever we need in order to do that. What would that be?

And it could be one of the Portrait of Promise goals - that's here, you could just put the number. It could be one that you heard around the table. It could be one of the Portrait of Promise goals that sort of is tweaked based on some of the things that have been said around the table. But give us your order -- you don't have to do all five if you don't want to. If you feel like there really is only one, or there's only one or two or something like that -- but we wanted you to have the opportunity to give us your top five.

And then, you can see the other information that we're asking for to go along with that. So, if there are specifics that go along with that. Like, if you feel like it's really important for us to do that particular goal in the education space, or the housing space, or where the particular sector or particular population, let us know that.

And then, the idea is funding websites, documents, connections, events, policies, models, or other resources to build momentum for this goal. Some of you talked about some of that going around the table, you know, like this is already really happening within the oral help world -- so maybe we can capitalize on that, whatever that may be. And then, whether you have personal interest or expertise or organizational resources to support this goal, let us know that, as well. Okay?

Now, it is 3:24, so we're going to close out altogether here in 35 minutes, and I don't know if folks need a little stretch break while you're completing page three, but I know that we also have some cupcakes in Linda Wheaton's honor.

And so, if folks would like to stretch, get a cupcake, maybe a cup of coffee or something, and come back and finish up this exercise - I think that that would be perfectly okay. How do you feel about that?

(Affirmative responses.)

DR. NOLFO: Yes? And before we send you off to get your cupcake, I just want to say, Linda, you're going to be hard to replace. Like, I understand that you're looking to infuse, you know, some new blood from the Health in All Policies task force. And so, this is one of the two seats on the Advisory Committee that's actually a dedicated

seat. We have one for a member of the Health in All Policies Task Force. We have one for DHCS, and that's in our mandate, but I feel like we were just incredibly fortunate to have you as the first representative from the HiAP Task Force.

I was telling you -- over lunchtime, I actually remembered your first day here, because I was a member of the public coming to that meeting, which was in January of 2014. And Jahmal introducing you, and so -- just how wonderful it's been to have you as a part of this team over the past four years.

The kind of insights that you have from insight of government -- I feel, like, have been just really, really invaluable. And just this wealth of experience that you bring to this table. So, thank you so very much. Do you guys want to join me in thanking Linda?

(Applause.)

AC MEMBER WHEATON: I just want to thank you. I feel like I've learned more than I've perhaps contributed. It's -- you know, I think we have -- there's a lot of crossover work. It's incredibly important work and thank you for the opportunity.

DR. NOLFO: A little certificate. (Laughter.) Thank you. We appreciate you.

Come and have one of those amazing chocolate

cupcakes provided by Sierra Health Foundation and then we'll come back into the room.

(Refreshments were served.)

DR. NOLFO: I wish I had a gold star to give to those of you who are left here in the room.

(Laughter.)

DR. NOLFO: I'm like really the folks who are going to power through it all stay with you to the end. I had the opportunity to go to the Equity Summit -- Policy Link's Equity Summit in Chicago a couple of weeks ago. Sandi was there, a bunch of our folks from Marin City were there. That was awesome.

It was amazing, but they really talked about solidarity. Solidarity, in part, being, like, I don't necessarily even know what you're fighting about, but I'm going to fight with you.

(Laughter.)

DR. NOLFO: I'm going to be right there with you, right? Like, if it's your fight, then it's my fight, and I feel like that quite often in this whole health equity movement. Like, if it's important to you, I'm going to stay and learn and be present until I really understand why it's so important to you.

So, now you guys are going to make me cry. But it's a fight that I really want to continue to be in with

all of you moving forward, whether it's with the Office of Health Equity or in some other capacity, but I feel like you really understand that notion of solidarity, right, and that power building - that we have the ability to do together. It feels like we're really at this moment in history where the forces are aligning for us to be able to do that. And so, that's pretty exciting.

Is there anything that surfaced that you guys were doing on your worksheets that you would like to have the last word on? Because I'm going to collect the worksheets from you. I'm going to probably follow up with you if it looks like there's some more that I need to know about what's on them, if I can't read your handwriting, if I need to just dig a little bit about something that you had to say.

AC MEMBER KAPPAGODA: So, you want us to put our names on this?

DR. NOLFO: Yes. On the last page it has a submitted by. You could put your name down there under submitted by or on the front - wherever. So, yes, put your names on it. And you can even put on there if there's a section where it's, like, I want to tell you more about this or, you know, if you didn't have a chance to, like, fill it all out but you want to just talk to me some more about it, you can just put that on there.

So, we had on the agenda to be able to talk a little bit about the next Advisory Committee meeting, which is going to be September 17th, and you're going to be chairing that, right, Sarah and Manel? Congratulations, by the way. I wasn't here when you were formally voted into office, but I'm so very happy.

