

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

DEPARTMENT OF HEALTH EQUITY (OHE)

ADVISORY COMMITTEE MEETING

MARCH 25, 2014

SIERRA HEALTH FOUNDATION

1321 GARDEN HIGHWAY

SACRAMENTO, CALIFORNIA 95833

Reported by: Melinda Nelson, CSR# 12496

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SANDI GALVEZ: Good morning, everyone. We're going to call the meeting to order. We're -- I think a few more members of the Advisory Committee might join us. But we do have a quorum, so we should get started.

I hope everybody had safe travels to the meeting today. As we get to know each other more, we might get to a point of doing role call for our introductions; but since we don't yet, I thought we'd go around and introduce ourselves. And I'd like for everyone, just to kind of get us in the mood today, to share a very brief value or key notion that you'd like to see come out of our strategic map. And I'll start to demonstrate.

My name is Sandi Galvez. I'm the director of BARHI, which is a collaborate of 11 health departments in the San Francisco Bay Area. And one of the key notions I'd like to see in the strategic map is capacity building for many different parties.

And I'll go this way.

ROCCO CHENG: Good morning, everyone. I'm Rocco Cheng from Pacific Clinic. I'm the Corporate Director of Prevention and Early Intervention Services. We're from Los Angeles area, serving five counties.

And the core value I have for this meeting is inclusiveness.

JAHMAL MILLER: Good morning. I'm Jahmal Miller, the Deputy Director for the Office of Health Equity.

Building capacity is actually a core component of the strategic plan that I'd like to see reflected.

RON CHAPMAN: Good morning. Ron Chapman. I'm the Director of the Department.

And I think the value that I'd like to see is sustainability.

GAIL NEWEL: I'm Gail Newel. I'm an OB/GYN physician from Fresno working for the Department of Public Health there for Fresno County.

And I'm not going to let you forgot about the Valley.

JOSE OSEGUERA: I'm Jose Oseguera with the Mental Health Services Oversight and Accountability Commission.

And the value that I would like to see would be accountability in terms of the strategic plan.

TERESA OGAN: Hi. I'm Teresa Ogan. I manage the Multi-Purpose Senior Services Program serving seniors here in Sacramento area.

The value that I'd like to see is that consumers are the experts in their own lives.

DELPHINE BRODY: I'm Delphine Brody. I'm here representing Mental Health Client survivors and LBGQ folks.

And I am -- the value that I would like to see here most is anti-threshold framework.

CARRIE JOHNSON: Good morning. My name is a Carrie Johnson, and I am the Director of Seven Generation, which is a child and family counseling service at United American Indian Involvement in Los Angeles.

And I think I'd also like to see capacity building.

KATHLEEN DERBY: Good morning, my name is Kathleen Derby. I'm with the State Independent Living Council, representing people with disabilities.

And I would like to see community involvement.

ALVARO GARZA: Good morning. Alvaro Garza. I'm the Public Health Officer for the San Joaquin County.

And I'm very interested in making sure we get equal opportunity for everyone, inclusive.

JEREMY CANTOR: Good morning. I'm Jeremy Cantor from Prevention Institute. We're a national organization dedicated to community prevention and equity, located in Los Angeles, D.C.; and our headquarters is in Oakland.

And I would say the principal that I would like to see -- I think I'll go with sustainability as well, long-term sustainability.

PATRICIA RYAN: I am Patricia Ryan. I'm the retired Executive Director of the California Mental Health Directors Association and consultant for CMHDA.

And the quality I would like to see us include is effective outreach and engagement.

NEAL KOHATSU: Hi. I'm Neal Kohatsu. I'm the Medical Director of the Department of Health Care Services.

And I'll take one of Patricia's words, engaging members, patients, families, communities.

DIANA RAMOS: Hi. Good morning. My name is a Diana Ramos. I'm an OB/GYN. And I have a couple of hats. I'm representing -- I'm the Director for Reproductive Health for the County of Los Angeles Public Health Department. And I am also the Vice Chair for the Latino Physicians of California.

SERGIO AGUILAR-GAXIOLA: Hello, I'm Sergio Aguilar-Gaxiola, and I'm the Director of the Center for Reducing Health Disparities at UC Davis.

And effective outreach, engagement sounds great, but meaningful as well. Outcomes in accountability.

(Unidentified conversation.)

FRANCIS LU: Francis Lu. Emeritus Professor in Cultural Psychiatry at UC Davis.

I'd like to just bring forth the value of integration. Integration of health and mental health concerns to make sure both are taken care of.

AARON FOX: Aaron Fox. Director of State Health Equity and Policy at the L.A. Gay and Lesbian Center.

I'm just gonna walk it back a little bit. I'd like to see us sitting around the table, being on the same page and moving toward an understanding goal towards our strategic plan.

HERMIA PARKS: Good morning. Hermia Parks, Director of Public Health Nursing and Maternal, Child, Adolescent Health for the County of Riverside.

The value that I would like to see is access to care, the importance of making sure that not only we have services, but providers. Thank you.

DEXTER LOUIE: Good morning. I'm Dexter Louie. I'm and ENT physician in San Francisco's Chinatown. I'm with the CMA -- California Medical Association Foundation and the National Council of Asian Pacific Islander Physicians.

What I'd like to see out of all the strategic planning is that we really follow through with action, how many of these strategic plans end up on the shelf.

CYNTHIA GOMEZ: Good morning, everyone. Cynthia Gomez. I'm a Professor of Health Education at San Francisco State and the Director of their Health Equity Institute.

And I guess my sense of values for our day today would be to have passionate engagement in our dialogue.

SANDI GALVEZ: Thank you, everyone. Before I start, moving on into the logistics, I wanted to just thank the Sierra Health Foundation for hosting us to providing a lovely venue for us to meet, as well as sustenance to keep us going for the next two days. We'll be hearing from them tomorrow. They unfortunately weren't available to speak with us today.

So I wanted to start off by going through the agenda. The first part of this morning we'll be doing a little bit of business from the things we need to take care of before we move on to more substantive discussions around the strategic map. And then we've going to have Dr. Chapman and Jahmal give us an overview of things that are going on in the office.

And then we're going to be having several presentations both today and tomorrow of some key initiatives that are going on that staff really felt would help inform our thinking around what's possible in the State to address health inequities.

And then this afternoon, then we're gonna start moving into more focused discussions on actually what's in the strategic map.

And then tomorrow, it will be more of the same. We'll be having some presentations. And then substantive discussion around the strategic map in the afternoon.

So since our last meeting, Rocco and I have had the chance to meet with Jahmal and staff in the Office of Health Equity a few times to debrief how our last meeting went and to make some recommendations for a little bit of changes for this next meeting -- today's meeting. And some of those changes that we're having is -- so last month's meeting we had -- two months' ago meeting, we had a facilitator -- facilitators Lori and Tim, take us through a very in in-depth discussion around very many key things, and we felt that in the interest of time, and given the short time line we have for preparing this strategic map, that it really would make more sense to have staff take a bigger role in having those more detailed discussions, having -- and then making -- preparing documents to have us then discuss and give feedback on, make recommendations. So it will be quite a little bit -- very different the way we're gonna be -- have engaging discussions in the next two days.

Also, Cynthia Gomez, who's had a lot of experience using Robert's Rules of Order has graciously volunteered to be our parliamentarian and help us stay on

track. And in a little while, I'm going to ask Cynthia to -- she's gonna talk a little bit about kind of a more simple way of using Robert's Rules of Order, to help make our meetings more effective.

So other than that, let me move into some logistics.

So per the Bagley-Keene Open Meeting Act, all of our meetings are public meetings. And members of the public are provided opportunities to comment on any issues before us. And, you know, we'll apportion available time to those who wish to speak.

If you wish to provide comment, public comment cards are located at the registration table and in the back of the room. Please complete a comment card, providing us with the manner in which you would like to be called forward. You don't need to put your name and affiliation; although, we would prefer that. If you don't want to provide us with that, that's fine. But just let us know on the card how you wish to be addressed and please return your completed card to any of the OHE staff. And during public comment period, you will be called to the podium, which is there (indicating); and you'll be identified by the way that you listed yourself on the comment card. Prior to commenting, please state your name and identify yourself.

The amount of time designated for each comment will be determined by the number of comment cards we have for any given topic and the amount of time we have available. And then Debbie will go over a few housekeeping items with us.

DEBBIE KING: Hi, everybody. Welcome. It's good to see you all again and new. I wanted to just go over a few housekeeping items; emergency evacuation plan. So if you have a fire here, go out any of the exits. This one is (indicating) for if there's another kind of emergency, you need to get out to the parking lot. So let's say there's an earthquake or something and they want you to move out of the building, go out to the parking lot through this door, please.

Restrooms are right on the other side of this wall, both men and women.

Wifi Internet access for those of you who have not identified that yet is Bannon Island. So let us know if you have any problems with that, B-A-N-N-O-N ISLAND.

And if you have not previously received our E-notifications, we tend to send those out about once a week or so. So please make sure that you sign up at the registration table, and we'll add your name to our E-blast list.

And we have staff over in this area (indicating), back over in this corner (indicating), up front, and over against the back wall. If you need any help, just grab one of us.

And we have some court reporters here who are helping us today. And I think Sandi will probably walk through identifying them and letting them introduce themselves.

I do have a couple of things to ask about that was not on Sandi's list, so I'm going to bring that up now. Please speak clearly into the microphones so the court reporters can hear you. Hold the mic close to your mouth, and if you can angle your tent toward them so they can see your names, that would be fabulous. And remember to identify who you are for their purposes when you speak. And please speak with a microphone in hand so that they can make sure that they capture everything.

Any questions? Thank you.

SANDI GALVEZ: So thank you, Debbie. So as Debbie mentioned, we are having court reporters. We're going to be taking detailed notes of all that takes place in the next two days to facilitate our meeting note preparation for our next meeting. And our court reporters this morning are Melinda and Natasha. And then we'll be having replacements in the afternoon. Okay.

And you're going to go by and put the stickers -- is that? You've already done it?

MELINDA NELSON: Yes.

SANDI GALVEZ: Okay. Stickers done.

And so two other things for logistics. Please put your phones on vibrate, and I will try to remember to remind folks to put them back on at the end of the day.

And just in terms of making sure we have good participation and we have ample opportunity to allow everyone to speak, please try to use the principle of the step up/step down. So if you're usually someone that talks a lot and if you're noticing you're, you know, one of the people talking all the time, please try to step back a little to provide room for others. And if you're someone who doesn't usually speak up as much, try to push yourself a little bit and speak up more. And Rocco and I will do our best also to allow opportunities for everyone to speak.

So and lastly if you're gonna use an acronym, please make sure to spell it out so that everybody can understand what -- that we're all on the same page about what we're talking about.

Before we move into the rest of the items on the agenda, I think I'll pass it to Cynthia now to go over the presentation on Robert's Rules of Order.

CYNTHIA GOMEZ: Not to bore you too early in the morning, but good morning. So one of the things I was asked was to chat a little bit about how it may be more effect -- I know a lot of folks were frustrated at our last meeting, partly because we were trying to really follow fairly rigid Robert's Rules of Order. And what I have advised is for us to consider modern parliamentary procedures, which really allows us to do this a little bit more simply. And if you're interested, I have both books here, both modern and Robert's Rules, for those of you who have an affinity to looking at things like this.

But just by way of background, the only purpose of these parliamentary procedures are to ensure a democratic process in a group discussion. So that's really the purpose. So just keep that in mind, that sometimes we're doing this because of that.

And just -- we'll be, hopefully, giving you sort of a one-pager or a couple-pagers of things for you to remember in the future. But I just wanted to go by what the four principles are that are working behind when we have these discussions. One is the majority rules. You know, that's how we function. And our bylaws reflect that so, you know, there's majority, majority rules on a decision; the rights of the minority, so members who are voting with the minority retain all rights and privileges. So just ensuring that just because you might be in the minority, doesn't change your value or status. And if we're hearing committee reports and there was a minority group that decided to put in their own report, the full group could decide to vote for that, rather than committee report. So, just allows for protection of minority views. Equality of members. I think, you know, many of us here, we're here about equality. So that applies to our membership, which is that everyone has equal voice around the table. And, again, these procedures are to ensure that and to make sure that no one is, you know, being ignored; that we expect each other to be courteous and respectful to each other, and that any one vote carries the same weight as another member's vote.

And finally, freedom of discussion. So the right to be heard and to hear others is really critical, and again why we have some of these procedures.

It's really -- hopefully determines how you vote is that you actually listen to the analysis, to the data presented, and the deliberation, and perhaps get persuaded through our discussion with each other about how you ultimately vote.

But, you know, no member's right to speak can be limited, except under the rule where we limit time for everyone, so everyone's limited. So I can't just say, "Well, I'm sorry, Sandi, you can only speak for a minute." "But," you know, "Teresa, can speak for 30." We can't do that. "Equal opportunity for all," using that terminology.

And finally, just on the -- the world of motion, okay the world of motions. So Robert's Rules has over 80 motions available. And I would like to suggest that

we go down to about 14, when we use them. And I want to give the notion that first of all motion is really needed to accelerate time. It's not really meant to be anything more important than that. Usually use it when consensus-building is -- you don't have the opportunity to do that in a timely fashion. So you go to Robert's Rules to make a vote, rather than just a consensus. I encourage Sandi to consider if there's consensus going around, we don't need a motion. If the sense is that we've come to an agreement about something, she simply states the consensus agreement. And unless somebody is against that agreement, then we go on to the formal motion and vote.

So again, we'll give you a little chart about motions. There's an order of motions so that you know that, you know, if we've been adjourned, you can't suddenly bring in a motion because you'd be out of order.

So there's just a very simplified thing to do. There's also no absolute need for a second. So I want to mention that because you waste about two minutes every time we sort of decide, Is there a second? That was used, again, from a parliamentary historical perspective to ensure that there were two people in the room that really wanted to deal with the motion at hand. And most -- I've never been in a group where there isn't -- where that is not obvious. So "seconding" is really an unnecessary thing. So I would encourage us not to have to do a second because we have a motion and go to a vote. Again, it just accelerates time.

So these are little things that I'd like to just encourage us and then if we get confused about, Where are we? There should be only one main motion at one time. And then you can sort of do things to that motion, if you will. So last time we got stuck at the amendment of the amendment. We don't want to do that. What I'd like to suggest we do, is that we all talk about how we would like a motion worded before we even bring it to the table, if we're gonna use a motion.

So rather than say, "I have a motion," I would say, "I'd like to discuss the wording of a motion to get everybody to think about it with me." And then if we'd all agreed on that wording, then we can have the motion to vote. We don't have to go through all those amendments of amendments of amendments.

So anyway, that's sort of the general spirit. But hopefully it both gives people the history who aren't used to parliamentary procedures, where it came from, what the purpose is. It's not really a rule or a law; it's really how we want to function as a group. So I think we can be more efficient for ourselves.

SANDI GALVEZ: Thank you, Cynthia. So unless there's any opposition, I recommend we move forward with the recommendations that Cynthia has put forth; one, that we don't need seconds; and two, that we try to reach consensus on wording of things prior to anyone introducing a motion.

Any objections? Okay.

DEXTER LOUIE: This is Dexter Louie. With regard to reaching consensus and reaching a motion, sometimes the discussion becomes really chaotic because it's not done in an orderly way. So we might want to -- but we have to be consistent -- go to the main motion and then amendment. Just could go the other way, you have five different suggestions to reach a consensus, but you never address them, A, B, C, D, E. Just a comment.

Thank you.

SANDI GALVEZ: Thank you, Dexter.

So the first official item on our agenda is approving our minutes -- sorry. I went through the agenda. The first thing is approving our minutes from our September meeting. They're in your packet. At last month's meeting, I believe it was -- sorry, Dr. Aguilar-Gaxiola questioned the accuracy of one of the statements, "AC members addressed the need to establish an aligned message prior to meeting with community leaders." That was written on page 3. A regional issue to address health inequities.

And so OHE staff researched and found the statement to be inaccurate, and amended the minutes by removing that statement.

So we need to approve the amended minutes.

Do I hear a motion to approve the minutes from our September meeting, as amended?

(Motion made.)

SANDI GALVEZ: With a show of hands, I want to hear all those that approve the minutes.

Motion carries.

The next motion -- the next item on our agenda is to approve our minutes from our January meeting. And I apologize. I did not open it up for public comment for the approval of our September minutes.

Are there any members of the public that would like to comment on our September minutes?

Okay.

So hearing none, the motion still carries of approving our September minutes.

Our January minutes. They're in our packet. Are there any concerns with the minutes? All right. It doesn't seem like there's any comments from Committee members. Would anybody from the public want to comment on our minutes from our January meeting, either on the phone or in person?

Did we receive any comment cards to this item? Okay.

So do I hear a motion to pass our -- to approve our January minutes?

(Motion made.)

SANDI GALVEZ: All those in favor? Please show of hands. That's 15 votes. Any opposed?

Okay. The motion carries.

Our next item of business is our bylaws.

So if you all remember at our last meeting we postponed discussion of our bylaws because the counsel wanted to give some feedback and make some recommendations to our bylaws. Those have been sent to you. And hopefully you all had a chance to review them.

Would anybody -- does anybody have any comments on the bylaws?
Dexter?

DEXTER LOUIE: Is this a voting item?

SANDI GALVEZ: Yes.

DEXTER LOUIE: Then I did submit to Debbie some comments after reading what was sent out, which had already gone through Legal. And I made some other points. And they're in the handouts.

SANDI GALVEZ: Would you like to go over them?

DEXTER LOUIE: If I can find them. I think on page 4, section 3. It's section E, and it's number 3. "Subcommittees shall be comprised of Advisory Committee voting members and when available, community members."

And I assume that community members -- this suggests -- "comprised of" suggests that these community members are members of the subcommittee. I don't believe that's the intent when I look at number 4 here. The community members can be the outside members, in which case they'd be advisors or consultants. But in either case, they have no vote.

Whereas number -- paragraph 3 suggests that they are part of the committee and therefore have a vote.

SANDI GALVEZ: So, yes -- go ahead.

DEXTER LOUIE: Number 3 is not clear.

SANDI GALVEZ: Yes. Number 3 is not clear.

Cynthia has recommended that we could add to number 3, "and when available, nonvoting community members." Add the words "nonvoting" to make is clear that they are not voting members.

DEXTER LOUIE: What gets me is a later question that "Are committee members open to the public?" In which case the public is there to observe, as opposed to be a member of the committee. So there are two issues there.

SANDI GALVEZ: I think I recall from our September meeting that we did discuss this a little bit and I -- from what I recall, the ideal was that on subcommittees there would be some outside experts that weren't on -- that aren't members of the Advisory Committee now, it would be appropriate to have them participate as a member of a subcommittee to provide that expert content. In which case, they would -- I think it's different than just someone from the public observing the meeting, but it's someone who's a member of the community who's not a member of the Advisory Committee, who's actually on that subcommittee.

Does that make since?

DEXTER LOUIE: Yes, it does. At a subcommittee level.

Cynthia, I would agree with Cynthia's recommendation that it be clarified as nonvoting.

GAIL NEWEL: I also on that same sense would wonder if we could change the word from "available" to "appropriate." Because I think they'll always be available community members.

SANDI GALVEZ: So there's the -- is there any disagreement on that? I was actually going to make the same suggestion, that we change that -- so we have two suggestions. One is to add nonvoting to clarify nonvoting for community members; and two, to change "available" to "appropriate."

ALVARO GARZA: Question. So how will "appropriate" be defined? And who would define them?

CYNTHIA GOMEZ: The bylaws say the Chair. I don't know if that helps; it's just a broad statement as well (inaudible).

ALVARO GARZA: We have been talking about the value of inclusiveness.

CYNTHIA GOMEZ: I think in bylaws, you want to avoid a lot of detail because you want flexibility. So I think if we understand generally what the spirit of that statement is, and then we can enforce our thoughts on the formation committee. It might be preferable for detailed language in the bylaws.

SANDI GALVEZ: Jeremy, did you have a comment you wanted to make?

JEREMY CANTOR: I would. Same question.

SANDI GALVEZ: Delphine?

DELPHINE BRODY: I would like to propose an alternative amendment to the draft bylaw or those two sections -- those two paragraphs of section E. I would like to propose that paragraph 4 be amended so that outside experts can participate as voting members of subcommittees. And that paragraph 3, be clarified accordingly so that it would say "subcommittees shall be comprised of OHE/AC voting members and community voting member," and leave out "appropriate."

JOSE OSEGUERA: I have a concern with that amendment because according to Bagley-Keene, any subcommittee that is comprised of the various different members of the committee are the voting members. The experts that come in just provide advice. They are not to have the vote opportunity.

JEREMY CANTOR: Right.

SANDI GALVEZ: Delphine, does that address your comment?

DELPHINE BRODY: I guess my concern is that we are not fully representative of all the communities that need help with health equity in California just among the members of the committee. So I think we could be greatly enhanced in our capacity through voting involvement of community members and subcommittees.

And I know that other Bagley-Keene governed decision-making bodies such as Mental Health Services Oversight and Accountability Commission have community members appointed to their committees, which I guess two of commission would be a subcommittee. And so I was applying that principle.

JAHMAL MILLER: Jahmal Miller, Office of Health Equity.

For clarification, we have our attorney from the Office of Legal Services at California Department of the Public Health, Katie Belmont. So, we welcome you to chime in as appropriate if you have any feedback that could help navigate the discussion.

SANDI GALVEZ: Katie, would you be able to comment on the -- on this issue of whether or not community members can be voting members?

KATIE BELMONT: I'm going to have to research that for purpose of subcommittees.

SANDI GALVEZ: So that's an item that would have to be researched.

Is there any other discussion about this idea of whether or not we would have nonvoting or voting members of the community and how we would decide to have them on the committees -- subcommittees.

DEXTER LOUIE: Yeah. This is Dexter Louie. I believe the gentleman --

JOSE OSEGUERA: Jose, "K."

DEXTER LOUIE: Jose, number K, I agree with him. I believe that's correct that this is the main body, and the committee is made up of its members. A subcommittee is just a smaller committee of the first level committee, therefore, a member.

I understand your concern about voting, but I believe this whole body is to represent the people in the communities of California.

SANDI GALVEZ: Cynthia.

CYNTHIA GOMEZ: Just to add, I think the concern is about our membership that we take that as a separate discussion because this is really just to address the bylaws. But I understand the spirit of what you're saying. But I do agree that that legally, I believe, our bylaws are actually correct in how the invited outside members can participate, which is nonvoting members.

SANDI GALVEZ: Aaron.

AARON FOX: I would just say, I've been on other bodies where we've allowed community members to sit on subcommittees and have voting privileges. And sometimes I think that it's helpful when there's a specific lack of expertise around the table that you need. I don't know that -- I don't think we have that here definitely at this table. And I don't know that it's necessary in subcommittee and

just from a process standpoint. I'm sure it would be a disaster to try to figure out the process by which to do that and then selecting them and then holding them accountable.

I think we should move on.

SANDI GALVEZ: Okay. Delphine, would you be -- so it seems -- so the comments we we've heard seems that -- I haven't heard comments necessarily supporting the notion of having voting committee members. I think -- I mean, I did hear clearly from our values, I mean, inclusivity and having community engagement I think is important to all of us, I think.

And I think that, you know, a very full-hearted effort was made to have as many communities in California as possible represented on this committee. And I think where -- so subcommittees are developed, I guess, at the discretion of the Chair. And -- at least according to what the bylaws say here -- and I think that when we identify that there is a need that we don't have present at the table, I think we can certainly make sure we address having some representatives of that group and take their comments very much to heart in our subcommittees, if and when we do it.

Would you consider resending your -- or withdrawing your amendment?

DELPHINE BRODY: Well, I would consider it. I would like to hear from the members of the public present here and also get a legal opinion from our legal counsel on Bagley-Keene and any other relevant laws or regulations that would require noncommittee members to have nonvoting privileges, just because I favor maximum inclusivity. And I recognize that great efforts were made to make this committee as inclusive as possible; and yet, there are so many groups unrepresented.

SANDI GALVEZ: We would have to defer vote on the bylaws, if we're going to wait for feedback on that item.

DELPHINE BRODY: Well, then, my question is: How easily can we amend these bylaws after we get that public comment and legal opinion?

SANDI GALVEZ: It's somewhere in here. This is the -- I'm in section I. It says, "Bylaws may be amended or repealed upon approval by the Director of the Department. 51 percent of all members present at that meeting may adopt, amend, or repeal the recommendation."

So we could pass our bylaws at a future point.

Kathleen.

KATHLEEN DERBY: You hadn't heard support for this, and I just wanted to make sure that you knew that I supported this. Also in my experience with the Oversight and Accountability Commission, they did have, you know, the majority of the committees were not members of the commission; and that worked fine. And that was able to be done. So I just wanted to make sure that I put that forward.

SANDI GALVEZ: Jose.

JOSE OSEGUERA: Just for clarification with regards to the commission. Those members that are part of the committees that are part of the community, they are members that have been elected to those particular committees. So, therefore, that grants them the right to vote. And we are basically following in accordance with the Bagley-Keene requirements for any state entity that is established for the purposes of looking at various different policies.

And I believe that this particular entity would also be considered one of those state entities and, therefore, have to comply with all the requirements of Bagley-Keene.

SANDI GALVEZ: Are there comments related to any other item on the -- oh, sorry. Dexter.

DEXTER LOUIE: I have -- on the handout, I have some suggestions. And since we are really looking at the draft, maybe after we discuss these issues, that Legal can come back with the right language and then we can bring it up at the next meeting. Otherwise, I don't believe we can wordsmith this to everyone's satisfaction.

But having Legal look at it, at least will allow us to move forward.

So if I can go to page 4, section E, item 5, the word "represented" is unclear, as to what the staff member's doing.

Based on our previous discussion of item 3, it's pretty clear that they're not members of the committee. But "represented" is a strange word.

SANDI GALVEZ: Maybe it's "present." My sense is that it's just, you know, staff needs to be present to document that the meetings took place and to staff the meetings.

DEXTER LOUIE: So my suggestion is that that be reworded.

Page 6, section F. Number 1, I think we discussed that previously when you talked about reaching consensus. But in my limited experience, sometimes motion makes it clear that it is an action of the committee. Whereas, when you reach a consensus, well, we all agree; but we haven't taken an action.

SANDI GALVEZ: So you're speaking in favor of the language that's there's right now. I think that's was incorporated in here.

DEXTER LOUIE: I -- I believe that's actions, F. I think maybe that was. And I added a little flourish in the form of.

But again, I would defer to legal to see if that's acceptable as a recommendation. Item 1 is not as important as item 3. Item 3 goes to quorum issue and how you count voting members.

Page 6, section F, item 3. If a member abstains is different than recuse in a quorum count. In other words, according to Sturgis or even Robert's, I believe -- I follow Sturgis -- is when a member recuses him or herself because of a conflict, that person is eliminated from the total count. So you don't count them in the quorum. If you start with 20 and a person recuses, now it's 19. Now the majority changes from 11 to 10.

JOSE OSEGUERA: And that is correct. Recusing is used when there is a conflict of interest and that person has to eliminate themselves from that entire voting process.

SANDI GALVEZ: Cynthia.

CYNTHIA GOMEZ: Again, I believe the spirit of the statement was actually not about that as much as if there appears to be clearly no desire to vote on a particular notion -- motion, that it is clear that there's either neither support or opposition. I think it's a guidance about how the presiding officer reads the room. But I think if what you're trying to explain here is the count of quorum be included in this, then we need to add language that says that that decision will be based on actual quorum proportion or something more explanatory.

But I think the spirit of the statement was actually about when to not proceed when it's clear that most of the group is not agreeing to the particular discussion.

DEXTER LOUIE: This is Dexter again. Again, I would leave it to Legal to word it in a way that serves the purpose that we intend.

I apologize for bringing up so many of these governance issues, but it helps us going forward once we solve them today.

If I can go to page 7, section G. Again, this is just preference. You're voting for people versus issues. It may be a little bit sensitive to have an open vote versus a secret ballot for voting on individuals. We're a small group here. We want to proceed in an orderly way without animosity.

So that's what I would suggest. And that's what we did the last time. It was a paper ballot.

JEREMY CANTOR: Right.

DEXTER LOUIE: So I would, again, defer to Legal to reword it, if that's the pleasure of the group.

And then lastly page 7, section H, on meeting logistics. Number 2, as stated here, we haven't decided on any. It kind of leaves it open and ambiguous. So we can decide to use Robert's, Sturgis, or anything else. Robert's and -- Sturgis is little easier to read, but essentially the same as Robert's.

CYNTHIA GOMEZ: Stating "any" allows us flexibility, which is -- I think the purpose there is to allow us to have flexibility and using any procedures we so deem.

DEXTER LOUIE: My last comment. This is Dexter again. I think you have to decide on one authority; otherwise, that flexibility is you're being arbitrary. We like Robert's today, but we use Sturgis tomorrow because it suits a different purpose.

I believe that would not be appropriate.

SANDI GALVEZ: I believe I heard another comment in the room regarding the last comment. Sorry, Pat.

PATRICIA RYAN: No, it wasn't me. It was -- the other comment was over here, but I do have one minor issue.

SANDI GALVEZ: Go ahead.

PATRICIA RYAN: Related to the last one. Section G, "In lieu of the voice vote and Advisory Committee may request a role call of who of hands." I think that should be "show."

SANDI GALVEZ: Yeah. There are definitely typos in this document.

Any other comments?

Well, I would like to speak of some of the items that you mentioned. First, page 7, section G, number 1, I believe we should put in here, "or secret ballot when deemed appropriate," I guess, "by the chair."

And I think I do agree with you that it's important to be clear what procedure we are using and unless at a point in time we choose not to use Robert's Rules of

Orders and use something else, then we can amend them. But that would be clear that that's the process we're using.

Cynthia.

CYNTHIA GOMEZ: Point of clarification. Chair, could you -- prior, in my presentation to the group, agreed to modern parliamentary procedures, I do want to note -- make not that that was something that the group had previous discussed. So I do want to get clarity because Robert's Rules does take effect the --

SANDI GALVEZ: Okay. So --

CYNTHIA GOMEZ: -- I just want to be clear about that. Whatever is the desire of the group. I just want to be clear that if we are stating Robert's Rules, we have very specific procedural.

SANDI GALVEZ: Thank you, Cynthia. Thank you for that clarification.

Then I would clarify it's Modern Robert's Rules of Order.

DEXTER LOUIE: Madam Chair?

SANDI GALVEZ: Yes.

DEXTER LOUIE: I make a motion then that we refer this to Legal for next draft to come to this next meeting.

SANDI GALVEZ: Before that, I just wanted to make sure that -- I wanted to hear all the comments so we have them on record and then we can then be able to give guidance to Legal of all the different comments we have before we're ready to pass it on.

So Jeremy, did you have a comment?

JEREMY CANTOR: Yes. One comment on pages 3 and 4, the Advisory Committee Roles and Responsibilities.

The only mention of the strategic plan is in number 7. It's to promote and help to advance.

It seems like there might be a bit more clarity there around "approval of the development of" and perhaps something about monitoring implementation. Particularly, I think -- I mean maybe it's where we are in the process right now. But it seems like that development and approval of the plan is a critical role for this body. And monitoring the implementation.

SANDI GALVEZ: Maybe what we could do is -- this is a suggestion. Section D, the first one, to assist the -- at the end of that first sentence -- to assist OHE in policy and plan formation.

I'm sorry, Jahmal. Did you want to say something?

JAHMAL MILLER: Yes. I can briefly comment on it when I present. We met with our Deputy Director of the Office of Public and Government Affairs at -- or Legislative and Government Affairs yesterday. And we talked about the role of the Advisory Committee.

We got -- I received clarification yesterday that the role of the Advisory Committee, as an advisory body to the Office of Health Equity, there's not a requirement that the actual plan be approved by the Advisory Committee. That's not to lessen, obviously, the importance of the weigh-in and the role of the Advisory Committee; that component is not required. The -- by law. By law. The approval is actually as they go through the approval process with the respect to strategic plan goes CDPH to the agency, secretary, and to the Governor's office.

So that's clarification by law. But once again, I want to reiterate, that doesn't lessen the role that this body has to obviously have lead and role as to weigh-in on what the strategic plan is gonna look like.

SANDI GALVEZ: Okay. So we -- am I back to my recommendation of adding -- that we assist in the OHE policy and plan formation. And maybe in 7, we can say, help to -- let's see -- "promote and help to advance the goals and objectives."

I guess I would leave 7 as it is and just make that change to 1.

Any other comments?

Dexter.

DEXTER LOUIE: Again since this is, as I asked earlier, an action item, then I move that this be referred to Legal for additional wording.

SANDI GALVEZ: All those in favor. Show of hands, please. 16 in favor. Any opposed?

DEBBIE KING: Public comment before voting.

SANDI GALVEZ: I'm sorry. Is there anybody from the public that would like to comment on the bylaws?

Did you receive any speaker cards for this item?

BETH MALINOWSKI: Hi, Beth Malinowski, California Primary Care Association. I represent Community Clinics and Health Centers across the state.

To the comment earlier regarding subcommittee makeup, which gets me thinking about a broader concept I just want to bring forward here that I think might be useful if you think about. So your bylaws are also just a more broad strategic plan and how we think about implementing it. Just really making sure that every point possible, we're really creating the space for engagement of communities and also organizations that represent communities. So I think about the space here today, and while there are providers that are part of this group, it's primarily behavioral health providers. Just want to throw out if we especially think about capacity building, long-term sustainability, concepts of access to care as it relates to the health of our communities that we're thinking about our safety and providers as well, and making sure they're part of the conversation.

So I think actually as I'm here also about other advisory committees that we're a part of or that we play this role where we're not officially part of the Advisory Committee but participate as a member of the -- just kind of broader observers.

And when I think about actually the Sac (sic) Committee, which is the Committee of Public of Healthcare Services, whenever they have an advisory committee meeting, they make sure to do E-mails out to a broader community stakeholders, even when they're preparing their agenda, they go ahead and do that as well, to make sure they're thinking about as many persons, getting as much feedback as possible going into the process. There's something to suggest that just hearing that this group is still new, to just think about, you know, learning from your own peers about ways to really enhance the ability of a group to get involved.

Thank you.

SANDI GALVEZ: Are there any comments on the phone related to the bylaws discussion?

Thank you.

We're actually right on time. A minute early. So I'd like to pass the agenda now to Dr. Chapman, the Director of the Public Health Department.

RON CHAPMAN: I'll stay here. Good morning.

I love parliamentary procedure bylaws. Very well done. You know, in the infancy of a group like this, this work is very, very important. I do make light of it because it can be dry. But I think those details are really, really important moving forward. Your successors on this Advisory Committee are really going to

appreciate the attention to detail that you put in at this point early on in the Advisory Committee's life.

So just a couple of small updates. We are, as most of you know, in the throws of budget hearings; see several of you there during the hearings. And very interesting this year, as the economy is turning around, to watch the activities around the budget hearings. The assembly, in particular, during our first budget subcommittee hearing, made an effort to invite stakeholders' advocates to the table, had an eight-person panel during the budget subcommittee hearing that I personally have not seen ever in my experience. It felt like it was unique. And a number of those organizations had brought proposals to the Assembly Budget Subcommittee. And they created a special agenda item, which they called Public Health Reinvestment, which again, I thought was very interesting.

I know that the Senate is actually considering -- or looking at some of these proposals as well. The Senate Budget Subcommittee Hearing was more of a traditional hearing. They did not have that particular agenda item. So we still have more hearings coming up over the next few weeks. And it will be interesting to see where all that goes.

Also, in terms of a Department update, we have been a part of an 18-month process to seek National Accreditation for our Department. There is a new voluntary effort in the United States. There are only eight -- I'm sorry, not eight -- two state health departments in the United States that are accredited at this point; Oklahoma and Washington. I'm extremely proud to share with you that we have submitted all of our documentation to meet the 105 measures set by the Public Health Accreditation Board. These have been assigned a review and site visit team, who will be contacting us with questions. And in the next few months, we're looking forward to their site visit, again seeking for the first time ever, National Public Health Accreditation; 18-month process and effort in our Department that I think brought a lot of improvements to the Department, which again I'm very proud of.

So you all -- we all have the deliverable of the a strategic plan to achieve health equity in California. Huge deliverable. No pressure.

And I was asked a few days ago, What did I want to see in the strategic plan? And my response was pretty quick. I said that, "I have faith in the process." And what that means is, I have faith in all of you. And I mean, all of us in the room, including the public.

Having watched the Office of Health Equity grow, having been an intimate part of the California Reducing Disparities Project and that process, I have become a firm believer in the process.

And, so I look forward to being a part of that process and joining you and, eventually as Jahmal described, what we all produce, will be going through the approval process through the Administration.

This is a strategic plan to achieve health equity in California. It is about all of us working together, all of our organizations and more, being committed to this effort. And Office of Health Equity plays an important role in facilitation convening. But we all need to be catalysts in this process. We all need to have a commitment to achieving health equity in California. And that's what this process is all about.

And today I know we're gonna be learning a lot. And then in the afternoon today and tomorrow really focus on bringing that strategic plan home.

So thank you all for taking the time out of your hard work on the front lines to be here and helping us to produce the first-ever strategic plan for health equity in California.

Thank you.

SANDI GALVEZ: So we're a few minutes ahead of schedule.

Are there any questions for Dr. Chapman?

I have one.

RON CHAPMAN: Sure.

SANDI GALVEZ: So the National Association of Chronic Disease Directors in partnership with BARHI, just released an organizational self-assessment for state health departments on addressing -- on achieving health equity. Has the Department considered implementing that?

RON CHAPMAN: You know, I'm familiar with that work. I've not actually looked at it myself. So I need to circle back with our chronic disease folks. If you have ideas about how we can be implementing that in our department, that would be great. Remind Sandi and others that we have a cross-cutting strategic priority of achieving health equity through public health programs. And that's an area that we're starting to focus on more within our department. A number of our -- we have 200 distinct programs within our department. And a number of those are working to achieve health equity through their work. But we need to bring it together in a concentrated effort. So we're going to be having more of those discussions in the Department. And I think this will be a useful assessment for us.

SANDI GALVEZ: So even though it was design -- it was by ACDD, it's actually not focused on chronic disease. It is intended for large scale organizational

use, and it really is for exactly what you said. It's really for, you know, departments that have chosen that they want to really do work on health equity, a way of assessing, Where are you at? Where are there areas that you could quickly move on? You know, What are your workforce development needs? So on and so forth. And it works really well in partnership and accreditation.

So I'd really recommend that the department look at it. And I think it might fit in very nicely with the strategic map for the OHE.

Cynthia, did you want to say something?

CYNTHIA GOMEZ: I brought this up earlier with Jahmal just to try to get ourselves coordinated.

So I understand that there is a lot of delays associated with the ICD ten-coding transition, which is going to result potentially up to a four- to six-month delay in reimbursements to our providers.

When we're looking at health equity in the State, those kinds of structural barriers are going to basically close down the most -- the providers are serving the most disenfranchised communities. So we don't have a six-month float in their budget. So I want just to bring it up because I feel like in this role if we're really going to be looking at health equity as a State, then all of those types of structural barriers that are actually happening because of State bureaucracy, we have to have a voice about how that cannot happen, particularly with the clinics that, you know, don't have large reserves to basically cover themselves because they're not getting another Cal reimbursement.

So we just really request that there be some real attention to the inequities that will happen within that delay.

SANDI GALVEZ: Thank you.

Did you want to comment on that?

RON CHAPMAN: No.

SANDI GALVEZ: Are there any other questions or comments for Dr. Chapman?

ROCCO CHENG: Not for Dr. Chapman, but a request for our court reporter: When we speak, please speak louder or speak up or get the mic closer so they can hear us clearly and record.

And if you have a problem hearing, please raise your hand so we'll know. The individual cue.

SANDI GALVEZ: Delphine.

DELPHINE BRODY: Yes. Dr. Chapman, one question: I understand that there have been a number of delays in different counties in the implementation of the Medi-Cal extension this year. And this may have to do with cash flow from state to county. I'm wondering if you have any information that you could share with us about this and what may be in the works to address these.

RON CHAPMAN: It's good timing Dr. Kohatsu left the room. I do not. I mean, Public Health is not involved in -- directly with the Medi-Cal expansions, especially not with the reimbursement cash flow issues. So maybe Dr. Kohatsu will have a comment when he returns.

SANDI GALVEZ: Okay. So the next item on our agenda is -- oh, please make it quick because we're out of time now for this item.

ALVARO GARZA: So to Dr. Chapman or maybe Jahmal or anybody else who's keeping up with legislation because I haven't been able to recently. But a few years ago there was a bill for a health equity index; and that didn't get very far, as far as I recall. So I was wondering if anybody has any update along those lines? Maybe Hernandez.

JAHMAL MILLER: Investigate on that.

SANDI GALVEZ: So thank you, Alvaro.

So our next item on the agenda is an update on OHE and the strategic planning process.

And I'm gonna turn it over to Jahmal.

JAHMAL MILLER: Thank you. Good morning, everyone. And I'm really appreciative for this new venue that has windows. Of course, to convene today and really grateful for the Sierra Health Foundation's hospitality in hosting us today. And I'm even more grateful for the Office of Health Equity staff. If you're staff, can you please stand, even if you've been staff in the past -- interns, can you please stand? Let's selectively give them a round of applause please.

(Applause.)

JAHMAL MILLER: Guys, you can be seated.

It's a lot of heavy lifting and really, really hard work to prepare and plan for this two-day meeting. They have been working tirelessly late into the evening assembling packages and doing site visits and working closely with the staff here to facilitate today and tomorrow's meeting. So I really, really appreciate an assembly

of just rock stars, in my opinion, in the Office of Health Equity. So thank you for all that you do.

Before I go into the presentation, I just wanted to quickly hit on a couple of keynotes with respect to staffing updates in the Office of Health Equity.

Building capacity, as I mentioned earlier, applies at many, many levels. One the focuses that I've had in almost six months in leadership at the Office of Health Equity is really just building up the capacity, both staffing and financial resources of the Office of Health Equity. And the strategic plan is going to be a major catalyst for our ability to do that.

But in the meantime, we've been staffing up as best as we can. And one of the areas of interest for me to sustain throughout the life of the Office of Health Equity is to have an intern -- a viable internship and fellowship program for both undergraduate and graduate students. And I'm happy to say that we've had our first cycle of interns that came through the UC Center, and they happen to be seniors at UC Davis. They just finished up the internship program. It went for just over two months. They finished up last week but took some time out to join us today. And I wanted to introduce them to you. And we have Eunji Kim. Please stand, Eunji. And Gladys Preciado. And let's give them a round of applause.