What I have told the unit chiefs is that we will come together at some point here in the next month or so that will get you guys together with them so that we can do some thoughts around the September meeting and do as much planning together while I'm still here.

But while we are still in this public space, I wanted to give anyone else who's around the table an opportunity to say if you wanted to weigh in any anything pertaining to the September meeting.

Yes?

AC MEMBER KAPPAGODA: So, one of the things I was -- just -- this prompted my thinking this afternoon was it would be great for the Advisory Committee to develop a simple work plan with timeframes for ourselves for the next year. And I'm not imagining something grand like a strategic plan but, like, two pages and we set goals for ourselves, like getting all the seats filled on the Advisory Committee, for example.

DR. NOLFO: Yeah. Yeah.

AC MEMBER KAPPAGODA: And then we work through those and we can evaluate ourselves at the end of the year to see how we've done.

DR. NOLFO: I like that.

And, in reference to that, by the way, we do have a few seats that are open and I just do want to say we have a new member who is coming onboard. We're going to bring her on formally tomorrow so she wouldn't count towards the quorum today since she's out of the country right now, but her name is Simran Khar (phonetic). I'm probably pronouncing her last name wrong. But she's from the Central Valley and we're pretty excited to have her. So, she will be at the meeting in September. But you're right - there are a still a few seats open, as well.

And in terms of doing the work plan, do you want to try to put that on the agenda for the Sustainability Subcommittee meeting in June or would you like to actually put that on the agenda for the September meeting?

AC MEMBER KAPPAGODA: I think we could probably work on a draft at the Sustainability Subcommittee meeting in June and then bring it to the full meeting --

DR. NOLFO: Fantastic.

AC MEMBER KAPPAGODA: -- for discussion in September.

DR. NOLFO: And so, the meeting that we're looking

at - we haven't nailed it down; hopefully this works on your calendar, Jo-Ann - is June 26th from 3:30 to 5:00. It's a phone meeting and Guillermo said he was available during that time. And that's open to anyone on the Committee and any members of the public, as well.

And so, we'll have more of an opportunity at that meeting, as well, to kind of flesh out for the September meeting.

Rocco, you wanted to say something?

AC MEMBER CHENG: Yes.

Now that we have this strategic plan --

DR. NOLFO: Yes.

AC MEMBER CHENG: Three or five years later.

DR. NOLFO: Yeah, right?

AC MEMBER CHENG: I would like to see some discussion on that and how we could line it up with the Portrait of Promise, how we could leverage both, and then really utilize the opportunity. They stay put so much resources into doing the CRDP project.

DR. NOLFO: Right.

AC MEMBER CHENG: Now that we have the Phase 1 of the strategic plan, what can we do more about it?

DR. NOLFO: Absolutely.

Yes, Sarah?

AC MEMBER DE GUIA: And kind of following on

Rocco's point, I was actually going to see if we can maybe suggest to the OHE staff, the other units, if maybe they could take, like, one or two particular issues or topics that they talked about today and maybe just do a little bit more of an in-depth presentation on them rather than kind of trying to give us --

DR. NOLFO: Sure.

AC MEMBER DE GUIA: -- like, the whole picture.

DR. NOLFO: Right.

AC MEMBER DE GUIA: Its -- the updates are great --

DR. NOLFO: Yeah.

AC MEMBER DE GUIA: -- because they kind of give us a good sense. And I know that we will be coming up -- in September, we'll be coming up on sort of the end of the legislative year, so if there's anything written that can be submitted ahead of time, that's kind of the -- that would be, like, a good overview, but then see if they want -- if they can go a little bit deep, so, like, CDEU - it would be great if they could do a presentation on the CRDP. And then, maybe Solange and Peter could maybe focus on a couple of particular issues or whatever. So, that would just be a suggestion.

DR. NOLFO: Absolutely. And one of the things that I'm proposing - we'll see whether or not it happens -

but for the unit chiefs to kind of rotate taking leadership for these meetings. And so, there may be one meeting that's really focused on what's happening in Solange's unit and one that's more focused on Peter's, and so for -- so forth, but so that you guys would work specifically with that unit chief on the upcoming meeting.

Yes?

AC MEMBER LOUIE: You know, I mentioned it earlier and, you know, I appreciate the updates, but no one asked me a question about anything. Do they have any problems? Any obstacles?

DR. NOLFO: Right.

AC MEMBER LOUIE: Anything that they don't recognize?

DR. NOLFO: Right.

AC MEMBER LOUIE: And -- none of that today.

DR. NOLFO: Absolutely.

AC MEMBER LOUIE: And, yet, we -- I've been here six hours.

DR. NOLFO: Well, that was what the whole SWOT Analysis was -- was taking your --

AC MEMBER LOUIE: But this was -- yeah.