(Applause.)

JAHMAL MILLER: And they provided -- they contributed greatly and then really helped us out in a tremendous way during the time that they spent with us. And I'm really hopeful that their health equity experience with us will help to shape the direction of their careers. So thank you for being here.

You received an E-mail from me by way of Marina, I believe, a week or two ago acknowledging a couple of recent hires that we've had; one Dr. Robert Lipton, who is going to be joining our team from the University of Michigan, as a Research Scientist III. And he'll be starting May 1st, I believe, correct? May 1st maybe? Okay. He might be joining us then.

But also we have a new team member that you're going -- another new team member that you're gonna be hearing a lot from -- some of you already have -- Dr. Tamu Nolfo. If you could stand. Tamu has been brought on specifically to really help accelerate our strategic planning efforts and to really strengthen the functionality and relationship that we have with our Advisory Committee members. And within three weeks' time, I believe, she's added significant value. And you're going to be hearing more from her later. And she's helped our staff, as an official staff member, really accelerate the strategic planning effort. And you're gonna hear from her momentarily and also throughout course of the next two days with respect to the latest and greatest around our strategic planning framework. She's a

Robert Wood Johnson Fellow and once again demonstrates what it looks like to help build capacity within a state government entity.

I met yesterday with some of our OHE leadership, with the Chief Deputy Director of the California Department of Public Health, Kathleen Billingsley, and the Deputy Director for the Office of Government and Legislative Affairs to get clarification on where we are with the time line. I recall Sergio at the last meeting, and many others on the Advisory Committee, wanting to get a revised time line, which we're gonna provide to you no later than next Monday. The reason we're not providing it to you today is because of the information I received yesterday was confirming that July 1 is our strategic plan and demographic report due date. So for some of you, that may not be new information. But that is the drop-dead date for us to produce our strategic plan and our demographic/disparities report. And we're gonna talk more about that.

But it's important to understand that because that July 1 is our due date, there are internal processes that we need to go through with respect to approval, at the CDPH level, the agency level, as well as the Governor's office level. So we're gonna talk a bit more about what role we'll play as staff and as an Advisory Committee to get essential stakeholder engagement and feedback within the next three, no more than four weeks, to inform this approval process and to expound upon the strategic framework that we're gonna flesh out over the next two days.

I suggest that the demographic report draft, that that be used as resource. Our Health Research and Statistics Unit team has really worked aggressively on advancing the disparities report that ultimately we're gonna add a comprehensive narrative to. And I ask that you use that information to inform the next couple of days. And I'm not sure if we printed that out or not. I know that it's online. So no worries. I just want you to tap into some of that helpful information around the social determinants of health that help to advance and inform or discussion over the next couple of days.

And for the agenda, lastly, before I go through quickly the presentation, there is a method really to the madness as we work collaboratively with Rocco and with Sandi to really assemble a -- an opportunity for us to learn over the next two days about what's happening within government and outside of government with respect to best practices, but that will likely have implications at a tactical level on our strategic framework so that we cannot just learn, but also to inform the discussion we're gonna have to see what resources we can potentially tap into for partnerships collaboratively. And that's kind of the method of the madness. So we didn't just accidentally by default include some community-based best practices, some foundation best practices with respect to Sierra, some government best practices around HiAP and CRDP efforts. They're very much so intentional to get us all on the same page with respect to what's going on and also how could they potentially inform these strategic planning -- planning efforts.

So with that said, I'm going to breeze through the presentation here.

Can you visually -- will you benefit from dimming the lights? Are you guys okay with both screens.

SERGIO AGUILAR-GAXIOLA: It is okay.

JAHMAL MILLER: Okay. Great. And there's a reason why I put bricks and a shovel on the front page, is because I believe that it's important that we -- as we advanced this strategic planning effort from where we left off in January, that we really look at this opportunity to build a very, very strong foundation that is sustainable.

And when I think about sustainability, I think about variety of issues around climate health and having a socially and economically vibrant state. But when I think about sustainability, I think about building a strong foundation, particularly when we think about our kids. When we think about the definition of vulnerable populations and we look at the mandate that creates the office, oftentimes, you know, we catch certain groups in populations that we don't integrate into our discussion. But when we realistically approach sustainability, in my opinion, it's about building a very strong foundation.

Novak Djokovic was a leading tennis player who actually was born in Belgrade, Serbia. Prior to his rise of heights in tennis, he used to nightly spend time with his family in the basement during the old war in Yugoslavia. And as a result of his success and all of that, he acknowledged the importance of building a solid foundation for our children. And it's in that spirit that I believe that we move forward, keeping our children and our youth as a -- not just indicators, not just metrics, but as catalysts and conduits by which we think about how this strategic plan is going to sustain us over the long haul. And how do we do that? Do you recall this diagram from the first presentation I made in January? And I believe it's by achieving health and mental health equity at each level. The social determinant language is very academic. And one of the reasons why I incorporated transforming the conditions in which we -- which people are born, grow, live, work, and age is because obviously people can relate to that language much better.

And as I advanced, kind of this diagram, and made some adjustments to it, I added those social determinants of health on the outside. Because it's important that we have healthy people that we advance in work to have healthy communities, healthy environments, and a healthy society. But if we look at it differently, we ask ourselves. What are we coming back to our children? What are we surrounding our children with when we think about the strategic framework and the strategic plan for the State of California? Are we positioning them to have access to preventive services? Are we positioning our children and our families to have food security and built environments that are conducive to healthy living and

environments that are safe, where the air and the water quality is high? Or are we surrounding them with many of these unhealthy defaults that contribute to many of the downstream disparities that we often talk about when we think about that much broader framework? So I see it as an opportunity.

A couple of weeks ago I went to -- I was in Washington D.C., at the First Lady's Childhood Obesity conference. I had the great opportunity and pleasure to meet Dr. Gail Christopher with the Kellogg Foundation. Hopefully that's a relationship we can tap into moving forward at the Office of Health Equity. But I was struck in her comments that she made on a health equity panel that opened up the Childhood Obesity conference and it really got at the crux of what we talk about. It's different of tapping -- of addressing disparities downstream, but really going into -- and I appreciate dialogue that I have with Sandi -- going upstream and really get at these deeply rooted inequities that are structural barriers, that are rooted in past policies and practices that contribute to, in many cases, disproportionately children of color, contribute to dynamics and environment that create persistently lower-income families and impoverished communities.

So as we move forward, we think about, How can we strengthen children and families? And that's something that she left with me. And another way, once again, to look at it, when we think about social determinants of health and we know care and prevention very, very important, but we also look at other ways in which children and families can have access to healthier lives. And we look at the role and the relationship between income and health and how that creates vibrant families; creates vibrant children; that gives them access to healthy housing options, nutrition, better neighborhood conditions, educational attainment. And that cycle completes itself. So that foundational element needs to be healthy kids surrounded by healthy families, healthy neighborhoods and a healthy community.

But we have challenges that once again we have to embrace. I want to thank our epidemiologist for producing some of these data points that I'm gonna show to you.

In January, I showed you the national statistics that showed an uneven distribution of household wealth across race in ethnic groups in Cal -- in the country. But this is for California where we see a disproportionate, once again, possession of wealth and how once again, we evaluate how income has a positive co-relation, sometimes negative, to people's life expectancy and quality of life. This is what's happening objectively when we look at the data in California that's driving many of the decisions that children and families are making on a day-to-day basis. We look at one in four California children living in poverty in 2012. And we see that huge gap. And we see that, you know, those who are 65 and older fall well beneath, which is great. But when we look at our children 18 and younger, that's a dynamic that we obviously -- I'm hoping we can address in our strategic framework.

We also look at, once again, the intersection of race, poverty, education; higher proportions of Latino and African-American children live in poverty compared to children of other races and ethnicities. Once again, just objective data. And these are sample data points. You have that comprehensive latest draft of all the data that we're looking at that's not just by race, but it's also by educational attainment level, by poverty level; it's by gender. But these are just some data points to drive home this role, unfortunately, that poverty is playing particularly against our children and our families in the State of California.

And also, the drill-down and the comparison and when we talk about how place matters in many of the communities that we're serving throughout the State of California, and it's an interesting contrast that we see here. One-third of California children are food insecure, when we compare what's happening in the Central Valley, Fresno County, to what's happening in San Mateo County. And it's interesting because even when you drill-down by county into these counties, even in San Mateo, I can guarantee that there are likely some statistics similar to what it is that we see in Fresno County.

But let this information kind of guide and inform the next couple of days as to how we think about a strategic framework that is not only sustainable, that is not only build on accountability, but really matters to the children and the families in the State of California.

So as I draw to a close, we look at, What are we up against? The need to position ourselves with infrastructure to challenge many of these corporate entities that have much more money than the Public Health Department to invest in much of the messaging that is currently taking place that's conducive with healthy living -- unhealthy living, and unhealthy options that we're giving families and communities across the State. That's what we're up against.

We're also up against here locally, once again, looking at 2012, Oak Park, which shares a border with East Sacramento. They call it The Fabulous 40's, East Sacramento. Oak Park shares a border with The Fabulous 40's. And Oak Park residents are more than three times as likely to go to the emergency room for asthma, diabetes, and high blood pressure. So we when look on the right-hand side and we see the baby that's being carried by that young mother, we ask ourselves, What adulthood, what's the future of this particular child going to be like growing up in a community where you have debris and unsafe built environments to access that are not conducive to healthy living?

Since October I've done over 250 some-odd meet-and-greets with stakeholders throughout the State. And I don't remember all of them, but they were very, very informative and enlightening. And I had a great trip a couple of months ago to Marin City and Marin County, the number one healthiest county in the State. But there were some interesting discoveries. When you look at the suburb of Ross in comparison to Marin City, and you look at the demographic disparities that exist

between these particular groups that are very similar and maybe less than a mile or two from each other, and what surprised me more than anything is when you look at the life expectancy difference, down at the bottom of each of these photos, you see life expectancy in Marin City is 78.6. And then you jump over to Ross, it's 94.4. But when you look at the overweight -- the 7th graders who are overweight or obese, 50 percent of the 7th graders are overweight or obese in Marin City. Now you look at 16.3 percent, 7th graders in Ross. Once again, objective disparities. We ask ourselves, Why do these exist? But when you look in the middle, there aren't any grocery stores. There are four fast food outlets, zero public parks Marin City. And we look at 63 percent of African-Americans living in poverty. We ask ourselves, In the healthiest county in the State, so why do these dynamics continue to persist? I believe we know many of the answers.

I talked to Sergio earlier about the Central Valley and Tulare County. And even before the drought, communities -- many communities across the State particularly in agricultural communities and rural areas were already distressed. So the drought just compounded issues that were already taking place in these areas. But I read a New York Times article that was really enlightening and resonated with me with what's going on in the Central Valley. The water is just filthy. Don't drink the water in this community is the messaging. You have an impoverished community predominantly of -- consisting of Latinos, who spend 10 percent, on average, of their income on clean water. Last time I bought water was because I just wanted to, not because I had to. I could go to the tap in my home, no problem, and drink it.

But we have many communities, once again, when we think about, what Carrie -- I don't know if it was Carrie or Kathleen that talked about certain areas that we just don't want to forget about, who are often under distress.

So moving forward, we have to disrupt current defaults. And we have to move forward with positive and healthy defaults. So I like my little man in the middle breastfeeding; it rocks.

So as I come to where we are with respect to the strategic plan and have Tamu come up shortly to just give a brief on where we're gonna be going over the next couple of days with respect to the strategic plan, we look at what's happening at the national level. 25 years of championing health equity with the CDC's Office of Minority Health, we move forward in April celebrating Minority Health Month. And we also, at the national level, look at the stakeholder strategy for achieving health equity. And what struck me was when I looked at the evolution of our process in January and ultimately with what we came up with on that second day and how there were very -- we didn't even use this national health equity framework to inform that process; but there are a lot of similarities. And I've had the privilege to talk with some of the people at the national office, and they are really excited about the process that we're going through because they strongly believe that what we come up with as a State will inform what's happening on the national level. But

I just brought this up. Just had a high level inform us what's happening at the national level, but to also be encouraged, if you're not already, and the similarities and what our focus areas are gonna be and that we came up with in January.

So when we left out at the January meeting, we had established a vision, a mission, and a central challenge. And it was a very organic process, very, very fun; very intense at times, very contentious. But I felt very good in that not only did we come up with a vision, the mission, the central challenge, but we came out with draft and strategic priorities as a staff, coupled with interviews of the Advisory Committee members we fleshed out even further. And you're gonna be reviewing that information here shortly.

So as I close, I just wanted to share, once again, with you. I saw a video at the First Lady's Childhood Obesity summit a couple of weeks ago that really resonated with me. And, once again, it takes us back to our children. And I'm gonna share this video with you shortly. But one of the opportunities that we've had, I and Julia Kaplan a couple of weeks ago had a conversation with some Nike executives about their "Designed to Move Effort." That's really addressing not just fighting childhood obesity, but it's more of a human capital model approach to the values and the benefits of healthy eating and active living. There are resources tied to it.

There's a effort tied to the First Lady's Let's Move Active Schools Campaign that's happening at the national level. But that conversation has opened up an opportunity for us to do some work with them through the Office of Health Equity and through some of our HiAP partners potentially in the State of California. So this video that I'm going to share about "Five More Years," it leaves a message with you that I hope will resonate and inform the next couple of days about what opportunity we have to create an environment that literally gives our children five years of their lives back.

So on this, I think we can dim the lights.

(Video shown.)

JAHMAL MILLER: So with that said, I won't ruin by saying anything else.

I want to bring Tamu Nolfo to give a brief, just update, on where we are with respect to the strategic framework. And she's gonna spend, obviously, much, much more time. And I want to commend her, once again. She's, like, super sick, but not contagious. But to show the courage and the commitment to just be here today and to continue to work from home, I really appreciate her. And I'm really, once again, delighted to have someone like her on our team who has really added significant value to the work that our Office of Health Equity staff has already been doing. So thank you so much.

TAMU NOLFO: Thank you.

Good morning, everyone. I'm not going to take much time. I know that we're closing in on a break, and we have a very full day today. I do blame my children for getting me sick, but I don't think that I'm contagious. So I'll try to keep my germs to myself.

This is a wonderful team to be a part of, I'll tell you that. And I have had the privilege of speaking with a number of you by phone or in person to try to pull together the agenda for today and tomorrow. And what you will see later on this afternoon is where we have come to in terms of our strategic framework. At your last meeting, you did a lot of hard work around creating a mission, a vision, a central challenge and your strategic priority areas.

And so we have been working with your Chair and your Vice Chair to really flesh those out and to come up also with strategic initiatives that we want you to beat up this afternoon. So you will have more instructions around that later today. I just wanted to let you know what the process was going to be, that we'll have that time this afternoon. Hopefully the conversations that you will be having in your small groups will be informed by some of the presentations that you'll be having, starting at 11:00 today. There are also a couple more presentations tomorrow morning. And then you'll be back in your small groups. And you'll have an opportunity to connect small group to small group tomorrow afternoon before reporting out to the larger group.

There will also be some opportunity to provide some public comment, both from the folks that are in the room today and on the phone. But, also, as Jahmal mentioned, over the next few weeks, we'll have the opportunity to receive some structured public comment, as well, to inform the plan that is then going to make its way up the ranks through the approval process so that we can have a strategic plan by July 1st. So with that, I'll turn it back over to Sandi.

SANDI GALVEZ: All right. I think it's time for a break. So we have a break for ten minutes. Sorry. One minute before our scheduled break.

Are there any questions for Tamu or Jahmal?

Patricia.

PATRICIA RYAN: Pat Ryan. I just wanted to comment on, it was all great presentations and the video was great; I just observed that there was no reference to mental health and any of the data, which I know, you know, you're using a data source and somebody else's materials.

But, talking about poverty and inequities without acknowledging the impact of trauma, and a lot of the trauma is very closely related to the poverty levels, is sort of eliminating a major cause of people's, both mental health and physical health issues.

So I think -- and I know that in our -- in the things that we identified that we're gonna be working toward, we -- we adequately, including mental health; but I think it's sort of a byproduct of our society separating health from mental health and treating physical health and mental health as something separate. And it's really not. In fact, you know, as far as the five-year, you know, increased or decreased longevity, suicide is the leading cause of death in this country. So that's just one part of the mental health impact on the data.

So I just want to make sure we don't forget that.

SANDI GALVEZ: Rocco.

ROCCO CHENG: I agree with what Pat did share.

I also want to add, I really appreciate the presentation, wonderful presentation. And also the quote from Dr. Gail Christopher.

I would like to add many children and family also deal with the barrier due to language, culture, and social differences and challenges. And especially in the State of California, we need to consider these. And we need to consider mental health issues and the impact of trauma.

SANDI GALVEZ: Yes, Sergio.

SERGIO AGUILAR-GAXIOLA: Just a comment. Jahmal you made a excellent presentation.

You spread something that I think that captured the level of complexity of the issues that we are against us -- or up against. And you presented data within the same county, Marin County, having Marin City and having Ross and the significant differences.

I -- I think that that's great reminder that when you present -- or we see data by ethnic groups, you know, that the picture really is much more complex than that. Because it really segregated data with Asian-Americans or Latinos or many other groups that are significant -- I mean, there are groups with significant disparities that I think that we all to be -- also focusing, you know, and not just put the data on the accuracy. And to identify targets, you know, as we get into the strategic plan of, you know, specific groups that may potentially benefit the most with this. But I think it is an invitation to -- just to think systematically that this is -- these pertain to the more complicated but at the same time with the opportunity to identify a specific

target groups and target, you know, by any variable that we might -- that would be worth focusing on.

DIANA RAMOS: Diana Ramos. I just wanted to say that was an outstanding presentation, Jahmal. And I think that was a great overview from the 30,000-level view and your slide 3 and 4 actually does include mental health and all the other social determinants of health. And there's no way that we can really pinpoint and expand on all of the other social determinants of health. And I'm sure as we get on with the strategic plan, then that's where we're really gonna get into the meat of -- of all of the individual initiatives.

I just wanted to say, outstanding presentation.

SANDI GALVEZ: Okay. I'm just letting folks know so we can try to stay on target, I'm gonna take one more comment. We also have to have public comment, and we are probably gonna have to cut our break a little bit shorter.

Carrie.

CARRIE JOHNSON: I just wanted to say thank you for that presentation. It really gave a great overview of the disparities and what we're seeing.

I also wanted to say that I really liked the comment, the strengthening children and families from Dr. Christopher. I really enjoyed that comment. I thought that was really important to -- because it just didn't talk about the current barriers, but the history and the historical barriers. I think those are so important for us to look at the historical barriers as well when we're doing this.

Thank you.

SANDI GALVEZ: I do want to briefly respond to the issues around the data. And correct me if I'm wrong, Jahmal.

A lot of the data that was in Jahmal's presentation was from the data report that is being created by the epidemiology group and the Office of Health Equity that is required by statutes. And there's a whole list of things that they're required to do. And that it actually is really focused on social determinant-type data and not health specific data. Because there's already a lot of data collected that we actually got all those reports in our last meeting, you know, to review on our own. So just to provide that context. I don't think it was an intentional oversight; it was just pulling from the data that's being put together from this data report that's required.

Hermia.

HERMIA PARKS: This is going to be real, real quick.

I just wanted to ditto Diana's comment regarding what Jahmal presented.

Thank you.

SANDI GALVEZ: Any public comment? Did we get any comment cards for this topic?

Can you please turn the phone on?

Are there any comments related to the update of the Office of Health Equity?

Okay. Hearing none, I'm going to call us on our break. Let's take five minutes. We have four, but let's take five minutes. Please be back at 11:01.

(WHEREUPON A RECESS WAS TAKEN.)

SANDI GALVEZ: All right. Thank you, everyone, for returning. So our first presentation this morning is from Lupe Alonzo-Diaz, the Deputy Director of the Healthcare Workforce Development Division of the office of Statewide Health Planning and, OSHPD, Office of Statewide Health Planning and Development Healthcare Workforce.

Thank you, Lupe.

LUPE ALONZO-DIAZ: Is there a preference in terms of where I stand or where I walk around? Does it matter?

TAMU NOLFO: Well, you're mic'd up right there. So if you can stand.

LUPE ALONZO-DIAZ: Okay. I'll try to -- thank you. Sure.

TAMU NOLFO: If you want a mic --

LUPE ALONZO-DIAZ: If I need it, I'll ask for it. Sure. So I'll do my best to stay here, but I'm definitely very well mic'd; that's for sure.

So thank you. It's an honor to be here. I'm Lupe Alonzo-Diaz. I'm the Deputy Director of Healthcare Workforce Development at OSHPD, the Office of Statewide Health Planning and Development, better known as OSHPD.

Thank you, Jahmal, for the opportunity to present on some of the OSHPD's priorities as they relate to Healthcare Workforce. And certainly, I think, for the opportunity to present to you some of the areas of focus for us and perhaps opportunities for collaboration. So I'm gonna do my best to stay on track in terms of my presentation so that we do have an opportunity to also -- so I can have an opportunity to have a discussion with you, as noted, in terms of opportunities for

collaboration and/or areas of focus and/or interest. So, you should have the PowerPoint presentation in front of you. Okay.

So I'm gonna run through some of these slides. All of the slides are available in your package. There are some slides that I might just mention; there's others that I'll just completely ignore. And that's okay because you have the information in front of you.

So, as you know, as a result of the Affordable Care Act, there's been an increased focus on Healthcare Workforce. And those challenges have been specifically noted as they related to primary care and mental health. And that's because regardless of, you know, where we are, there are a number of, both opportunities, as well as challenges, as it relates to Healthcare Workforce. There are some very similar areas, depending on whether we're talking about primary care or whether we're talking about mental health. And then there are other areas of parallels. So discussions around shortage, what does the number look like? So the "how many." There's also discussions in terms of "the who." So "who" is part of that Healthcare Workforce so there are challenges and opportunities as well with respect to culturally and linguistically responsive practitioners.

There's also, in addition to the "how many" and "the who," there is also discussion around "the where," which is the distribution aspect of it. And so it's very complicated. I oftentimes get asked the question, So do we have enough healthcare practitioners to meet the needs of Californians as a result of the Affordable Care Act or in general? And it's really hard. There is no yes-or-no answer. There's a "yes," "no," and then there's a "maybe." And all three responses are appropriate because it's about the "how many"; it's about "the who"; it's about "the where." And everything else really falls into those buckets. You know, do we have the number? In some cases, we do. And in other cases, we don't. We know, for example, that there is a reduction and that there is an undersupply of primary care practitioners. And there's oftentimes an oversupply of specialists -- and that's the "how many." When it comes to "the who," we know with certainty that the practitioner, whether we're talking about primary care or mental health, does not reflect the demographic diversity of Californians. And there's a slide to that effect in one the future slides.

And then the distribution aspect of it. We know, as well, that in some areas there is an undersupply across the board. So these are some of the not priority professions that we focus on. So when I talk about primary care, we're talking about practitioners, advanced practice nurses, the nurses, P.A.'s, community health workers, promotores, et cetera in the same way that as we are talking about mental health. It's a very broad-based number professions.

So I mentioned a little bit in terms of the "where" and in terms of the "how many." One of the things that we do at OSHPD, is we serve as the primary care office, and we partner with HRSA, with the Health Resource Service

Administration in order to designate facilities and committees as underserved. What does that mean? It means that we have all this data that's available to us, and we, in essence, identify communities and say, Wow, based on the patient population ratio, based on proximity to a practitioner, based on demographic information, like infant mortality rate, we designate those communities and those facilities as health professional shortage areas. There are four different types of shortage areas. There's the health professional shortage area, the HPSA, and that's the primary care component. There's the mental health shortage area. There's the dental, and then there's the R.N.

And so if we were to do an overlay of the primary care, mental, dental, and R.N., you'd actually see that regardless of where you're sitting, where you're living in California, you're likely to have an underserved community. And you'll note, for example, there are, in California, 137 mental health professional shortage areas. That's about 3.9 million Californians. That number is growing and not because -- it's not a static number. That number fluctuates and changes based on the data that we receive. And it fluctuates and changes based on the number of providers and the access to services in those communities.

But, in essence, you know, and as you look at the totality of this map, you'll see that, again, regardless of where you're at, you are likely to have a shortage area.

So I already mentioned about cultural – culturally competent and culturally responsive practitioners. You know, what's interesting to note really is, in addition to the actual numbers themselves it's just the lack of parity. And we know that parity is important. We know that responsiveness is important. And we also know that the research bears out over and over, time and time again, which is that the -- that access to practitioners that are culturally responsive is the biggest indicator of access and quality to care, more so than even access to health insurance.

So when you equate everything and when you equalize everything, the one factor that will always be a competing factor will be the access to culturally competent and culturally responsive practitioners.

So -- and as you see the numbers, you know, the numbers bear out, which is that we don't have a representation in terms of California's diverse communities. Latinos is the one that's probably the one that's easiest to note, just in terms of 40 percent -- almost 40 percent of Californians are Latino. Every -- out of every two children born, 1.2 of them are Latino. And that number is growing. More than 50 percent of California children in preschool and kindergarten have a Latino surname. More than -- what is it -- more than two-thirds of underinsured and uninsured individuals speak something which -- other than English at home.

So when you think about it from that perspective, it really doesn't matter which data we pull out. It doesn't really matter how many stats we pull out because the research bears out, which is, it doesn't look good.

So I'm just going to skip through some of these slides because these are the specific slides that relate to OSHPD's programs.

What I did want to note was just this particular area. And this our strategic plan in one page. And so as we look at our strategic plan and our focus for OSHPD as it relates to Healthcare Workforce, it's in five very specific strategies. And I'm just gonna outline the strategies very broadly, and then I'm going to focus on one specific strategy within that core element and talk about it a little bit more. And it's not to suggest that there aren't other opportunities for collaboration, but as I was thinking about what to share with you, these were some areas that I thought would be very easy, natural partnerships for us to consider.

So as we look at the priorities for Healthcare Workforce, these are in order to be responsive to the Affordable Care Act. And there are five different strategies. And they run the gamut of the strategies. The first one is pathways, just getting folks to be interested in health professions and in mental health professions. And there's really big differences in terms of those individuals that are interested, that have access to those services, that have access to the information. And as we talk, particularly, as we talk to pathway pipeline development programs, and we talk to programs that focus on middle school, as well as high school students, the lack of information is astounding. It's scary, frankly, because there is just so many misconceptions about what it means to be a good R.N. or P.A. or Allied Health Practitioner, or Community Health Worker. And oftentimes it's that lack of information that can really pose to be challenging and likely sometimes pose to be the biggest barrier. There's this big misconception that you have to have an A-plus average or at least a solid A-minus average in order to enter med school. And that's not the case at all. But it's those urban myths, those urban legends that oftentimes keep repeating themselves. So pathways, just getting people to be interested in health professions.

Training and placement. That one is pretty simple. Training them and exposing them to access to care, exposing them to primary care, as well as placing them in access to underserved areas where they're doing primary care. So the theory here is that if you expose students, if you expose residents to primary care, they're more likely to be interested in primary care. If you expose them to clinical vocations in primary care settings underserved communities, they're three times more likely to practice in an underserved community. And the research bears out. If in a clinical rotation, P.A., R.N., a lot of Advanced Practice Clinicians, if you expose them to underserved communities, they're likely to stay in those underserved communities. So training and placement.

Financial incentives. That one's pretty easy. Scholarships, loan repayments, stipends, you name it. Any strategy that incentivizes an individual to practice primary care and to practice and/or mental health and to practice them in underserved communities.

Systems redesign is the one that I always find really fascinating because it's the one where we look at the system as a whole and we say, Are we providing access to services in a way that's quality, that's efficient, that's affordable, that is accessible, that is culturally responsive, et cetera, et cetera. So it's really looking at the system from that perspective and saying, Is there a different way of delivering care?

Finally, the last one is research and policy. And data isn't oftentimes the sexiest piece. But research and policy bears out, which is that if you have the data, you can tell the story. And, particularly, as you're considering your initiatives, that you're considering your activities, it's certainly important to consider a number of different alternatives and to consider a number of different strategies. And some of them will be funding. Some of them might be programmatic. Some of them might be policy oriented. And this is where the data comes in.

So I'm gonna spend a little bit of time on some of these more so than others. So on the Pathways and Pipeline Programs, we do have a program called the Mini-Grants Program. And it awards ten to twenty thousand dollar small grants to nonprofit organizations. The exclusive focus is in order to increase awareness and exposure to mental health -- mental health and primary care as professions.

I'm going to skip this slide. This is just a fancy. Because every slide should have something fancy and pretty to look at.

So another one -- another focus is around Training and Placement Via Primary Care Residency. So there's been a lot of discussion around primary care and a lot of discussion, particularly, in terms of where physicians and primary care practitioners play into this model. The Governor's proposal does include a proposal -- the Governor's budget includes a proposal that would fund for three years, expansion of primary care residencies in Song-Brown, to include other primary care practitioners. Again, the focus around training and placement being that if you expose advance practice clinicians and residents to underserved areas in primary care, they're likely to stay in those areas. And that research bears out for a lot of the OSHPD programs, which is that 15 years after their service obligation ends, more than 50 percent of practitioners remain in that area. That's because we really see it as almost, if you will, a local stimulus package, if you will, which is we really hope that the residents and the practitioners that practice and that do their service obligation there; that they will find love; that they will marry, have children; that they will buy a house, not necessarily in that order; buy a car; go to school. So we're really looking for opportunities for them to cement and really create the seeds in that community. And once they've created the seeds in that community, then they're less likely to leave.

We've also found, which is really interesting, that about 60 percent of residents, when they choose their first residency of location or of priority, they oftentimes end up choosing a zip code that's either the same or ones that hold over

from the zip code of where they went to high school. And that really says a lot about primary care practitioners. And it just says a lot about advanced practice clinicians, which is the reason why their choice of location is either the same zip code where they went to high school or the zip code over, has to do with who's living there, which is their parents. So the opportunity to have that familial support, that opportunity to, you know, to establish a family or buy a house or buy a car is also really dependent on the family. And we've also noted in our experience and in our research that spouse support or partner support is also really, really important. Because oftentimes the partner might not, you know, might not have the same access to career opportunities and so having a partner with opportunity to get support so that the -- so that they can get those career opportunities is really important as well.

Another focus is around financial incentives. And so we recently last year received a \$52 million grant from the California Endowment. Of that \$52 million grant, 31 million is for the Health Professions Education Foundation, and 21 million is for the Song-Brown Program.

The Health Professions Education Foundation is a really unique beast of its own. It's the only public foundation of its kind. So it's the only public institution that's a foundation that is within state government that's allowed to raise money. And it raises money specifically for the purposes of providing financial incentives to students and practitioners from underserved communities. In exchange for a financial incentive, they are required to provide direct patient care in an underserved community. The stipends and scholarships range from a gamut of 5,000 to 105,000; very competitive.

The good news with the foundation is -- it's good news and it's bad news. The bad news is that we always have more requests for dollars than we have actual dollars available.

The good news, I suppose, from that story is that the research, as well as the anecdotal feedback bears out, which is there is a lot of interest in practicing in underserved communities. But oftentimes folks are having to lead the lifestyle of choice. And when you compare salaries, oftentimes that might not be very competitive here if you're making a choice between primary care and a specialty. So having that information upfront, having that information in high school, in undergrad, in a post-graduate program, as they're completing -- some of them -- residency programs, is really, really important for them so that they can make those decisions and they can make informed decisions.

The other one, the 21 million is for Song-Brown. And as I mentioned earlier, Song-Brown doesn't provide grants to individuals, but it provides grants to add additional slots in residency programs for F&P's, P.A.'s, R.N.'s, and Family Medicine programs.

This is another one in terms of Systems Redesign that I thought would be interesting. OSHPD has the unique ability to suspend the Business and Profession's Code or any other code that limits scope of practice. What does that mean? It means that, if you can imagine, with most -- with all professions, there is a Scope of Practice Law. And so the Scope of Practice Law is typically in one -- two directions. It either says, Though shall do this, this, this, and this, A, B, and C, and X, Y, and Z, but not, you know, D, E, and F. Or it has the other ones which says, Everyone else can do A, B, C, D, E, and F; and you can do everything else. And so, as you can imagine, sometimes it's really complicated.

So with the Health Workforce Pilot Project, what we do is, we evaluate, test, and demonstrate pilot projects in order to look at expanding service skills and/or expanding skill sets for practitioners. What does that mean? It means that there are -- if you look across the board at any given state, there is no one true -- there's no one clean way of saying, R.N.'s only do A, B, and C. Because the only clean -- because I was trying to figure out, how can I -- how can I illustrate this in a really pretty picture? But in California, it's A, B, and C. In Arizona, it will be A, B, and C, minus 1, 2, 3. And then in D.C., it might be X, Y, and Z without A, B, and C. So it gets really complicated really fast. So what OSHPD does is we focus on the Business and Professions Codes, and we say, All right, is there an opportunity to expand the skill set of that existing practitioner? Is there an opportunity to enhance how that person, how that profession delivers care?

One of our more controversial projects just ended in December of this year. And it was around first trimester abortion services. So I mention that one just because it typically gets people's attention. So in the scope of practice prior to our -- prior to our pilot, it was clear as mud that in terms of first trimester abortion services, first trimester abortion services that are from an aspiration technique are considered surgery. So the law basically says, first trimester abortions that are an aspiration technique are surgery. Then the law says somewhere else, it says that only individuals that are licensed by the medical board can provide surgery. So the law doesn't quite clearly say no one else can do first trimester aspiration techniques, but it does say, If you walk across the path, you'll see that only, you know, M.D.'s, that are licensed by the med board and surgeons, obviously, can perform aspiration techniques.

So what our pilot did is evaluate. If we were to identify other Advance Practice Clinicians, like your SNP's and your P.A.'s and your certified nurse midwife, who would have been given the exact same training that medical residents receive, could they have the same outcomes? Could they have the same patient safety? Could they have the same patient safety? Very important. And could they have the same efficacy? So we evaluated that across the board for four years. And low and behold, if they're given the same training, with the same supervision as medical residents receive, as surgeons receive, the answer is, Yes, they can.

And so we get into the business of, Can they, not should they? So it's not up to OSHPD to decide, Should they? Should Advance Practice Clinicians have that expanded skill set? We just test, demonstrate, and evaluate whether that's even an option.

So the one that we're looking at right now is community paramedicine, which is really exciting because paramedicine in a lot of allied health professions are really where you see a lot of the diversity. So in community paramedicine there are 27 states that have some -- some law around community paramedicine, which is that in addition to paramedics doing ambulatory care, they can also do some outreach; and they can also perform some other primary care preventive services. In California, it's prohibitive. So in California, the statute is really clear that the scope of practice is related to the prehospital environment. So there's no opportunity for primary care for prevention services.

So what -- so we are currently reviewing this application that was submitted by EMSA, the Emergency Medical Services Authority. They are the licensing -- they're the certifying entity for paramedics. And, so they're gonna ask the question, If we were to provide them with adequate training, could they, for example, perform safe immunizations in schools and school-based health centers or in skilled nursing facilities or somewhere else that's outside of their scope? So that is the question before us.

Then the last one that I'll focus on really quickly -- because I was given the sign -- is around public mental health services. And many of you are familiar with our work in this area because you've been engaged. And I really appreciate that engagement because it has definitely strengthened the outcome and the product. So, as you know, with workforce education and training, there is a five-year plan. That five-year plan was approved by the California Mental Health Planning Council at the January meeting. And as a result of that plan, that plan, in essence, identifies the strategies that the State will, in essence, support and invest in. So this is always the slide that I think is the most interesting because this is the slide that talks about money. So, in essence, we started with \$234 million. Of the dollars that went to the site, it's \$114 million. So that \$114 million is what we have for the next four years. It's a five-year plan with a four-year budget. Because, you know, everything has to be complicated. So as you can see, there are strategies there in terms of how we will invest. We'll invest in stipends, loan assumption, education capacity, consumer and family member employment, regional partnership, and recruitment and retention, as well as evaluation.

The one that I think is really exciting to note is the consumer and family member commitment. And that's \$10 million. You'll see that it's a \$10 million commitment just for the first two years. And that's because we'll be required to present an interim evaluation to the planning council after two years so that we can then discuss opportunities for future funding and consumer and family member.

There's been a lot of discussion in terms of supporting, you know, peer certification. There's been a lot of interest in terms of how to professionalize for -- to professionalize that workforce and certainly is part of the Department's commitment in order to engage in those conversations. And because it's a multi-governmental approach, you know, OSHPD isn't the only agency that has a stake in that conversation. The planning council does. The OAC does. There's a number of different entities. So it's our intention to work hand in hand.

But we have developed an advisory committee that is almost -- it's beyond 75 percent of -- by peers and consumers. And the purpose of that advisory committee is to help advise us in terms of how to invest the \$10 million over the next -- over the next four years.

So I did lie. There is one more slide that I did want to share with you, as the crane is -- or the -- what do you call it? The cane is pinching at my neck. So this is really exciting. Some of you might know CalSIM, which is a State Innovation's Model. It is an innovative proposal that's being proposed by the State of California in terms of how to innovate the way we deliver healthcare systems. So there is one component around the workforce. And workforce is identified as the building block within all systems' delivery. So we are developing a work group; and, in fact, they're meeting Friday for the first time around community health workers and promotores. The concept being that since CMS, as of January 1, allows their reimbursement of nonlicensed practitioners in the health delivery system, this might be an opportunity for us to look at how to integrate CHW's and promotores in the health delivery system. So we'll be looking at roles and responsibilities, skills and core competencies, education and training, as well as reimbursement and financing with the ultimate goal to develop recommendations that the State can consider as it submits a proposal on CalSIM.

The rest of it, no PowerPoint is complete without begging, asking that if you're interested in more information, please consider signing up for one of our E-mails. You will not be inundated with E-mails. You might receive, at the most, two E-mails a month. And it basically -- particularly the first one, the OSHPD CA general one, if you sign up, every month you'll receive not more than two E-mails and you'll get to hear all of the information that we have on RFP's, RAMP proposals, advisory committees, requests for solicitations, anything. So that's really where you'll get all of your information.

And this one is my contact information. So I'm hopeful that I've left enough time for questions.

(Applause.)

LUPE ALONZO-DIAZ: And if I would have been allowed to present in Spanish, it would have been so much faster.

And Jahmal knows my old joke.

SANDI GALVEZ: Thank you, Lupe.

Are there any questions?

Aaron.

AARON FOX: Aaron Fox, L.A. Gay and Lesbian Center.

Thank you for the presentation.

I had a question on your -- let's see, one, two, three -- fourth slide, talking about underserved areas and you talked about underserved populations. And I know that HRSA has specific definitions for those. And I feel like they've been sort of dragging their feet in identifying LGBT as an underserved population or a special population. And I was wondering, Do you have the same definitions for underserved populations as HRSA, or does California have their own definition, depending on what we see here in California?

LUPE ALONZO-DIAZ: We have both. It depends -- so as it relates to Federal designations, we use the Federal definition. And that's because all states are required to use the Federal definition for health professional shortage areas. And so those designations are specific because, as you know, it allows community clinics, as well as communities in general to acquire additional funds. So we do have to use the Federal definition.

For a lot of our other programs, we use the Federal definition, as well as our own definition. So we call them medically underserved areas, MUA,'s which is not a technical Federal term. So, yeah, sometimes we use that, not for the purposes of Federal reimbursement because that's a HRSA, you know, deal, but for the purposes of eligibility for other funding that we have.

But on that note, with respect to HRSA, you're absolutely correct. And the guidelines and the criteria and the formulas that are used to develop that algorithm for what a designation is have not been updated since before the '70s. And, in fact, ever since the original definition, we've not updated them. "We" as the grander government -- not we OSHPD, to be really clear -- but HRSA is actually in the process of gathering public comment on what additional criteria should be included for that designation, with expectation by the end of this year we should have a new definition. So I highly encourage you to submit comment. And then we can do that ourselves through our program officers, so I will raise your feedback to them.

AARON FOX: Great. And then do you have LGBT or sexual orientation or gender identity as a consideration in your MUA's of any kind?

LUPE ALONZO-DIAZ: That's an excellent question. I don't know, but I will make a mental note to ask. I know that it is -- it is part of the -- I don't know what it is for the MUA's, but I do know that for some of our other programs, we do -- that is part of our consideration and is part of our criterion.

HERMIA PARKS: Hermia Parks, Director of Public Health Nursing for Riverside County, California.

Thank you so much for your presentation. (Inaudible) Okay. This is California.

I've got a lot of questions. And I know that I don't want to monopolize the whole group with my many questions. And I'm certainly gonna sign up to get involved with your group because I've got some questions and some concerns.

So I have two questions to pose for you this morning. The first question is: The registered nurses program. Okay. So to become a Public Health Nurse, you must have your Bachelor's of Science in Nursing. Part of that process means that you have to go into the community and receive at least 90 hours of community work, whether you work in the Health Department, whether you're working in a community-based organization. I'm just wondering if you've had the opportunity to reach out to your various schools of nursing. Because part of the problem, the challenge that we have for nurses going into the community and working in different facilities, is that the schools of nursing are providing incentives for them to go into the hospital. So we have a shortage in the community of nurses working in that arena because the hospital pays more than when you're working in the community.

The other question that I have -- comment is regards to your community paramedic medicine service. Some red flags really came up for me in terms of where does this put nurses that work in the community, if you've got a paramedic who has not gone through a four-year training, providing services, you know, to diabetic patients, to asthma patients? I mean, I know that it's not something that's currently involved in California; but I am concerned about where this gonna lead us and the future of nurses.

LUPE ALONZO-DIAZ: May I respond to a couple of your comments, not all of them --

HERMIA PARKS: Oh, okay.

LUPE ALONZO-DIAZ: With respect to the public health nurses, I'm hearing your feedback. As it relates to, if it's the licensing certifying component of being a public health nurse, that's outside of our realm. On the other hand, for -- that would be the Board of Registered Nursing that is responsible for that aspect of it. As it relates to some of the programs that we have, we do have R.N.

scholarship and loan repayment programs. And then, in those instances, we try to be very responsive and we have an R.N. Advisory Committee that helps us develop the scoring criteria for how to award. We typically award -- I'd say -- about four to five million per year in R.N. scholarships and loan repayments. So if you'd like to participate in one of our advisory committees, we absolutely welcome you.

As it relates to the community paramedicines, we've received that feedback from a number of different practitioners. So, you know, that -- that aspect of it is not new. It is currently undergoing the OSHPD review and approval process. We are the neutral conveners that allow the project to -- to be administered in order to test and demonstrate and evaluate. We work -- as I said, we're currently going through the review process. We have a public meeting scheduled for next week, April 9th; and we're encouraging our constituents, both those that are supportive, as well as those that have concerns, and/or opposed to it to provide comment, either in writing or in person. So if you send an E-mail to any one of the E-mails, we'll make sure to note it as well.

But your feedback is consistent with what we've heard others.

SANDI GALVEZ: Thank you.

I do want to let the group know we are officially now in our lunchtime, according to the agenda. So if your question is -- you feel you really have to ask it, please leave your card up. Otherwise, I'm hoping Lupe can stick around during our lunch period; and maybe people could have individual conversations with her. We also have two public comment cards. I want to take those first.

Our first one is from Lilyone Glamden.

Can you please come to the podium.

The next one is from Bill Glasser, and -- one minute each of you.

LILYONE GLAMDEN: On slide 5, do you have that access to information about mental health or behavioral health providers?

LUPE ALONZO-DIAZ: I believe we do, yes. I can include that next time.

LILYONE GLAMDEN: Thank you.

SANDI GALVEZ: Bill.

BILL GLASSER: Just --

TAMU NOLFO: Bill, we'll have to ask you to go to the podium. It's part of the process. Thank you.

BILL GLASSER: Just wanted to find out more about the promotores meeting that you were mentioning and love to participate. Thank you. If you could give me some contact info.

LUPE ALONZO-DIAZ: Yes. Absolutely. I can do that. Yes.

SANDI GALVEZ: Gail had her hand up first. Please, let's try to make it brief.

GAIL NEWEL: Yes, very briefly. Gail Newel. I'm an OB/GYN in Fresno County. I want to comment that you please consider diversity and gender, as well, in your workforce, not only girls -- encouraging girls and women to enter dentistry and medicine, boys and men to go into nursing. My own personal experience in the medical workplace is that traditional gender roles have led to a very disruptive work environment. And that needs to go away. And I think that will happen as we get more diversity in that workforce.

SANDI GALVEZ: Thank you.

Jose.

JOSE OSEGUERA: Sure. Jose Oseguera, Mental Health Services Oversight and Accountability Commission.

I wanted to thank you for an excellent and thorough presentation. Had a quick question in regards to the \$10 million that has been set aside for consumer and family members. Is part of that money going to be used for peer certification? Just wanted to know what -- how that money is going to be utilized.

LUPE ALONZO-DIAZ: And I'm just pulling up that slide. So leave it to Jose to ask the tough question; right?

So the answer is "I don't know." And that's because we have an Advisory Committee that has been set up in order to help us define how to invest the \$10 million. But as I've noted in many meetings, it's really -- at this point, today, there is no peer certification process. So there is no money that can, in essence, support peer certification. If you ask a lot of the advocates, they, you know, they will tell you that they would like a system to be set up. And they would like it to have some combination of state authority, as well as a balance with community partnership. Well, that requires legislation. And it requires a thoughtful approach to that. So while we have funded projects like "Working Well Together" that have helped support some of that thinking and some of that knowledge, it is part of a much larger strategy that includes the planning council, that includes our other government partners in order to ensure that -- that multi-state department approach is respectful of where we're all coming from.

So it's really -- you know, at this point today, I can't tell you whether it's "yes" or "no," other than it's "no" because right now the way that -- right now peer certification doesn't exist. And what I've -- what I've told advocates is, frankly, you want legislation. Advocates, you know, should be -- and this is -- this is part of the strategy, right, in terms of trying to figure out, Do you have the money? Do you have authority? Do you have the ledge? Do you have the support? And so as part of that strategy, it would be in everyone's best interest to have authorization, to have legislation that authorizes peer certification. Because that legislation would then require, Who does it? How they do it? When they do it? How they evaluate it? Because right now, there is no authorization. There is no legislation. There is no authority that says, It should be the planning council. Or it should be OSHPD. Or it should be MUE-defined certifying body. There, you know, so you want to have those mechanisms in place. And speaking as a former advocate, I speak from that perspective. Because regardless of where I sit, regardless of what title, I'm an advocate. I'm an advocate at heart, and so I speak from that truth.

SANDI GALVEZ: Before I go to the next committee member, Ashley Rosales, please make your way towards the podium.

Okay. Go ahead, Delphine.

DELPHINE BRODY: Okay. Thank you so much today for this presentation.

In terms of the allocation for peer support, the 10 million that's part of the mental health workforce and education and training five-year plan, I think it is very positive. But it needs an explicit focus and attention to an inclusive process, culturally responsive and trauma sensitive philosophy that -- that frames the entire certification and -- in addition to the authorization legislation regs that you mentioned. CalSIMS is also very positive, but I feel it needs specific focus on culturally defined practices, traditional -- culturally traditional healing arts, peer support and carve outs for these.

When it comes to the -- both the private foundation grant and the other funding that is set aside for -- for the -- excuse me -- the incentives and loan forgiveness, specific attention carve outs are needed for, particularly, peer support outreach, engagement, health education, mental health, and substance abuse prevention and crisis alternatives, advocacy and system navigation, which all can and is being done by peers, but without this sort of support that they need.

So those -- those positions are -- are highly transitory and vulnerable to budget cuts. That can be changed through better planning. The same is true for culturally defined practices and -- and here, I include practitioners of traditional healing arts, alternative and holistic practices, and -- and LGBTQ specific practices.

I agree with Aaron that LGBTQ and other populations need to be exclusively included when we're looking at what the healthcare workforce needs. So the HRSA criteria are grossly outdated and inadequate. And I hope we can all make comments on that.

Thank you.

LUPE ALONZO-DIAZ: If I might just respond to one, the feedback with respect to the consumer and family member -- I'm sorry, consumer and family member Advisory Committee and how to allocate those funds.

The purpose of the Advisory Committee is to help develop and advise the Department in terms of how to invest the \$10 million. We do have a meeting coming up and I can't for the life of me recall what the date is. But on that very last slide, if you sign up for the wet E-mail, you will receive information. It is a public meeting. One of the outcomes from our very first meeting is to help development some categories of funding that will then translate into RFS's and proposals.

So very much -- we're very interested in your feedback. If you have specific criteria that you want us to include in terms of evidence based -- community-based

best practices or things of that nature that we should consider and/or note as we're determining how to invest and how to prioritize those investments and those requests, I highly encourage you to either attend or submit feedback or pick up the phone. Everything works.

SANDI GALVEZ: Thank you.

Ashley Rosales.

ASHLEY ROSALES: Okay. I'll be quick. Thank you for a wonderful presentation. My name is Ashley Rosales. I'm a registered dietician, nutritionist with Dairy Council of California and also public policy representative for California Dietetic Association.

In this wonderful presentation, I failed to see points of the role that registered dietician nutritionists have in nutrition promotion, prevention, policy, and access to healthy food, which is obviously critical to community health and healthy workforce. So I just wanted to extend awareness of that and to be involved in whatever capacity to support the role of that in this discussion.

Thanks.

SANDI GALVEZ: Thank you.

Alvaro.

ALVARO GARZA: Hola, Lupe.

LUPE ALONZO-DIAZ: Hola.

ALVARO GARZA: So I had two questions. Just for the -- that is: Is OSHPD in your program basically dealing with Western medicine only? Or are you partnering, collaborating, to bring in traditional healers, to bring in more diverse communities?

LUPE ALONZO-DIAZ: That's an excellent question. You know, it -- we're moving in that direction, but traditionally we have focused on Western medicine. But, you know, through our strategic planning process and through the feedback that we've received from our constituents, we realized that that isn't the only model, nor is that oftentimes the most effective model. So -- but we are -- as we are evaluating all of our programs, that is one of the lens that we're looking at, just like another lens that we're looking is around diversity and diversity not just being around race and ethnicity. So that is a key component.

Thank you.

SANDI GALVEZ: Diana.

DIANA RAMOS: Hi. Diana Ramos. I just wanted to comment on the workforce expansion in terms of physicians. I'm a Latino OB/GYN. And I know one of my mentors said when I was training, that we could probably put all the Latino OB/GYN's on a table and be able to dance; that's how few of us there were at the time.

But I want to comment on the fact that we may be building a false hope and pipeline because we can't start young enough in order to get the -- the students into medicine. And when they do get into medicine, then you are building them up for -- and I just saw this in today's paper -- \$160,000 in loans to get that medical degree. And now with the increasing number of medical schools, there's even less residency slots because overall programs -- I mean, those are Federally based. So we're -- we're building up, you know, a pipeline that perhaps is not gonna be even realistic and feasible. And -- and, so just hoping to consider. I mean, I think it's great that the program is increasing a handful of slots, but a lot more needs to be done.

And the other issue I wanted to bring up was the liability issue. I think it's great that people can practice at the highest scope of their abilities, but then we always have to remember that we, as physicians, are the ones where the buck stops. So when there's any malpractice, anything that goes wrong, it's gonna be the physicians. So something has to be done if their scope of duties is going to be expanded to really include some sort of liability of responsibility in that as well.

SANDI GALVEZ: Sergio.

SERGIO AGUILAR-GAXIOLA: One of the best one-hour presentations delivered in 20 minutes.

LUPE ALONZO-DIAZ: Thank you.

SERGIO AGUILAR-GAXIOLA: Just a simple question. This covers 2014 to 2019. Looking at the crystal ball, what's gonna happen after 2019?

LUPE ALONZO-DIAZ: That is -- that is a simple question, yet not an easy one.

Dr. Gaxiola's question was around a crystal ball and what's gonna happen. You know, I -- I'm really hopeful -- I'm -- I'm an optimist. So I'm really hopeful that as -- you know, the funding is set aside for ten years. We know that so much is changing. And so much changes every single day, whether it's new anecdotes, whether it's new paradigm models, whether it's new delivery models, there's just so many changes that are going to occur that I fully expect that when we're starting to have this -- the money dries up in '17, '18. That's the bottom line. There's no money for statewide wet programs after '17, '18. So I fully expect that we will be engaging our community partners our government partners, you know, the county behavior health partners -- partners, we'll be engaging others in terms of looking at what that model looks like. It might not look like what we have it now. And, in fact, I would hope that it doesn't look like what we have it -- as the way we have it now, just because the models are shifting; and the way we're doing business today ideally will look really different than the way that we do business next year and the year after. So that when we're having these conversations in '16, '17 or '17, '18 about what happens when the dollars dry out in '17, '18, we'll be talking about a different health delivery system. We'll be talking about a number of other folks that have access to health insurance -- or access to quality culturally responsive services. So, I guess as the crystal ball is saying, Yes, we're still gonna have this conversation, but it's gonna look different. It's gonna be different. It's gonna be exciting. But some of these challenges will also exist as well.

Thank you.

SANDI GALVEZ: Jahmal.

JAHMAL MILLER: Thank you, Lupe, for presenting this wonderful information, as we're going to spend some time the next couple of days rounding out the strategic framework and strategic plan. And understanding our task as an Office and as an Advisory Committee to come up with a cross-sectoral, kind of multiple disciplinary strategic plan for the State of California, what we'll, you know, briefly can -- would you envision, you know, our ability to tap into a sister

organization within government that is, you know, advancing work that has very much to do with our ability to achieve health equity?

LUPE ALONZO-DIAZ: I -- I truly believe that the role has to be both the strategic and tactical. And it has to be both. The tactical is really easy to describe, and then, in fact, I believe there's even a slide that identifies some of the different opportunities. And those are tactics. Those are just tactics in terms of -- so as I talk about signing up for our list or participating in an Advisory Committee, or helping us to define an RFP, I think that those -- those are the tactics approach. That's the tactical stuff that we can easily present and I can easily share with you right now.

What I'm interested in is -- in the strategic conversation, is in looking at this from the perspective of the strategy, rather than the actual details. So all of the programs that we have at OSHPD as they relate to healthcare workforce really focus on underserved communities. And that's -- that's the distinction is that all of our healthcare workforce programs have that focus. There is no general program that we have that does not have the focus of underserved community. So when I talk about strategy, not tactics, I talk about -- and we started to have this conversation -- I talk about, you know, whether it's developing programs, whether it's prioritizing the way that we do funding, whether it's looking at what we do and how we conduct our business from a different perspective. I really see us as partners in that, hand in hand. Because the tactics is, I think, what I did today. This is what we're doing. This is how you can participate. This is how you can invest in our direction. But I'm more interested in the flip side of it, which is the strategy, which is starting from ground zero and saying, Where are you going? This is where we're going. How do we go together?

SANDI GALVEZ: So I have a quick question. Relating to the mismatch between current -- current healthcare professionals and the need of the -- the demographic need of the State, I was curious about the mismatch, if there is any, between the API professionals and the need in terms of language. There's so many different languages covered in the API group. I mean, one of our colleagues talked this morning about the need to aggregate data further. So I was wondering if that's available; and if it's not, I highly recommend it become available.

LUPE ALONZO-DIAZ: I'm not -- vigorously. Because as you can see, this one just has the API, as well. And it's not broken down. So obviously not only does it depend on the profession, but obviously depends more importantly on the community. And the API Committee -- API community is so broad and diverse, that when we're talking about, for example, individuals from Japanese decent, and it's not the same thing as talking about folks from the Vietnamese community.

So absolutely. When the data is available, I think that the data clearly lays out where there are some challenges and parity. The challenge is the data. And

that's because most of the data that we collect comes from licensing entities. And there are some licensing entities that are best practices that collect that data. And there are other licensing entities that don't even collect information on race and ethnicity. So it's positive that it starts with that.

SANDI GALVEZ: Thank you.

Can you please turn on the phone line. Let's see if there's any comments on the phone before we close.

Are there any comments related to this presentation from the phone?

Thank you.

Delphine, do you have -- do you have another question?

DELPHINE BRODY: Very briefly. Sorry to speak twice.

I wanted to emphasize that the -- that my comments on -- on the need for a specific focus and carve outs for peer support and -- and culturally defined practices applied not only to mental health, but to -- to all of behavior health and -- and primary care, and specifically can be applied to the California Endowment Grant for financial incentives and the paramedics pilot.

I -- I see that -- and I think the paramedics pilot is very positive generally. It's great to expand that program to address all those needs. I would say that the last five bullets in this -- under the second subheading, where there's a lot of bullets on slide 14, those roles can all be played by peer support specialists and culturally defined practice -- practitioners.

So those also -- those different forms of practitioners need -- need a leg up here.

Thank you.

LUPE ALONZO-DIAZ: Thank you.

SANDI GALVEZ: All right.

So -- oh, Dexter.

DEXTER LOUIE: I'd like to -- when you're talking about distribution or maldistribution and Sandi's comment about Asian-Pacific Islanders. You know, at least for medicine, as well as maybe pharmacy and dentistry, there is a disproportionate representation of Asian-Pacific Islanders. For physicians, it's about 22 percent nationally. And in California, it's probably greater than that. On the other hand, we talk about cultural competence and language access. I'm second

generation. I would dare to -- I would venture that majority of these Asian-Pacific Islander physicians are either well-educated and come from Taiwan, or they're second, third, fourth generation Asian-Pacific Islanders. I learned my Chinese when I was in practice. You can bet my children aren't gonna learn any Chinese at all. So trying to match language and culture doesn't work. It's gonna be difficult. So I would not let that be the goal. It's finding the right practitioners to end up in the right community and willing to learn culture and maybe having to learn language.

SANDI GALVEZ: Thank you.

So we're gonna have an abbreviated lunch period. We've cut 20 minutes into our lunch period. We have lunch until 12:40.

(Lunch break taken.)

SANDI GALVEZ: Welcome back from lunch, everyone. I want to get started, because we have three back-to-back presentations for pretty much discussion running. We will need all that time.

I would like to -- before we do start -- to ask you to try to think of the questions that you ask related to how what they're doing relates to our strategy. Try to focus our questioning to make sure we get through the three presentations and then have time to have our small group discussions this afternoon.

So our first presentation this morning is from Marina Augusto, talking about the California Reducing Disparities Project.

MARINA AUGUSTO: I'm pretty loud as it is. So I hope I don't blast you. It's good to be here. I apologize for not being here this morning.

So I hope you had a good lunch, and I hope most of you were able to get out and get some fresh air.

So I feel very privileged, as always, to be here to talk about a very important initiative called California Reducing Disparities Project. But before I begin, I know there's a few members that are new, and so my name is Marina Augusto, and I'm the chief over the community development and engagement unit.

And again, my presentation is just to talk to you about the California Reducing Disparities Project and how that will interface or relate to the OHE strategic plan.

I always caveat my presentations by saying that sometimes I speak too long or I start sharing stories, because I just get excited about the work we're doing in OHE. So please forgive me beforehand if I'm long-winded or I take a little too

much time, but I think it's important to always convey the voice of the communities in which I work.

So just to bring some perspective in terms of the organizational structure, where the CRDP is housed is in the community development and engagement unit, and that's one of three units within the Office of Health Equity.

So just to take you back a little bit, so in 2012, when there was a reorganization and transition and the elimination of the Department of Mental Health, four staff and the CRDP moved over and transitioned to the Department of Public Health.

Now, throughout my presentation, I'm going to be talking about population reports and also project leave contact information, and so I just wanted to mention beforehand that on our website, we do have a California Reducing Disparities page that has links to the population reports, also informing materials that I might be referencing throughout my presentation.

I also have staff here at the meeting. Staff would you please raise your hand or stand? That are there here to answer any questions you may have regarding the population report, accessing the web page, and even in an effort to connect you with the project leads who have been the movers and shakers on the ground regarding this project.

So, before I begin with my overview and before I begin to tell you why I'm very excited and enthusiastic about this project, I want to acknowledge a few of our members in the room who have really -- who really have a historical perspective and also have really led the efforts behind the California Reducing Disparities Project. And that's Dr. Aguilar-Gaxiola sitting in front here, Dr. Cheng, your vice chair, and General Jeff, who is not with us today, and Ruben Cantu, who I saw in the audience earlier, a representative from the OAC, Jose Oseguera and also Pat Ryan, who was formerly with Mental Health Directors Association. They have all been partners in moving this effort forward.

So as most of know, I have been with the state for over 17 years. And so there's not a whole lot of projects or programs that come along that really excite me, and -- but I have been fortunate enough to have worked in various capacities with vulnerable populations and underserved groups that have kept me inspired.

And when I first heard of the California Reducing Disparities Project was when I accepted a position over at the former Department of Mental Health under the mentorship of Rachel Guerrero, who has worked over 25 years in the area of culture and linguistic responsiveness, both at the county level and the state level.

And through her mentoring and being at the Department of Mental Health, I just got really inspired by the effort of this endeavor. And the reason for that is

because it really struck me as a new way of doing business, a new model, if you will, a new approach.

And so this project is really built on a grassroots partnership from community stakeholders and with partners at the state level. That's pretty unheard of. And again, as I just mentioned, I have been with the state for 17 years. So that's pretty unheard of.

Usually what happens at a state government level is that they'll talk about stakeholder engagement or stakeholder community involvement, but then when you dig a little further, that might mean one or two meetings of talking to a few key people. And then we go off and we develop programs and we design, you know, activities or efforts within the state that doesn't necessarily reach or that doesn't necessarily address the issues at hand.

So early on, what we learned with this project is that had to be different, and it had to be different because of the populations that were really focused in this effort.

And so the initiative is a key statewide policy initiative to improve access to care, quality of care, and improve mental health outcomes for racial, ethnic, and LGBTQ communities. And one of the innovation pieces of this effort is to grow community-defined evidence.

And because I want us to be on the same page, I want to just read the definition that I have from the National Latino Behavioral Health Association and also the National Network to Eliminate Disparities.

So CDEs are a set the practices that communities have used and determined to yield positive results as determined by community consensus over time, which may or may not have been measured empirically, but have reached a level of acceptance by the community.

Now, this is innovative in the sense that most often what we're used to using as far as treatment modalities, be it in many fields and settings, are evidence-based. And so this kind of switched up the game a little bit and piqued the interest of many -- many communities who have been using different approaches to bring wellness to their communities.

So if it's a Hmong community garden that congregates people to just bring them together, to be able to discuss difficult issues around mental health or around domestic violence, sexual assault, what efforts can we and practices can we embrace that bring wellness, but they aren't necessarily proven, you know, in our level, in our mentality on how if they're effective or not.

So the impetus or the foundational piece is that the CRDP really rests with two documents that came out in 2001 and 2003. And these documents spoke to the

disparities and ongoing burden on minorities and under-served populations. Just a quote from the supplement to mental health states, "Racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to the overall health and productivity."

So it was by way of these two documents that really brought national spotlight to ongoing disparities and challenged individuals to look at systems and promising directions and approaches to address them.

Now this slide really speaks to and has a lot of text on there about the history or where did the CRDP come from in terms of commitment of resources. Oftentimes in this work what happens is that there are a lot of well-intentioned individuals. So I could work at a department, we can get cultural and linguistic competence training. We can interface with various communities, but if there are no resources tied to any of the ideas or the programs, we're not going to get very far.

So you heard Lupe talk earlier about the importance of building a culturally responsive workforce, bilingual, bi-cultural, but you also need dollars. So later on in the slide, I'm going to talk to you more about the funding for this project. But there was an initiative that passed called the Mental Health Services Act in 2004. And because of the passage of this law and the creation of the Oversight and Accountability Commission, this project was really -- really able to lift off the ground.

And again, just acknowledging the efforts of others -- other partners that helped in support this endeavor.

So I -- I failed to mention that -- so back to this slide, in 2007 the legislature approves the 1.5. Then we have the policy direction from the Oversight and Accountability Commission in an effort to spearhead this project.

In 2009-10 is when the Department of Mental Health developed requests for proposals that went out. And there were execution of seven contracts under three requests for proposal solicitations.

In 2012, I mentioned earlier, the Department of Mental Health was eliminated. The Office of Health Equity was created. And then in the Governor's budget, there's an allocation of 15 million per year for four years for what we're calling a CRDP Phase 2. I'll explain more about that in later slides.

This slide is very, to me, very impactful, because before 2004, mental health needs were really going unaddressed. There wasn't really, you know, an additional funding stream to help individuals with severe mental illness. Many individuals suffering from mental health conditions were -- were treated in incarcerative systems of care.

So we're really talking about our criminal justice system, our hospitals, and emergency rooms. And so really, the funding from the MHSA provided an opportunity to develop prevention and early intervention programs. And so that's really the component in which the CRDP sits, is in the prevention and early intervention piece.

California's mental health delivery system before the MHSA was frequently portrayed as a failed first model. And as I mentioned, the safety net of an underfunded system had become many of these other systems, the courts, the emergency rooms. As far as the MHSA, the taxpayers approved a one percent tax on incomes above a million dollars to fund the MHSA.

What I would like to say about the MHSA, which really inspires me as well, is that the legislation really puts client's consumer family members and those with lived experience at the front of decision-making. So there's a whole lot of community stakeholder language and the importance of getting individuals with mental health issues what they need to keep them in the community.

And oftentimes, you know, many of us may have family members or friends that are in need of support, mental health assistance and support, that doesn't necessarily mean they need to be institutionalized. What they need is community support in whatever fashion to get them there, to bring them wellness.

And so to me, that's the beauty of this funding stream. It's really driven by folks who are committed to providing these extra supports to individuals suffering with mental health conditions.

But with respect to the CRDP project, the CRDP is the -- is less than one percent of the funding stream because the MHSA fund is in the (inaudible).

When I talk about the CRDP vision and recently my staff and I met with Rachel Guerrero, who I mentioned before, my mentor, because she was really the visionary behind this project, we talked about what was the overall -- you know, the overall goal, the overall mission, if you will, of the CRDP.

And so I'd like to put this quote up there about service delivery defined by multi-cultural communities for multi-cultural communities. If we're not engaging communities about our efforts and really listening to what works, what doesn't work, then how can we improve? We're going to continue in the same pattern, have the same systems, have the same approaches, and we're going to get the same results.

So we're looking to identify strategies and improve outcomes, implement selected community-identified strategies. We also are looking to develop a community participatory evaluation component, and hopefully replicate this model throughout the nation.

And I think I only have about five or six minutes left, so I'm going to speed up. I wanted to just give you -- this is a schema and a model that has been used since inception of the project. And I think this will help when I discuss the CRDP Phase 2, because now I have used two kind of a Phase 1 and a Phase 2.

So, the Phase 1 is really about the request for proposals that went out to have three main deliverables. The main deliverables included the creation of the strategy planning work groups focused on these populations. Someone asked why these populations and not others? So as I mentioned previously, the foundational seminal documents that help move the CRDP forward were based on four populations and then LGBTQ was added based on community input and other partners' input.

And so the strategic planning work groups worked in concert with the project leads for each of those respective communities. They served in an advisory and kind of guiding body, similar to what you are doing for the Office of Health Equity.

Some of these strategic planning work groups included a membership from 12 to 56 -- 56 members, representatives from across the mental health field to include clinicians, service providers, cultural brokers, gatekeepers and more.

And the whole goal of the strategic planning work group and that first RFP was to develop population specific reports. And that's to highlight those community promising practices to identify ongoing barriers and to make recommendations on how to improve our systems.

The next RFP that was issued was for the California MHSA Multicultural Coalition, and so for all the groups that weren't included in the first RFP, the coalition is really meant as a new platform for others. So those with deaf, hard of hearing, military, other groups, emerging groups, to have a platform to talk about MHSA efforts, to be able to provide recommendations, and also work very closely with the five strategic planning work groups on looking at the limitations and the gaps in this project, because there were many. And then lastly, the California Reducing Disparates Facilitator/Writer.

So from each of the population reports that were developed for those groups, a comprehensive strategic plan for the State of California on reducing mental health disparities has been drafted and is currently being reviewed by our leadership at CDPH.

And so although those population reports are stand-alone reports for each of those communities, what Ruben Cantu in our audience today did was in partnership and in concert with the other contractors, attended many of the community forums, provided feedback in their population reports, and then also served as a point person to gather all of that information into this comprehensive plan.

I'll skip through a couple of slides so I can get to the end.

So one of the things I would like to say also is why the CRDP is unique. The CRDP is unique because, like I mentioned earlier, when we talk about community engagement processes, this was like a -- this was like a multi-layered approach to gathering information. Did we reach all regions of the state? No. Did we have our limitations? Yes. Could a lot more have been done? Absolutely.

But we run a fine line of, you know, how -- how much time to leave money in the coffers unspent or to really do an extensive, inclusive job. But these are all things we can look forward to in terms of improving upon our processes.

But to have a layered approach from a grassroots level, in two and a half, three years in addition to that to have a strategic planning work group to provide input another layer of eyes and ears and guidance. And then I would just like to say in each of these components as far as the population reports, they were vetted before they were finalized. They were vetted at about three different increments in time. And you don't often find that.

So, I'm out of time. But one last kind of link I would like to talk about, and I wanted to just talk about the move from CRDP Phase 1, to CRDP Phase 2. So all the work that has been done for the last three years in terms of the CRDP Phase 1, is those population reports and the finalization of a comprehensive strategic plan.

The next, which is CRDP Phase 2, is to take the recommendations from the comprehensive plan and implement at the local and state level. So we are -- currently we need to wait until the finalization of that comprehensive plan so that we can have the blueprint, if you will, on moving forward.

The other thing I would like to mention in terms of the interdependencies of these contracts, that was also kind of a new idea, a new concept. So the three requests for proposals that went out, the deliverables were attached to RFP number 1, RFP number 2, RFP number 3, so the CRDP partners under those contracts all had to work together. And so that -- that -- you know, that posed some challenges, but I think it also strengthened and unified this effort.

And my last comment is that the eyes of the nation are on this project. We have -- we have had many of our CRDP partners be invited to White House meetings where they have interfaced with President Obama's health advisors. We have had SAMHSA, substance abuse, you know, at the federal level looking at these population reports.

And I think what we learned through this process is that the community wanted more than what we had originally laid out. The community wanted systems change, community level changes, and so the comprehensive strategic plan

that we do have really speaks to overarching themes, 25 recommendations, departments are called to action, and so I'm very much looking forward to the next phase and how we can talk this committee and this group on how to integrate a lot of that work and put action behind it.

Thank you for your time, and I'm available to take questions.

(Applause.)

JAHMAL MILLER: I just wanted to add a note that you moved past at the end. I wanted to make sure you got extra time. But I wanted to just make sure that we reiterated the value of this -- this particular project.

As Marina mentioned earlier, there's a huge emphasis on investing in rigorous evaluation on the back end of this particular project and rolling out the \$60 million over the next three or four years into these defined -- community-defined evidence efforts that are taking place throughout the state.

And that's big. Because as we talked about the expiration of funding, we want to demonstrate that these efforts work. And we talk about the infrastructure, and infrastructure building needs that will persist after the funding is done. So we want to be very strategic in investing and rigorous evaluation, because often that's where we miss the opportunity. We invest a lot of time, and then that money, you know, just expires over a period of time. And it's very difficult to demonstrate that the program's actually worked. So that pie chart really told the story about what our opportunity is, just a sliver. And Rocco uses that slide a lot.

But our hope is that our piece of the pie for mental health disparities work across not just those five cohorts, but as we think about the other vulnerable populations that we didn't explicitly address in that effort can benefit from the evaluation component of the CRDP project 2.0, the second phase of that.

So I just wanted to add that on. And I know Marina, speeding through the end, that's something that she would have expounded on more. So thank you, Marina.

ROCCO CHENG: I have a request from the court reporter that when you speak, please speak directly into the microphone, speak loudly and clearly, and one person at a time, so you will be clear to them.

SANDI GALVEZ: I want to remind the public, if you have comments, please fill out a comment card related to this item and pass it on to staff so we can get them into the queue. So, Patricia?

PATRICIA RYAN: Thanks, Marina. You've been working on this very hard and so have a lot of people in this room for a very long time.

I just want to point out or make sure that those who are not as involved in mental health understand that even though the CRDP project is one percent of the Mental Health Services Act, that the intention -- the intent of this statewide program is to inform and develop a strategic plan to be -- to be incorporated and implemented at the local level, 95 percent on an ongoing basis of the funding for MHSA every year goes to counties. And there are many requirements in the act that -- in fact, the act itself requires that this be community-driven, that it recognize cultural and ethnic disparities.

So just because one percent or less than one percent is going to this particular statewide project, which is a great project, doesn't mean that we won't be able -- won't be expected to and won't be addressing these issues on an ongoing basis and hopefully learning more and more as we go on.

SANDI GALVEZ: Okay. Next person is Jeremy.

JEREMY CANTOR: Thank you. And thank you, Marina, for the presentation.

So I actually just want to give you a little bit of time to expand on your final comments and in the spirit of Sandi's initial recommendation to us to really look for what the relevance is to our charge, and I think we've seen through our meetings one of the core issues for us to wrestle with is how do come from a determinants of health perspective integrate mental health, physical health together?

And so, you know, this morning Pat made a comment about trauma, and Jahmal's slide -- a number of slides about early childhood. And it seems like there are these places where they're -- clearly there's the same kind of upstream factor at play both for mental health and physical health.

I'm wondering if you have ideas about how we can use this CRDP process or product or the principles or so forth to inform our work. I mean, personally, everything I know about this process, I just learned.

So guidance on how to interface with that. Part of that, I'm sure I'll get from Rocco and Pat based on their experience, but I would love you to have a minute to expand on that.

MARINA AUGUSTO: Sure. Absolutely. I think one of the kind of issues I have around this is something that Pat said and something that we were also a big part of over at the Department of Mental Health. And so, County Mental Health Services or County Mental Health Departments have cultural competence planning requirements that are modeled after the class standards.

And I believe Dr. Lu and a few others really spearheaded efforts at the Department of Mental Health to -- and I believe California was the first in the nation to have these cultural competence planning requirements that counties basically have this logic model to improve access, retention.

And so when I'm looking out in the room and I see Dr. Lu, I see Pat who was pivotal in working with the Mental Health directors, I see Dr. Kohatsu, who, you know, the Department of Health Services is now responsible for the cultural competence planning requirements, it's a new lens on looking at these community-defined evidence promising practices that aren't necessarily Medi-Cal reimbursable and how the question that was asked of Lupe earlier are you looking at shamans, are you looking at guardetas [Spanish] or guardetos [Spanish] and other approaches that we can integrate into our systems that would be more welcoming and maybe more effective approaches to working with communities.

So I hope and I envision that this committee will help guide that process of what I see as a system's change approach of not just looking at, you know, what we have been looking at in terms of these approaches that are Medi-Cal reimbursable that may not -- have no funding, because we don't know if they work, and how we could raise that level of evaluation.

SANDI GALVEZ: Thank you. Thank you, Jeremy, for the reminder of folks to try and focus our questions really on what our strategic map can really benefit and interface with the presentations that we're hearing.

We're going to hear a lot of interesting information. If you have comments about what they should be doing that's different, maybe try to save those to have individual conversations with them afterwards.

So next on the list was Delphine.

DELPHINE BRODY: Thank you. Delphine Brody. Thank you so much, Marina, for the presentation. I also took part in CRDP. My involvement in the LGBTQ producing strategic planning (inaudible).

And share your enthusiasm for the entire project and I'm excited about the 30 day -- sorry. The 30-day public review coming up for the -- for the strategic plan. And I want to emphasize that not only should this CRDP be seen as a break-through in California and nationally, it's for good reason that the eyes of the nation and internationally are on this project. And it should be replicated in other states. And, you know, improved upon.

But it can also be replicated in other health disciplines within public health, specifically in primary care, and in substance abuse prevention and treatment. I think that many of the principles apply probably and the same is true for the cultural competence requirements that the state has with the counties.

These are important measures that not only incorporate the federal cost standards, but expand upon them in that hold counties accountable based on their performance with specific criteria.

So it's -- so it's different than simply saying these are the guidelines and feel free to do things as you wish, but more -- it -- it's very specific instructions without being too specific to counties to -- to ensure that cultural competence happens in -- in -- in the program. Thank you.

SANDI GALVEZ: Jose?

JOSE OSEGUERA: Thank you, Marina. An excellent presentation.

I just wanted to clarify in regards to slide number 8, the MHSA funding composition chart, the account currently doesn't hold billions. It basically, as the money comes in, the money goes out. And given there has been improvement in the economy, we are at this point in time in terms of tax receipts collecting a little bit over a billion dollars. But that money ultimately goes out to the various different programs.

We have community services and support, prevention and early intervention, workforce education and training, innovation, capital facilities and technological needs, and then we also have the administrative funds.

I just wanted to clarify that.

SANDI GALVEZ: Thank you, Jose. Gail?

GAIL NEWEL: Gail Newel. Thank you, Marina. This represents an immense amount of work on your behalf and others.

And I -- I am a little concerned it seems like gender is lost in the CRDP. And I know you're charged with looking specifically at racial, ethnic, and LGBTQ communities. But can you talk a little bit about how you might be looking at gender within those groups?

MARINA AUGUSTO: So as I mentioned, there were limitations in terms of the original RFPs that went out. The focus was really on the -- on the five population groups. But in addition to that across the lifespan, there were specifics around gender.

And I -- I believe moving forward, there are -- some of the population reports do and Rocco, you might be able to help here, but in a few of the population reports, I do recall where there was efforts made to, you know, track the age categories and also the gender, splitting out groups and focus groups and addressing males, you

know, the needs as far as the mental health. And I'm thinking of one, the Hmong community as an example.

But I think it's an area we can improve upon in terms of the implementation piece, and adding language or having a focus in our solicitations that go out. We can make that effort. And I do want to say that the strategic plan -- the draft strategic plan has not been finalized. We are waiting for internal approval before we can go out to a 30-day public review. So that's also going to be an opportunity to get more feedback from the community in terms of -- in terms of how we can improve upon the strategic plan.

And we are planning three community forums, which will keep the Advisory Committee informed of when those dates will be.

GAIL NEWEL: Thank you.

SANDI GALVEZ: Sergio, you're next and I'd like to ask Kate Karpillow, if you could please make your way towards the podium while Sergio is asking his question?

SERGIO AGUILAR-GAXIOLA: Thank you. Thanks, Marina. Great overview. Just to follow up on Pat's observations or comments, that the CRDP partners are already, you know, collaborating in many respects with the -- at the local level with counties.

And just to give you an example, there are counties that I -- I have learning in the past few months that have embraced some of the frameworks that can -- in the population reports in terms of the strategic directions and recommendations to develop a -- a, you know, a community stakeholder dialogue in how to approach reducing mental health disparities.

And it is -- it is actually very inspiring to see that. And I just wanted to share that that is the case. There are at least -- you know, there are several counties that I'm aware of, and there might be others -- others -- other partners might be aware of as well.

SANDI GALVEZ: I guess, Kathleen, we have one last comment. Gail, do you have another comment?

GAIL NEWEL: Sorry.

SANDI GALVEZ: Please be as brief as possible.

KATHLEEN DERBY: Thank you, Marina, that was a (inaudible) presentation.

I just wanted to ask a little bit more about the involvement of people with disabilities. I know -- I heard you mention people who are heard of hearing, and I just wanted to find out if there are people with physical disabilities or other sensory disabilities involved?

MARINA AUGUSTO: So it's been a while since I reviewed the population reports, but I -- I don't recall seeing data or information on engagement of individuals with disabilities.

I do know within the larger scope of the California MHSA Multicultural Coalition, there are members who sit on that coalition that represent those individuals with disabilities.

But again, more effort around that, not only from the CRDP effort, but an Office of Health Equity effort in outreaching and engaging the Department of Rehabilitation and other (inaudible) process. But thank you for bringing that to our attention.

SANDI GALVEZ: Okay. Kate Karpillow. Please identify yourself and your organization.

KATE KARPILLOW: Hi, everyone. I'm back. I want -- I want to make two points. I want to first say that the effort CRDP did was truly groundbreaking of deep policy and practice import, reflects considerable leadership on the part of the state, and Marina in particular, for stewarding this through a highly collaborative process, which is the way to go.

Saying that, as you all know from previous testimony, I have concerns about the past of this project, which is that there was no systematic analysis of the implications of gender, being women and girls, in the population reports.

And that was then. This is now. And I'm not one to beat things up that was then. So the question is, what are you going to do now? And I would ask the members of this committee to see this as an opportunity as well as staff, that you have \$60 million going out in state money. And that we should be concerned, as I know my friend Darcel Lee is, that when we roll out funds to deal with African-American population, that we're really looking at depression among African-American woman, that we're looking at the implications of mental health for domestic violence victims in all these different populations.

And I see so many heads going up and down. I have had a marvelous conversation, a deep important, I think ground-breaking conversation, which Jahmal Miller last month. I'm very hopeful but it will take those of you in this room to keep raising this question and to make sure there's -- there's contract language about gender that you're evaluating on the basis of gender, and that there's program money specifically targeted to women, girls and men and boys, because

sexual socialization affects both in different ways, and public resources will not be well-spent unless you look at the implications of gender and socialization.

That's my bit. Thank you very much for the time.

SANDI GALVEZ: Thank you. Please turn the phone line on.

Are there any comments or questions regarding this presentation on the phone? All right.

Well, thank you, Marina.

Our next presentation is going to be on Health in All Policies. And Julia Caplan, the program director for this project, as well as Connie Mitchell, the director of the policy unit, will be giving this presentation.

CONNIE MITCHELL: All right. I just set my alarm. When the blues start playing, then I got to stop.

I'm Connie Mitchell. I'm the public health officer at the Office of Health Equity. I oversee the policy unit. And in the policy unit, we have three teams. One of the teams is a Health in All Policies team that you will hear about from Julia Caplan in just a moment.

But I wanted to also tell you about our Climate and Health Initiative, and also our healthy places initiative so you can be a little bit oriented to all the variety of work that's going on in the Office of Health Equity.

So these are the three teams. Julia leads the public health -- Health in All Policies team. She is actually on loan to us from the Public Health Institute with funding, and we greatly appreciate from the California Endowment and also Kaiser has also contributed funding to some of our work. And she has brought -- the Public Health Institute has contributed staff for the Health in All Policies team that we would not have had without that arrangement. So we have been very grateful for that partnership to get us going.

Kathy Dervin is the team leader for our Climate and Health Initiative. I'll talk just a little bit about that.

When I first came at the Office of Health Equity, I was like a little bit stumped about why climate was in there and maybe some of you are like wondering about that too. But actually, now I have become very well-informed that not only all the problems that you know about, whether it's obesity or mental health, are likely to affect the most vulnerable that live in California, but also climate change will.

It will be the poor who won't be able to get an air conditioning unit or won't be able to move. It will continue to be poor and seasonal workers who have to take jobs during the summer where they can't get appropriate resources to keep them cool, and they end up in the emergency departments with heatstroke and worse illnesses.

So that's a very -- the idea that climate change will affect the most vulnerable Californians, first and foremost in our work.

And then Dr. Neil Maizlish heads up our Healthy Places team. This is a -- just a wonderful endeavor that started with the Health in All Policies task force. They did outreach around the whole state to find out a simple question. How do you know that you live in a healthy place? What does it look like?

So we had a series of focus groups and community outreach so that people could just say in lay terminology, I know I live in a healthy place because it would look like this. It would have parks. It would have schools that were open in the evenings so you could have adult education or you could have parent meetings. It would have easy access to transport. It would be easy for me to walk my children to parks or recreational activities. It would be easy for me to get to a store where I could buy fruits and vegetables. So the people know what it is to live in a health place.

And we took those descriptors and we converted them into indicators that Dr. Maizlish is now populating those indicators down to the zip code level in the State of California. And this will be an accessible database for everyone to retrieve information to describe the community in which they live.

So this slide just emphasizes that climate change will impact all Californians, but the most vulnerable will suffer the most. Climate change will magnify any existing health inequities; depression, asthma, some of our infectious diseases because we'll have more mosquitoes, a whole variety of things. And this map is showing that in L.A. County, more African-Americans and Latinos live in high risk areas compared to whites and average incomes.

This slide is describing what we call co-benefits. Reducing greenhouse gas emissions, not only gets the gas out of the air, the carbon monoxide out of the air, but it also helps us in many other ways.

So if we are decreasing our fossil fuel dependency and getting people out of cars and getting them -- we call it a mode shift, one day a week, see if you can get public transportation to work. Go to the grocery store, get a couple of bags on the back of your bike, and try that once a month thing even to just get started.

Mode shifting people, we're going to have an increase in physical activity, we're going to have improvement in our air quality, we're going to have a drop in our major chronic disease and a drop in obesity.

And we actually have data to support that. We have data that we share with urban planners and an urban planning model so they can do some predictive modeling, if I change the stream in this way, what kind of health benefits will I get?

Energy-intensive food systems so you have more local food available, you're using up less of the green space and the agricultural space around cities, helping to have very healthy infield development so that people have access to services, they're not driving, they're not using a larger portion of their monthly budget to pay for gas and to pay for car upkeep. And that goes along with urban sprawl and compact development and green space and tree canopies, so that we are as cool as we can be.