DR. NOLFO: Okay. Good.

AC MEMBER LOUIE: This -- but this was the one opportunity.

DR. NOLFO: Okay. Fantastic.

AC MEMBER LOUIE: Otherwise, I was just listening.

DR. NOLFO: Yes. No, I absolutely hear you, Dexter, that I think that that's one of the things that, over the course that I've seen in the four years or whatnot of this Advisory Committee is, like, how to make the most out of having you guys during this time, because there are real challenges that we have in the Office. And so, how do we pull from you what you know --

AC MEMBER LOUIE: Yeah, we don't know --

DR. NOLFO: -- to be able to help --

AC MEMBER LOUIE: We don't know those challenges.

DR. NOLFO: -- help us with those challenges?

AC MEMBER LOUIE: Yeah.

DR. NOLFO: Right.

AC MEMBER LOUIE: Okay, I won't call you.

(Laughter.)

DR. NOLFO: Yes, Jo-Ann?

AC MEMBER JULIEN: I would just echo. I think it's worth seeing we're having similar thoughts, but I love when people have an activity, a breakout, a brainstorming because we all come with so much that we want to give.

DR. NOLFO: Right.

AC MEMBER JULIEN: And it's just -- it's a matter of, yes, feed us information and impress us with what's

happening, but also let us be experts and let us help and let us really dive in and roll up our sleeves and be creative.

DR. NOLFO: Exactly.

AC MEMBER JULIEN: And so, to the extent we could do more activities like that, exercises - I think that's really fun. It's also engaging, but then you're getting value added.

DR. NOLFO: Right.

AC MEMBER JULIEN: That actually -- oh, I wanted to talk about the positions that are open on the Advisory Committee.

DR. NOLFO: Yes.

AC MEMBER JULIEN: I would love to see people that are a little bit out of the box in terms of their expertise. So, I would love to see someone with an education -- someone who could influence education, who knows how the education system works and what the caveats are in the education system.

DR. NOLFO: Okay.

AD MEMBER JULIEN: Somebody with that knowledge, I think, would be really valuable to our conversation since education is so central to public health.

DR. NOLFO: Okay.

AC MEMBER JULIEN: And then, also, maybe somebody

with some economics.

DR. NOLFO: Yes.

AC MEMBER JULIEN: You know, somebody who attacks policy.

DR. NOLFO: Right.

AC MEMBER JULIEN: People who really understand how determinants of health are impacted and influence, because I feel like we have great skillsets and we're diverse, but we need some of these other people --

DR. NOLFO: Yeah.

AC MEMBER JULIEN: -- to come into the echo chamber.

DR. NOLFO: Thank you.

Mike?

AC MEMBER WITTE: I think I've said this before, so sorry --

DR. NOLFO: Is that on? I can't hear you.

AC MEMBER WITTE: -- if it's repetitive but --

DR. NOLFO: There we go.

AC MEMBER WITTE: I think it would be good to have somebody from public safety involved - that's fire and police -- and/or police. I think that they're sometimes often seen as barriers for a lot of the population we take care of and we heard that today in terms of police versus the African American community, and that needs to get

healed. So, I'd love to have them at the table.

DR. NOLFO: Thank you.

Dexter, were you trying to say one more thing?

AC MEMBER LOUIE: Just --

DR. NOLFO: Would you mind passing him the mic?

AC MEMBER LOUIE: This is Dexter Louie, again. Yeah, just based on what Jo-Ann said about an education person, we are going to elect a new superintendent of public education for California this year and he'll bring in a -- he or she will bring in a staff -- well, I think it's Thurman or Tuck - but (laughter), you know, we just had the push. You remember I commented on the Legislature congratulating itself on funding 7,500 preschool slots, but they forgot to mention that, in 2008, they eliminated 75,000 slots.

DR. NOLFO: Right. Right.

AC MEMBER LOUIE: So, yeah, we need to get that funding back.

DR. NOLFO: Well, if there are no more comments, I'm assuming there are not any from the public, but I don't know.

Maricella, thank you for staying with us all day.

She was one of our interns and we're so happy she came back and spent the day with us.

So, if there are no more comments, then we're

going to close out and adjourn this meeting. And it's been wonderful spending the day with you. Safe travels home. Thank you.

(Applause.)

(Whereupon, the OHE Advisory Committee meeting was adjourned at 4:02 p.m.)

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CERTIFICATE OF REPORTER

I, REBECCA HUDSON, an Electronic Reporter and Transcriber, 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, and that I thereafter transcribed it.

I further certify that I am not of counsel or attorney for any of the parties in this matter, nor in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 15th day of May, 2018.

Rebecca Hudson

REBECCA HUDSON