The OHE Climate and Health Team. These are some of their major endeavors. We have been working hard to prepare California for extreme heat and issued public guidance on that. We have been developing the California climate adaptation strategy called safeguarding California.

We are also activity working with the CDC on a project, building resiliency against climate effects -- it's called a BRACE grant -- so that we are developing communication and public health education programs for all public health departments in the State of California.

And our OHE Healthy Places Team, we have -- these are the models I was talking about. It's a long name. The integrated transport and health impacts model or we to it as ITHIM.

It's actually a modeling tool, a predictive modeling tool that local planners can use so that they can go in and put in new parameters for their community. Widen this streets, add more bicycle lanes, increase the sidewalk capacity, how is that going to not only get people to be more activity, but what can we predict in terms of decreased asthma rates, what can we predict in terms of decreased diabetes, or decreased obesity. It's a really fascinating project.

And then Healthy Community Indicator Project, where we're creating the standardized core set of valid indicators. To me, that may be -- this may become one of the keys measures of the success for Office of Health Equity.

If we are able to look at some of the strategic planning that we do around the social determinants of health, we need a way then to measure how are you actually moving this along, and this indicator project, that's the long-term goal for it is to become a way to measure our progress in addressing the social determinants of health.

So these are some of the things that people told us what is a healthy community. I think it's great for you all to you keep this in mind as you think about the strategic plan. It has to meet the basic needs of all. It has to have quality and sustainability with regard to environmental issues, adequate levels of economic and social development, of course health and social equity, social relationships that are supportive and respectful, and you can see how each of these measures now are being converted. We have 50 indicators that have been defined; 14 have been populated in the State of California and are already accessible on our website.

With that, I want to introduce Julia Caplan. Julia is our team leader for the Health in all Policies team. She's going to talk about what is health in all policies as a conceptual base, about the task force, its formation, how the task force is engaged around the issue of health equity, and then that will lead right into the discussion. Thank you.

JULIA CAPLAN: Thanks, Connie. Wow, this is the best spot in the room. I get the view of the trees and everything. You are all missing out looking out this way.

So I'm really, really grateful to have this opportunity to talk with you about what we're doing Health in All Policies. And I have been looking forward to this conversation for a long time, because Health in All Policies, the task force is named in the statute that created the Office of Health Equity and the concept is described in that statute, this topic has been discussed a lot in last two Advisory Committee meetings, and has also been named in the early draft of the strategic map.

So it seems appropriate to have this conversation. In preparing this talk, Connie and I really thought about what information we needed to bring to inform you all as you make decisions about the strategic planning process, so that you can link the work that's happening within the office to this larger visionary piece that you're working on.

I also just wanted to say that I always welcome input and suggestions for what we should be doing with the Health in All Policies Task Force, but I'm hoping that the discussion today will, as Sandi said, really focus more on exploring the whole strategic planning process. But I'm here today and tomorrow and welcome other conversations about the task force as well.

So let's see. Health in All Policies. So let's talk about the reasons for Health in All Policies. I think as you look at the slide, we see pictures of some pretty big societal problems. Things like pollution, loss of farmland, violence, traffic, congestion, climate change, poverty, variety of injustices. These are complex societal problems. These are things that no one agency or sector or organization can solved on their own. They're interrelated. Oops. There are implications with all of these for health, mental health, and equity.

And so we really, you know, that kind of puts us in a bind especially the way that governments are traditionally organized. We have, especially in a large state as California, the state level we have the large institutions, these very large agencies that work largely separately.

Health and All Policies has been around as a global concept and movement for quite a long time, but it's much newer in the United States. And in fact, California is the first state in the country to embrace this as a formal approach at the state agency level.

And so that creates great opportunities to be creative. And it also creates a challenge because we're also learning as we go there is no roadmap for this. So as we have been doing this work, we have developed a working definition of Health in All Policies as a collaborate approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

And we have also identified five things we really think of as the key elements of this work. The first health sustainability and equity, the reason that I think this is important is because we see these three priorities as interrelated and really inextricable. We can't promote any of these goals without working on all of them together. That really goes back to what Connie was talking about in terms of climate change, health, and equity.

Intersectoral collaboration, I've already talked about. Benefiting multiple partners is a co-benefits concept and really pursuing multiple goals with single strategies. Engaging external stakeholders. So from our perspective, we're working within governments, so this is being responsive to community needs and also bringing in diverse experience and expertise that we may not have within our institutions.

And the final one is really the crux of this work, which is about creating structural or process change. So really changing the way that we do business to make health, equity, and sustainability at the core of our decision-making no matter what it is we're talking about, and building that into decision-making processes as a regular and normal part of what we do.

As I said, we're the first state in the country to do this work, and we're now four years in, which is hard to believe. And so we have gotten lots of questions from other people about how we do this work, what are the lessons that we have learned, and so our team has produced two documents which are available for free on the web. I'm happy to provide the URLs later, but one of them is a guide for state and local governments on Health in All Policies, and the other is a report that was requested by the Institute of Medicine last year on Health in All Policies.

So I'm going to talk about the task force now. The task force was created in 2010, and it was created by an executive order by Governor Schwarzenegger. And Governor Schwarzenegger, as you recall, was very interested in physical fitness, he was concerned about obesity, he was also really interested in how to address climate change.

During his time in office, he came to understand that those things actually are not -- those are not separate goals, but they're really linked and require collaboration and, in fact, the health impacts of pursuing climate change go far beyond obesity.

It's not just about getting people out of their cars and getting them more physically active so that they're smaller, but it was really about addressing major issues around chronic disease, mental illness, injury, really recognizing that this is about societal transformation.

And I think he also really embraced this big idea that we're not just -- we're not going to solve our health issues by treating disease and injury better. That's certain part of it, but we really need to make our communities healthier in the first place so that we don't need as much treatment, and people can be healthy before they go to the doctor's office.

The task force's executive order charged the Strategic Growth Council with creating the task force. And the Strategy Growth Council, or SGC, is the cabinet level body. It's made up of secretaries of a number of agencies and it reports to the Governor.

And the SGC was charged with really creating this task force. The task force is facilitated by the Department of Public Health. The purpose is to identify programs, policies, and strategies to improve the health of Californians, while also promoting the SGC's other goals which largely have to do with environmental sustainability. And also the executive order calls for robust stakeholder engagement.

Since then under this governor, the task force has also received support from the legislature through senate concurrent resolution and was also codified within the Office of Health Equity. And as Connie mentioned, staffing is provided through a public-private partnership which is really essentially when we are pursuing innovative strategies that sometimes government is not quite ready to get behind or the funding streams are not fast enough to respond to fast-moving needs of real social change.

Here's a picture of the logos of our members. The Strategic Growth Council has 19 state agencies to the task force. So this task force is only made up of state agencies, departments, and offices. And it's a very diverse group that includes organization like our Department of Transportation, labor, parks, schools, forestry, land use planning, food and agricultural, and others.

And the first thing that we did is we asked the folks on the -- on the task force what is a healthy community? And did that exercise that Connie talked about where they put up a healthy community framework and kind of got to that a healthy community has so much to do with our neighborhoods and how and where we live.

And then we asked people, what do you do and really took the time to learn about the different departments in our group and help them understand what it (inaudible) to health. And we are still learning and probably always will be. There's just a vast number of partners and issue areas.

An important next step was to create some alignment around a common vision within this group. And so we looked at that definition of a healthy community, and we created aspirational goals. And the first several that are bulleted here really come from that healthy community framework, that aspirational vision that all Californians will be able to safety walk or bike or take public transit, have safe, healthy affordable housing and so on.

And then the second one, which is the sentence at the bottom of the slide, is really not so much about healthy communities, but about healthy policy-making, so the idea that when people at the state level are making decisions, that health and equity are going to be considered in that process and the decision-makers are going to have information about the health impacts of their decisions.

The task force went through a long process, held -- it was actually a short but very intense process -- held stakeholder input workshops around the state, and ultimately developed a report of 34 recommendations. They're organized around these topics areas that you see on the screen.

And these topic areas relate directly to the aspirational goals. You will notice that there are certain things missing. There is not a topic area here around the economy or job, for example. And I'm sure that each of you can identify other things that you think are very important that are not here.

This is not a comprehensive strategy for addressing health in California. Rather this was a set of recommendations of things that state agencies felt that they could do that were feasible, that involved collaboration, where we had the members on our task force. And so even with 19 agencies, there was some very important issues that were not represented on the group. And so I just kind of want to give that caveat. And this set of recommendations was presented to the SGC.

The recommendations were not enough. There was a decision that needed to do something with them, so the task force took those recommendations and prioritized nine of them, and then developed implementation plans. And this was done again at stakeholder workshops around the state.

The implementation plans detailed discrete action steps, and named partners who was going to participate in them. And now our staff team, we call ourselves the backbone team, we're facilitating the process of working with our task force members to carry these out.

In a minute, I'll give you some examples of what some of those are. These are a few features of the current structure.

So the participation of the task force is voluntary. It's not funded. And this is key. There is some funding for our team, our backbone facilitation staff, but the individual agencies that participate are doing this on their own time. So it's really important that we pursue goals that are -- that align with their existing goals.

We also use consensus decision-making. I know that's different from this body here today. The consensus decision-making, while it may sound difficult, and it has been at times, it's been really important for us to really understand what concerns are, develop very strong recommendations, and I think it's lent a lot of credibility to our work.

And then the other piece I want to say is the focus on win-wins and embedding. Embedding is the idea of building health and equity into existing state processes and existing work. So taking health programs that are already happening and making them better.

These are a few examples of some major accomplishments of the task force. The first is one that I find particularly exciting regarding access to healthy food. We were able to bring together three departments, education, food and public health, and each department has contributed funds to create a farm to fork office that is working to develop strategies to support regional distribution systems to make it easier for institutions to purchase local produce.

The second one, one of our really leading members of the task force is the Governor's Office of Planning and Research, which issues guidelines that are used by cities and counties to make land use decisions, and had lot of implications for zoning, where parks go, a lot of equity issues about who gets access to parks, whether or not you can have a farmer's markets or community gardens in your neighborhood. And they're revising those guidelines entirely with the very strong health and equity (inaudible). We're very excited about that, and are doing that in partnership with the task force.

And then the third item here is that we're working with the Department of Corrections and General Services, which handles state food purchasing contracts to actually change the contract language so that the Department of General Services is procuring more nutritious foods to make it easier for our Corrections Department to provide more nutritious foods in their menus.

And the last one has to do with the partnership around -- with education around school siting decisions and ensuring that the school facilities decisions are made in ways that really align with community goals.

One of the big questions that we asked ourselves as we did this work is about what -- what do we work on? You know, when we look at health and health equity, there are a zillion different ways we can approach this work.

And so for the Health in All Policies task force, the big question was what unique role can we play? We know that there are already so many different organizations and institutions pursuing these same kinds of ideas. What's different about us and what is the value added?

And what we identified and this really came back to us from our stakeholders, was that stakeholders wanted us to do more to foster collaboration, to shape funding streams, to provide guidance and tools for local decision-making, to gather data, to share data, and also to really support bi-directional stakeholder engagement, both getting input and disseminating information.

And I'm almost at the end here. I wanted to share a little bit about some of the opportunities and challenges.

So overall successes of the task force itself have been, I think, really building trust and understanding between departments. And we actually did a small evaluation in our second year and found that that was really true, breaking down silos. We have seen some concrete changes at the state level that are going to have significant impacts on healthy communities such as the general plan guidelines and other pieces.

And also we're just seeing a growing recognition of this approach and the impact of addressing social determinants of health and health equity.

I know I'm out of time. Thank you very much.

(Applause.)

JULIA CAPLAN: I am going to go through one more slide, actually. I can't leave. I just wanted to let you know.

But I want -- before I close, I want to say something about some of the challenges, too, because I think it's really important to keep in mind. Some of the limitations of our work with the task force. One of them is the financial limitations and that are agencies, the member agencies, don't have resources to do this work.

One is that the actions have been taken in areas where there's traction or opportunity, and so that's different from the comprehension strategy. And we're only working with state entities and there are many other players at the table.

In addition, there is not an agreement about the meaning of equity and health equity, and different departments have goals around equity about serving vulnerable populations, but they often have different definitions of what that means, which are determined by federal funding streams. These are some of the challenges.

And as I close, I want to pose a few questions for reflection. Connie and I were kind of thinking about what the relationship is between this work and the work of the Office of Health Equity, broadening this Advisory Committee.

And I think that it's important to think how the task force aligns with the Advisory Committee's goals and strategic planning process. I'm interested to hear if there are questions you would like us to bring back to our task force members. We meet with them quarterly and we can engage them in this process, but we need direction about how to do that.

Do you have ideas about what that would look like? And also, are there barriers to achieving equity that are posed by state agencies or departments where you would like us to bring that information back to the task force. So with that, I'll close.

SANDI GALVEZ: Thank you.

(Applause.)

SANDI GALVEZ: Okay. We have seven minutes for questions, both from the committee and the public.

We have one public comment card. Delphine, why don't you start?

DELPHINE BRODY: Thank you so much, Connie and Julia. I really appreciate the work you guys are doing on this.

In terms of -- really I guess outreaching to and educating the most vulnerable populations, both on climate change and the HiAP array of issues, it seems like there's great opportunity to work with community members as -- as peer outreach and ambassadors perhaps.

And -- and they in turn can educate their communities on things like community gardening, farm to fork opportunities in their area. For example, in the area where I live, there is a limited amount -- very limited of local fresh produce from -- from farms in our area that is sold at a community store, and most of the local folks bypass it completely and get candy and other junk foods, stuff in cans.

So I'm just thinking like if there's a way that -- that community members can educate each other about the value of nutrition and -- and community garden, for example, that would be an awesome way to increase the effectiveness. Thank you.

SANDI GALVEZ: Thank you. Jeremy.

JEREMY CANTOR: I think Cynthia was next.

CYNTHIA GOMEZ: Hi Julia. Thank you so much. Really exciting (inaudible) on public health council when some of this was really getting off the ground. It's impressive to see what has been accomplished. Just really great, great work.

I do have, I think, related to your question is, from my perspective, you have built some of infrastructure that's needed for us to do our work, which is this cross-agency collaboration that, you know, which we don't want to redo (inaudible). In some ways I hope that part of what can happen is that we can bring some of the things that we might be identifying as (inaudible) to be across government agencies to come to your group, so I guess that -- hear from you as if that's realistic or if the group even can see themselves as being a part of what we're doing as well, so that as we're building our strategy, we see this as being very interconnected set of activities.

And the second part of that question is, and if not, what can we learn from what is taken thus far as we (inaudible) things that would require cross-agency collaboration.

SANDI GALVEZ: Okay. Jeremy. And please can you limit it to one minute?

CONNIE MITCHELL: Did you want me to respond? We actually -- thank you for asking that question, because I think that's foundational, is how is this -- and it's actually in the statute -- how is this group going to work with this other independent group, that's not even really -- although the Department of Public Health staffs it, it's accountable to the Governor's cabinet for Strategic Growth Council. So how is that going to integrate?

We had a meeting following the last Advisory Committee meeting. We had a meeting with Sandi and Linda Wheaton, who is the liaison. She's on the task force, and she's on the Advisory Committee, Linda Wheaton from Housing.

And what we decided was that, you know, again, we're all breaking snow on this. But this group could come up with some ideas and say, "We think that a policy level change is needed, and we think it's needed across a couple of different departments." Is this something that the task force would be interested in helping us to do? And vice versa.

Because the task force could say, "We're real interested in this equity issue. We're getting kind of stuck here and there. We're not sure what direction is okay to you. Can you advise us, or do you have an idea, or is this something you can kind of take and go with?"

So that's the process we're about to engage in, is to be two mutually supportive organizations, each preserving their autonomy, but with strong bi-directional communities. Does that help?

CYNTHIA GOMEZ: Yes.

SANDI GALVEZ: Okay. Jeremy?

JEREMY CANTOR: Okay. I'll be very quick.

Thank you for the presentation that involved in the Health in All Policies work from the beginning. That was a great summation of it.

And I think one of things -- so two things. I want to make an observation, and then I have a question for you. One for our group. I think one of things I really appreciate about the way that you all have approached your work is this sort of visionary component. And I think that list -- that kind of aspirational list is something for us to really think about and look at as we're developing a strategic plan. So it isn't all sort of deficit focus order very wonky.

You now, last time we talk about the Willie principle? Unfortunately Willie's not here to carry that insult, so for the moment I'll carry it. Those are things that people can understand, it translates into real world experience in a way that, you know, embedding an institutional practices is a little bit harder to gather. So that's my observation.

My question is, is around sort of developing the methodology for understanding health and equity impacts. And if you can say a little bit more about it, it seems like a lot of -- there's been this really good conversation with other agencies and there's also this complementary piece, which is defining, as Dr. Maizlish did around mode share.

Okay. So how do we actually understand what the impacts are of certain decision-making? And if you can talk about is there -- is there -- I assume there's a lot of room to grow in that direction, and that that's part of the conversation across agencies. If you can talk a little bit about that and how equity maybe fits into that?

JULIA CAPLAN: Yes. There's a huge amount of room to grow in that area. I think a lot of our work has focused in the last few years in getting the representatives of the different departments and agencies simply being behind the idea that equity is a key priority.

And I think we have gotten there. But in the process, we have also uncovered that everybody has really different ideas about what it means and what it looks like. And are we talking about equality of outcomes, equality of inputs? Are we talking to health equity? Are we talking social equity? Are they different? Are we talking about environmental justice, or are we talking about the other equity issues?

So I think there's -- we're in a bright moment to really deepen this conversation and move to the next step, but it hasn't happened yet. I also think a lot of this work is happening department by department. So there's some departments that are much more advanced in this area than others. And it does really depend upon technical expertise.

And so our team are largely a facilitation team, but when there are opportunities to bring in technical experts, (inaudible) some of these issue, we do.

So, for example, with some of the workaround, the Strategic Growth Council has grant-making programs, and we recognized there is a need to invent more equity criteria into the grant-making program itself. We brought in experts from within the Health Department who really lent expertise in terms of very specific input. This is what you could do and, you know, bringing in those details.

I think in terms of health impact assessment as a methodology that, you know, is used in a lot of different arenas, and it tends to be very project-specific as opposed to looking at overall systems. So, you know -- and I think that that's changing as well, but it's a growing field and you should be very much involved.

CONNIE MITCHELL: I'll add one thing too. I think that this group could say (inaudible) here's four core principles around health equity. Here's five key definitions. We'd like to see if every agency would be interested in adopting those. We can take them back to the task force and get some feedback for you.

So I think that that could be a very reasonable goal for people to share.

SANDI GALVEZ: Thank you. Neal?

NEAL KOHATSU: Julia, I wanted to say that I think that comment you made about how people view health equity, and you brought in social justice and social equity and environmental justice. I think even though our focus is, in fact, in this health realm and I applaud what HiAP has done. I think it's great work.

For us to get there, sometimes I think we should think of other perspectives. Let me give you the (inaudible). Those of us who work in schools, we want to work on the health aspects, but then they remind us that we know we are very hard pressed to do performance measures in the education space and the accommodation

for the health (inaudible) might want to bring in, they are teaching and doing education in and of itself, not just because it has an impact on health.

And similarly, the jobs piece, as you said, you can't cover everything in there. But jobs and education were two areas that I think societies, communities, individuals push for the value in and of itself, even though it has health implications.

So I think while we're striving for that health outcome, we should think of other ways of viewing -- viewing the world as well, even though our target is health equity.

SANDI GALVEZ: Thank you, Neal.

CONNIE MITCHELL: And you'll see in the statutory requirements for the department that they're asking us to look at exactly what you just described. They want to know about income equity, inequities and equity. They want to know about education and child development inequities, because those are the drivers of the health disparities.

NEAL KOHATSU: Right.

CONNIE MITCHELL: So I think even the statutes are pointing us in the direction you're talking about.

NEAL KOHATSU: Thank you.

SANDI GALVEZ: Dexter?

DEXTER LOUIE: Thank you. Dexter Louie. Actually, Neal, your comments and then Connie's comments go to exactly what I was thinking about how important is education. Education, as we saw from the last presentation, has everything to do with income.

In addition, if you're looking at grassroots, and I saw that you had interagency contact with Department of Education. And so from a grassroots' perspective, and I have been on my school board for a numbers of years, there are a thousand school districts. And every school district has multiple schools in each community. Each community is so different. So, you know, I would suggest that that's an area to investigate for those partnerships.

And then the other piece of it is health and obesity. Of course, this has now become a multigenerational issue, because obesity starts -- you don't fix it with adults. You try to avoid the problem with the children. So where does -- where is most of the contact? You know, six or seven hours a day in school. It's not at home. And maybe the parents are available and maybe not. But the contact is six hours in school.

So I suggest that our group look at that as a way of addressing this multigenerational problem. Thank you.

SANDI GALVEZ: Thank you, Dexter. Teresa?

TERESA OGAN: Hi. I wanted to just ask about what is being done to address senior issues? So not just access to, you know, parks and things like that that our seniors can use that are safe. But so many of the seniors that I serve cannot even get off their front porch.

They might be able to get out the front door, but they often can't get off the front porch because they lack a ramp, or they lack a lift, or there's not room to build a ramp. Or there's a million and one reasons. So bringing healthy foods and exercise options to our seniors.

And also kind of along those lines is, a support for community gardens, and is there some kind of a process that can be put into place to help our communities build gardens together that are also intergenerational. So, you know, maybe thinking along the lines of seniors go in and teach youth how to grow a garden. Maybe they don't have to get down on the ground and do the work themselves, but they can help instruct.

And the youth go home to their families and they create a meal together and they take that back to the senior and they share a meal together that's healthy and it's intergenerational, which as I think you know, reducing isolation, start talking about health consequences.

It's bringing families together. It's bringing communities together and it's teaching our youth how to (inaudible) healthy (inaudible).

SANDI GALVEZ: Thank you, Teresa. We have three --

CONNIE MITCHELL: I would just appreciate if you might tell us what policy barriers or opportunities are there so we can advance this (inaudible). I mean, we can do this separately. I mean, you're talking about programmatically, which it great, but we work at the state level.

So if you could tell us what we can do to help facilitate that, we would love to hear. We can do that off-line. I just wanted to follow up with you.

SANDI GALVEZ: Okay. We have three community speakers present. Please open the phone lines so we can get that prepared.

So can I have Gabino Arredando, Kate Karpillow and Darcel Lee, please come to the podium.

GABINO ARREDANDO: Hello. Good afternoon. My name is Gabino Arredando. I work with the City of Richmond, and just wanted to commend of the work of the Health in All Policies group, and also kind of bring the link to how anything that gets created at the state level, how it's going to impact the local level.

And I think with the example of the Health in All Policies group, I think the beginning session people talked about the capacity building and the city has been able to use a lot of the resources and a lot of material that has been coming out of this group to be able to put it in our own area.

The City of Richmond is currently creating a Health in All Policies strategy and ordinance which creates an interdepartmental group to get all these concerns together and try to (inaudible) together with the school district, with the Health Department, and with the city.

And so, for example, I think somebody mentioned community gardens, somebody mentioned ramps. There's an actual entity that somebody could go talk to to get their concerns met. So as you develop your strategic plan, we don't forget that cities and local and community-based organizations have somebody to talk to, a person, to be able to implement the different things identified.

And our last barrier has been -- one of our biggest barriers has been data. So we have been -- the example of having local data is very important, but for us, it's neighborhood-linked level data. So, for example, in our zip code in Richmond, the Iron Triangle of Point Richmond is the same zip code, which is one of richest and poorest neighborhoods in the area.

So sometimes we need to have data that's really at the local level to make those decisions so I can get our Public Works department excited or our Code Enforcement Department excited to work on health.

And we use this data to inform our training, so we have training for 700 staff members on health equity, but we still need those resources, we still need those expertise. Our health department is in the county, so they have to give priorities to different cities. But we say that, you know, the City of Richmond has high health disparities, so we need access to that information, access to those resources, and public health data, that we can get from the county and from the state to being able to implement what we have. Thank you.

SANDI GALVEZ: Thank you. All right. Either Darcel or Kate.

DARCEL LEE: Thank you. Darcel Lee from California Black Health Network. I think the work you all have done has just been outstanding and I really commend you for bringing together 19 agencies to work on this, because I know what a collaboration like that must take.

But I also really echo what the previous gentleman just said, is that there's a lot of work being done at the local level, and how are you going to integrate the work from community-based organizations, especially advocacy organizations that are working on Health in All Policies as well into what you're doing?

The reason I say that is I know in our organization, we're doing a lot of work with the churches and we're asking them what does a healthy community look like to you? And letting them define for us what that looks like, and then taking data and using it as we have some of our programs and our policy-making.

And it's been very incredible to listen and hear what people in the community actually think a healthy community looks like, and then take that data and aggregate it as we develop our policy-making strategies.

So I think there is some opportunity in working with some of the community-based organizations to incorporate into what they're doing as well. Thank you.

KATE KARPILLOW: I actually have more of a question, which is on the violence prevention and public safety objective that you have.

Have you integrated any of the groups at the state level to work on domestic violence like out of the AG's office or (inaudible)?

JULIA CAPLAN: Quick response to that, our violence prevention work has so far primarily focused on kind of the end use principles around community's safety, but we're delving more deeply into supporting evidence-based practices around violence prevention community safety. We're working closely with the Attorney General's office. We're building a relationship with the Board of State and Community Corrections, which holds a lot of the kind of repository for (inaudible) evidence-based work, and funding streams around that area.

So I think that, yes, and domestic violence is definitely part of that discussion. We're very much in the exploratory phase. It would be great to connect with you off-line and talk more about that.

SANDI GALVEZ: Thank you. Are there any comments on the -- or questions on the phone?

RAJI MITRI: This is Raji Mitri, member of the Racial and Ethnic Mental Health Disparities Coalition and the CMNC. Aging adults, particularly aging single adults, and especially aging single males who do not have much support and experience transition of serious nature like losses of employment, relationships, identity in the community are highly vulnerable for serious mental and physical health risks.

This group that must not be subsumed under older adult populations needs more attention in health equity. I think really they have been overlooked. We need to be looking at that aging population, call it transition aging older adults, if you want.

But they are in a very vulnerable place as they move into the older years. And we must catch them before they fall into serious depression, substance abuse, and suicide risk.

SANDI GALVEZ: Okay. Thank you.

RAJI MITRI: Thank you.

SANDI GALVEZ: Any other comments from the phone? Okay.

Thank you very much, Julia and Connie.

(Applause.)

SANDI GALVEZ: Our next presenters will be from the Office of Internal Affairs with Covered California project. Our presenters are Patrick Manh Le and Lindsay Petersen.

PATRICK MANH LE: Good afternoon, everyone. My name is Patrick Mahn Le. This is my partner in crime, Lindsay Petersen.

You know, we really want to thank you for letting us speak today. (inaudible) opportunity to be in a group like this and share input and insight really helped us to improve upon our next (inaudible). And really, we all know this is a really historic time for (inaudible). So we're really excited to be able to be here today and share our story with you.

So today we want to do two things. Number one is give you an update of open enrollment and where we are today, with less than a week for the deadline to sign up for a Covered California plan.

And secondly, we want to tell you about from this open enrollment, what did we learn and what lessons did we take as we move forward to not only improve for the next open enrollment window, but make sure that on the final days, we (inaudible) as we can.

But before we start, we always like to illustrate the work that Covered California does, you know, really common stories about what it means to be uninsured. So some of the nightmares, for example, what happens if you're

uninsured and you're doing a home repair, and you get in an accident and break your leg?

So on the next slide, this poor man is going to fall off his ladder and break his leg. And the uninsured cost is about 2,500 for non-surgical care. But if you do get surgery, the costs can jump to \$17,000 to \$35,000. So it's really expensive.

And if I can share a personal story with you. When I moved to the United States a few years ago, my dad was uninsured at the time, and got in a car accident. Non-life-threatening, but when he walked out of the hospital, it was an \$8,000 hospital bill. And it was -- you know, it was scary. It was frightening.

By the way, I signed up my dad to a Covered California plan, so make sure you get your family members signed up.

But really the story, right, is that it's frightening to be uninsured. And one of the comparisons that was made to the public is that just like it's the law, right, to get car insurance because you never know when you'll get in a car accident, it is now the law to get health insurance because you never know when you're going to get sick or need a doctor.

And there's uninsured stories really (inaudible) the mission for Covered California, which is really to improve health access and provide affordable, quality health insurance and reduce health disparities in California.

And so that's why we work with 11 health plans with names that the public mostly recognized, Kaiser Permanente, and Anthem Blue Cross, Blue Shield, Healthnet. We also work with six dental plan providers. And, you know, you have heard this spiel before, but regardless of the plan you pick in Covered California, all plans follow the standard benefit design; right?

So regardless of the plan you pick, there are ten essential services that will be covered from inpatient/outpatient services, emergency care, prescription drugs, and most importantly, regardless of the plan you choose, you won't be denied for preexisting condition.

And, of course, one of the most appealing parts of Covered California is that if you pick a plan through the state exchange, depending on your income and other factors, you might qualify for assistance, helping you reduce your costs for health care and potentially also reduce your (inaudible) subsidies and reduce out-of-pocket cost. And so for many, many families premium assistance has been really, really great to really reduce the cost of care. So, that's the basics of Covered California.

Now I want to kind of transition over to giving you an enrollment update and where we are. So from the opening of open enrollment on October 1st until February 28th, we did enroll about 880,000 individuals to Covered California. So

on our side of the house, which is the red pie chart. We can see that about 87 percent of people who selected a plan do receive premium assistance. So it's a great thing people are receiving help to pay for the cost of care. And on the Medi-Cal side, you know, we have about 1.7 million people who have enrolled as of February 28th.

Now, the question that might arise is on the 64 percent on Medi-Cal, what does it mean to be likely eligible? That means that people, when they identify they were eligible for Medi-Cal, but we still need to do some follow-up work to make sure they submit their information to the counties who follow them and make sure that (inaudible).

So, when we started the enrollment process, we worked with the University of California Los Angeles and UC Berkeley to -- with the model called the California Solution of Insurance Work. And it was a research and study that was done by these two universities to really help paint the picture of the enrollment landscape and what would be our target goals and our projections.

And so we estimated that by the end of our first open enrollment, we would enroll about 580,000 individuals. And as of February 28th, we actually enrolled 880,000. So we exceeded our projections and you can see that subsidy eligible, same thing, we exceed our projections. So we are doing really well.

So here's a breakdown by ethnicity and race. I'm sure, as you know, when we looked at our numbers, we wanted to see where were some communities that we could improve our enrollment with. And from the beginning, we saw that we could do better with the Latino and the African-American community, particularly when we adjusted our enrollment strategies to make sure that we have a process that can increase enrollment numbers in these (inaudible).

But otherwise in other communities, like the APA community, we're doing really well. You know, but this is our first time enrollment, so we are learning as we go.

So here's a more visual breakdown. As a side note, if you can see Medi-Cal, the Latino enrollment is up 38 percent. Here's the breakdown by region. And again, we're doing really well in some areas. If you look at the greater Bay Area, we are doing really well. But there are some areas in the state where obviously we can do better. The Central Valley, Fresno, San Diego, areas where we could do better.

And finally, the last breakdown I wanted to (inaudible) is age. And again, we're doing well, but there are areas that we could do better. So for example, 18 to 25, we're not where we want to be. But again, 18 to 25 is a notoriously difficult population to get to.

So I do want to give a shout out for President Obama who has been doing extensive outreach. People like me, right, appearing on shows like (inaudible). I don't know if you saw that. It was extremely awkward and she was (inaudible) at the same time. He's working to get endorsements from top celebrities like LeBron James and Kobe Bryant, you know, so hopefully there's some work to be done at the federal level to open us up.

Then I want kind of share with you some of our consumer response in terms of what was the enrollment process like. So 60 percent of those surveyed enrolled -- found the overall enrollment process in Covered California easy to complete, which means that 40 percent of the people found it a little difficult.

And full disclosure, that number actually that the people that found enrollment a difficult process increased. And so we're going to look at our numbers and our surveys to figure why that is, but some of our early assessments are because as we approached the end of open enrollment, people who never had insurance before are signing up for the first time. And signing up the first time is, you know, complicated. It's a very complex system to navigate. For many, it's the first time to hear terms like co-pay, or insurance, deductible. So it's a learning process. And we're going to look at that data to see how we can make that easier.

But on a good side, almost 80 percent of people were able to find information they needed to choose a health plan that is right for them. And I think this is a testament that, you know, some of the tools that we offered, for example, on our website we have a shop and compare tool, where people are able to compare directly apple to apple, you know, the different plans that are available to them and find that really fit their budget, you know, the response has been (inaudible).

As you know, drum roll, (inaudible) too early as of March 15, we broke our million enrollment. It is a great milestone. I would feel better if we can give a round of applause because it's a great number.

(Applause.)

PATRICK MANH LE: We're doing really well, and so it's a great story time in terms of opening access to health care.

So I'm going to turn it over to Lindsay, who is going to talk more about what we learned and what we're hoping to accomplish.

LINDSAY PETERSEN: Hi everyone. So we have been in a test, learn and adapt phase for the past six months. And we have done what we can to adjust and learn in improving enrollment as open enrollment has been going on.

But once it's done on March 31st, we will be able to take a step back and really kind of assess our data, and look at what went well and what we can do better for this coming fall when it will be happening all over again.

Sorry. We need to fix a technical issue. There you good.

So our director, Peter Lee, likes to discuss three pillars for success. And what we have noticed is that all three of these different pillars, plan management, effective outreach and marketing, and smooth enrollment all have a role to play in mitigating health disparities in California as well.

And so first of all, I'll discuss plan partnership a bit. So Covered California has a rigorous application process and detailed contract that our health plans sign, and they -- it's not just sign a contract and we're done. They agree to work with us throughout the year to -- in a variety of ways. And one of them is to focus on health disparities and agree to participate in workshops in a variety of other areas.

I'll also point out that in our application to become a qualified health plan, we have an value E metric where the plans will list efforts they currently have going on that are focused on cultural competency. And a few of those questions are how to better understand what types of interpreter need they'll need.

So how do they gather racial and ethnic data. How do they get and do they get estimates of the number of physicians, nurses, physician assistants, office staff, and plan staff who speaks languages other than English and/or bilingual.

What do they do in terms of promoting health literacy, because health and human services estimates that about 50 percent of Americans are quote, unquote, health illiterate. And what that means is that they have knowledge and background to be able to make health decisions for themselves.

And so one of the plans is we need to help promote that. How can we encourage that more? Some of the other questions we ask are, how do they measure that cultural and competent care is being given, and how can we improve that in future years?

So when they sign, they know that they'll be participating in these types of things. And then on there also, in the contract, that's what they agree to there.

So we also recognize that Covered California is about to have a pretty large, rich data set, a variety of populations of people in California, some of which are not used to having and utilizing health insurance. And so what we have going on now is some -- some requests for proposals for several vendors do some strong analytics on this data and help us understand how people are using their health care and eventually point us towards best practices and delivery system reform efforts that

are more integrated in managed care. And we're very excited to use this data to inform enrollment in future years as well.

So I'll turn it back over to Patrick briefly to talk about outreach and marketing.

PATRICK MANHLE: I'm back. So as you know, marketing is really an essential piece for Covered California in terms of really how we deliver, you know, the marketing to our audience, make sure they understand what's available to them.

Our marketing strategy is really a three-point approach. So the early part was to really focus on the education. And as you know, there's a lot of misinformation about the Affordable Care Act, and what it means.

To illustrate, for example, my boss was at an event, and then one of the questions that he received from the audience is, "I heard that as part of the Affordable Care Act, you have to have a chip implanted in your brain so we can access your health data," (inaudible).

And so it's real, right? It was a question from a real person that was worried about the impact of the Affordable Care Act. So obviously our first step in our marketing was to really provide information that was factually correct to our consumers to make sure they understand what they're getting into, understanding it is a complex thing to navigate.

And then once we -- we, you know, provided that basic information, our second goal was to really attract consumers into a plan. You may have seen our advertisement on TV, on the radio, on YouTube or Facebook, we're on there, which really is about conveying what it is -- what it is like to have a Covered California plan, to have health insurance.

So the strategy for the attract piece is to really show real stories of real Californians who got health insurance and how it changed their life. Some of the spots you see will be real Californians who have health insurance after 15 years of being uninsured.

And finally, the last piece is to really drive enrollment, and we use a mix of education and attraction to make sure that people go to the right channel to enroll.

And so, you know, the enrollment piece, we really want to make sure our consumers know that there are different channels that they can use to enroll. They can go on our website, use in-person assistance. So really drive that through the enrollment. Just so the presentation is not all text, here's some sample of some of our really awesome the marketing strategies, which are also available in other languages.

And, in fact, all of these marketing strategies are available on very different channels, like I said, it's on billboards, on buses, online, it's on (inaudible), you know, so it's out there.

So, you know, we always shift our strategies to make sure it's appropriate. So right now less than a week left of open enrollment, we want to make sure that we direct people to the right channels for them to enroll.

So as we said it before, in terms of our enrollment to specific communities with the Latino and African-American communities, we're not where we wanted to be. And that really drove, you know, a shift in our strategies.

So for example, in the Latino community, we decided, you know, it was obvious that we needed more in-person enrollment. We needed to go beyond the website and the call center and really offer the community in-person enrollment where you could talk to a real person to have their questions answered.

And so we decided to have regional grassroots campaigns that focused on seven key areas of the state, where we really work with our (inaudible), our certified counselors to make sure that we go out in the community and provide that information and services in person.

One of our great things that we did partner with the Dolores Huerta, co-founder of the United Farm Workers and a great figure in the civil rights movement, she has been helping us have rallies and she made a couple of advertisements which really helped drive enrollment.

Same with the African-American community. We increased our presence on paper, on TV, and on radio ads.

Just a couple of things, we are following up on leads and applications as my boss likes to put it, we're aggressively but politely encouraging people to finishing up their applications, if they haven't done so. So we are doing mail outreach, e-mail or telephone.

In terms of enrollment, as part of the piece about making sure that we can have more in-person enrollment, this is an evolution of our certified enrollment counselors over time.

In December, we started with about 2,000, 3,000 enrollment counselors. And now we're at about 5,000, 58 percent of them are actually bilingual, who are Spanish. So really that's to illustrate our effort to improve enrollment in person.

And then these are grantee reach as of February -- March 10th. I'm sorry. We have 11.3, you know, reach with Californians. So we are continuing our enrollment.

LINDSAY PETERSEN: So we'll discuss smooth enrollment. So there are five areas that we'd like to highlight that we really pushed forwards between January and March, which was the second half of our first open enrollment.

The first one was improved customer service. We hired 350 additional Covered California service center employees to assist with calls. And something that we hadn't anticipated was that it's more than just one phone call. There's many, many questions to be answered. Sometimes you'll make a call and realize you don't have all the relevant pieces of information in front of you to complete the sign up. And so this was crucial.

Increase bilingual staff at call centers, improvement to Spanish language support options, increasing chat resources, and then expanding the line capacity as well at our call center.

Additional subservice tools for consumers. We posted subsidized applications in other languages, including Spanish, Chinese, Vietnamese, and Korean. We continued improvements in consumer ability to check on application status.

We developed interactive voice response applications. We improved the frequency of updates to information phone lines with answers to top questions. And we added a searchable FAQ page. We improved customer service -- excuse me, consumer communications by refining operational and quality control processes to improve notice accuracy. And so we implemented e-mail campaigns, we improved frequency and consistency of public communications as well.

We improved web functionality, and there was focus in Spanish on that to the Spanish website and Spanish collateral. We optimized network capacity to prepare for the March volumes that are happening now.

We reviewed on-line post-enrollment survey comments daily and took those under consideration. We prepared for a comprehensive review of enrollment website to improve usability, site navigation and coordination across the dot com to the enrollment websites.

And we improved service for other communication channels. And we have a variety of communication channels. They include agents and certified enrollment counselors and a few other things with people who have contracted with us.

And I'll just point out we have Latino enrollment which was an (inaudible) earlier. And the first two weeks in March, it is 32 percent from 18 in the earlier months. And we also focused on the immigrant community, mostly through our CECs, which our certified enrollment counselors, and that was through partnership

with plans who developed a variety of resources and enhanced those (inaudible) throughout open enrollment, so they were able to serve that community better and help them understand health care options, help translating confidentiality documents from DHS and getting those out, so they can see them in the letterhead.

And we gave money to outreach and education grantees that focused on immigrant populations as well.

PATRICK MANH LE: We have the nerve wrecking time signals in the back, so we're about done.

I do want to give a quick (inaudible) landscape talk. I want to preface this by saying that Covered California, as a state department, is federally-funded. It does not take positions on any type of legislation.

But we thought that you would be interested in some of bills that are happening in the legislature.

Number one is SB1877 by Senator Cooley from Rancho Cordova area, which would create the California Vision Access Care Council, which is kind of an exchange type of exchange to provide vision plans.

And second one is SB1005, Senator Lara from Los Angeles, who created separate parallel exchange as well to cover undocumented populations. Both of these will be state funded, so it could take appropriation of the California general fund. It would also assess fees from the participating vision for health plans.

So again, we don't have any position on any of these bills, but we thought it would be a good FYI for you.

And now we're ready to take some of your questions, if there are any.

(Applause.)

SANDI GALVEZ: Aaron?

AARON FOX: Aaron Fox, L.A. Gay and Lesbian Center. Thanks for your presentation.

I just had a question I think it is on slide 22, which talks about health plans in disparity work. And under the second bullet where it says, QHPs are required to and provide additional matrix on sexual orientation and gender identity.

My understanding is that's optional; right? There's not an actual requirement for health plans in Covered California to collect that data and then report it to Covered California; is that correct?

LINDSAY PETERSEN: I believe that is correct. It's something I would have to double check on and it's something that we were exploring a change in the future for the next contract.

AARON FOX: Okay. Great. Thanks. I just wanted to clarify that.

SANDI GALVEZ: Sergio?

SERGIO AGUILAR-GAXIOLA: Thank you for the presentation. I'm looking at the slide 28. This is the total five month enrollment versus base six-month projection by ethnicity and race.

And I'm looking at the numbers, you know, how short the projections have been for Latinos, and especially Spanish-speaking Latinos. And the news has been all over the country and all over California for a while.

And, sure, there are new strategies to reach out to these populations, including the ones you mentioned. Are you -- are you looking at what extent the barriers outreach strategies that you are using to try to find out which are the ones that are most affected.

And by the way, this is not surprising, let me tell you. CSPAN and all their agencies, way before it was implemented, they were anticipating that the groups that were going to be with the less coverage if nothing was done, it was going to be those who are English-speaking. Okay? So I think that unfortunately these didn't get into the -- into the roll out, plans early enough.

And sure, here we are about the end of the first enrollment phase. And then there's going to be the (inaudible) October 1st again. And my hope is that there are contingencies in that period between March 31st and October 1st in which major outreach campaigns and tested -- you know, tested outreach strategies that have a group, you know, that are the most effective.

PATRICK MANH LE: Yeah. And, you know, we understand that, you know, when we started this process, enrollment was not where we wanted it to be. But we are very data-centric organizations so we did have focus groups. In the Latino community, we surveyed our call center representatives to see what were some of the challenges in enrolling members of the community.

And we took that feedback to really modify the strategy. So we explained some of these. For example, there was a need for greater in-person enrollment. We really need to go beyond our call center. We need to go beyond our Spanish website or Spanish application. And so that's why moving forward, we really focused on those grassroots initiatives, to provide the community with in-person enrollment.

And we identified a lot of other issues. For example, there was a lot of concerns especially with multi-(inaudible) families, where some members were documented in the United States and were eligible for coverage, but had family members undocumented. And there were a lot of concerns about what happens if I turn over my information to the government.

So to address that, we translated official documents from Homeland Security and ICE saying, "Hey, whatever information that you submit will not be used by, you know, immigration authorities." And we translated this information and put it on the website, our CECs have it on the ground to be able to put away these fears.

So we are constantly listening to the feedback about how we can do it better and, you know, hoping that at the end of the open enrollment we can take a third, and fourth look at see what were some of the things we could do better next time.

SERGIO AGUILAR-GAXIOLA: Thank you.

SANDI GALVEZ: Diana?

DIANA RAMOS: Thanks. Your last statements were a good segue to my question.

So for the next open enrollment, one recommendation I would give you that I'm hearing from a lot of providers, physicians who are delivering these babies is that women are not aware of the fact that they have to pay for the delivery depending on the plan, so some women who have a broad plan are having to pay \$5,000 because that's their deductible.

So had they known, then they would have perhaps opted to get a plan that they would have paid less. So I don't know if there's any way with the enrollment information, you have on there if you deliver a baby, because the prenatal care is covered, but the delivery is not. So if you have a baby, this is the cost to you if you are in the bronze, you know, the gold, whatever level. So just FYI, that's information that I would really want.

LINDSAY PETERSEN: That's wonderful. Thank you. I also just realized that pregnancies can span over two years, so potentially someone could see the deductible twice through pregnancy. I mean, if someone were -- sorry. If someone were to get pregnant in October and then it spans into the following year. If that's how -- that would be something else on the same topic.

ALVARO GARZA: Thank you. Thanks very much for the presentation. And so a question specifically on your slide 22, also, that I didn't hear that's specifically important to this advisory group, is that it says that the health plans are required to address health equity and health disparities.

So can you give us more information how you are requiring them to do that and what to do and so on?

LINDSAY PETERSEN: Sure. Yeah. We -- we -- this year, we have had a few meetings on network and quality forum topics, and one of them was focused on only health disparities. It was a day-long workshop that we held in Los Angeles in January.

And during that, we had a lot of productive discussion that we took note of, and it's information that we want to use after this month when we kind of take a step back from open enrollment and assess what we should require of our plans in the next coming year.

ALVARO GARZA: So you don't have anything specific then?

LINDSAY PETERSEN: It's still in the process.

ALVARO GARZA: All right. Got it.

SANDI GALVEZ: Delphine?

DELPHINE BRODY: Thanks so much for your presentation. I -- I commend you guys for the outreach efforts. I think you're doing a lot of great work in that area, and you're gathering on outreach, I think, in -- in -- in terms of (inaudible). But I want to emphasize that I feel there are structural flaws with the setup of Covered California and the roll out of ACA in California and elsewhere.

I'm concerned particularly about people who are not eligible for Covered California, who are not informed at the time that they -- that we enroll in Covered California that, we may fall through a low income hole and not be eligible, and then have to start all over again and applying for a Medi-Cal expansion, which is for some reason delayed for a long time.

And that's -- that was my experience. I'm sure it was many others who are extremely low income. And I'm -- I would like to see more outreach that is focused on that.

In fact, after I received my letter from Covered California saying I'm no longer eligible, I'm not eligible because of my low income, I got one saying, "Don't forget to enroll before the end of enrollment." So if there was more targeted outreach based on eligibility status and enrollment status, that would be really helpful.

But overall, I think what's needed is -- is a structural change that addresses those gaps, because people are falling through that. And I'm excited to see the

legislation to support undocumented immigrants and vision care. That's really positive.

SANDI GALVEZ: Thank you.

ROCCO CHENG: Thank you. Very informative presentation. I was pleasantly surprised that Asian tend to be higher. That's very different from our local experience. So I wanted to address more this effort made regarding the population and that in terms of geographic distribution, that certain area of (inaudible). That's the first question.

The second question is that a number of people who completed application versus enrolled, it's quite a big difference. I don't know if you can talk about the differences, and what are some of the (inaudible) -- between people complete the application versus enrollment and what is some of the strategies to actually encourage them to actually enroll?

PATRICK MANH LE: Yeah. For the first part of your question about data, obviously we're still in open enrollment, so we still have a team of people that will crunch the data. After open enrollment, we should take the time to analyze all the numbers that we have in determining what was successful, what was not, and what areas we should focus on in the next year.

So we're going to have this data for you and we will hopefully have some key take-aways from that.

In terms of people who started an application and then actually selected a plan, there's different factors as to why they haven't went across the finish line. Maybe, you know, they want the determination and decided not to get health insurance, or maybe the premium system is not enough. We don't know.

But we have leads, as we talked about. We are following up on these leads. And so we have mail, we have telephonic outreach, we have e-mail to make sure when people start an application and select an option, which language would you like to be reached in, we will make sure we coordinate that and outreach to people who started an application in the language they prefer to make sure we can help them get over the finish line.

So these are some of the things that we're doing and we'll see how it works.

SANDI GALVEZ: Dexter?

DEXTER LOUIE: Dexter Louie. I guess this is just for your information. So, I'm a physician in San Francisco. And I work with the San Francisco Free Clinic. And these are people who are uninsured but working. So one day, the medical director and I had a chat. He was saying that even though the

clinic hired a social worker to help enroll people, and these are English-speakers, not Chinese-speakers, the problem that the social worker found with their free clinic compliance was cash flow problem. Even with a subsidy, they have a cash flow problem.

So that's just information from the director of the free clinic.

SANDI GALVEZ: Hermia?

HERMIA PARKS: Hermia Parks, Director of Public Health Riverside County.

A question regarding your black African-American population. What was some of the areas or challenges that they had to go through prior to you going out and doing your additional outreach to the churches and so forth?

PATRICK MANH LE: The challenges were fairly similar. That is we needed to make sure that it was in-person, because there's a lot of challenges in terms of enrolling by yourself. So the self-service tools in itself are challenging, especially for people who are going through the insurance process for the first time.

So going on the website is a great way to learn about insurance, but it requires, you know, multiple steps to make sure you understand what you're getting into.

So when you use self-service tools especially when you're enrolling for the first time, it can be challenging, you know. And our call centers have been having a long wait time, so our focus to make sure we remove these barriers is that we do in-person enrollment.

Again, the grassroots is the most effective in enrolling folks into a health plan. So in terms of outreaching to the African-American community, we make sure that -- well, for example, we had rallies and enrollment events on Martin Luther King Day. We make sure that the partners that we work with were people have significant presence and influence in the communities.

So we do enrollment (inaudible) with an organization like the Black Health Network. We work with churches. And so we make sure we identify partners in the community who already have these relationships to make sure that people, when they enroll, have the personal connection with the person that's helping them with the process.

And like many things in the world, relationships are such a key important aspect of doing things. So for us, you know, removing the barriers without identifying where the relationship exists and partnering with these organizations, to make sure we remove these barriers in enrollment.

SANDI GALVEZ: Thank you. So I actually have a question. I'd like to go back to slide 22, because I think this is one of most (inaudible) of the section with regards to the map.

And it seems like from two questions that were asked by Aaron and Alvaro, that the things that are listed here as actually required or not required at least as of yet. I do want to go through this list and get clarity on which are actually required, which are not required yet, just so we'll have enough information to see if there's anything in our section that we can help with.

So other than things that are required, what are the actually required? Of the things that are listed as required, what is actually required?

LINDSAY PETERSEN: This was -- this was language that I took from our contract, so it should all be required. I'm planning on following up afterwards on Mr. Fox's question about the sexual orientation and gender questions.

But this is all language that's straight from our -- oh, excuse me, the contract that plans signed.

SANDI GALVEZ: But I understand from the answer to Alvaro's question regarding what is the -- what's in the plan -- what's required in the contract regarding addressing health equity and health disparity, that it's not required yet. That's being developed.

LINDSAY PETERSEN: Oh. Oh, I'm sorry. I misunderstood the question. These are -- they -- they agreed to participate in workshops and they agreed to report out on their efforts in -- in some of these -- these areas that we asked them about and evaluate, after which they put in their application, which is, I'll give you information on breakdown of their staff, and their health care provider diversity and things such -- such as efforts they put for health literacy and efforts they put towards -- to improve gathering of racial and ethnic data. And then saying what they're actually doing with it. Are they using it? And then how are they applying this towards understanding if culturally competent care is being given and if they are moving the mark, as a plan, in that area.

So they agree to report to us on how they're doing in those areas. And it's something that we haven't been able to use as much as we would like in the past few months, but we plan to step on it heavily in this post-enrollment phase.

SANDI GALVEZ: This is an area that would be useful, I can at least speak for myself, to have more information on exactly what that looks like. Because I think that's an area where there's a lot of (inaudible) section.

Jahmal wanted to comment on this as well.

JAHMAL MILLER: On January 21st of this year, I attended, Aaron was there as well, Ellen, was at Covered California's health equity meeting. So we have our hooks in to the early phases of that discussion.

And we spent a lot of time talking about data variation. You had multiple health plans listed. And you had, you know, on the continuum best practices, you had those like at Kaiser Permanente that's capturing for the most part a lot of the demographic data at the levels that you can really make substantive decisions from in evaluating whether or not disparities efforts and measures are working.

And then you had other health plans that were the opposite end of the spectrum, and some right in between. So the discussions are early. I believe that, you know, we can look to this -- this health equity convening of Covered California to inform that process. And like we said, we have some staff and members of the Advisory Committee who are a part of those discussions, and that could be an opportunity for us to further discuss as a part of our strategy.

SANDI GALVEZ: Thank you. Staff, please open the phone line. And in the meantime, I would like to call two speakers. Darcel Lee and Garbino Arredando to the podium.

DARCEL LEE: Good afternoon. I wanted to take this opportunity to make a comment, because we are -- California Black Health Network is a Covered California grantee, and we have been entrenched in this work for the last six months. Along with Covered California, we have a lot of boots on the ground.

Your question was a very good one and I wanted to make sure we answered that for you.

First, I want to talk a little bit about -- and I'll do it quickly, so that sign won't go up. It's been a build as you go process. We're all learning just like Medi-Cal -- Medicare was, like social security is. This has been a build as you go process. And we're learning together.

And I will say that Covered California has taken a lot of time to work with us on our concerns, of which we have had many, and has been supportive and has been very responsive.

There's a trust issue in our community, a big trust issue. And we have had to spend a lot of time on the ground explaining to people what this is, why it is, how do you do it, and what's good for them, and what isn't. That's been major. And we have found that it took a lot more time than we thought it would with educating folks as to why they even needed it.

It takes one-on-one as -- as they mentioned. It's takes partnering with a number of organizations. We have a collaborative of ten organizations across the state. We need more.

It takes a lot to explain the plans, because what has happened, we found, is exactly what someone mentioned, someone will buy a silver plan and they really need the bronze, because they don't enough about it. They end up with more out-of-pocket expenses.

So we have now partnered with enrollers to help explain these things a lot better. There's concern among our doctors, because the doctors have been cherry-picked in some cases and are not part of -- our black doctors, and are not part of the health plans. So that's been a big concern and we're working on that from a policy level right now.

Those were challenges and opportunities. We're doing a leg briefing for the California Black Caucus. We'll be doing that right after the numbers are official, so that we can help them understand what the challenges and opportunities are and get them to partner with us to work on meetings and have more opportunities for events and town halls in their districts, so we can get more people covered.

We going after our own set of celebrities. We're looking for celebrities, okay, that can speak on behalf, because we know in our community, a lot of folk listen to the celebrities.

We increased and stepped up our efforts for after March 31st to work with churches. And we have been working with them, but we got to do it at a greater level, because our folk still listen to their preachers.

And then working on a plan for earned media buys is something else we're looking at. We respond to hearing what's on radio and TV, and we haven't had a lot of that. So we're trying to do that as well, using celebrities as spokespersons.

Those are some of the high-level briefings that we're doing, but we're trying to do more as well.

SANDI GALVEZ: Thank you for the information. Also, another speaker, Gladys, no last name?

GABINO ARREDANDO: Hello. My name is Gabino. I'm with the City of Richmond. I also wanted to make a point with my previous comment about getting local data in these initiatives.

So, for example, we're not an enrollment entity. The City of Richmond is not a grantee, but we're very supportive, because it's in our general plan. It's part of

our Health in All Policies. And many CEOs are part of trying to get more people enrolled.

However, when we try to find out the data about how many are uninsured in Richmond at the city level so we can give a call to action; hey, we need 20,000 people that are uninsured; you know, it took us awhile to figure out how many people we had uninsured. It was different people who were telling us different numbers. And this impacts us, so we're trying to get council, we're trying to get CBOs or people to move forward to have staff to work on this.

And also -- but once we were able to get the numbers, I think it helped us be organized and how we're going to outreach to our communities. And also getting periodic updates of, hey, you already hit 5,000, you already hit 1,000 would also be beneficial to be able to move forward in getting more people enrolled.

And also having one-on-one contacts again. So when I had this question about how many people in Richmond are uninsured, who am I going to call at Covered California? So I just looked at the press release and call the press person. And then I had problems to being able to talk to somebody so I could get those numbers, I could put it in my staff report for the city council to get support to be able to move this forward.

At the end, we were able to do that, but it shouldn't take that many steps. And I think that as part of the strategic plan that you're working on, how -- what other resources are you giving local entities to make system changes easier? So thank you.

SANDI GALVEZ: Thank you.

GLADYS PRECIADO: Hello. My name is Gladys Preciado. I'm a student at UC Davis. And my question is just a simple question.

I'm really concerned about the numbers and that Latinos and African-Americans have low numbers of enrollment. And I'm just wondering if there's any discussion about strategies to like collect data on like what barriers exactly are preventing these communities from enrolling?

I would just like to know if there's any, like, if you provide online or if there's any research being conducted.

One thing is historically, like Latinos have been excluded from having health insurance, and I'm just really tired that this community has been included as well as underrepresented, like, people of color.

And I feel that there's one way to really like tap into why these things are happening is doing research and collecting data before programs like this are implemented to prevent this from occurring.

Thank you.

PATRICK MANH LE: Introducing Drew Kyler from Covered California.

DREW KYLER: Hi there. I thought that was such a great question, and so well put, that I just wanted an opportunity to respond to it.

I think you're right. I think that historically -- well, I think that Patrick and Lindsay have done a great job. I think we could have done better in a lot of the ways.

I want to give you a little bit of context. We did a pretty large amount of research with CALCIN project which is UCLA and UC Berkeley's research team and also at the NORC Research that we did out of the University of Chicago.

We noted there was over 9 million Californians who were uninsured prior to the Affordable Care Act. To put that into context, we put about 3 million of them into coverage through the Medi-Cal expansion and through Covered California. So we know there's a lot of work to do on all fronts over time.

We also know that the uptake rate wasn't the same across race and ethnicity, unfortunately. To provide some context, the -- the research that we did, we know that -- you know, on a 4-to-1 basis, folks, especially without English as a first language, enroll in-person systems; so 4-to-1. It's a huge, huge ratio. We take that very seriously.

We focused very intently on upping the number of certified enrollment folks on the ground that we had that were bilingual, but also giving folks the opportunity to know where they could go.

So having them on the ground isn't enough; right? But also finding places where you can go where you feel safe. I think as Darcel mentioned, there's a trust issue at play here. There just absolutely is for a variety of reasons. So we are very serious about understanding how to be better on the ground, because we know that's what works and we continue to know that works as opposed to online or over the phone.

But we also know there is a huge amount of Californians -- so there will continue to be 6 million uninsured Californians in this plan year, 6 million. It's a huge number. So we know that as -- so we know that while the -- the 40 some odd percent of Californians who are Latinos specifically we need to get enrolled, that our number will be somewhere in the low to mid-20s by the time we're all said and done.

We also know that there are millions of folks who need to come into the exchange. Another thing I would note, just as a point of clarification, about one and every five people who enroll in coverage don't identify their race or ethnicity. And given that we know that trust is an issue, we think anecdotally it's certainly possible that some folks tend to not report as opposed to others. We can't be sure of that. That would be just my guess.

So we know there are certainly -- the numbers could certainly be skewed, but because we don't require those fields, in many way it's hard to know.

Does that help a little bit? Thank you.

SANDI GALVEZ: And do we have the phone lines open? Are there any questions from the public on the phone related to the Covered California presentation?

Okay. Thank you.

HERMIA PARKS: Yeah. I just -- Hermia Parks, Director of Public Health Riverside County.

You know, I was looking at the information that you both shared. Thank you again for updating us regarding what's going on with Covered California.

And I just wanted to turn this around and look at the positives around this, because I was reading on page 12 the fact that we now have health plans that are required to look at the disparities. I mean, the application to be qualified as a health plan, there's language in there that they have to work towards these areas.

I think that's a huge plus for to us to really move forward to assist on doing that, to help with the data, to help address health equity and health disparities. That's huge to have this in the contract for all health plans.

I think it's a real plus for us to really move our work forward.

SANDI GALVEZ: Thank you, Hermia, for that.

Okay. Well, thank you very much.

PATRICK MANH LE: And if I can, one last note. I admit, I confess, I did the ultimate external affairs sin and did not leave our contact information on the slides.

But us being able to be in the space and gather input from you is super important for us to gather that feedback and make sure we can bring it to our leadership and make sure those changes are implemented.

So I hope the event organizer can share our contact information, because when we hear things like there's structural issues with Covered California, we need (inaudible) care benefits, these are things we want to know, and these are things we need to hear from you for us to be able to implement these changes.

So, you know, Lindsay, myself, Drew Kyler are always available. If we can be a resource to make this process -- this historical process better, let us know.

And again, thank you so much for allowing us to be here. And we'll see you soon again.

(Applause.)

SANDI GALVEZ: Okay. So we're going to take a 10-minute break and then come back and roll up our sleeves and move into our small groups.

(Pause in proceeding.)

SANDI GALVEZ: Let's reconvene our meeting.

So we had a lot of really good presentations this morning, and I'm hoping that we can use the information that we gleaned to help think through our strategic map.

As Jahmal mentioned this morning, we are very lucky to have Tamu join us as staff and help guide us in this process. So without further ado -- are you going to go to the podium?

TAMU NOLFO: Yeah.

SANDI GALVEZ: Okay. I'm going to pass it to Tamu.

TAMU NOLFO: Hello everyone. How are we doing?

Hey everyone. How are we doing? Good. Fabulous. Wonderful.

So at the last meeting, as I mentioned, you had done a lot of great work creating mission, vision, central challenge, strategic priority areas. They need to be fleshed out a little bit. There wasn't quite time to do that around the table.

You gave the authority to your Chair and Vice Chair, Sandi and Rocco, to work with us as staff to be able to do that.

I was brought on four weeks ago, and at that point started engaging in discussions with them as well as reaching out to as many of you as I was able to get your thoughts about the process and what you wanted to see as a part of the process and as a part of the plan.

And so what you have as one of the handouts is what I'm referring to as a strategic framework. So I know there has been talk about the map, but this is what I'm just referring to as a strategic framework. And it is absolutely a draft.

So one of the things that Jahmal and I heard from Sandi and Rocco was that it would make sense for us, as staff, to take the first stab at trying to build out those strategic priorities into some initiatives that maybe you could respond to, and that's what we have done.

So I wanted to let you know is how we came about sort of getting the information together to formulate these initiatives. So they were based on the conversations, once again, that we had with Sandi and Rocco, the conversations where I was reaching out to you as staff members, doing individual and group interviews with the OHE staff, and then there were also a number of documents, also, that we were pouring through.

So there were all of the notes that were written up by Tim and Laurie Fallon, and you all received those and they're also posted on the website for those who would like to see them. And so combing through those notes and seeing what was important to you that came out at the last meeting.

There is a federal plan addressing health equity. So really looking at what -- what is happening at the federal level. It's this HHS, Health and Human Services action plan to reduce racial and ethnic health disparities.

There are state health equity plans. So there has been lots of night and evening relay going into those of looking at the state plans and what are the other states doing, so we don't need to recreate the wheel.

There are county plans. There are some counties that are doing very innovative work. There's work in organizations like BARHI and Friend's Research Friendship Institute. And so it's looking at what are kind of these great minds coming to. CPEHN, the California Pan-Ethnic Health Network has the landscape of opportunity, cultivating health equity in California. So lots of great work has been done and how to we synthesize that; right?

So, it's all of that work that's been done, it's looking at what is currently being done within the Office of Health Equity, and you received a couple of presentations today to help you get your arms around that work, that is currently being done.

And then there's also the data disparities report that you all have the draft of. And so that also is informing us in terms of, well, where are these disparities, what do they look like, and how can we bring that into our thinking around the initiatives?

There's the statute itself that created the Office of Health Equity. And there are the documents that informed that statute. So I think that was pretty much my list of what went into creating this initial list of initiatives that you have; okay?

But we know that this is not the final list. We know that you need to wrestle with this some and come to some general consensus about what else we should take into consideration with this list of initiatives.

What you also will see noted in this handout that you have is a section that says annual goals and it says to be developed. And we didn't want to develop the annual goals yet at this point for a couple of reasons.

One is, we're not quite sure whether or not this is the list of initiatives that we're going to land on. And also because it was going to be a bit much to wrestle with at this meeting.

So know that the goals will be developed, but we're not going to deal with that part today at this meeting.

So what I'm going to do is I'm going to go through these initiatives with you at a little bit of a clip, because I know about our time situation today. I told Sandi that it was fine to let the last presentation go over some, because it was an important conversation to have, and we could be flexible with what we're doing during this time today and tomorrow around this strategic framework.

But I'm just going to read them off, and if you have questions about what they represent, like you want clarity on them, then you can go ahead, and we'll ask those questions at the end. So just make note. Check if you have questions about them.

If you have issues with them, if you don't like them, if you think they should be reworded or anything like that, you're not going to work them out here in this space. You're going to work that out, sorry, in the small groups. And I'm going to give you some guidance for what to do in those small groups; all right? So right now it's just clarity about what the initiatives themselves are.

I need my reading glasses. Okay. So, the first strategic priority is to identify and disseminate actionable information on disparities.

The first one, build a network of communication and support for health equity work statewide.

The second is to develop and host an interactive, informative and engaging state-of-the-art website with timely, accurate data, relevant research and evidence-based and community defined practices.

Number 3. Convene annual health equity summits for practitioners and policymakers.

Number 4. Build awareness of the Healthy Community Indicator Project, an asset that strengthens the state's data capacity and is driven by social determinants of health; encourage its use for planning purposes.

You'll see an asterisk after some of them. Those that have an asterisk refer to initiatives that the Office of Health Equity will be responsible for under current resources. If there is no asterisk, then all other partner -- all others, so all the other ones without asterisks, we can look at implementation or adoption as partnerships are identified and resources become available.

Any questions about that first set of initiatives, just what they are?

So the second set of initiatives, embed health and equity in all policies across sectors.

Number 1. Partner with the HiAP, which is Health in All Policies, task force to embed health criteria in decision-making, grant programs, guidance documents, and strategic plans.

Number 2. Coordinate through HiAP possibilities for transportation and land use planning to support access health, mental health, and health care services.

Number 3. Inform climate change, and Cap and Trade initiatives regarding unequal impacts on vulnerable populations.

And number 4. Develop and disseminate policy briefs, based on recommendations from the Office of Health Equity Advisory Committee. That would be you.

Any questions clarifying those?

Yes, Delphine.

DELPHINE BRODY: Thank you. On the items to be considered for strategic priority A, in terms of convening the annual equity summits for practitioner and policymakers, I support that, but I would like to see emphasis that that also includes stakeholders, including individual clients and patients and their families and community members who have not yet been able to access health care services that they're seeking.

TAMU NOLFO: Thank you very much, Delphine.

That kind of feedback and information is perfect for your small groups. That's where we're going to collect it. So this is just to clarify if there's any

misunderstanding about the initiatives. Properly scolded, but it okay because we enjoy you being at the table. Okay.

SANDI GALVEZ: Tamu?

TAMU NOLFO: Yes.

CYNTHIA GOMEZ: Thanks so much for this.

A question on initiatives for B. I'm just curious as how kind of we landed there versus other cross-sectors; right? This is -- some of this we talked about earlier today. But it seems like we're pulling out some very specific ones and then we're kind of not including others. So I just wonder if you could speak to that a little bit.

TAMU NOLFO: So the language that was provided in those in numbers 1, 2, and 3 for B were proposed by Connie and her staff. And so I don't know, Connie, if you want to speak to that. Do you want it speak to that, Julia?

JULIA CAPLAN: Yeah. I'll just say that whoever is in that group, we would welcome you to add or broaden it, and it's definitely not to meant to be a comprehensive list. It's a starter.

TAMU NOLFO: Thank you. And we're also going to have Office of Health Equity staff in all of the small groups so that they can serve as a resource and to be able to discuss what the current capacity is, what possibilities are.

I'm going to move on to C.

Okay. So C is embed equity into institutional practices.

Identify partnerships to conduct assessment of health equity practices throughout state departments and state-funded programs.

Number 2. Integrate efforts to address the root causes of health inequities and CLAS compliance as considerations for funding and allowable activities of all state-funded program plans.

I think that's specific program plans, not programs plans.

Facilitate comment understanding of health equity and the social determinants of health between public health, mental health, and health care services providers.

Number 4. Facilitate access to training and technical assistance for grantees of state programs on health equity, including incorporating health equity modules into current categorical training provided by state and federal programs.

Number 5. Identify partnerships to support the expansion of culturally and linguistically appropriate services, including assessment, technical assistance and training, and CLAS compliance as a consideration for funding.

And number 6. Explore strategies to reduce differential access to the opportunities presented for the Affordable Care Act/Covered California while also strengthening the state's safety net for the remaining uninsured and undocumented.

Any questions about those?

D. Empower communities in disparity reduction initiatives.

Number 1. Conduct a scan to determine how local communities are currently mobilizing to address the social determinants of health, and how they are measuring their success.

Number 2. Assess and build broad-based community support on health equity issues through education and dialogue.

Number 3. Help increase the civic participation of the communities most impacted by health inequities.

Number 4. Incentivize, recognize and publicize local efforts addressing health equity and the social determinants of health, both emerging and established.

Number 5. Provide support to local efforts to build health equity into strategic plans, train staff, evaluate impact, and connect with funders, colleagues, and other communities.

And then actually it had said trained staff and volunteers. So we can also put volunteers in there. I'm not sure why that got taken out.

Number 6. Utilize and encourage expansion of current campaigns to promote dialogue with California communities on local initiatives address the social determinants of health. Also we're missing a "to."

Explore the feasibility of initiating local task forces to increase health and equity in all policies.

I think this was spoken to a little bit earlier today by one of the speakers from the public.

Number 8. Strengthen current and existing California Department of Public Health and Department of Health Care Services prevention approaches to address the social, environmental, and economic conditions that impact behavioral choices, such as tobacco use and safe sex, substance abuse, and physical inactivity, through community-driven and system-wide strategies.

Number 9. Employ the California Reducing Disparities Project to reduce mental health and community health disparities and seek partnerships with other sectors that work to improve conditions in historically underserved communities in California.

Where you see words that are underlined or phrases that are underlined, it means that on our website, you can click through two more information about that, so it clicks through to the website that discusses that further -- or to that document that it references.

Are there any questions under C, empower communities in disparity reduction initiatives?

All right. Last one. Develop and align sustainable multi-sector infrastructure and support.

Number 1. Develop workforce development opportunities, including a speaker's series aimed at increasing the capacity of state employees to effectively address health inequities.

Number 2. Strengthen the health equity workforce development pipeline by utilizing fellows and interns in the implementation of the strategic initiatives.

Number 3. Identify new resources and redirect existing resources to support the strategic initiatives and provide leadership to align resources in support of health equity.

Number 4. Recommend that health equity be embedded as a priority in existing streams, state, local, and private.

Number 5. Identify potential public and private partnerships for all appropriate strategic initiatives, including governmental, corporate, educational, research and philanthropic institutions.

Number 6. Manage the public health climate action team catalyzing public health efforts to reduce greenhouse gas emissions and achieve health co-benefits.

Number 7. Closely monitor progress of national HHS action plan to reduce racial and ethnic health disparities and seek opportunities to increase California's role.

And number 8. Build upon existing efforts to address the unique health and mental health needs presented through the lens of gender and sexual orientation.

Any questions on that one? Okay. Yes, Jeremy.

JEREMY CANTOR: It's not well-formulated questions, but --

TAMU NOLFO: That's okay. We'll take them anyway.

JEREMY CANTOR: So, there are some things here that are sort of repetitive across some of these or seem very similar. And I'm just wondering if that's -- if that's a role for the smaller groups to discuss or if you want to -- for instance, like the workforce development opportunity speaker's series under 8. There was another piece about training staff. The bit about health inequity being embedded into existing funding streams, I think also was in the bit about institutional practices.

So I think -- the question is sort of as we go into our small groups, how we should look at those redundancies or just identify them to massage later?

TAMU NOLFO: You know what I might do is to put them potentially under concerns. So you have some criteria -- or not criteria. You have some areas that I'd like for you to address in your small groups. And let me see if there are any more questions before we move on to that.

JEREMY CANTOR: I had one other. Not a well-formed question. But should we take -- it seems like almost all of this is focused on state government activity. Is that -- I mean, if our plan is supposed to be for the entire state.

So I'm wondering -- for instance, there's a lot of focus on government funding, but for the private sector there's nothing.

TAMU NOLFO: Actually, that's not quite true. And that it's -- for example, number 4, the last one I just read off, recommend that health equity be embedded as a priority to existing funding streams, state, local, private.

So where it seemed appropriate, we specifically talk about the state without being a purview where we would potentially have some influence or would like to start. But where it wasn't, then we moved away from that. Like looking at number 5, including governmental, corporate, education, research and philanthropic institutions. So I hope that you see there is a mix, there's a balance.

JEREMY CANTOR: Okay.

TAMU NOLFO: Yeah. So we are looking at this in terms of being a statewide plan, but where it made sense to focus first on the state, that's what we're doing.

But if you have concerns, or if you have ideas, then that's where you get to flesh that out in your small groups.

JEREMY CANTOR: Great. That makes sense.

NEAL KOHATSU: I had a somewhat similar question as Jeremy. Just looking at the whole array of activities. Should we be trying to characterize in certain ways, such as can they be done statewide or time limited or just leave it wide open or degree of specificity 30,000-foot versus some or more 10,000 or 5,000 or should we just look at just for are they important? And I didn't know.

TAMU NOLFO: No. It's a great question. And so this is what we would like you to kind of getting to the priorities on this, which is the last.

If you turn the page away from the blue boxes, you'll start looking at essentially your worksheets to get your notes to us. We would like your feedback in your small groups on -- you're going to be looking at either 1 or 2 sets of initiatives.

One group is going to be looking at two sets of initiatives. They're going to be looking at A and B, because there are only four in each one of those. The other groups are going to be looking at one set of initiatives. And within that, what we would like is your advantage -- your -- what you see is the advantages of going after those particular initiatives, your concerns going after those particular initiatives, the critical success factors. So what you would see as needs to go right. How we'll know we're on target with this. What you would hate to see go wrong with this.

D is any recommended additions, deletions or modifications. So did we with miss something really important that should be here? Do you feel like there's something on here that this that could be taken off. Do you feel like there's something on here that should be modified.

As Delphine said, she was in support of that particular initiative, but she would like to see it broadened and modified. So that's your opportunity to do it. And all you have to do is mark which one you're referring to. Like A-1 or E-5 and then your comments so we know if there's one in particular you're referring to that we can match that up.

And then at the very back page, E is potential partners and what those partnerships might look like. And that may be your own organization or research institute or your own CBO that you feel like would make any really good partner with that particular initiative. Or you can recommend. You think CPEHN would

be a great partner or whatever it is. It could be an agency within the state. It could be a federal agency. So what those partnerships might look like.

And then the last one gets a little bit to what you were you saying about prioritizing. So we want you to prioritize high, medium, and low, and the criteria that we would be wanting to consider is the impact, the scope, the resources required, and the urgency. Okay?

FRANCIS LU: Yes. This is tremendous outline, very helpful.

I just had a question about the next step when we go into small groups and I'm just -- I got a sense that perhaps we would be going back into the same small groups we were in last time which, to my recollection, were kind of undifferentiated.

And I'm just wondering whether it might be -- consideration might be given that we might want to choose a small group that we feel that we have more expertise in to participate in.

So, for example for me, I think that I have some more expertise in groups C. And I feel I could contribute more by going in that group. It's not that I'm simply in a small group I was in last time, I may or may not be focusing on that topic.

TAMU NOLFO: That's a great point. Thank you.

So we will work this out then in just a moment with the small group situation. So let me finish taking the questions before we do that. Dr. Gaxiola?

SERGIO AGUILAR-GAXIOLA: Thank you. As I was reading along with you, the five areas under A and B, the specifics under initiatives, I was trying to figure out how are we going measure this? You know, what are the measures that would be used? And some of it -- and that forces us to really look at the language in ways that we can use smart and perhaps to weed out some of them that are too specific. I mean too -- too general. Because I think that we are thinking constantly on how, where do I measure these things? And how are we going to be making progress?

And because I didn't see that you have -- that the metrics are not included in your --

TAMU NOLFO: Exactly. That's what I was saying about the goals, that the goals have not been fleshed out yet in part because we didn't know if these were the right initiative.

SERGIO AGUILAR-GAXIOLA: Oh, okay.

TAMU NOLFO: But I think that does make sense. And I've heard SMART -- actually I've heard the acronyms differently, but we have got specific, measurable, accountable, actionable, realistic --

SERGIO AGUILAR-GAXIOLA: Yeah.

TAMU NOLFO: -- times. So we can keep that in mind as well as we're deciding whether or not we have the right initiatives on the page.

Linda?

LINDA WHEATON: A point of clarification here. Only the items that are asterisked are resourced for the Office of Health Equity?

TAMU NOLFO: Correct.

LINDA WHEATON: Everything else -- okay. Given that in particular and to Jeremy's point about the apparent redundancy or similarity within these, I first of all, am oriented for thinking that we ought to try and do a few things well, especially measure them. It seems a bit overly ambitious given the lack of resourcing in particular.

It seems one of the ways that it might be helpful to look at things that are similar is actually to array the items and indicate which of the objectives they address. I think I would have a clearer -- it would be clearer on what kind of different things we are going to do.

So my just gut level is we have to cut this by at least half or something unless -- and focus on how we would do a few things well.

TAMU NOLFO: So that with want definitely to be put on your paper around concerns, because what we're going to do is we're going to look at trends across individuals and groups in terms of what's coming out of these different areas to help us move to the next step.

Yes, you need a microphone.

DEXTER LOUIE: Thank you. Dexter Louie. I agree with Dr. Lu's recommendation that we self-select because there you will put your resources where they need to be, your expertise, and you're really looking for a greater degree of specificity. Which means, am I (inaudible) I didn't know about? It wouldn't be worth very much. Thank you.

TAMU NOLFO: So I would put that out to you. Sandi, if you want to --

SANDI GALVEZ: Go ahead and comment.

TAMU NOLFO: I don't have a problem with that at all. We can absolutely formulate groups based on choice of which priorities -- areas people would like to be in.

SANDI GALVEZ: Just sort of a caveat, I think we may need to adjust. It could be that we end up with everybody in two of these areas and nobody in any of the others.

TAMU NOLFO: So maybe we could do just kind of a simple visual to see if I call out a priority area, you raise your hand to say that that's the group you would like to be in today and tomorrow; okay?

So A, identify and disseminate actionable information on disparities? Perfect. So there are three people, Delphine, Kathleen, Patricia in that group. Good.

Next one, embed health and equity in all policies across sectors? Teresa, Linda. Okay. That's a start. We may need to pull some more towards that. Okay.

C, embed equity into institutional practices? Sandi, Dr. Garza, Dr. Lu, Hermia, Aaron. So we have five in that group. Good.

D, empower communities in disparity reduction initiatives. That's one, two, three, four, five, six, seven, eight -- do I have the right -- one, two, three, four, five, six, seven, eight. So there are eight in that group, which is a little disproportionate from some of the groups that only have two or three.

Let's see the third one. Develop and align sustainable multi-sector infrastructure and support?

Nobody wants to be involved in group E, huh? Okay. So what would you guys like to do with that? Do we have recruits for E?

JEREMY CANTOR: I'll do E.

TAMU NOLFO: Oh, we do have recruits for E. Nice. Although -- okay. Well, let's try this again, because I want to make sure that we are recruiting from group D as opposed to one of the other ones, which only had a few members to start with.

So Dr. Garcia, you were not in group D?

ALVARO GARZA: Right. I was in C.

TAMU NOLFO: Jeremy, you were; correct?

JEREMY CANTOR: I hadn't chosen.

TAMU NOLFO: You hadn't chosen yet? What other hand did I see.

GAIL NEWEL: I'll go to E. I was in B and I'll go to E.

TAMU NOLFO: Perfect. So we have Gail, Jeremy --

PATRICIA RYAN: But I was in A.

TAMU NOLFO: So we have two people in group E?

PATRICIA RYAN: I'll go to E, but that leaves two people with --

TAMU NOLFO: Right. So that's not what we want to do. So if you guys are okay with that, we can do that. We have great minds. I guess one of the other groups only has two people in it as well.

CYNTHIA GOMEZ: Didn't you say A and B were going to be combined into a group?

TAMU NOLFO: I did. Thank you. I appreciate that. Okay. So, Patricia, you said you were in which group?

PATRICIA RYAN: A.

TAMU NOLFO: A. So good. We'll have you go into E then. That will be fantastic.

So now there are three people in A. A and B are being combined.

So raise your hand if you were either going to be in A or B? One, two, three -- if you had originally said you were going to be in A or B. Really? That's it. Okay. That's fine.

So you guys, it looks like there are still four of you, Linda, Kathleen, Delphine, and Teresa that make up the A/B group. Patricia, you're going to be in E with Jeremy and Gail.

NEAL KOHATSU: I'll move from D to E.

TAMU NOLFO: Thank you. Raise your hand if you know you are in C? Just everyone knows where they are? Perfect.

Raise your hand if you know that you are in D? Good. You guys worked it all out. That's good. So we are going to -- yes, question.

SANDI GALVEZ: I originally had a comment that wasn't about who was what group.

While I agree that this cannot be accomplished in three years, I also think it's important to have some kind of aspirational goals that we want this office to do that may not be all covered in this three-year period. I'm not quite sure how to do that. But I think that there's a lot of good ideas in here, and I don't want to see them get lost.

TAMU NOLFO: So maybe I would put that down under advantages? That it's ambitious. It's a way to capture the ideas so they don't get lost. It's something to aspire to?

So one more question?

DEXTER LOUIE: I just want to comment on your -- Sandi said it. Sometimes your long-range goal needs the right thing. You have to have it. But your baby steps haven't started now in one, two, three years. Is that right.

TAMU NOLFO: That's right.

DEXTER LOUIE: Otherwise you'll never get started.

TAMU NOLFO: So what we're going to do is we're going to utilize this room for two of the groups. So those of you who are addressing A and B can meet at this end. Those of you that are addressing C can meet at this end. Those of you that are addressing D can go into the room where there was lunch. And those of you who are addressing E, we will show you to the secret room that you haven't seen yet.

All right. And this is what you're going to need to do; okay? When you get there, you will have until 4:30. So you're going to have about 35 minutes. And then you're going to pick back up again tomorrow as well.

Spend a few minutes just jotting down your own notes on the pages about what you think. And then have a conversation with your group about whether or not you guys are more or less on the same page, or if you have some differing views.

We'll need for one of you to decide that you are going to help co-facilitate along with an OHE staff member. And one of you is responsible for actually capturing the notes that are going to be presented back late tomorrow afternoon.

There's not going to be a report back today. It's going to be late tomorrow so you have some more time to work in your small groups. Okay?

And what I'd like for you to do when you do capture your notes is on the flip chart paper to put them so like advantages are all on one page, disadvantages are on one page like that. Okay?

And there are flip charts in all of the rooms for all of the groups. So go ahead. I'll show group E to where -- I'm sorry. Someone is asking a question.

MEREDITH LEE: Are the members of the community able to go the meetings?

TAMU NOLFO: Thank you. Community members, you are more than welcome to sit in on any group that is of interest to you.

And so I will walk E to the room where you are going to be. Find your places, please.

(Pause in proceeding.)

TAMU NOLFO: Welcome back. If you could find your seats. Okay, folks.

I just wanted to let you know that as I mentioned before, we are not going to be reporting out on your small group work at this time. We're going to continue over tomorrow to have more small group work.

And then there will be a report out afterwards. I also did want to mention that members of the public, if you wanted to write on the same papers that have that strategic framework to provide your feedback, that we would love to have that from you.

Either give it to me today, give it to me tomorrow, if you're coming back tomorrow.

For the Advisory Committee members, hang onto those papers, because you can use them tomorrow, and I would like to collect them from you tomorrow.

There is also a comment as to whether or not the framework can be made electronically for you, not PDF. And I'm more than happy to do that so if you want to be able to make comments right in the documents and send it back, that's perfect as well.

And what I wanted to say about also getting public feedback on this is that, as Jahmal mentioned earlier, we were really up against a very, very tight time line and the levels of approval take quite a bit of time in order to have the strategic plan actually approved by July -- by July 1st.

So what we're doing is we're actually pushing to provide an additional three weeks to be able to get public comment, which means we would like to distribute this document, this framework, after we have hashed it out after this meeting, and we have gotten the feedback into it that comes out of this meeting out to the public to be able to get response on the same areas that you have been responding to, the advantages, and the concerns, and all of that.

We are also going to be make available online a way to be able to do that as easily as possible, where people can write or type directly onto that -- I don't know if anyone has a typewriter anymore.

But you can write directly onto it and either mail it to our office or fax it to our office. So we're going to try to solicit that and to encourage you to be able to do that as well with the groups that you represent or have some influence in, your constituents, if you have meetings that are coming up in a next few weeks, share the document and get feedback on it.

Either put it on a single one of these sheets and get it back to us, or compile feedback that comes out of that meeting, or whether people want to submit individual feedback. And we will take all of it and we will scan through it and we'll see what the trends are.

DEBBIE KING: So they can send anything, too, to the OHE mailbox?

TAMU NOLFO: Thank you. So what's the OHE mailbox?

DEBBIE KING: Ohe@cdph.ca.gov. And that is a central repository that you can send any comments and feedback to. It's where all of our (inaudible) come out of.

TAMU NOLFO: So it's oh@cdph.ca.gov.

SANDI GALVEZ: I'm assuming that be would in the instructions of whenever this electronic feedback giving process happens?

TAMU NOLFO: Yes. So I just wanted to give you guys a head's up, because I knew that was one of the big concerns that came out of the last meeting, is how do we get feedback? Jahmal?

JAHMAL MILLER: I know we can talk more about it tomorrow, but I did want all of us to, particularly the Advisory Committee members, to think about one or two very, very constructive and productive ways during that three-week period the best optimal way to get additional feedback from stakeholders.

It could be from the local community, within your organization you serve, it could be done electronically. We're very open and flexible as to the best way that works -- that works with you -- works for you.

Once again, three weeks, it's not optimal. But we share that burden with you at the Office of Health Equity. As we're going to use our stakeholder engagement list to reach out to folks.

So I believe with your efforts, our efforts, public in the room today and tomorrow, we should get some robust feedback that really reflects what the mandate stipulates that we are to do in making decisions to the strategic plan.

TAMU NOLFO: Thank you.

SANDI GALVEZ: Okay. So we're getting ready to wrap up the day. I did want to open it up to feedback about how the day has gone, if anybody wants to share that. This is a good time to do it. Anybody?

Nobody has anything to say. I'm shocked.

DEXTER LOUIE: I'm good. Dexter Louie.

I think the presentations were really educational, but because we're dealing with such a complex issue or issues, sometimes it raises more questions than answers. And that's probably good, because I think we have a room full of real leaders and thinkers. So I think it was a good day.

SANDI GALVEZ: I think related to the presentations, I think they were really useful. I have to say, I'm not entirely sure how useful they were for the top -- the job at hand of developing our strategic map.

I felt like the discussions and the presentations weren't necessarily focused in that way. I do hope that in the future meetings, once the strategic map and data recorder are developed, we'll have more opportunities to have other presentations and be able to think about the processes.

Any other comments or thoughts? Okay. With that, I will open it to the -- I'll open it to the public if there are any comments that the public would like to make for items that weren't on today's agenda.

And also, please open the phone lines to see if anyone is on the phone.

SIEK RUN: There's no one on the phone.

SANDI GALVEZ: Thank you for participating. Thank you all for staying with it through the end of the day. Have a nice evening. Get some rest. See you all tomorrow.

(End of proceeding.)

**CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
DEPARTMENT OF HEALTH EQUITY (OHE)
ADVISORY COMMITTEE MEETING
MARCH 26, 2014**

**SIERRA HEALTH FOUNDATION
1321 GARDEN HIGHWAY
SACRAMENTO, CALIFORNIA 95833**

Reported by: Melinda Nelson, CSR# 12496

Charlotte A. Mathias, CSR# 9792

SANDI GALVEZ: Good morning, everyone. Please take your seats so we can get started, Everyone from the committee that's here.

We have enough members present to begin.

Well, I hope everyone had a restful evening and you're prepared for a lot of group discussions, which is what the bulk of our entire day will be today.

Before I begin, I just wanted to go over a few logistics with folks. As a reminder, we have court reporters present who will be transcribing the meeting. Procedures for proceedings today, so it's very important that when you speak, you hold the microphone close to the mouth, and also please, if you're -- especially if your on one of the side table, turn your card with your name towards them to they make sure they get everyone who's speaking clearly.

Also for the public, I do want to remind everyone that per Bagley-Keene, all our meetings are public and there is ample opportunity to give public comment throughout the meeting. If you are interested in providing comment, and there will be public comment opportunities after both of our first two presentations and at a couple times during the day when small group feedback starts occurring.

If you are interested in giving public feedback, fill out one of the cards that staff has -- there's a table right there somewhere -- and give them to staff so that we can make sure you all have an opportunity to speak. And we'll -- we'll give time according to how much time we have left per agenda item and how many speakers we have.

Please turn off your ringers on your cell phones as not to interrupt the meeting. And once again, as I mentioned yesterday, let's operate with the step-up, step-down principle. If you normally are someone that speaks a lot, try to be conscientious of that and give opportunity for others to speak. And if you're not someone who usually speaks out a lot, try to encourage yourself to speak up.

So this morning we're going to have a couple of presentations, one from the Greenlining Institute, and one from our host, the Sierra Health Foundation, to tell us about some of their initiatives, both of them.

I wanted to emphasize what we heard yesterday that we are now on a very abbreviated timeline. We have less time for the Advisory Committee to actually give comments and, you know, ample discussion to the strategic plan that we had originally thought we had. So really this is our last chance to give detailed discussion -- I'm sorry -- to the plan.

So please, during when we have these two presentations, this is an opportunity for their information to inform our strategic plan. It's really not the right time to be trying to inform their projects.

So, if you have feedback, I think it's wonderful and take your cards or find them afterwards and give them that feedback, but please try to focus your questions or comments on how what they're doing really would inform the strategic plan for the office.

It's really important that we stay on time so we have all the allotted time we have on the agenda for our group discussions this afternoon.

Did I forget anything? Staff? Yes, and please one person speak at a time. We're way ahead of schedule. Can we start the presentations, or do we have to stay on the -- well, can we change -- can we have the presentation earlier than planned? Okay. Is Carla Saporta here already? Okay.

Let me take this opportunity then to open to the committee. Are there any questions or comments that that you would like to make while we're waiting for our first presenter to arrive? Yes, Hermia.

HERMIA PARKS: This is just a comment for me. When I left here yesterday, I made a decision to be involved with the activity that talks about embedding equity into institutionalized practices or processes. And at the time that I met with our work group, I felt real confident about this is the group I needed be.

And then I went home last night and I got up this morning at 2:00 thinking about it. And my thought was as I went through the strategic plan is that I can see myself getting involved with all of these, and I can't do it all. So I'm really looking forward to this afternoon having the opportunity to hear what the other groups have come up with in terms of their activities. But I'm really excited about the process. Thank you.

SANDI GALVEZ: And just to respond to that, so the way we're planning this afternoon, we're going to have more time with the group that we -- that original group we each chose yesterday to have more in-depth time to go over all of those questions we were supposed to go through for the listed activities.

And then we're going to do three rotations of having, you know, two different groups meet together and kind of cross-pollinate ideas, if you have recommendations for the other group. And we're going to do that in a way that each group gets to meet with every other group to be able to do that. So we are going to be -- we do have that planned for today.

Dexter, did you have something you wanted to say?

DEXTER LOUIE: Dexter Louie. I don't know about the rest of you, but in our group yesterday, it was a confusion about how to -- how to address the issues that were listed. We had nine or ten or eleven in our group versus the overall

strategy. What are we supposed to come up with vis-a-vis the Office the Health Equity?

So maybe you can help us on that. I have difficulty understanding the task.

TAMU NOLFO: Sure. Good morning, everyone. Tamu Nolfo. So Dexter and I have been talking about this particular small group, which was D, I believe, and there was some discussion about whether -- so on the worksheet that you were given, there were various items to respond to. There were advantages and concerns and critical success factors and whatnot. And so in their group they were asking should we be trying to address every single one of the initiatives in our strategic priority in those various areas, the advantages and concerns and whatnot, or should we be doing it more at a local level?

And my response was that you can do either. It really is the will of the group. That was the feedback that we're going to take and look at the trends and synthesize to the best of our ability and incorporate to the next version of the strategic framework. So if it's helpful to you to do each one of the initiatives, to respond to each one of the initiatives, in all of those areas, that's great. As I said, you can just mark the one that you're responding to as in A-1 or A-2.

If it makes more sense to cluster together, like we think all of these initiatives could benefit from partnering with education and the educational sector, and this is what that might look like, then that feedback is also welcome. So it's really whatever makes sense in your particular group. You have that flexibility.

HERMIA PARKS: Okay. I'm Hermia Parks, Department of Public Health Riverside County. What we did yesterday in response to your comment was to go through each one of our initiatives and we identified which ones are applicable to our particular group. And the plan is to have recommendations made to move some of those initiatives over into other groups, because there was a lot of crossover. So that was something that we went through with our particular group yesterday.

SANDI GALVEZ: Anybody else?

JAHMAL MILLER: Jahmal Miller, Office of Health Equity. I encourage everyone to -- to get clear on, synthesizing your discussions with each of the strategic imperatives and priorities, thinking specifically about an organization and innovative group that might be doing that particular idea or possibility with and start with your organization.

I really -- it will be really great to see a strategic plan that models with innovation. Looks like and that's not so deeply routed in what the government can do, but really being open to what private foundations can do to major health system

that's doing something very well that the state would benefit by advancing that work to scale.

Sometimes that helps to actually apply to what that possibility is that we're talking about, and that helps to do two things at once. It helps advance the discussion about that particular possibility, but it also links us to an existing model that works. So I really, really encourage innovative thought in the discussion to really opening up ourselves to, you know, the non-status quo. I really encourage that.

SANDI GALVEZ: Thank you, Jahmal. How about anyone else? Any other comments that are -- Jose? I'm sorry, Gail.

GAIL NEWEL: Thank you, Jahmal. That's very helpful, your comments, and in that regard our group has some questions that others in the group might about terminology with the word cross-sector versus multi-sector.

And it seems as if strategic priority B, cross-sector there means within the state and across different sectors. And E, multi-sector means private, public, and government and geo-collaboration.

Can you or Tamu clarify that and also if there's some way we could -- some other word besides "sector" that we can use that would make it clearer in the priorities?

JAHMAL MILLER: So when I see -- so in B, in coming back to the need for us to come up with a comprehensive cross-sectoral strategic plan, I see that having implications at the federal, state, private, local levels. And when I look at B, for example, where it says, "Across sectors," I looked at that one in particular to really add much more implications within government, inclusive of state, possibly even local. But in other places where it's referenced, and I do agree that you don't need to be consistent in how we're applying it, the cross-sectoral or multi-sectoral language -- where is the other location?

PATRICIA RYAN: It's in E.

JAHMAL MILLER: Yeah. That one is much more consistent with the cross-sectoral outside, inclusive of government, but not limited to, and I think that the -- the best way to encompass that is maybe by -- yeah. Like number 5 possibility, "Identify potential public and private partnerships, including governmental, corporate, educational, research, if philanthropic institutions." So I see where there definitely can be confusion. But like B, that's more of the government cross-sector when I think of working of government and cross-sector possibly including the local health departments and other municipalities. But then the last one is much, much broader.

GAIL NEWEL: Thank you.

TAMU NOLFO: This is Tamu. And also I would add that we probably need to come up with better language to differentiate between the two. I think you exactly got it.

SANDI GALVEZ: And sectors to me really speaks to there's the transportation sector, you know, the kind of big fields of practice, that are separate from the health sector. And I think B refers to all these different sectors, and that E that affect a multitude of sectors that need to work together to provide the multi-sector support and infrastructure for this initiative.

Are there any other -- did you want to say something? You were just informing me? Jeremy.

JEREMY CANTOR: Good morning. I was in the same group with Gail. And one -- a couple of ideas, concepts I came up with that might be useful in other groups, along that line of sectors, we talked about it -- I think it was Cynthia -- color coding by who would be engaged in the different activities. But I think that was your point, Jahmal, too. Let's identify who the players are that would be involved and be clear about them.

Because I think in most of these there's potentially -- there's potential for government agencies, NGOs, private sector, et cetera, et cetera. So let's try and delineate that. And also let's try to think through what the time frame is for some of these things. And some of them you can see okay, we can do this next year, and some of them very clearly they're not going to happen next year. And that may be some actually more interim where we get to the goals conversation. Even in looking initially and picking through where they fall in the time frame.

And my last observation is just that it does seem like I'm not clear -- the words equity and disparity are here, and I'm not clear whether it -- in some cases why it's disparity and why it's equity.

Overall, I think we sort of had a conversation about the difference between disparities and equities, but I'm not sure if we landed on anything. For instance, in A, it's seems to me it would be disparities and inequities. We're talking about disparities being patterns of disease outcome, and equities being a social factor. So that may be something for us -- another terminology for us to really clarify across the board.

SANDI GALVEZ: And I think that speaks to having multiple folks contributing to the creation of the document, who may not use the same terms.

PATRICIA RYAN: Yeah. I was in the same group. We spent a lot of time, obviously, talking about the cross-sectors or multi-sector issues, but we kind

of came to the conclusion, wrongly it seems like, that in B, we were really talking about state government sectors and that could be transportation, education, health, et cetera. But it was all related to the state, which we're now hearing is not correct.

And then in E, we were having a hard time kind of making sense of the long list, because some of the items seemed to apply only to the state and only maybe to the OHE, while others seemed to be much more broad. So it was -- it was hard to get our arms around the differences between the two.

SANDI GALVEZ: Thank you. Going back to what Jahmal said, I mean, this is -- in order to accomplish health equity and achieve health equity in the state, it's going to require the collaboration and, you know, the work of many, many different partners, not just the Office of Health Equity.

But I think when -- I would recommend that when this plan is completed, that very clearly differentiate between the activities of the Office of Health Equity is capable of and will be taking primary responsibility for carrying out, and those that would be more around trying to influence the practice of other parties, because I think it can be confusing. Alvaro?

ALVARO GARZA: So, I'll -- I'll add to this discussion since it reminded me of a few things. I was in group C, and we had some little confusion amongst us as well in terms of institutional practices. And some were thinking that's only health-related type institutions, and the other several of us thinking, no, it's got to be institutions across-sectors and multi-sectors, because to really go upstream we have to impact the practice, if you will, which we're talking about across all of the departments, et cetera.

And then we decided several of the initiatives belong both in C and B. That's just pretty much where we left it. It's very -- we have to get some clarity on these things. We're doing that, I think, in our discussions.

SANDI GALVEZ: Well, I believe our presenters are here. Is that correct? Yes. Okay. So without further ado, then I'll invite Carla Saporta to please come to podium from the Greenlining Institution.

JORDAN MEDINA: I'm Jordan Medina. I'll be presenting with her. She just stepped out.

SANDI GALVEZ: Okay. Thank you.

JAHMAL MILLER: This is Jahmal from the Office of Health Equity. All of your feedback is great. I just -- I encourage you today to just lean in to your discussion. If there's something in there that doesn't make sense, ask staff, but I really mean, like, I want your fingerprints all over this and we, as staff, will sift through it you have questions. We will reach out to you directly. But don't

hesitate about being innovative. If there's something in there that you don't like, if there's something that's not there that you would like to see reflected, think big. So really don't -- don't hold back and use today as an opportunity to really get into a place where you really feel comfortable enough with. And then beyond this meeting today, over the next three, no more than four weeks or so, you'll feel better about what it is you take to your constituency or to your organization, your community-based organizations. So don't hold back. Let's do it right.

ROCCO CHENG: As Sandy mentioned earlier this afternoon, we have three rounds of cross-group discussion, conversation, so we could probably clarify some of the issues as well.

CARLA SAPORTA: Ready? Good morning, everyone. My name is Carla Saporta, and I'm the health policy director of the Greenlining Institute. And we're very excited today to be here to present to you a report that both Jordan and I co-wrote author on Boys and Men of Color, increasing job opportunities in the health workforce. The report is actually titled, "Pathways Out of Poverty, Boys and Men Color, and Jobs in the Health Sector." And there is a copy in your packets.

And so Jordan and I will be co-presenting today to walk you through sort of why we did this research in the first place, our major findings and then our recommendations and what we're hoping is that some of our recommendations might sneak their way into your strategic planning process. So full transparency on that one.

Jordan, do you want to say a little bit about yourself?

JORDAN MEDINA: Hi, my name is Jordan Medina, I'm the health policy fellow with the Greenlining Institute. And as Carla mentioned, I'm the co-author on the this report. I'm really thankful and excited to be here today. Really excited about the Office of Health Equity and its direction.

CARLA SAPORTA: Great. So thank you. I want to point out before we get started that we are talking about boys and men of color. We are part of the Boys and Men of Color Alliance. So this is a population that we're very invested in seeing increased opportunity and improved health outcomes for this population.

But also that when we're talking about boys and men of color, we really also can be talking about disconnected youth. So that -- that sort of broadens the reach in terms of who the population really is, and it encompasses a lot of our youth that just aren't actually making it through the system for whatever reasons.

So for those of who you don't -- are not familiar with the Greenlining Institute, we are a policy research organization, multi-ethnic. We have a 40-member coalition that has actually been a part of our coalition since day one.

We started out as a civil rights organization working on anti-redlining activities at the banks. And we actually just call ourselves the antidote to redlining, hence the name Greenlining. So that's kind of how we got our name.

We actually were at our rally, and someone said, "What do you guys call yourselves?" We said, "We're Greenlining, because we want to reverse the trends of redlining."

I have the pleasure of leading our health policy work at the institute, and our main focus is, as I mentioned, are on boys and men of color. Also access to the health care, so ACA implementation, and then we do a lot of work around community benefit.

So why look at boys and men of color in the workforce? Well, first of all, we are already a majority/minority state. So at this point, if we're not creating solutions for our youth of color, particularly our young men of color, that means we're not going to be having an economically viable state in the near future.

Furthering drawing that point is that our males zero to 24, 70 percent of them are of color. So this means they're African-American, black, Latino, Asian, Southeast Asian. So there's a lot of the population, our youth are now black or brown, and we have to be addressing the needs of these populations.

Why BMoC and the ACA? Well, first of all, the expansions under the ACA are actually a great opportunity to kind of engage our youth and get them interested in health careers. We also see that our young men of color are particularly one of the populations that are going to benefit the most from the expansions that have occurred. They're finally able to access Medi-Cal benefits. They're also going to be able to access coverage under Covered California. But when -- through the alliance, what we realized is was that when we go into the communities and actually talk to the youth themselves, they don't care about health. It's not on their radar. What they want is jobs. They say, "I don't -- the idea of taking care of myself, that's secondary to anything else. I need to find a viable job."

And so that's one of the reasons why we said, "Ah-ha." Let's connect the two. We need to increase our health workforce. We want to get our youth engaged in the process. We want them to enroll in coverage, because that's going to help them at least deal with some of the baseline issues that might need to be dealt with, but how do we do that? Let's get them jobs first.

So this is sort of our theory of change. We see it as a self-efficacy model. If we can get our youth of color, particularly our young men of color, jobs in the health workforce, they're actually going to finally see that there's people that look like them in the health workforce.

Now when our young men go into a facility or a clinic, they don't necessarily see people that look like them. There's a dearth of leadership within those populations. And when we're talking about the health workforce, we're not just talking about doctors and nurses. We have actually really believe there's the ability to get our young men of color jobs within some of the allied health professions, some of the other lower level jobs where they can have a career ladder up into other positions within the health workforce.

We also actually really see an opportunity to get our young men of color to become community health workers, and that we want to promote that type of model so that they can be in their community spreading the word that health and taking care of yourself is a good thing and you also can have a job while doing it.

So then the last part that I would add is that because we do have a lack of sort of representation of young men of color within the health workforce, we've also seen an opportunity as you diversify the workforce through a gender-base model in terms of diversity as well, we can add in some culturally competent care models that would help.

One of things that a lot of our men also talk about is that when they do go to a clinic, they don't feel like they're heard or that their needs are truly understood when they're entering that facility.

So now I'll hand it over to Jordan, who will head us through a little bit more of the why, and our major findings. And I'll take back over to talk about our recommendations.

JORDAN MEDINA: Thank you, Carla. So right now, the health workforce in California of the newly created over half a million health jobs, 36 percent will require limited educational retainment. And what this means is that you'll be able to access these allied health profession jobs through community college courses, through easy certificate classes right out of high school.

It's not -- they don't require the traditional four-year trajectory of having a bachelor's and then going onto med school or obtaining an advance degree. These are really easy, accessible jobs that you would be able to get within like ten months to two years, which have -- which means -- which means that boys of and men of color will have access to these jobs almost immediately.

And as you see, the other graph shows that the job growth in California, so by 2020, it's estimated that the health sector will grow at about 27 percent. All other industries in California are estimated to grow at approximately 17 percent.

And so once again, this extraordinary growth in the health sector, let's figure out ways to great solutions to get boys and men of color to be a part of this growth,

so they can access the money, the jobs, and increase their overall health outcomes through these jobs.

And why is it important for boys and men of color to access jobs? Well, because if you look at the employment rate and the employment statistics for boys and men of color in California, they're pretty low. So in 2009, almost 30 percent of black males in California, ages 16 to 24, were jobless, which equals three times higher than the national unemployment rate. Some more statistics that in 2012, white male unemployment was 10.1 percent. This is in comparison to African-American male unemployment that was almost 18 percent and Latino male unemployment rate of 12 percent.

And once again, if you refer back to Carla's -- documents in Carla's presentation, she mentioned 70 percent of our boys and men of color under the age of 24 are -- sorry 17 percent of our boys under the age of 24 are of color, which means that it's -- this is an unsustainable fact path forward, and that if we don't lower the unemployment rate for boys and men of color overall, it means that California in its future we're headed for some serious fiscal and employment troubles.

And boys and men of color in the health workforce today, allied health professionals by race. Allied health professionals is actually one of the most diverse groups of employees within the health sectors, very diverse. As you can see in the report, it breaks it down a little bit further for you. We can give you some concrete statistics.

But when you look at it by gender, you will see it is overwhelmingly dominated by women. Once again, we believe that increasing the gender dynamics, the gender diversity within the allied health profession can really bring an opportunity to increase that culturally competent care that Carla was mentioning earlier, and also provides opportunities for boys and men of color to once again increase their economic productivity, and get jobs. To be able to get a job, be able to have a well-paying job, to lead a more stable life for themselves and their families.

And then why is it -- why is it in California's best interest to do this? Why should we be focusing on boys and men of color? Why does it matter that we should get them jobs in the health sector? Well, if you look at where California spends their money, about \$180,000 to put a man of color through the juvenile justice system over the course of a year.

Public education, our per pupil spending ranks near the bottom of all 50 states at \$8,500. So it makes fiscal sense. Putting more focus on making sure boys and men of color are prepared educationally to attain these jobs in the long run saves California tons of money.

And then -- so this is more of our research. So to get the results you see in the report in front of you all, we did stakeholder interviews with people who run non-profits that look at -- that target specifically boys and men of color with foundation leaders, with policy people.

We also did a literature review. What information is already out there? There's tons of information out there about programs that work, programs that are effective. It's not necessarily all compiled in one easily digestible format and report.

We also engaged Boys and Men of Color Alliance partners. So as Carla mentioned, we are a part of the alliance. We all come from different backgrounds, different areas, but we're all committed to the same goal of increasing opportunities for boys and men of color. And so through our conversations with them, this is how this report kind of organically took place.

And some of the challenges and opportunities that we identified through the report are, number one, we need to make sure that our boys and men of color are receiving a quality education so that they are able to access these jobs and are prepared to take these jobs.

Number two, we think it's really important to look at our criminal justice system in California, how boys and men and disproportionately affected by the criminal justice system, and by shifting emphasis from school to prison pipelines or from focusing on criminal justice to shift some of those -- shift some of that money to making -- to education, to more outreach, to more pathways of pipeline programs to make sure boys and men of color are targeted from a young age to know they know there are other options for them, that there are ways for them to make money.

And then we also looked at masculinity and men's health. We see these really as intertwined to being two different sides of the same coin. Number one, when we talk about masculinity, we're not always talking about health and how health is an integral part to making sure you are able to be a fully functioning member of society, that you're mentally healthy, that you're physically healthy. That's where men's health comes in. And we're thinking a lot of these -- a lot of the structures at the Greenlining Institute bridges how people get a lot of the social determinants of that.

And what we're realizing is that being in economically deprived neighborhoods, being in school systems that aren't adequately funded or teaching them adequate material to make them able to get a job, also just living in economically depressed situations, all of these have an effect on men's health and make it very difficult for them to be fully integrated into society to be prepared to take on these jobs.

And, so as I mentioned earlier, California has one of the lowest per pupil spending rates in the country. We currently rate 49 out of 51. This is in contrast to just a few decades ago, when California's public education system was looked at as a model, as an example of what other states in the country could do.

Another resource that we mention in the report and that we're actually meeting within the near future, school-based health centers. So what we realize is that in California, specifically in the Bay Area, a lot of poor families, a lot of brown families, a lot of families without insurance, access their health care through school-based health centers. It's a great model. It serves a lot of needs. Even with expansion of the Affordable Care Act, we still think these will be a vital asset and need in the communities, but only 27 percent of school-based health centers in California provide youth engagement programs.

And what we really think is, if you can expand these school-based health centers to not only address the physical and mental health needs of students in school and their families, but if you could also use these as models to get boys and men of color interested in health careers in the first place, maybe not only are they going in to access health care to go see a doctor, but they're also learning, well, how can I become an allied health profession one day? How can I become a nurse? How can I become a doctor? And is it possible for these school-based health care centers to become more integrated into the curriculum in the schools they're already in?

So, opportunity; to connect boys and men of color to school-based health centers and health internships as a part of the program; we think a vital age – a vital bracket to be looking at is middle schools. We know there's a lot of attention placed on early education, and a lot of attention placed on high school, but middle school is really a definitive period for boys and men of color and youth in general to really get them interested in careers, get them interested in college, get them interested in their future. If you start that in high school, it's too late.

Criminal justice system. Almost 50 percent of inmates who reactivate do so within the first six months. Men of color between the ages of 18 and 29 even most likely. So we need to provide alternative to incarceration and/or on-the-job training for offenders.

Once again, some of those opportunities and programs, specifically we looked at some in San Diego, focus on how can we provide alternatives to incarceration for first-time offenders.

BMoC masculinity and men's health. Men -- males only represent about 15 percent of the allied health professionals, and are 24 percent less likely than woman who have visited a doctor within the past year, and 22 percent less likely to have neglected their cholesterol test results.

What we need to do is promote self-efficacy models. Talk to boys and men of color. Tell them why health is important. How can health help you get ahead? How being healthy will help you get a job. We need to look at some of the models of African-American male achievement initiative in Oakland mentioned in the report, the White House actually had someone come out and look at the model a few weeks ago. That's a great model. Is there a way we can expand it? Are there ways we can implement that across the state?

CARLA SAPORTA: Thank you, Jordan. So now I have the pleasure of walking you through all of our recommendations. And some are what's in the report, and then there's a couple that I just kind of slid right on in there, because I thought they might be interesting to you all.

So the first is that we need to have sustained, long-term funding for each learning activity. So Pro Tem Steinberg actually got us \$250 million for linked-learning, and right now they're in the process of sort of distributing out those dollars. But it's not sustained. It actually is a link for a couple of years. He's right now trying to get more money to be coming into the fold, but it's unclear at this point if we're actually going to be able to continue on with that type of program.

And that's working directly with our Department of Education to make sure that the dollars are distributed out to those types of programs, working with your community colleges, working with our different public school institutions to actually have internship programs based out of the schools or curriculum and workforce training programs that are based out of our schools, so our youth can be engaged that way.

One of these big things with these dollars, though, is that we need to make sure that any time there's a pot of money, that's it's equitably distributed based on the demographics of the population. And sometimes when we're talking with equity, that means you need to give a little bit more to certain populations that need that extra boost. So we're not talking about equal distribution here. We're talking about equitable distribution. And I want to make sure that that's really clear.

The another thing is that we really need industry buy-in into all these efforts across the board. And this isn't the only slide that I'm going to mention industry buy-in on. And I think the Office of Health Equity actually has a unique sort of posture within the state that it can hold, especially with some of the different relationships on the advisory, with Jahmal's relationships, that we can actually really engage our industry, get them to understand why they should be helping promote these types of linked-learning activities, because it's a win-win for them as well.

Not only do we actually get our youth engaged if workforce training which is great, get them interested in the jobs, but it also gives the industry the opportunity to be training their like new set of people. Okay. I have one minute, so I will rush

through. The next is to partner with school districts. You can't do linked-learning unless the school districts are engaged.

The next piece is really the criminal justice part. So I mentioned in the industry buy-in. We really believe the industry should be engaged in doing targeting hiring, regional level targeted hiring. This is the type of agreement that we have done at the local level, usually around with like government contracts and that type of thing. We actually think we can do it with the private sector, and it would be helpful to have state agencies promoting these types of models.

The next is to provide wrap-around services, so as we're training the -- those that are coming out of the incarcerated system and the criminal justice system, let's provide them the services to understand what it's like to get a job, how to get a job. And there's actually some models out that that are popping up around the state around actually training the formerly incarcerated to be community health workers to then go actually train or work with populations that also have been formerly incarcerated. So let's actually get people that understand the needs of the formerly incarcerated to help the formerly incarcerated.

The other thing is that our state statutes are archaic. If you have a criminal record, you cannot get a job in the health workforce. Our Board of Profession Code blatantly says if you have a felony, you have a misdemeanor even, oftentimes you cannot get a job. We need to actually take the recommendations of the Equal Employment Opportunity Commission and move towards individualized assessments of individuals.

So that basically means that if you have a criminal record, that when you move forward in a job application process, they're looking at what you have done since that record, not that you just have committed a crime at one point. And we have had some success at Covered California in changing some of that language, and it's still a difficult task even if you actually -- in getting someone into a health career.

The next one is ban the box. So there's been a great success. We passed legislation last year at the government level that we passed that an employer cannot ask somebody what their criminal history is until they have actually deemed they're qualified for the job. That's great. The problem is, because we got rid of the box, we have nothing to measure now. So we don't know actually what success looks like.

So we're looking at ways we can do research and figure out what that success looks like, and do we actually need more mechanisms in place or more programming in place to make sure that those that are formerly incarcerated still have the ability to get the job and actually stay employed in their job.

And then the last thing I'll touch on is on our masculinity and men's health points. First, we really actually think we need to have research on the physical, emotional and mental health of boys and men of color. We don't have good data out there as to what that really looks like for the population, and we actually don't have data on what it ultimately looks like for the productivity of that population in terms of getting jobs. We see the unemployment rates, but we don't know how the health sort of the status of the population sort of meshes with that. And that's something that we really think the Office of Health Equity can lead on.

The next is actually meaningful portion of the mental health dollars to boys and men of color. And this goes back to the equitable distribution of the funds. This includes also some of those models I mentioned are centered around community health workers. Let's actually use some of the dollars for workforce training in getting our young men out there helping populations like them.

And the last is that we really need to have early exposure to health careers through school-based health centers. We think it's a double win on this one. You provide the physical and mental health services that are necessary for our young men of color, and then also you get them engaged and realize they actually, too, could in the future have a health job.

So with that, we'll take questions.

(Applause.)

SANDI GALVEZ: Neal?

NEAL KOHATSU: I think that you present a very exciting model. There's a TV segment on CBS Sunday Morning, I saw a model where young people who were from impoverished backgrounds and who might not have gone to college were engaged in a very academically rigorous day. They showed up and there was a lot of training that they got, but the goal at the end of the tunnel was internships at some of the major, big corporations in New York.

I wonder if there is similarly a pilot project, because I think it's a great potential idea to go out in all of our different communities and sectors, academia and government, to push this. But then people say has it worked? Has it been evaluated? Has someone -- and also demonstrated engagement of the young men of the community that they want to go for health careers versus, say, careers on Wall Street or San Francisco and more management.

JORDAN MEDINA: So the Alameda County Health Career Partnership is a really successful model. They actually -- they have more boys and men of color and more people who want to join the program than they have funding and capacity for. And one of the models that works really well is the emergency medical tech program, where boys and men of color, even if they have like criminal background or like very impoverished don't necessarily come with an innate interest

in health careers. They find out like, oh, emergency medical tech, it's a fun job, it's kind of exciting and what it does is it provides them a foot in the door with a lot of career ladder, I think. It's like a seven- or eight-step career ladder where they can take extra classes to become more certified, maybe even be eligible for educational reimbursements, and move up the ladder to become nurses, to become physicians, to move across to other allied health professions.

And that's mentioned in the report. It's more information, but I think that's one model that could be replicated and reach more people as it currently is if it had more funding and more sustained funding as I mentioned earlier.

SANDI GALVEZ: Aaron?

AARON FOX: Thanks for your presenting. Aaron Fox, L.A. Gay and Lesbian Center. I always add this in whenever there's a discussion of how young men of color, especially, you know as we note, two-thirds of new HIV cases in the United States are among gay and bisexual men, and of that, African-American gay and bisexual men are eight times more likely than white men to contract HIV.

So this is really remaining becoming pandemic as far as the young African-American population goes. And there are also higher rates in the young gay and bi Latino communities as well. So I think that that's something that we can look at that relates to a lot of this.

And the second thing that sort of jumped out at me, which I talk to people a lot about all the time, is the drug war and incarceration. And I think that maybe we can also look at how California can take steps that the federal government might not be willing to take policy-wise to fix some of these problems with so many people being incarcerated, going to jail, going to prison for things they should be not be in prison or jail for.

CARLA SAPORTA: I just want to thank you for both those comments. And particularly on the drug war issue, what we have seen is that really our black and Latino populations are incarcerated at a higher rate for drug -- for possession of drugs when they have the same usage statistics as other populations. So I think that's really huge.

And then one of the other things is that when we're looking at it, it's not just a possession of drug issue. They're often then criminalized for intent to sell, which then adds another layer of -- that leads them usually to a felony rather than just a misdemeanor charge. So I think that those are a lot of issues we need to be addressing. And there are some good models.

One particularly that Jordan mentioned out of San Diego where they do programming rather than incarceration to work with the youth to get them sort of these wrap-around services that are needed. A lot of times, we talk about the issue

of healing in our communities, and that's really what we need to be focusing on in terms of a lot of these populations.

SANDI GALVEZ: Thank you. Hermia?

HERMIA PARKS: Thank you so much for that very informative, very -- for me personally, I'm trying to use the word without getting a little emotional -- sad presentation that tells the statistics. And I've heard this before, and each time I hear it, it's still brings up a lot of emotions for me personally.

There's a couple of things I want to share. I'm so happy to know that you are looking at policy change. Because I think with this issue, the only way to make any effect or dent is to look at policies. And I think Jahmal mentioned that yesterday when you talked about your meeting at the White House. So I think that's a real positive thing.

You talked about funding in terms of sustainability. That's always huge. As a previous black youth health coordinator for San Bernardino County, it was a struggle to deal with very little money to deal with a huge problem. So the issue of sustainability is something that really needs to be addressed on an ongoing basis. It's a challenge.

And then you mentioned the alternatives to incarceration. In Riverside County, we have the wrap-around program. And that program -- I think our program is a little bit unique in comparison to the other states or the other counties in that it's a partnership with the Department of Education, Social Services, Probation -- what's the other partner? Mental Health.

And we also have public health nurses in that program that deal with the health issues regarding those youths. And we have seen amazing, amazing outcome. This is an alternative to going into the juvenile system. They send them home and provide wrap-around services to the juvenile as well as their families, jobs for them, work, cross-training. It's excellent. It's an excellent model that really needs to be adapted throughout every county, I feel.

And just the third thing, you have a program called AB 109. I don't know in some of you may be familiar with AB 109 in that they're doing early release of those that have been incarcerated and providing services for them very similar to the wrap-around services, but more for the adult men of color.

Again, thank you for the presentation. It's a huge undertaking. I know that the White House is really committed to this project, and it's great that you're making these changes. Thank you.

CARLA SAPORTA: Thank you.

SANDI GALVEZ: Thank you, Hermia. I want to let the folks know we have three public speakers, six of you with cards up and ten minutes. So please, please keep your comments brief. Patricia?

PATRICIA RYAN: Thank you very much. I think what you're doing is great also. Just a couple of comments and questions and suggestions, and I'll try to be quick.

One is specifically related to the MHSA recommendations. I just wanted to, I guess, clarify and make some recommendations there. One is to make sure you understand that the statewide web funds are being administered by the OSHPD, and the five-year plan is being developed now. I don't know if you've weighed in on that, as far as workforce needs.

As far as devoting more money of the MHSA to programs that support young men of color, the funding is really at the local level. So, you know, I would encourage you to be involved at the local level to try to advocate for more funding on an ongoing basis in the future.

And then I wanted to say finally, realignment AB 109 with people coming back to the communities, that the whole idea is to break the cycle and try to get people the services and the supports that they need. So I hope people are getting involved at the local level advocating with their boards of supervisors to use some of that realignment money to provide services, substance use, mental health, and other community support services and not just to pay for more jail time at the local level.

SANDI GALVEZ: Thank you. Linda?

LINDA WHEATON: Have you identified opportunities within the Affordable Care Act for these initiatives?

CARLA SAPORTA: So there are some. Obviously, as I mentioned, the expansions, so just really making sure we have the likes of Covered California and others that are distributing out outreach and education and enrollment dollars, making sure they're giving to organizations that target our young men of color. That would be one.

The other is that I did mention that we do work on not for profit hospital community benefit. We believe that as there's a lot of changes around the community benefits under the ACA, and a lot of those things have actually been based off of what we have already been doing in the state of California since '94.

And so we see an opportunity that as more people get coverage, that hospitals will be less needing to provide charity care free and reduce cost services, and can

start to allocate more dollars into prevention programming in the community. And so that's one thing that we are looking at as an opportunity as well.

SANDI GALVEZ: Jeremy?

JEREMY CANTOR: Thank you. And thank you, Carla and Jordan. This is a fantastic presentation. And I appreciate that you mentioned community benefits. I think that's actually something for all of us to look at and how that aligns with our goals.

One quick comment and question. The comment is just, I have seen it so many times, it's so striking, that figure about the annual cost of incarceration versus all sorts of other services. And I think it's a reminder for us that equity really is about good government. That's an example of misallocation of resources.

I'm wondering if you could talk just really quickly – you talked about industry buy-in and practice. I think you're right, that's kind of a real opportunity for us and I wonder if you could say a little bit more about that and some sort of specifics that we can consider as we're developing our strategic plan.

CARLA SAPORTA: Sure. So there's different models out there, and actually our workforce investment boards have demonstrated ways to actually get industry buy-in in some ways through regional efforts. But one of the things that we really are looking at is how do we engage at a regional level for our private partners? We're talking directly -- I mean speaking directly about hospitals or our regional clinics. So making agreements with them that would mean that they're actually going to be doing targeted hiring of our young men.

In Alameda County, the Alameda County Health Department has actually done this. And they have verbal agreements that have worked. And what that means is that their health facilities really are actually hiring within the community to diversify the demographics of who they're hiring, so that it actually reflects our young men of color as well.

But what we would like to see that is in actual contractual agreements. I think verbal agreements are great, and then once leadership changes, a lot of times they go away. And so there have been models in terms of targeted hiring as I mentioned. This usually is done at a contract level between a government agency and then an entity that's trying to be hired, a lot of times it's within construction work. And so they said it's something like 80 percent of the folks that are hired for the job have to come from the region where the job is located.

And so that's the type of model that we actually would like to see implemented and we think it would be great if state agencies like the Office of Health Equity were helping to promote that at a regional level.

SANDI GALVEZ: Thank you. Carrie?

CARRIE JOHNSON: Thank you for your presentation and the report. You said that you go around to different places when you were doing this report gathering the information. It took place at places that serve males of color. I'm just wondering if American Indian and Alaskan views are a part of this? And where did you get that data?

JORDAN MEDINA: So on some of the information, you may see an American Native or Alaskan Native on the information data shared. I think part of the problem with collecting that is that the population sometimes is so small in the state or just like across the country that some -- some of the data sites or data collection service literature used didn't explicitly have that information readily available.

And I think that honestly that's an area of more improvement within the whole boys and men of color alliance and the issues that we work on. I think a lot of times, we do or solely focus on black and Latino and we miss the -- we miss Native American, we miss Alaskan natives. And then sometimes also when we talk about -- when we talk about Asian demographics and we talk about Asian men, we don't just aggregate that information and break it down actually by ethnicity.

So part of that and I think part of the push that Greenlining has been doing is that we want this aggregated data to make it more easily accessible. We know which populations really need the most help.

And, yes, so I think that that's great, and I think that would also -- I mean, that's equity. That's health equity figuring out -- I know the census recently released information that they might make it easier for people to report their race and ethnicity and break it down by bi-racial and all this different stuff. So I think steps like that are in the right direction? And I think it's an area for improvement.

CARLA SAPORTA: I'll add, too, if you have recommendations of organizations we should be reaching out to, we would really welcome that.

SANDI GALVEZ: Thank you. Delphine?

DELPHINE BRODY: Thank you so much for your presentation. I -- I really applaud the work you guys are doing. In terms of strategies to address these issues, and I would be willing to venture that these disparities that you're talking about are more than just disparities or health inequities.

I think this really points to the fact that when we see systemic avoidable, unjust and unfair disparities which are health inequities, they're not simply social inequities outside of the institutional framework. They happened within institutions, in multiple sectors that we want to partner with in our strategic planning

and -- and moving forward to achieve health equity are currently part of the problem through the policies that -- that have led to the school pipeline, the drug war, criminalization of so many boys and men of color.

I think that -- as well as inequitable distribution and in partners hiring and other solutions you referenced, I'd like to see more discussion about (inaudible) reduction and restorative justice as -- as necessary and -- and helpful and innovative ways to address this (inaudible) also, and cultural and linguistic proficiency are needed to where we want to be, I believe. Thank you.

CARRIE JOHNSON: All great points.

SANDI GALVEZ: Thank you, Delphine. Jose?

JOSE OSEGUERA: Jose Oseguera. Mental Health Services Oversight and Accountability Commission. Thank you for your presentation today. I think it's very timely, urgent and necessary given it speaks to demographics.

I wanted to ask a question and that is as it relates to my school. I was basically told that individuals with names such as mine with my first and last name, they were not supposed to attend a four-year college.

So I want to ask you, what are doing for early intervention? That is, getting kids early on to they prepare for college and if they take the adequate courses and move in that trajectory?

CARLA SAPORTA: That's a great question, and I don't really have an answer. I mean, we -- we haven't done a lot in terms of actual high school level intervention and looking at those policies. They're part of the Boys of Color Alliance. There is a work group that looks specifically at education issues.

As Jordan mentioned, though, we do believe that our middle schools are a place where we need to have more focus. It's an area where our students either decide that they're going to move forward and really take high school seriously or where they start to believe that they're just inadequate and unable to move forward.

So, I think that there needs to be more research in those area as well. But there is the Boys and Men of Color educational worker as well.

SANDI GALVEZ: Thank you. Dexter?

DEXTER LOUIE: Sandy, I'm mindful of speaking too much, but on the education, I feel I have to say something. I'm Dexter Louie, and I'm minority physician, but I was on my school board for 14 years, and I think it's important that you do get the school boards, each them, on-board to the project and educated on this whole issue of minority education.

And it's not just middle school, but K through 12, and it's preschool. And so I -- if you have not presented to the annual CSBA's, California School Boards Association, annual conference where all school board members attend, then I will give you contact information.

CARLA SAPORTA: Thank you.

DEXTER LOUIE: Try to move us in the direction of the education as well. That's another reason I spoke up.

SANDI GALVEZ: Thank you, Dexter. I appreciate it.

Okay. So now we have three speakers and, staff, please turn on the phone lines so we can see if there is anyone on the line who would like to ask a question or make a comment.

Our first speaker is Tahira Cunningham. Our second speaker is Lilyone Glamben. And our third is Dalila Butler. Please make your way towards the podium. Thank you very much.

TAHIRA CUNNINGHAM: Good morning, everyone. Tahira Cunningham with the CPEHN. So a couple of things, we really want to thank the Office of Health Equity for having this presentation today.

CPEHN is part of the Boys and Men of Color Alliance, work quite closely with Greenlining, so we're very pleased to see this presentation today. And we really feel like the Office of Health Equity and this Advisory Committee has such an opportunity to really highlight a lot of the bad things, unfortunately, that are happening in our communities, but also highlight the great things that are happening locally and statewide as well in your strategic planning.

There was a question around, you know, what are some of the things happening at a local level in early education? And the mention of the education worker. There are some fantastic things happening in L.A., Fresno, Stockton that we would love to highlight and provide information. So CPEHN is absolutely a resource for you all to bring what the overall alliance it doing in regards to education.

The overall alliance provided recommendations around the local control funding formulas. That's a critical place for us to focus on our boys and men of color and target resources to them. We really think by using presentations like Greenlining's and the data that's been provided by both the Office of Health Equity and Dr. Aguilar, for example, in the very first meeting, that you guys can really look at all of those together and highlight the populations that really need the most

resources, and by doing that, you will, you know, provide equity in families, in communities and across the state as a whole.

So again, we really appreciate your time and attention in listening. Thank you.

SANDI GALVEZ: Thank you.

LILYONE GLAMBEN: I just want to piggy back on Tahira's comments. The positive --

SANDI GALVEZ: Please identify yourself.

LILYONE GLAMBEN: Oh. Lilyone Glamben from ONTRACK Program Resources. Thank you for your positive and innovative approach to this particular demographic need. I just want to highlight the incarceration demographic that you were -- that you are including.

And it's certainly in terms of this particular group, what an issue it is, but it's across gender, across race. And we just encourage the Advisory Committee in your strategic planning process to make sure that the incarcerated and formerly incarcerated demographic is included.

Given California's inverse leadership, you mentioned where we are in the educational spending, given our -- given our leadership role in the country in terms of the incarceration population, the report final work would be incomplete without some kind of targeted expertise being consulted, maybe from the public health impact, especially around behavioral health needs. Thank you.

SANDI GALVEZ: Thank you.

DELILA BUTLER: Good morning. Delila Butler, PolicyLink. I just wanted to first of all say thank you and to echo, you know, quite a bit of what Tahira said.

Full disclosure, PolicyLink, as well as CPEHN and Greenlining Institute have been deeply involved in the boys and men of color work. So obviously, when we're making those -- drawing those connections between the economy and the healthiness of California, and the success of California, that ran true for us being so deeply involved in the boys and men of color work.

And for me, one of the things that I think really was highlighted here was really aligned with a lot of the points that Jahmal made in his initial presentation really talking about, you know, that overlap between really focusing on our youth and our children and how can we improve health there. We know it will have major impacts as well as thinking about those social determinants of health that really impact the health of our communities.

And so I really appreciated kind of the focus of this effort to look at both of those things.

I had one question and one comment. My question is, you know, we did have a presentation from the Office of Statewide Health Planning and Development for health care workers development. I'm wondering how this work is being tied to the work that they're doing there to develop the workforce with the ACA opportunities. Because I think there could be a role for the Office of Health Equity in making these types of connections across the work being done.

And then I also just wanted to say that I think there is an opportunity to -- I think Jeremy asked about just the (inaudible) learnings you have all had with this work. To take those learnings and apply them across other sectors.

Since we're thinking about workforce development, not just for health care, but maybe in some of the other sectors as well, you know, transportation, thinking about housing and other opportunities, it would be great to hear about ways to make those connections.

Thank you so much again. This is awesome.

SANDI GALVEZ: Thank you.

CARLA SAPORTA: Sorry.

SANDI GALVEZ: Did you want to respond quickly?

CARLA SAPORTA: Yeah. I just have one response to that. I would just say that on the sort of connection to other industries, there actually are a lot of opportunities. We're looking at -- Greenlining has worked a lot around the Community Reinvestment Act and the dollars the banks are required to give -- put into the community.

Also right now with 535 -- SB 535, that was chaptered in 2012 that took the Cap and Trade dollars and has 25 percent of those dollars have to go into those most hit by pollution. And (inaudible) and the governor's office, they're actually really interested in engaging in these conversations with other regulatory entities, like the banks, like the hospitals to talk about how they can do some impact investing.

That's actually a conversation we have been having with some PolicyLink as well.

SANDI GALVEZ: Thank you. Do we have any speakers on the phone that would like to ask a question or make a comment?

Okay. Thank you very much. Thank you so much for your presentation. I think it will be very informative to our discussions this afternoon.

(Applause.)

SANDI GALVEZ: So our next presentation is from the president and CEO of Sierra Health Foundation, who is hosting our meeting today.

So I would like to welcome Chet Hewitt to the podium.

(Applause.)

CHET HEWITT: Good morning. I wanted to thank the Advisory Committee for the invite here today. I actually poked my head into the sessions over the past day or so and got a little taste of what you're doing here today, and understand how important this particular endeavor is. I'm very honored that you chose to allow us to be your host here today as well.

So my sense is that the staff have done a good job in making this very important meeting happen in a way that facilitates good conversation and allows the important work of the Office of Health Equity to move forward.

We say that -- I'm here today, but I have a couple of caveats to make. So I'm going to talk about the Center for Health Program Management, the Sierra Health Foundation, and talk about some programmatic work that we're involved in that may interest you as well.

A lot of your presentations have been focused on programs. I'm actually not going to start off by talking about programs, because in our work, as we moved towards addressing health disparities, inequities, and working with social determinants of health, one of things that we had to come to grips with as an institution is our infrastructure and the (inaudible) we had to actually make that happen.

Is this better? So we'll talk a little bit about that particular journey. And for me this is not a sales job. This is the work we actually do.

And I hope that as you think about the work that you're engaging in, that as I tell our story about our journey, that you'll be able to discern issues and perhaps obstructions that may be forthcoming in your particular work, and perhaps our lessons will help you figure out how to better overcome them.

So again, it's not a sales job. This is not promotional material. A lot of work in putting this together over the past couple of days just for this particular meeting, but I think it's a story we'll share.

So I serve as the president of the Sierra Health Foundation and the Center for Health Program Management. We are one of the oldest health conversion foundations west of the Mississippi River. We were born in 1984, and we have had several decades -- this is our 30th year of what we consider to be innovative work.

We were one of the first health AIDS funds in 1985. We were the first funders on maternal child health. We built one of the first health leadership programs in the State of California. And we have had a long history of focusing on young people, most recently REACH, and now a program we call Positive Youth Justice Initiative, which I'll talk a little bit about later by example.

In 2014 -- actually, in 2012, we got started thinking about the social determinants of health, health equity and how our programming work was not really sufficient to address those particular issues.

We had for many years designs initiatives that were born within the walls of this institution. We would ask people to apply and participate in those particular activities. Usually met some set the standards that we would create. You know, your ability to operate as an institution, your interest in a content area, you would apply to us and either you would become a grantee of ours or not based on some internal assessment.

We realized that given the distribution of mental health in California, particularly in our 26 counties, particularly as we look further into the Central Valley that that model really wasn't working. A lot of our investments were in urban areas, which clearly that needs to happen.

But we also knew that a lot of rural communities were suffering as well. And we wanted to figure how not only to expand our reach, but to also expand our impact. So we created the Center for Health Program Management. Two institutions, but one agenda, promoting health equity, reducing health disparities, and working on the social determinants of health. Really paying attention to how socioeconomic status was impacting health in our particular communities, being very clear that it wasn't a single point of (inaudible) response, and being very clear that what we needed were partners, not grantees.

And for us, that may sound like a lot of language, but it's really, really important in terms of how we roll out that particular work. Because if you were simply interested in getting a grant, and weren't deeply committed to the work that we were engaged in, we felt it lessened the likelihood that we would be successful in our particular work.

So here, this was our kind of articulation of the importance of health equity and how that would be deployed within our program development work, working at the highest level, avoidable inequities being the focus, and really focusing on communities where we know that under-investment had taken place for a long time.

Around health disparities, looking at rates, looking at that amount of distribution of health and really mapping where that was taking place. Being very clear, and I have some good friends in the foundation that just went through a huge exercise similar to ours and found that their grants did not align with inequity at all. That many of the places they weren't actually investing weren't places where there was no reason to invest. We're not going to say that. That would not be accurate. But it wasn't the places where you would get the largest forward movement.

And there are reasons for that. A lot of places that you map health and equity are places that have been under-invested for a long period of time and lack the kind of institutions that usually allow communities to meet the threshold for investments from foundations.

I call it the hamster ring. You know, they don't write good enough grants, so they don't get investment, so we don't invest, so they don't write good enough grants, and they never get investment. You think about being on that particular cycle over and over again. There are whole communities that are being left out of this particular conversation.

And even as we talk about health equity and the social determinants of health, we also realize that that whole lexicon is not familiar to many of the communities in which we work. We had that conversation amongst those of us who have had the great fortune of being engaged and perhaps being trained to understand what that actually means.

But I do a lot of talking in communities. And I'll tell you, when I talk about health inequities and the social determinants of health, people kind of look at me a little blankly and wonder sometimes, what the heck is this guy really talking about?

So for us it was really being and playing that translation role and developing the capacity of groups and new sets of leaders, new generations of leaders. This is not about age. It's about new generation of folks who are committed to their communities who need to understand things we're talking about.

And clearly on the social determinants. Paying attention to where you live, work and play. All right? So rates, inequities in terms of access, the care and quality of care, and then how those things were playing out in the environments in which people are living out their particular lives.

This became the kind of framework, the operating framework, for Sierra Health Foundation and the Center for Health Program Management. This is a slide that was shared to me by a person on our staff. I thought it was really quite powerful.

"Men and women of all races are born with the same range of abilities. But ability is not just the product of birth. Ability is stretched or stunted by the family

that you live with, the neighborhood you live in -- by the school you go to and the poverty or richness of your surroundings. It is a product of a hundred unseen forces playing upon a little infant, the child, and finally the man."

In my earlier slide, I did correctly say a woman as well, if that was appropriate. Sorry I didn't make that correction into the final edits because it wasn't a correction. It's not a piece you play with, because this was actually presented by Lyndon Johnson at a commencement speech at Howard University almost 50 years ago. This is the 50th anniversary on the war on poverty. And they were calling this question even back then. Fifty years.

What came out of this particular effort was really the launch of the war on poverty. And the construct that came out of that was really one that was focused on this notion of social equality, equal Rights Act, and other legislation at the time.

And what it resulted in was a set of siloed systems all trying to work on independent sets of issues that were aggregated in poor communities. And we stood up an infrastructure that actually does that fairly well. If you think about it operating independently. Not about the coalescence of the forces, but the statement made in his previous statement.

So we were in agreement with President Johnson's statement, but challenged by the system we had to work with as well. Now I am a former county welfare director. Seven years in Alameda County and ran a large system, integrated social services. We had adult (inaudible), food stamps, health care enrollment, child and family services.

And even though we were integrated under a common management umbrella, we basically operated as five different departments. The interesting thing was that if you looked at our investments, which is about \$300 million a year into communities, over two-thirds of those dollars went to four neighborhoods, East Oakland, West Oakland, South Hayward and Fruitvale.

So our ability to think about how we could aggregate those dollars and think more broadly about what was really happening was limited by the construct we were working with. By this construct, and I'm not saying this to make anybody feel uncomfortable, it's how we actually operate. It makes accounting very easy. You can account for dollars within those particular silos.

And even some institutions, like foundations, operate in this particular framework in mind as well. We think about health care and ACA and it involves a lot enrollment and costs of moving from volume to quality, to better education and gateways to work, human sources and the social service safety net and regional economic development, well that sometimes even circumvents the community that we care so much about, you not simply not include them in conversations -- important conversations.

We've been working on trying to develop a model that looks more like this. This is our framework for building a healthier California. We believe those health systems are not only focused on cost and volume, but on health and wealth. We work with educational systems not simply as gateways to learning our path to employment, but really around healthy development. Because many of us are socialized through those particular experiences as well.

And that's really a important thing if you think about expulsion rates and suspension rates and kids not be in school. Because that is a level of socialization that takes place as well. You think about youth and the mental health services that promote health, and not just simply support subsistence living.

I have a colleague who always tells me the difference between food stamps and not having food stamps is like between being hungry and starving. And we like to think that additional security is more than about being satisfied people simply hungry as opposed to starving.

So a very different mindset you bring to the world. And the socioeconomic community development to build environments to support health. All the ways that those in more wealthy communities think about that taking place as well.

As you see, it actually works through communities. That's the focus point for us, as opposed to just simply kind of vertical approaches, you know, moving up. Some unforeseen goal -- because the top of those arrows, there wasn't really much of any kind of an accounting mechanism to say that people are not receiving benefits of some type or not.

So you got to think about it in different ways. And if you can do that, then you can have counties that are better organized to promote health. And as you know, if you look at the national county health, you know we have some counties that are trailing very far behind other counties around some of the health (inaudible), particularly those up and down that 99 spine that we call the Central Valley and down into the Coachella Valley as well.

Under invested communities, and like I said in my earlier comments, not a lot of infrastructure. We don't invest because of that, and clearly they're the drag on California's, you know, march towards better health for us all.

And then California, in the aggregate, you can use the county level, California being a healthy, more vibrant place to live. This may seem like a simple slide, also I wanted to share with you from my colleague Robert. But this is the division. Moving from that equality framework that we have, everything was equal in the 50s, to one that's about equity. And that's not a different distribution of resources. Right?

You know, the far left side, this is not a political statement, you notice that the little guy can't see. On the right, yes, it does mean that resources are used a little bit different. But the end stage of all this is that everyone is better off. Everyone gets a fair share, a fair share, a real opportunity to be the healthiest.

Now, health is not simply around a physical state, but it's also about, you know, social, culture integration as well. I'm being told to speed it up, so I will.

So, in this model, what does the foundation bring? Well, clearly we're a foundation. We can investment. We have money that he can put on the table, and we have to do that. We have relationships that are 30 years old. We funded a lot of small communities for many, many years, and we led with those partnerships.

We have 270 health alumni, health (inaudible) that we actually trained or distributed across California and we work with and we think bring back to us real knowledge and information. And, of course, the reputation we think is pretty good.

What does the center bring to this? Of course involvement. We have to change that kind of staffing that we actually employ here at the foundation. We're not simply foundation office that collects data. We need to know how to facilitate conversations. How to be culturally sensitive. How to actually aggregate knowledge, not just for ourselves, not just reports that we pay to produce. But by folks who are in rooms like this one, who bring a sense of experiences that need to be valued to these particular conversations.

Clearly infrastructure. The center serves as an infrastructure for communities that lack, thereby leaving us no easy out for not investing. And clearly this notion on impact, sharing the knowledge that we get through our evaluation, involve communications system will really strengthen your foundation as well.

So this is the structural piece. So we're putting together ideas, infrastructure, people, and money, more politely framed as investment, that's money, and we focus it on disparities, inequities and specific kind of commitment to underserved communities.

Our current programs. Positive Youth Justice, I'll talk a little more about this. Healthier U, which is one of the state's first place workplace wellness programs, end east campus. A partnership with the state controller's office, SEIU, labor, as well as California Health Services. Trying to really figure out how to reduce health care costs an ethical workforce.

The national dialogue on mental health. The first dialogue comes out of the Newtown tragedy. The President had a two-pronged strategy, right? Gun control didn't go very well. Mental health, particularly for young people, wanted to do ten dialogues. First one held right here in California. We used the center as an

aggregation tool. Four foundations to put up the resources. 300 people showed up at the conference center, real time discourse, built a health plan in a single day. School district will carry that plan out. Again, not grantees. Partners.

And the respite care partnership. (inaudible) money. Built a complete system, alternative system for mental health here in Sacramento County. Respite centers in eight different communities, including some of the cultural linguistic communities which we know are under-represented for mental health care delivery. Respite centers for full-time mental health crisis can actually show up and walk in and get the kind of assistance in their community they actually need in.

We find that reducing the use of emergency departments for mental health services, it's not where you want to go. I can tell you the terrible story, the experience of learning what goes on of a woman who's on that steering committee who helped design the evaluations is a consumer of those services who spent three days tied to a gurney in an emergency department waiting to be served.

I'm blessed and fortunate enough not to have mental health problems. But I tell you, if you did that to me, I would probably be quite disturbed at the end of the three-day period. The issue is, we can do a lot better. Cost, quality, and access, if we organize ourselves differently.

Quickly, we will assume the launching -- this is the last piece. We're California's first health and wellness funds in eight new counties in California with a set of partners focused on these same sets of issues I described earlier.

We started out in 26 counties in Northern California. We'll soon be at 40. The communities we are going to are those places I described earlier that often get overlooked and whose need is significant and deep.

My last two minutes are on positive youth justice initiative. I might go over a minute or two. But positive youth justice, a by-product and evolution of the California Youth Authority as signed by the Governor, pushing control of what happens with young people back to the county.

We thought it was an enormous opportunity to reframe juvenile justice from its focus on incapacitation or detention and put it more in a track around youth development. All right? Because the idea of these systems and their origins are really around a rehabilitation of young people. That's not what's happening in California over the past several years.

(inaudible) data. (inaudible) report. System cost for kids who are crossover youth into a child welfare and juvenile justice experience. If you know about any of these populations individually, the outcomes are horrible despite huge investments. Average cost of a group home in California, about \$9,000 a month. Average around the state for some kids, seven years, fifty percent won't graduate,

fifty percent will be homeless within two years, fifty percent of the young women will have a child within two years, less likely to be employed.

Utilization of outpatient mental health services, and this is about a quarter of crossover youths, up to four years outside of care, over 40 percent of all mental health care utilization for system engaged (inaudible) came from a single (inaudible) down in Los Angeles. This is your transition-age youth.

They go from being a (inaudible) to being with the sheriff's department, on general assistance, on welfare, early parents, poorly educated. We can do better. One of things we really want to do in our particular model is focus on youth development, change the development trajectory of youth who are engaged with the system. Using real data to change system's thinking about how they interact, which deals with the disparities. The disproportionality in terms of involvement in those systems, I know you heard this in your previous presentation, is a real issue.

I said 75 percent of the kids in our system in Alameda came from four neighborhoods. We know where we should be investing.

Wrap-around services, a wonderful model. Under-utilized in the youth justice system, used heavily in child welfare, almost absent in juvenile justice despite (inaudible) being the same funding stream that's for both populations of those particular kids.

And then this piece here about trauma, which we think is really -- the trauma that kids experience that often leads them to be in those particular situations. 75 percent of all kids in juvenile justice have at least four adverse childhood experiences.

Untreated trauma, early parents, passing on those experiences to children, generational cycle of the system (inaudible). Here's we're working for PYJI on, four counties, San Diego a large county, Alameda mid-sized, Solano and San Joaquin full partners who are committed to transforming their juvenile justice systems.

Here's some data on the center. Now I'll end quickly -- sorry for going over a few minutes -- and take a little questions you might have.

(Applause.)

SANDI GALVEZ: Thank you. Neal, would you please start?

NEAL KOHATSU: Thank you very much, Mr. Hewitt. Fantastic presentation. One of the things that we're particularly addressing within the group is trying to work, as your foundation clearly demonstrates, across sectors.

You mentioned talking to some of your colleagues in philanthropy. Do you have any suggestions about not only coordinating partners within philanthropy, but across government and private sector? I know it's something you wrestle with as well.

I think there's a growing acceptance, as you said, among people who be able to turn social determinants of health and thinking of a stream within government, but in business as well. I think one of the difficulties is we want to work with cross-sectors, but it's hard to get everyone in the same meeting room, and it's hard to coordinate just from philanthropy, let alone government, business, employers, schools.

So any suggestions for this kind of larger effort would be great.

CHET HEWITT: Well, I think one of the things that we have found we have got to do, is we have got to go to them as opposed to calling them to us. We often organize meetings even in wonderful locations like this and sometimes it's really hard for folks to show up, particularly given their experience of not always finding value when they do.

And so, you know, we have gone to them in many respects and showed up at conferences, environments where they're conducting their business. One of the partnerships that we're most interested in at this particular point is an emerging conversation with the Federal Reserve, who's really interested in linking community development with health and what they call the emerging health economy. All right?

And they bring a whole different set of actors, (inaudible) institutions and others. And so things like the social capital meetings that was held in San Francisco, one will be held in New York in June. And we're in the process of organizing one here for Sacramento, probably in the fall.

So I think, you know, going to where those actors are, making a case in ways that are relevant and important to them at this point seems to be a really successful strategy for us.

NEAL KOHATSU: Thank you.

SANDI GALVEZ: Thank you. Gail?

GAIL NEWEL: Yes. Gail Newell, public health physician in Fresno County. Very excited to see you expanding into the Central Valley. And I just -- I wanted to call on this group of the Advisory Committee members and the office to really pay attention to the valley.

Briefly, my mother's an (inaudible) poet. She's part of a collection of poets who wrote the Highway 99 collection which was a best seller in the poetry world. And I think there's this romantic version of the valley, a kind of idealized farm worker kind of community there. But when I'm working in the public health department with \$9 per capita, per person, compared to \$150 to \$250 per capita in other counties, that is not romantic. And something has to change.

It is not enough for foundations. There's many foundations who have come in and dropped and run. And it's not enough. Someone's got to get in there and actually get dirt under their fingernails to make a difference. They have to learn to speak the language. They have to engage the community. And this is not happening. Thank you.

CHET HEWITT: Well, I don't have much to add. That statement, as we lawyers say, stands on its own. I will say that it's one of the reasons we opened an office in Merced, because we -- our point is to make the point and the case that you can't fly by and drop in (inaudible) or resources and expect things to change by themselves.

We also believe, you know, if you look at some of the county health rankings nationally, you know, the valley is considered to be the Appalachia of the west. That's how it's described. If you really want to have a healthier state, you have got to start in the valley, not because I have a preference for doing so, but that's what the data suggests.

Those are places that are hard to go. They're fraught very complicated issues. I have a colleague who said to me, "Did the foundation come into some new wealth or something? Why would you be going there?" No we haven't. We haven't had some huge increase in our endowment.

We're going for the same reason this group has been organized. We're going because we should and we need to. We believe in better health for all Californians, and have to be committed to going to the places where that's not the case, and the valley is one of them. So I totally support what you're saying.

(Applause.)

SANDI GALVEZ: Hermia?

HERMIA PARKS: Hermia Parks, Public Health Riverside County. Thank you so much for your presentation. Very informative. Excellent resources for us.

Like Gail, I just wanted to know perhaps in partnership with Riverside County, we have a wrap-around program that's very unique that we've (inaudible)

not only mental health and social services, probation, we have health which is public health assistance providing services to that population.

So just my thought is, you know, are there any plans for expanding to Riverside County? I know the California endowment has (inaudible) money in our county. Gail talked about the valley and (inaudible) and our need for services there. So I just wanted to know what those plans would be for our county. Thank you.

CHET HEWITT: You know, we have an interest and kind of increasing our (inaudible). We'll see how this valley work goes. I don't have any board members here, so -- and I say that in jest, because our board has been very supportive of our desire to go to the places that they believe and they data shows that we should be in.

And Riverside and Empire, Coachella Valley and other places as well. I consider them to be, look at the data, places that need increase investment -- increased investment not only in programs, but in infrastructure. That is a big part of this that needs to take place as well, so yes.

SANDI GALVEZ: Delphine?

DELPHINE BRODY: Thank you so much for Sierra Health Foundation's many contributions to increasing wellness where it's most needed.

I especially appreciate your focus on trauma sensitivity and innovative solutions that address -- address neglect, abuse and trauma as the root causes -- as among the root causes of people being sent into the juvenile justice system and people being placed in psychiatric hospitalization and the respite partnership collaborative and positive youth justice initiative are -- are excellent model programs.

I want to say that this focus on trauma sensitivity is needed, I think, across sectors in our strategic plan and I'm hoping that we can -- we can pay close attention to that along with the needs of folks who have been in the juvenile and criminal justice systems to -- to access health care and -- and jobs and housing equitably. Thank you.

CHET HEWITT: Let me just say really quickly, I'll consult and work with our selected counties, six initial and now four are run in combination with Nadine Burke Harris from the Center of Youth Wellness of San Francisco.

And I will tell you that her presentations impact on trauma and the behavior of kids, kind of neurophysiology associated with that, has been extraordinarily well-received by probation in terms of, you know, explaining certain behaviors and

deepening staff's sensitivity to certain issues that present themselves in those environments as well.

It is -- it has been remarkable in terms of its impact on the internal culture of institutions, which needed to think differently about the people they actually engage. So I really appreciate that.

SANDI GALVEZ: Jeremy?

JEREMY CANTOR: Thank you. Thank you for the presentation and for hosting us as well and the good use of slides, too. They're great.

One of the items I'm taking away from your presentation is the importance of place-based work in focusing where the need is greatest. I'm wondering if you can say a little bit more about the health and wellness fund that the foundation is developing, and if that's -- if it's not fully developed, it would be a great thing for us to keep track of and know more about.

CHET HEWITT: A couple of things. As I said, we talk a lot about place. We also talk about community. Because some people's relationships is not geographic. Some people it's surrounding experience, gender identification and other issues where people see a certain level of affinity which may not be rooted in a zip code.

But a lot of that does track back to place, because poverty aggravates itself and the effects the poverty has on health and welfare. So we try to be mindful of that, although our focus, as you say is really about place.

The fund correctly -- as correctly in your assumption is still under development. We're thinking about extending three things to the San Joaquin Valley. One is we will bring back after a two-year hiatus for redesign the health leadership program. It will focus on health inequity, social determinants of health, and health disparity.

It will be managed by Institute for Foundation Health Studies at UC Davis, Dr. King Kaiser, and the school of management from UCSF under Dr. Richard Callahan. So we bring together both the management side of this and the knowledge side of it, so we can build stronger institutions.

We also going to extend our (inaudible) organization work, which is funding kind the capacity and development of leadership teams across minority organizations to the valley as well.

CHET HEWITT: And then we will invest in small grants to kind of spur some level of innovation, what we call our short term R and D budgets, to invest in some things that might work. As one member of the committee suggested, we're not looking to drop things in from other environments.

We're really interested in catalyzing a level of momentum that will allow institutions in the valley to see some of this work in their own interest. A healthier workforce, better for the economy. Better education system, better for the economic development. You know, healthier communities, better access to fresh fruits and vegetables. That's where we grow them. You would think they would be accessible in that environment. Not the case for tens of thousands of families.

And these are not agendas that we feel are fraught with consternation. If you think about the community being at the center, since we all live in the community, we believe we can bring new entrance, new participants to that particular conversation. And we'll invest in activities that they actually define as well.

The last thing I'll say that we think is really interesting is that we see it not simply as programmatic investments, but also economic development investments as well. Entrepreneurship for some of these communities. If you look to the recent data about what will happen because of the drought in the Central Valley, 20,000 farm workers lose their jobs.

Think about what that means for those particular families. The mental health associated with massive loss of employment, the economies of some of those small towns and communities. Because we know to (inaudible) if you really are honest about the social determinants of health, then that particular downturn has grave health implications associated with it, you know, as well.

So not this program, but just have a broader vision about what we could invest.

JAHMAL MILLER: Thank you, Chet, for accepting the invitation to speak and hosting us for the last couple of days. The information you provided for us as a group, for me personally, was very, very invaluable.

Having experience working in governmental at Alameda County, and now in private sector with a private foundation, what would you say that one strength or asset with respect to all of the different kind of silos, what is that one asset or strength that as a government that we bring to the table that you learned from your personal experience that would be ideal for us to hardwire into the strategic plan approach? And I ask, because yesterday building capacity came up as one of the core components of what we want to see in play. And also sustainability which is the key to this work. So that's the perspective I'm asking for.

CHET HEWITT: You know, I've been in and out of post-service three times. And I think one of the things that I have enjoyed about it was our ability sometimes to mandate the service, particularly when we were humble enough to make sure they were informed not just by our own prerogative, but by good information and the voice of community as well.

I don't take that lightly, and nor should one use too much of a stick to get people to do things. But it is an inherent power within the public sector. And around these issues, it would be great to see it deployed I think in a more vigorous manner as well.

The other thing that I think is really, really important, and I take from this in a modest way from my time in public service, is it's really a creation of blue-sky space for people to think differently about how they interact, how they conduct their business as well.

I said on one slide that one of the things we had to really grapple with here was the role of program offices. One the powers of any institution is that you can mandate certain things. You're going to be spending your own money. Right? But as a foundation that now works with 95 percent in partnership, we sat down at table with folks who some of them have very different opinion than we do.

Even though the foundation, which is kind of a monolithic group, and you have to share power, and share influence in ways sometimes systems find, you know, quite challenging. And we have had to have staff actually retrained, because a lot of what we do now is not simply the financial monitoring of grantees, but the facilitation of conversation about progress.

They really do require different sets of skills. And so I encourage you to kind of wield that public authority that you actually have and do it in a way that allows us all to be along for the journey.

SANDI GALVEZ: Let's put the phone on. We don't have any public speaking cards, but I want to make sure there isn't anybody on the phone that wants to ask a question.

Is there anybody in the public that would like to ask Mr. Hewitt a question or make a comment? Okay.

CHET HEWITT: Thank you.

SANDI GALVEZ: Thank you so much for your presentation.

(Applause.)

SANDI GALVEZ: Okay. To try to catch up on time, we were scheduled for a break. Now, it's officially passed according to the agenda, to move us into your next place. Please take a brief break on your way to the small group discussions.

We're going to have the small groups meet in the same places as they met yesterday. I believe that was A and B over here. C was in the that part of the room and I don't actually know -- I know one of them was a secret room. D was the lunch room, and E was the board room around the corner.

To members of the public, feel free to go and join any of the small groups '2conversations that you would like to be part of. And so we'll be in the small groups through lunchtime. And we'll be getting further instructions, I'm assuming, from our small group staff as the facilitators. Thank you very much.

(Lunch break taken.)

TAMU NOLFO: Hello folks, how are we doing? Good. Okay. We're kind of in the home stretch. I wanted to bring you back here for just a moment and let you know what you can anticipate coming up.

So we had originally intended on going into our group share. But we're going to take another half hour for you to be together in your small groups to finish talking, going through your sheets. And I'll come around and I'll check and I'll see how you're doing. If it looks like half an hour is a good amount of time; if it's too short, then we'll extend it. So this is what we're dealing with in terms of our time. These are the things that we have. We want you to have enough time in your small groups to work out what you need to do in your small groups. We want you to have enough time with your small groups speaking with other small groups one on one. And we also want you to have some time to report out to the larger body what came out of all of that. So that's kind of what we're balancing. But we have some flexibility in the agenda to balance as we need to. So what we're gonna do now is go and have you spend a half hour in your small groups. If it seems like that's enough time, I'm gonna start moving you into your groups communicating with one another. So what that's going to look like for example for the first round, in this room we have the A/B group here. We have the C group here. We'll have the C group come over and join the A/B group. The A/B group will share with the C group the highlights. And then I'll let you know when it's time to walk back over to the other side of the room, and the C group can share with the A/B group their highlights.

The same thing will be happening for groups D and E. And then we'll swap it up so that each group has an opportunity to speak with each other. And so the highlights that we're looking at is for you to review your initiatives that you want to share with the other group. What were key for you in terms of: Were there any initiatives that we felt like really didn't belong here or that we had major concerns about? Were there any initiatives that we felt like were really missing here? So it's up to you what it is that you'd like to share. I can't tell you how much time you're gonna have right now, because it's gonna depend on how much time you need in your small groups, whether it's going to a half hour or whether it's going to be more. But more or less, what we're thinking now is you're going to have 15 minutes to

share overall what you came up with and for them to share with you before we start switching to other groups.

Yes, Gail.

GAIL NEWEL: Gail Newel. Would you clarify, again, for the group, who the strategic plan is addressing? Is this a strategic plan for the OHE? For the State government? Or for the State as a whole?

TAMU NOLFO: Yes. It is for the State as a whole. And I'm gonna, actually, to let Jahmal take the microphone so he can be more explicit.

JAHMAL MILLER: So it's the Health Equity Strategic Plan for the State of California. Our role, as an Office of Health Equity, is an oversight role to where when we look at who is going to have responsibility on executing across some of the tactics, the Office of Health Equity obviously is gonna have the role in doing that. So that's where we think about the Health in All Policies work. We think about our mental health disparities work, CRDP efforts, our climate and health. So there is areas where we will actually possess that direct accountability and responsibility to execute against. But then there will be some other governing partners, some community-based organizations; that's where we get into more of the recommendations around the components of the strategic plan. So we'll have oversight and don't really use the word "accountability" to the extent that we can't hold a, you know, a private entity or another government entity outside of the scope of the OHE and CDPH accountable, per se, but we want to leverage those asset and resources that are taking place in the Office of Health Equity, in the HCS and CDPH. But understanding that's a piece of a much larger pie. So we'll have an oversight responsibility and try to position ourselves to win by including those partners outside of our immediate scope of responsibilities that we know are aligned with our health equity work in the State of California. And the likelihood of us achieving success in those places is much higher versus a random, you know, distant partner that we're going to say, you do, X, Y, and Z; and we have no influence over them.

RON CHAPMAN: So the esteemed legislature created the Office of Health Equity. And the law mandated that we create a strategic plan. The law did not say that it's the strategic plan for what the Office of Health Equity should do. The strategic plan is how to achieve State -- to achieve health equity in the State of California. And in order to achieve health equity in the State of California, it has to wade through the Office of Health Equity. It has to involve all of us in the room and many, many people and organizations that are not in the room.

So hopefully that makes it clear. I think Jahmal made it clear what the role of the Office of Health Equity is, but I just want to make sure you understand that, again, in order to achieve health equity in the State of California, this goes way

beyond the office, department, state government. Hopefully that explains -- I see lots of nods.

TAMU NOLFO: And that's one of the reasons why one the questions that you're asked is about partnerships and what those partnerships might look like and within that, funding. If there's funding that's attached to those partnerships that you think would be beneficial in moving forward with these initiatives, let us know that, so we can take that into consideration as we continue to build out this plan.

Any other points of clarification before you go back into your small groups? The public, you're welcome to sit in on any groups that are interesting to you. You can move around from group to group.

Yes? Fantastic. Okay.

Enjoy.

(WHEREUPON A RECESS WAS TAKEN.)

SANDI GALVEZ: So from participating in all the conversations that I participated in, sounds like you had a lot of synergism -- synergy, and great discussions this afternoon.

So now for this next section of our -- of our meeting, what we're going to do is share the highlights from each group of what -- kind of synthesizing all that, you know, that was adapted from your -- to your box, based on your initial group discussion, along with the conversations that you had with the other two groups so that we can go on public record and share with the public and those on the phone the synergy of everything we discussed today.

So how about group A. Can someone from group A share with the larger group and the public the key themes, any key changes, and/or additions or deletions from Box-A, based on all the conversations of the day?

It could be the Advisory Committee or if you elect to have one of the staff that represented that was at your group during the discussion can do it. We just need to get it on the record what has taken place. Any discussions related to our central challenge in Box-A.

UNIDENTIFIED SPEAKER: Sandi, we would like to give the opportunity to an Advisory Committee member -- we would like to give the opportunity to an Advisory Committee member or if they would like to refer to staff.

SANDI GALVEZ: Any advisory member from group A like to give that report? Going once; going twice.

Okay. Delphine, would you like to?

DELPHINE BRODY: I'll give it a try but --

SANDI GALVEZ: I mean, if you don't want to go to the podium, I don't think it's necessary. I think as long as it's on the microphone so people can hear.

DELPHINE BRODY: Hi. Sorry. I don't have our -- our notes, which are quite complex, as a cheat sheet. But I'll do my best to summarize. But, please, others feel free to chime in because I don't know that I have the perfect summary here.

We were concerned about inclusiveness in A-1 through 3. And that included the network of support, which we -- we would like to see be fully inclusive and adequately funded in order to really, both identify and disseminate the information with all -- all of the groups that are impacted, involved from the start.

And the web site should be closely linked A-2 with A-1. And there are -- there are some good models out there to look at it. They should be interactive and accessible to people with disabilities; fully engage people and use all the threshold languages.

The summit, we're a little concerned, may be beyond the capacity that we have, given funding. But, possibly we may get it in other funding and/or combined with the summits like the one that CPHEN puts on.

Building awareness, A-4, through the Healthy Community Indicator Projects, we talked about some, but not a lot. Again, tell me, if I'm missing something.

We are -- we are concerned that -- it's absolutely essential to have fully -- fully engaged stakeholders that -- that center on the communities directly impacted by the disparities.

And the -- for A, B, and the first three items of C that we -- that we discussed, that peer support and community-defined practices be -- be integrated into -- into all fields and embedded in all policies.

And with B-1 -- we -- I'm sorry. We want to make sure that the word "equity" is included as the type of criteria to embed in B-1; that we're talking about health equity criteria in decision making; that be in consultation with -- and that B-1 through 4 be done in consultation with the community members who are directly impacted. There is quite a long list of those community members, but we should not shy away from being specific and having -- having a -- an overall, overarching term for all of the strategies that identify these groups as -- as specific to the populations as necessary to ensure that they're included. And these would include,

not only racial -- historically underserved and unserved and inappropriately served racial and ethnic populations, but LGBTQ, people with disabilities, formerly incarcerated people, groups that have been identified in our discussions.

We also talked about C-1 through 3. And so sorry, I'm at a loss without -- without the notes that we had.

SANDI GALVEZ: You're doing a great job.

DELPHINE BRODY: Thank you.

Identifying the partnerships. We discussed -- sorry. I'm -- I really don't have notes for this. Sorry. If someone else wants to fill in on C, that would be really helpful. It's hard for me to ad lib in this short time frame.

CONNIE MITCHELL: Connie. No. No. You did great.

I'm Connie Mitchell. Did you want to talk about A, or just go right on to B? Or what did you want to do?

TAMU NOLFO: I would say go on to B. Because we would like --

CONNIE MITCHELL: Okay. So B-1 is partner with Health in All Policies Task Force to embed health criteria. And as Delphine said, the major concern that we have there was to add "to embed health equity" in decision making grant programs that is lacking in the strategic plans.

Under 2, "Coordinate through the Health in All Policies approach possibilities for transportation and land use planning to support access to health, mental health, health care services." This one, while we saw that transportation and land use planning was certainly in this purview of the -- and reaching out to nonhealth agencies, it's seemed very particular to healthcare services. So while we think that there should be a strong focus on reaching out to transportation and land use efforts with regard to everybody, we also encouraged group C to consider including transportation and land use planning when it comes to access to healthcare services and having healthcare institutions do all that they can to coordinate with those efforts.

Under 3, "Inform climate change and cap/trade initiatives regarding unequal impacts on vulnerable populations," we actually saw that this cap/trade investment strategy, which is to invest cap and trade funding into disadvantaged communities as a huge opportunity that lies before us. And this is probably going to turn out from a -- going to turn into an area, I think, of interest that all of us will share, is how will those decisions be made? How will these communities be identified? How will we ensure that funding is getting to those that are most in need and that the outcomes are moving in the direction that we want them to go. So this might be

something that we'll want to tease this out a little bit more because I do see it as an incredible opportunity right now with funding associated with it that we need to be very mindful of.

The number 4, "Develop and disseminate policy briefs, based on recommendations," our committee felt like that developing briefs or analysis of policies is something that there's people that are good at doing this and that with regards to the Office of Health Equity, maybe we can help to inform and provide some technical assistance. But it's -- it's complicated for a state agency or the executive branch to develop briefs. But we can certainly help to inform. And we think that it's important to disseminate those. And we've got all those in development but (inaudible).

Was there anything else, Julia, to add? I think the two overriding issues that we have are always, not only to be inclusive, but to model inclusivity in all of our processes and that it's not just about bidirectional communication, but by directional learning.

(UNIDENTIFIED INAUDIBLE SPEAKER.)

CONNIE MITCHELL: Did we include all the things from C? Yeah, we did.

SANDI GALVEZ: Speak to -- (inaudible).

CONNIE MITCHELL: I don't have those notes.

SANDI GALVEZ: You want to -- okay.

Well, just to continue with B, I guess, group C recommended that the initiatives for C and B are similar but different, in that we saw B being more around sectors that are not all sectors outside of the health sector, and that C is really around the health sector, everything under H -- HAS. And so with that in mind, that, the first four initiatives, the first four strategies under C would also in appropriate language fit under initiatives for Box B.

So things around assessing current practices with different sectors around health equity, integrating efforts to address group causes of health inequities and things around cultural competency, linguistic access for populations into activities of state-funded programs, facilitating common understanding across different sectors around what health equity and social determinants of health mean. And then facilitating training and technical assistance for grantees of state programs around what health equity means.

That those kinds of activities could go under B. And at least it seemed like there was agreement with that. So that was the additional additions to B.

So for group C, does someone want to present for group C? Folks want me to present group C?

So the first one being the change in the title of group C to embed equity into institutional practices and policies of the health sector or system or somewhere we -- we're putting it in the hands of staff to help wordsmith a lot of this stuff.

So let's see. I'm trying -- major changes where we looked at strategy 6. And first of all, broke it up into two strategies, one really focusing on access issues around ACA. And then the other one focusing on building the State safety -- the State safety net for uninsured populations. And we also felt that those didn't really fit under the purview of really -- of really focusing on changing institutional practices and building capacity to health inequities; and it really either should be under the infrastructure box in E or maybe its own category. So, you know, that was a recommendation we made.

We kind of clumped 3 and 1. That we, you know, the State really needed to help facilitate a common understanding around health equity and the social determinants of health between all the different types of professionals and -- and type of work primarily in the -- the health care services, mental health, public health, and social services. And that, that probably, you know, would be clumped then with -- in order to do an assessment of what's going on across all these different programs, there needs to be an understanding of what we're gonna be talking about. So 3 and 1 were kind of lumped together.

And then 2, 4, and 5 would be clumped together. So that would focus more on providing guidance from the state or locally funded programs from this -- around in the -- in the HSS -- HHS to be able to focus on broadening of the scope of the work, to include things to address the root causes and social determinants of health, as well as making sure that it's culturally appropriate services and community fine practices. And then that the state would provide training and technical assistance for those grantees to be able to do that, which is 4, as well as expansion of class, which is 5.

We spoke -- group D recommended that the No. A strategy be moved to Box-C. And we saw it as a more specific outcome under, I think, it was 2.

Did I miss any of the key things? And then, you know, we had a lot of wordsmithing specifics that are in all of our notes. I think that was it for C.

How about a report from D about the key things in D.

Karen.

KAREN BEN-MOSHE: Karen. Thanks. So number -- so we had a lot of initiatives. The first one was to conduct a scan to determine how local communities are currently mobilizing.

We thought this was important. We think it's really -- there's a lot of good work going on in communities; and we need to make sure we know what that is. And that's an important -- one of the important first steps.

We talked -- am I supposed to read each one of them?

TAMU NOLFO: You can just give us the highlights.

KAREN BEN-MOSHE: Okay. Good. So we talked a lot with many of you about number 4, which is about -- currently about incentivizing, recognizing, and publicizing local efforts; and that we need to be really clear about what the intent of this is. So if it's about incentivizing, that that's important into the language that we might want to be even stronger and include language around investing.

We also talked about the fact that if it's recognizing and publicizing, that that's very different; and that that is something that might be combined with something else or might be appropriate in a different group.

We talked about 2 and 6 potentially falling under group A, which is around, kind of, communication.

We talked about -- let's see -- so D-8 had also gotten moved to our group. D-8. And we talked about potentially -- E-8. Sorry. E-8 also got moved to our group. And we talked about just a lot of concerns around the fact that that's the only initiative that calls out specific, specific groups and whether that fit in D and whether that should be combined somewhere else or eliminated. What else? I think -- was that the highlights? What did I miss? Oh, okay. Thank you.

So we talked a lot about evidence-based standards and evidence-base criteria and the need for there to be other practices. We talked a fair amount in our group and with all of you about the language that we use for community-based kind of knowledge and that it's important that we use clear consistent language. And also just that that is something really important that we focus on moving forward.

We talked a lot about the need for community buy-in. And, I think near the end of our conversations, we also talked about life-course approaches. And that that's something that hasn't really come up yet, but that it might be something we might want to think about incorporating.

Did I miss anything?

ROCCO CHENG: I just want to add one more comment about our community-defined evidence. There was some discussion about that, what's the

standard, who gets to define it, actually SAMHSA has a clear definition about community-defined evidence. You have to have theory of change. You have to have logic model. You have to have outcome measures to prove that it's some -- to demonstrate some sort effectiveness. However, it's in combination and collaboration of community coming up, it fits right here. What is important to look at and measure, measure the change.

SANDI GALVEZ: Thank you. How about group E, box around infrastructure and support.

Anybody from that group want to share that?

AIMEE SISSON: I guess it's me. Aimee Sisson. I'll just say, in general our -- so we were group E, Develop and Align Sustainable Multi-Sector Infrastructure and Support. So looking at human resources and funding to support this work, in general we felt that there was an emphasis on work that the Office of Health Equity could do within this strategic priority. And we felt, in general, that that should be broadened. So that we should be looking beyond building capacity at the Office of Health Equity by building infrastructure statewide. So looking beyond government. And again that emphasizes the multi-sector, which is the title of our strategic priority.

I think -- kind of going through these one at a time, the first two address workforce. On number 1, we felt like the Speaker's Series was a little bit too narrow, and this should be more focused on developing the ambassadors who could spread this concept of the importance of health equity and building capacity, not just in state government but across sectors.

And then, number 2, again, addressing workforce, but more on the pipeline, broadening this, again, beyond the Office of Health Equity, but essentially collaborating with leadership academies that are existing or developing new leadership academies related to creating a workforce that has the capacity to address health equity.

Numbers 3 and 4 both relate to identifying funding or redirecting and aligning funding to support health equity. We felt that the concept of embedding health equity as a priority in funding was important and really central to this work. In order to do that, I think, moving on to number 5, getting at public and private partnerships. We saw that this initiative was really foundational and precursor to all the work that needs to happen in strategic priorities, but really also in strategic priorities A through D as well. And we have emphasis on identifying on new partners with whom we are traditional partners, even beyond the Health in All Policies partners within government both looking, for example, at business and to these folks that have the capacity to create new jobs, for example.

Let's see. Related to number 6, which has to do with the Public Health Climate Action Team, we felt that in concept, it's really important to relay the

message that climate and health equity are related to each other; but we felt that the specific work of managing a program might be too narrow and specific (inaudible) and for this higher-level strategic plan. We also didn't feel like it fit in necessarily well with infrastructure. And we had some discussion about potentially connecting -- or moving this with strategic initiative B-3.

In regards to number 7, and the National Action Plan to Reduce Health Equity underlining this plan would not work. We, again, felt like we should go more broad and look at additional plans at the Federal, State and Local level that relates to health equity and potentially align our work and our plan with those plans in order to draw in additional funds.

In regards to number 8, building on existing efforts related to this plan's gender and sexual orientation, our group felt like this was not related to infrastructure and had a discussion with the group that addressed D, and ultimately, I believe, came to the conclusion that the particular lens of gender identify and sexual orientation is sort of -- is encompassed in the definition of health equity that is being put forward by this group and that it isn't necessary within the strategic plan to call out one group as being necessarily more important than others. So in place of E-8, we suggested a new E-8, because we felt that what we had wasn't necessarily sufficient to achieve a strategic priority of E. And so we created a new concept of health equity zones that would be -- identify the Office of Health Equity and its partners by identifying zones that are in particular need of funding and other resources to address health equity so they have particular disparities and then direct funding and other resources towards those groups. This was just a preliminary concept. It wasn't necessarily a -- fully fleshed out. But we sort of took more of a place matters approach in keeping with Sierra Foundation presentation that we heard this morning.

And then, I think, finally, I'll just say that we wanted to make sure that mental health is included in all of this work moving forward. We have a tendency to focus on physical health and so wherever possible to make sure we're including language and strategies that are specific and inclusive of mental health.

And I'll open it up to anyone else in the group to add.

SANDI GALVEZ: Thank you, Aimee.

I think the one thing I'd like to add and to encompass this whole conversation as well, is something that was discussed in all of the -- at least all of the groups that we -- that group C went to, is that there was an intent when Rocco and I met with staff to go over this document prior to today, there was an intent that the document before its, you know, the final document should include definitions at the top about what do we mean by -- What do you mean by social determinants? What do we mean by root causes? What do, you know, all the key terms that are in here that there needs to be a common understanding what they -- what they all mean in the

beginning of the document so that we're all, you know, we all know what we're talking about. And also that health encompasses mental health, physical health, and clinical services and public health.

So with that, Tamu do you want to talk to us about -- actually, no. I need to get public comment about this particular part. Tamu will be talking about next steps in a minute.

Are there any additional comments from the Advisory Committee before we go to public comment?

DEXTER LOUIE: Thank you, Sandi.

I hate to sound like a broken record; however, I went to the last page on our worksheet, and under potential partners and prioritized. And, again, you know, I think that it's what Jahmal called relatively low maintenance group, not easy to pick though because schools have their own difficulties. Green Lining said we're number 49 in school funding. They didn't -- they forgot to tell you that in 1950's we were number 5 in funding, number 5, top 10 percent. So they have their issues too.

In any case, between the California School Board Association, which is where your school board members from every community, they come from every community, a thousand school districts. You multiply that by the number of schools in each district. And ACSA, the California School Administrators Group, they're in Sacramento. You can talk to them both. Start it now because you're dealing with a intergenerational problem to now. Parents -- you are parents, and so on. So I prioritize that as really high because it has really high impact. Scope is great. Resources required; schools have some money, and they have their own budget, of course. And so it's really important. I think every legislator knows about the problem with schools. They've cut their funding by 20 or 25 percent in the past five years. I mean, just cut. So, I think, that's a place that we should prioritize.

My own comments, thank you.

SANDI GALVEZ: Delphine.

DELPHINE BRODY: Thank you. I just want to express that I'm concerned because I sense that there's not agreement on how to handle calling out particular populations that are impacted. And I think -- and I've heard others say -- that clearly identifying the populations who are -- are currently and historically facing disparities and inequities is gonna be critical. And incorporating that lens, it said in the former initiative E-8, presenting those needs through the lens and -- well, and with the direct involvement of people from those populations, I'm very concerned that if this strategic plan simply leaves out any specificity,

that -- that many populations will be ultimately left out when we move to implementation.

And I think when we define terms like health inequity, it's going to be crucial for us to call out as many of the populations as we know are impacted as possible, including those for whom -- the many for whom data is not yet being collected, including the Native Americans and Arab Muslim folks in California and so many other, LGBTQ folks mostly don't have data being collected for us.

So I -- I hate to see for -- a streamlining of our -- our -- our strategic plan that -- that doesn't -- that smooths over the specific groups that need -- need attention.

Thanks.

SANDI GALVEZ: Paula.

PAULA BRAVEMAN: Thank you. Yeah, I would like to support what -- what Delphine just stated. And I think it would be very important -- although, I think it could be and probably should be done upfront as part of the definition of health equity; and that we take the -- this one is live -- how about this? Any better -- Do I need to repeat what I just said? No. Good.

That we're not ambiguous about the fact that -- that the issue is justice and social justice and that we're talking to groups that are relevant groups or groups that have historically experienced discrimination and exclusion.

And I think it's probably very heavy for folks at the State to take that step of that -- that kind of language in their statements. But I think if you don't, then the resources are up for grabs for whatever group wants to say, you know, there's, you know, there's each disparities between my group experience and this -- this other -- this other group.

So I'm hoping that will happen and that it will specifically call out racial, ethnic, socioeconomic, gender, LGBTQ, disability.

FRANCIS LU: I'm wondering -- I'm wondering if it would be helpful to have a motion and maybe a vote on -- on the Advisory Committee on this issue? Would this be helpful, I'm wondering? Or I'd like to make that motion.

SANDI GALVEZ: Well, I -- I was thinking it would be -- because I actually think that the definition in the statute that defines vulnerable populations includes all of those groups, it includes language around historically -- it does.

The definition in the statute is "vulnerable communities include, but are not limited to women; racial or ethnic groups; low-income individuals and families; individuals who are incarcerated and those who have been incarcerated; individuals

with disabilities; individuals with mental health conditions; children, youth and young adults; seniors; immigrants and refugees; individuals who are limited-English proficient; and lesbian, gay, bisexual, transgender, queer; and questioning communities; or combinations of these populations."

Vulnerable places means, "places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents."

So that is the language that's in our statute. Do you folks feel that including that definition in the front of the framework would not capture what has just been said?

FRANCIS LU: I think that definition's great. I just -- I guess the question that Delphine was getting at is that it's -- is, How is it actually going to be captured in the strategic, you know, planning and initiative going forward? Because that's a huge number of groups. And, you know, so...

SANDI GALVEZ: I actually -- I think if the question is about how it's actually gonna to be, you know, like, What are the specific strategies, I think that moves into the next -- the next part of the agenda. So before we move to the next part of the agenda, I'd like to get comments specifically to -- to this part.

So we have two speaker cards. And is the phone line still open? If anybody on the phone would like to speak to this, please make -- identify yourself. Is there anybody on the phone? Okay.

So we have two speakers. Dalilia Butler and Beth Malinowski. I think that's what it says.

DALILIA BUTLER: Hi. Thank you so much. I'm Dalilia Butler with Policy Link. And I just wanted to, first of all, to say thank you for the opportunity to participate in these conversations today. It's been -- it's been absolutely wonderful to kind of hone in on some of the, just, suggestions around the potential strategic priorities.

And I was, you know, in talking with our group and just hearing a number of the different groups talk, there were some things -- and I'm wondering if they're, you know, would possibly be opportunities to think about some overarching principals that help to, not only to guide the work of the Office of Health Equity, but also key partners who we would be having conversations with. So some of the ones that came to mind to me were things about being responsive or intentional or thinking about, you know, opportunities to be innovative. You know, one of the conversations was about workforce development. And someone said, How do we make sure that when we're doing this workforce development we're reflecting, you

know, the communities or we're involving those communities who are experiencing inequity?

So something like a set of principles that will help us to bring to mind these really important considerations as we're continuing to do the work and get more specific.

Thank you, again.

SANDI GALVEZ: Thank you.

And I think in a little bit, Tamu will be talking about next step. And part of that will involve an opportunity for the public to give comment and then I think any comments you want to give in, you know, in writing, I think we'll really appreciate it.

BETH MALINOWSKI: Hi. Beth Malinowski. California Primary Care Association. I was here yesterday and just came this afternoon. So it's really exciting to see kind of where things have ended today. And I think we really appreciate the discussions that are happening, the direction things are going in. I just want to -- as I was hearing earlier the conversation around, I think what we're calling Box-C -- is that correct? -- that some particular items there. As we think about the ACA, and thinking about it beyond just health coverage, I might encourage the group to think about, How is it that we can, kind of, use, really, the ACA as a -- as really a way to -- to initiate the dialogue in a few of these areas. So maybe thinking about what are the components of the ACA that could impact Box-A, Box-B, Box-C, and the different components. There may be some good reason that we think about, just engaging other stakeholders, especially in the health system, to think about where the areas ACA alignment and the different components of the different boxes. So it's kind of concept one.

Concept two, really appreciate folks calling out the importance of the remaining uninsured and making sure that we've got coverage and safety net access to everyone -- additionally -- throughout that, you know, CPCA and the other safety net providers probably be very interested in being involved in conversations around that and drawing that link with the Department of Public Health.

And thirdly, I'll just speak to the importance of definitions, particularly as it relates to thinking about how we are we defining social determinants of the health. I know in the, kind of, health system side of things our conversations right now, with plans with the State or Department of Public Services on payment reform, the same and other concepts are really getting us to think broadly about, How do we not only define it, what are the indicators we use to measure change over time and to look to see where we're having success? And if this group could play a leadership role in helping us think through those things, I think, that would be huge. It's something we're not seeing at a national level yet. I think some other states are starting to dig

into it, but we're really one of the first. And I think any guidance that this group could provide on making sure we've got those indicators, not only for our health systems, but for other groups, I think, that'd be really meaningful.

Thank you.

SANDI GALVEZ: Thank you, very much.
Tam, do you want to take us to the next part of the agenda?

TAMU NOLFO: Good afternoon. I'm Tamu Nolfo, the OHE staff. And, I thank you, for hanging in there for a long couple of days. You did some really tough work.

So it's my time to, kind of, wrap it up. In terms of what's been **accomplished:** Coming into this meeting, you had your mission, your vision, your central challenge, and your strategic priority areas. And we provided you with some initiatives under each one of those strategic priority areas, also called the boxes, that you were able to respond to. And you did a great job responding to them. And so we have a lot of feedback now to be able to go back to our offices and rework those initiatives, potentially rework those strategic priority areas to see whether we have the right ones, whether we have the right languaging for them, whether they need to expanded. So we have a lot of that information that's come out of those small groups.

What I'd also like from you, if you're willing to give them to me, are your personal notes. So if you have been writing on this (indicating), as I've been asking you to, there are pages (indicating) for you to put your own personal notes. And this also includes members of the public, that you also have the opportunity to write your notes and provide them to me so that as I go back to the office and start synthesizing this, working with the rest of the staff, working with your Chair and your Vice Chair to get this to the next level, that all of that feedback will be encompassed.

So there are administrative approval processes for -- this is actually considered a legislative report, calling it a strategic plan. But there are administrative approval processes. And my understanding is that it normally takes about ten to twelve weeks in order to get through this process. And if that were the case and we're to meet our July 1st deadline that's in the statute, that would mean that we would need to have a pretty clear idea of what this plan was going to look like within the next couple of weeks. So we're really on a very accelerated pace here. What we're doing is working with Dr. Chapman and this process to try to buy a few more weeks so that we can get some additional input. So over the next few weeks it's going to be really important that if there are constituents, if there are communities, if there are stakeholders that you think we need to hear from on this process, that you provide us with that information. All right?

And so I spoke a little bit yesterday, but I'll just repeat myself; that you can use this form; we will get it out in a Word document to make is easy to manipulate, to beat up, in whatever ways you or your constituents would like to. We're also going to make it a form that you can type into online, that's my understanding, is that we can work with our staff to do that hopefully within the coming weeks to make that happen. And that it can simply be e-mailed back to OHE@CDPH.ca.gov. Or it can be mailed to us. Or you'll be able to use our web site in order to provide that feedback directly into the typeable form.

So as we receive that input, as we go through all of this, I'll be doing debriefs with the staff that helped to co-facilitate the four groups. There will be another version of this framework. There will also be goals that get fleshed out under that framework, which you didn't have at this meeting; we thought it was too much to deal with at this point, especially since we weren't quite sure whether or not these were the right initiatives. So we'll also be moving onto that.

And so that's where we are in the process. It's going to be a very quick process. When we meet again in May -- so at this point, we've talked about May 12th and 13th; and those are the dates that we have reserved and that Sierra Health Foundation has offered to host us again. But my understanding is that there is a conflict with May 13th, that that is a day when there are a lot of mental health advocates who are going to be here in Sacramento doing work. And so we don't want to have people try to be in two places at the same time or to have to decide. And so that's one of the things that we need to put out to the group, whether or not we're comfortable with having a one-day meeting in May, perhaps, limiting it to May 12th. At that May meeting, you will certainly have the updated version of the strategic framework. It will be much more fleshed out. And it will likely already be in the pipeline making it's way through that administrative approval process. And so there will be an opportunity to provide some input where we may be able to make some minor changes to it at that point. But we probably will not be able to make substantial changes to it at that point. So that's why we may be okay with having a one-day meeting, as opposed to having a two-day meeting. But I'm going to throw that out there to you, Sandi, to maybe facilitate.

SANDI GALVEZ: As the Chair, I think it would be remiss if I didn't state some concerns I've been hearing.

TAMU NOLFO: Yes. Sure.

SANDI GALVEZ: I mean, one of the observations I made from several of the, you know, the groups that we went around, is I think there is a lot of concern about, you know, the devil's in the details, what, you know, what are -- how are these things -- what's gonna be the actual goals of each of these really good statements. But how they get implemented, I think, is of concern to folks. I think the comments we had right before this section, I think are endemic of that. So that -- that's concerning to me; that, you know, as an individual. And I think I've

heard it throughout the day. So related to that, I guess -- and my understanding is that sometimes there, you know, there are opportunities to move back, even though there are legislative deadlines, to be able to incorporate more time for public feedback to be able to make sure that what goes to the legislature has been properly vetted.

So what is the possibility of something like that? It just -- I want to put it out there, because I feel like I would be remiss if I didn't say it.

TAMU NOLFO: Sure. And I don't know if Jahmal or Dr. Chapman, if either of you want to speak to that.

JAHMAL MILLER: I appreciate the feedback. And that's something that staff, with our leadership, we've discussed. I don't have a response today without the ability to go back and continue to have, you know, dialogue with our leadership to discuss the realities and real options that we have. So I'll leave it at that. We take that feedback to heart, and we'll respond accordingly. But definitely would like Dr. Chapman to chime in.

RON CHAPMAN: So I actually do not know the answer to the question of an extension on the deadline. I'm not sure mechanically how that would work, but we'll check on that.

And I think a couple other points; one, you know July 1 will come and go. And, you know, whatever point a document is produced, that time will come and go. What's most important in my mind is what happens after that. And so we've been talking about, you know, this being a living document. I mean, too many of us have seen plans that just end up on the shelf. I don't think any of you are gonna let that happen. That's why you were chosen to be on this Advisory Committee. But it really, in my mind, this is a key process; but more importantly what happens after that. So I would like to see that plan continue to be improved and worked on after July 1 or whatever date the document is publicly released. And we just started talking about, What does a dissemination plan look like? How is this plan going to hit the road? And what does that look like in communities throughout the State? We need to start putting that together.

So there are a lot more pieces beyond just the creation of this plan, which are very important to the success of the work that we're doing right here.

SANDI GALVEZ: I'll have -- let the Committee have a chance to -- and I have some other concerns I'd like to raise, but I'll save those.

Francis.

FRANCIS LU: Well, so I'm -- I'm just wondering how the Advisory Committee can be helpful to, you know, help the staff, you know, fashion the

strategic plan from here on out; and given that our next meeting is scheduled for May 12th and 13th, and given the time line and all of that, that was just mentioned, and also this conflict of May 13, I'm just wondering if there's any possibility of, let's say, moving up the meeting into late April and still provide an opportunity for the Advisory Committee to be helpful to the staff in -- in the process.

If that's not possible, which I certainly can understand logistically, would there be possibility of the plan being, let's say, disseminated maybe to the small groups, you know, the section, like section C that I was part of a small group; that the section C section be distributed. And then without violating Bagley-Keene, can I as an Advisory Committee member provide comment back to the staff just on a one-on-one sort of response; just so that you'd have the input from the individual Advisory Committee members? So I'm just wondering about those two possibilities as ways of helping the staff.

SANDI GALVEZ: Patricia.

PATRICIA RYAN: I was just wondering if -- well, having had lots of experience with stakeholder processes in the past and hearing lots of criticism, not necessarily directed to me, but just in general, criticism against whoever's holding the stakeholder process that it wasn't inclusive enough, there wasn't enough time, et cetera, I'm just wondering if it would be helpful or, you know, what you would think, what staff would think about the Advisory Committee making recommendations to the OHE to request that there be an extension on this. So it wouldn't be coming from you as State staff, but it would be coming from the Advisory Committee, who cares about these issues and cares about getting them done right.

SANDI GALVEZ: Do you want to respond to that or wait?

RON CHAPMAN: That concept is up to the prerogative of the Advisory Committee.

JAHMAL MILLER: And I'll chime in. I'm not familiar with the precedent around that. But I ditto Dr. Chapman's feedback and response to that.

One thing I do know is that we will, as staff, be very, very resourceful with our ability to engage with each of you as we, leading up to this meeting, had one-on-one interviews and multiple correspondences for us to be able to flesh out even the framework that you guys have fleshed out even further over the last two days.

So we're gonna be very flexible, obviously, within the parameters that we have as staff to just continuously engage you throughout this process, as we advance a strong draft to agency, full review.

So that's the part of the process that I know we won't, you know, compromise. And once again, we're looking forward to getting that additional feedback that you will from your stakeholders. But the time line is still a prerogative of the Advisory Committee.

TAMU NOLFO: And, Dr. Lu, you asked how you might be able to help us. I would say that when I reach out to you, if you have -- if you can make time within your schedule for some interview time with me, that would be wonderful. I know that I was able to speak with some of you prior to the meeting, but I wasn't able to speak with everybody.

SANDI GALVEZ: I'd like to ask Legal -- so if the -- can we individually each give input to each of the -- all the goals and strategies that will be, as of yet created, can we each do that and still abide by Bagley-Keene?

KATIE BELMONTE: So, Bagley-Keene would prevent you from discussing with one other your opinions or having an intermediary such OHE, you know, expressing what one OHE member advised to the other. But one-on-one conversations, you know, with your constituents, with the OHE staff is fine. It's problematic if you broke back into -- what you're, essentially, would be proposing to do was break into subcommittees -- and that would be subject to Bagley-Keene again. So that probably won't work for your time frame.

TAMU NOLFO: But I can conduct individual interviews with them to get their feedback?

KATIE BELMONTE: As long as you're not, you know, conveying the others --

TAMU NOLFO: Correct.

KATIE BELMONTE: -- opinion.

TAMU NOLFO: Right.

SANDI GALVEZ: And then the synthesis of that information needs to be made available for public review.

KATIE BELMONTE: Correct.

SANDI GALVEZ: Which is going to be proposed is going to happen at our next meeting in May, what date?

KATIE BELMONTE: Generally that would be done in a special way where it would be posted as materials on the agenda for the public to view.

RON CHAPMAN: So, wait. Don't go yet. So I know under Bagley-Keene to form a subcommittee with the maximum of two members; right?

KATIE BELMONTE: Correct. Well, you can form any subcommittee, but if -- as long as three or more --

RON CHAPMAN: Three or more, then you follow Bagley-Keene.

But if there's two, then you don't --

KATIE BELMONTE: Correct.

RON CHAPMAN: -- have to follow Bagley-Keene.

KATIE BELMONTE: Yes.

RON CHAPMAN: So there are whatever, eight boxes. Is it possible to form a subcommittee of two members for each of those A through E?

KATIE BELMONTE: That's a little complicated. I would need to check back with my legal office on that.

SANDI GALVEZ: Linda.

LINDA WHEATON: I'm not clear on what the actual formal, the length of the review period would be.

TAMU NOLFO: The administrative review period?

LINDA WHEATON: No. The public review period. So if this is, especially for processes where authentic engagement is, you know, our plan is all about community engagement, so surely we will -- I mean, in representing from the Health in All Policies Task Force State Departments where we have very strict public comment periods that typically would never be less than 15 days, more commonly 45 to 60, the length of a public review period on something going to the legislature is very important to us. So I'm not clear right now what that would be.

SANDI GALVEZ: I mean, it seems to me if it's not going to be available until -- for public review until our next meeting, there has to be then an extended period of time after that meeting for there to be effective public comment on it, beyond just us looking at it that one day in May.

TAMU NOLFO: So the information that I received is that as a legislative report that is due on July 1st, that takes ten to twelve weeks to move through the administrative process, that essentially this is the public review.

LINDA WHEATON: But there's no draft. I mean, the public needs to review a draft. There's not yet a draft that's going through the administrative review. Someone could easily challenge what's going through is not what ultimately goes to the legislature.

JAHMAL MILLER: This is Jahmal, Office of Health Equity. In the mandate it -- it really provides guidance around decision-making and collaboration of the Advisory Committee. In the mandate is not -- I don't recall there being language that says public comment; like for instance, we have our CRDP, which is independent of this, that strategic planning process hardwired into that effort is this public comment period for full transparency dating back to the September meeting, which is why we want to come back next week to ask the revised time line based on some additional research. The meeting we had in September last year had the July 1 date pretty much as our date, when the strategic plan would be done. But still subject beyond that, there was an opportunity for there to be public engagement and comment and vetting. And also to allow for any opportunities for any amendments. We're still trying to research, kind of, the origins of that September date that that was in the original time line shared in September. Because it's not -- the only the date that's in the mandate is July 1 that says when the report is due. So it's -- we just need to do some research internally as to, kind of, the history and the origin. I agree with you with respect to the opportunity for public comment. But once again, I mean, in black and white, it says July 1. But totally hearing you, I want to go back and do some research. And one or the other we'll get clarity as to what we actually need to do and to also explore, you know, what are the alternatives for us to remedy this tight window that really none of us asked to be placed within.

SANDI GALVEZ: Jeremy, you have the mic.

JEREMY CANTOR: So -- and this is, obviously, very concerning to all of us. And one thought, maybe as part of that research is the extent to which we can -- Dr. Chapman even mentioned in everything that this is not a final product, but there being a process. And we actually delineate the process moving forward. So this may be is the initial framework, but there's going to be -- but the extent to which we can actually build -- I just can't see going to constituents and saying, either, Sorry, you missed the meeting in March and the plan's made; or saying, You have, you know, three days to comment on something.

So I -- just thinking about how we build in some more robust -- give people a sense that this is before we -- in the next year somehow there's going to be some, you know, opportunity for that genuine robust engagement. We understand, you know, the people will understand the restrictions we're under.

Another thought is to do something -- this is not so much for the public engagement, but our engagement, is to do something web-based in April. Potentially maybe you send out a draft to this group to look at, and then we all have

a chance -- or on the web -- it can be open to the public, where committee members get a chance to respond and the public as well. So you don't have to deal with the logistics of trying to get us all together in -- you know, maybe I think a two-hour webinar could potentially work as a way to get things put together.

TAMU NOLFO: I actually asked Legal if we could do something like that -- correct me if I'm wrong -- but I was told we would have to have staff at every location where you were.

JEREMY CANTOR: Even if it's web-based?

TAMU NOLFO: It would be considered a teleconference.

JEREMY CANTOR: Anybody can come to my office. I mean, potentially we could do regional. But at any rate.

And lastly, I support Pat's idea.

RON CHAPMAN: So, I mean, Bagley-Keene applied -- I'm thinking about your idea here. And I'm thinking back to an agency call, stakeholder call, I had with the secretary talking about our CalSIM state inpatient model proposal. We had 1,000 stakeholders on a call. It was unbelievable. And it was two-hour webinar.

I mean, there's a difference between convening this Advisory Committee under Bagley-Keene and Office of Health Equity having a two-hour webinar for stakeholder input. Right? That doesn't fall under Bagley-Keene.

So, you know, if you all are convening a call and then that doesn't fly; right? She'd nodding her head "yes." So Office of Health Equity --

KATIE BELMONTE: Yes. There's nothing opposing the Office of Health Equity running their own, you know, public forum on the webinar to solicit public comments.

TAMU NOLFO: So one of the ideas that we have had -- I'm glad this is coming up -- is to actually to do teleforums. And so that is altogether possible. I've had teleforums myself in order to engage communities. You can call tens of thousands of households within a few minutes. And essentially it's like participating in a radio show, where you can listen in to what's being discussed; you can also use your keypad to, kind of, vote on things like if you were given options around priorities and questions and what you would be most likely to be involved in or that kind of thing. You could use your keypad to indicate that. You can also use your keypad to indicate that you would like to come on the line and speak with the person who's moderating or with a panel that's on. And so that is one way to engage large

groups of people at one time. So we could think about doing that. It would just need to happen at a clip.

SANDI GALVEZ: At a clip?

TAMU NOLFO: Meaning, very quickly. Because the process that we're on -- and I mean, you can pull together one within a couple of weeks. But it's also looking at Who are you calling? Where are you getting those phone numbers from? So traditionally you get them from like voter registration lists. And maybe you do a particular county or a particular region or whatever it is that you want to do. Most people are not going to stay on the phone. Those who are interested will stay on the phone. It generally excludes people who have cell phones, as opposed to land lines, unless you specifically have permission to call their cell phones.

If you do have a database of phone numbers where you have agreement from those folks that it's okay to contact them and you can utilize them, so right. So there are issues that are certainly involved with doing it, but that is a possibility.

SANDI GALVEZ: Okay. We can discuss in a minute whether that's a viable option.

I did want to read to the committee what the language says related -- in our statute related to this plan.

The plan is due July 1st: "Shall be developed in collaboration with Health in All Policies Task Force" -- which I'm not sure how that's happening at this point.

"It shall establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of the strategies." And then it needs to be (inaudible) periodically and what have you. And it needs to be -- "it needs to seek approval from the public on the plan through inclusive public stakeholder process."

So that's what the legislation says about this plan needs to be developed what needs to be in it. So I just wanted to share that information with you all from our discussions.

Dexter.

Yeah, Rocco. Our phone line has been disconnected. We need stop the meeting to --

ROCCO CHENG: For one minute.

SANDI GALVEZ: For one minute to reconnect that line. So patience, please.

(Recess taken.)

SANDI GALVEZ: I would like to advise anybody from the public that would like to speak to this, please prepare a card and send to to us.

(Meeting reconvened.)

SANDI GALVEZ: Are there any members of the public that would like to speak to the issue of --

Are there any members of the public on the phone that would like to speak to the issue of the time line, the abbreviated time line of the plan and the process that we have been discussing for any more input into the planning before it goes to the legislatures?

Okay. Thank you.

Dexter, you were next.

DEXTER LOUIE: Thank you. Dexter Louie. I'm reading over the statute. And as I read it, there are three sections that we are trying to work through in order to deliver this product. The product is this plan. And the product comes from OHE. It does not come from the Advisory Committee. It says here that "OHE shall seek input from the public," which is what Sandi said, and which has already occurred.

Second part is, the report -- "first report is due July 1st."

Then the third part, the very last page section F, which Legal would have to help interpret, "Office of Health Equity shall establish an Advisory Committee to advance the goals of the office and to actively participate in decision-making."

We've had four days of active participation in what might open OHE's plan, not advisory plans -- not Advisory Committee's plan. I see nowhere here where Advisory Committee has to say, Oh, this is good enough to send in. It doesn't say that. It says Advisory Committee participates, and there is public input. So it's still OHE's plan.

Legal, I don't know if "actively participating in decision-making" means we have to say vote it up or vote it down. I don't see that.

KATIE BELMONTE: No. The Advisory Committee's role is advisory in nature. It's ultimately the statutory -- of the statutory mandate is for the Department of Public Health to make the final determination as to the strategic plan and to issue it.

So you're providing input in the decision-making; you have been. And I think there is a separate provision -- I don't have the statute in front of me -- that -- that also talks about this Committee's role in providing feedback to -- for, I think, the strategic plan needs to be amended every two years and updated.

DEXTER LOUIE: Not less than every two years.

KATIE BELMONTE: Yeah. Not less than. And then part this Committee's role would also be providing input in that as well.

SANDI GALVEZ: Yes.

DEXTER LOUIE: So I think that there is nothing to prevent OHE from putting together its report to submit on the date that it's due. At least I don't see it.

JEREMY CANTOR: Right.

SANDI GALVEZ: Well, there's also nothing prohibiting us from requesting an extension of the Advisory Committee to the plan. I think the question is: Do we think that the process has been inclusive enough? And also, given that the plan has to include much more than is currently in the plan, is the public going to have opportunity to give input to that? So I think that's kind of a question to consider.

Patricia, do you have your card?

PATRICIA RYAN: Yes. Yeah. So I'm struggling to figure out how to best make this work. But I think everybody who is sitting around this table feels morally obligated to be as inclusive as possible in soliciting meaningful input from the public.

And at this point, I don't feel that the public has had -- had the opportunity to -- to provide meaningful input to a plan. Because there hasn't been anything really to respond to or to provide input to.

And I don't -- and I don't feel like I've had anything, to date, that I could share with other constituencies that I am here to -- to try to represent, to allow them to have input to the Advisory Committee OHE process.

So, I just sort of feel like, even though we could figure out some way to argue for how we -- how OHE complied with the letter of the law, I'm not sure that I would feel comfortable with whether we complied with the intent of the law and the intent of the Advisory Committee. And I'm not, in any way, trying to say that the Advisory Committee should be responsible for writing the plan. That is the

responsibility of OHE staff. Our goal is to be advisory. But I sort of feel like we can't do our job fully without having a little bit more time to flesh this out a little bit more and get maybe some additional input to something in writing that could be shared with people before you share something with the legislature.

And so to that end, I guess I would like to make a motion that we -- that we take a position in support of asking the legislature to allow maybe an additional month. I'm not sure what the amount of time would be to help provide and help us to do a better job and you to do a better job of soliciting public input to this process.

And, you know, having been involved again with a lot of stakeholder processes and knowing in the past how many, many state departments have not complied with deadlines for submitting reports, it would not be the first time that a state department didn't comply with a hard deadline. And if you have the support of the Advisory Committee that's here to help you do the best job you can, hopefully that will give you a little bit of extra breathing room and support for the legislature and the staff that you would have to be talking to.

SANDI GALVEZ: If there's a motion, can we discuss it? Or do we have to discuss it before there's a motion?

DEXTER LOUIE: No. She had made a motion --

SANDI GALVEZ: So now we can discuss it.

DEXTER LOUIE: Correct. As long as (inaudible).

SANDI GALVEZ: Okay. Discussion?

DEXTER LOUIE: She cannot withdraw. You can only amend it --

PATRICIA RYAN: Does it need to be seconded, though?

SANDI GALVEZ: It doesn't need to be seconded.

Discussion?

Linda.

LINDA WHEATON: I would suggest that -- she mentioned a month. I think, given the summer or whatever, it would be longer than that. Besides, August 1st the legislature is on recess anyway.

So I would think I would leave it to the discretion of the Office of Health Equity to decide the time frame, but the main objective should be adequate time for complete review, certainly by the members of the Advisory Committee and the

public before a plan goes through the Governor's office for transmittal to the legislature.

SANDI GALVEZ: Any other comments?

DEXTER LOUIE: Dexter Louie. I would speak against the motion.

I believe that notwithstanding the issue of intent versus spirit of the law, is that there is a date that's been posed. We can ask for a postponement. It may or may not be forthcoming. I doubt that it's going to be forthcoming. And we will be facing the same issue again.

I believe that the statute indicates that OHE is responsible for coming up with a plan with or without our final approval. We've had our input.

So I would speak against the motion.

SANDI GALVEZ: Alvaro.

ALVARO GARZA: So I -- I speak in favor of the motion.

I think we should make some effort to extend the time where we can all feel that we've done a good job. Good enough job. And it still doesn't feel like it's good enough. Certainly not in another month or so, much less in two weeks.

So if we like to even want to extend that from one month to two -- I mean, the OHE has the resources and you'll have to decide. But we -- you have to, I think, recognize our time limits as well that it's really hard for some of us who have a lot of other obligations to take time off, time off for these meetings and so on. But we're committed. And I'm committed, for sure, to do as much possible.

But so far, it's still not good enough. And if it goes into July or August, it might be what we need.

And it's just a question, if it's not out of order, I recall hearing -- maybe in the first meeting or second meeting, that once it's given to the legislature in July, if it's July, that it goes to the public for some time period for some input. Did I hear that's changed now?

JAHMAL MILLER: So the week before I started in September, the first Advisory Committee meeting, the time line that -- the office that we shared, had the most consistent date that I'm familiar with, particularly learning about the office and the mandate is July 1st.

And what I articulated earlier is wanting to research the origins of the September; there's a September date --

ALVARO GARZA: Right.

JAHMAL MILLER: -- that shared. And we still haven't really been able to put our finger on, kind of, where. So in an ideal world, if we were complying with the July 1 date, based on that original time line, like that summer month, like up to 60 days or so, will be that period to where pretty much the final report is done. It's done. But it's out there for public review, public comment; and then that September 1, it's like -- I'm going to have to re-read through something, but I've seen -- aside from that time line, I may have seen the September date. And I think even with -- within that time frame, if the process is allowed, you know, to move forward within that time frame -- I mean, that seems to be the most reasonable. But just based on what's here, September is not in there. I'm trying to be compliant with that July 1.

SANDI GALVEZ: We do have one comment card from someone in the public. Dalilia -- I'm sorry, is Beth still here?

SIEK RUN: No. She's asked for you to read it.

SANDI GALVEZ: Okay. Statute -- this is from Beth Malinowski from the California Primary Care Association. "Statewide" -- statutes aside, I would agree with statements of advisory members that this process was not sufficiently -- has not sufficiently included stakeholders. This plan, ideally, will have statewide implications -- something -- across all sectors should be -- organizations across all sectors should be engaged with; work with other departments stakeholders lists to do this. That is the public comment.

Any other?

Delphine.

DELPHINE BRODY: I also just want to speak in support of Pat Ryan's motion.

I think that even though it's true that the legislature may simply override any request we make and say July 1st is it, there's no extension, I think that it's still important, based on the principal of this decision of -- of all of the stakeholders who are impacted by health inequities that we do our best to try to include them and -- and to meaningfully and authentically engage the stakeholders who are directly impacted.

So that's why I support the motion.

SANDI GALVEZ: Pat, before you go, if we're gonna think of a date, and I think Rocco and I were discussing we propose October 1st, we think, if we have our

meeting May 12th and 13th, that would still -- I'm assuming that at the end of that meeting we, at least, felt that we would have had a chance to give our input; that that would still provide two weeks in the month of May for public input and then ten to twelve weeks after that for the internal process that needs to happen once the public has had a chance to actually weigh in on the actual plan that is being proposed before the Board. So that's, you know, we wanted to add that to the discussion. That October 1st, if we were gonna ask for an extension would be an appropriate date.

Patricia.

PATRICIA RYAN: So I think based on what Jahmal said, it's -- it's critical that we understand what the language is in the statute. Because if there really was a plan for us as Advisory Committee members to advise you on an outline to submit to the legislature by July 1st, and then go through a public comment period, which would be a three-month public comment period -- two month, I guess --

ALVARO GARZA: Three. End September.

PATRICIA RYAN: Okay.

FRANCIS LU: Can we find that out now --

PATRICIA RYAN: -- however long, whatever the statute says. I think it would be helpful to find that out, because I think that if that was the intent, then that is -- that makes sense, you know, an outline where we've given our best shot at providing input, we'll have another opportunity before it goes to the legislature. The Advisory Committee has done it's work, because, you know, in a limited way, shared the information with whoever our constituencies are. And then there is a proper period for the public to -- to have input and for you to do some kind of a stakeholder process with the public.

TAMU NOLFO: The research that I did looking into this was that the July 1st date was actually the final product that was -- that was it. So I mean, we can continue to dig further, but that was the information that I got.

SANDI GALVEZ: Just I want to clarify once again the statute reads -- "the plan needs to include" it goes to the legislature July 1 -- "needs to include established goals and benchmarks." It's not an outline; it's the actual full-filled, full plan that needs to go before the legislature on July 1st.

Neal.

NEAL KOHATSU: I agree with all the comments.

I'm speaking in favor of Pat's motion about the need for stakeholders.

But I would just go back further just to today's process. The extent that -- and I was only in one work group, and I had interaction well others. The extent that we reworked -- and I commend the staff for doing all that work to prepare it -- but we're talking about impacting every sector of California schools, healthcare, jobs, employers. So just to even do the plan, I'm not even getting into stakeholders, but the opportunity to gather the proper information and identify and create the plan, I would say OHE needs to be given that opportunity. And I would add on, all the stakeholder input.

I'm I -- I'm in the healthcare sector as Medical Director of Department of Healthcare Services. And just so we could cover the areas, I stepped aside from D. So I, you know, just on creating -- helping them get that interaction, which is part of our role of the Advisory Committee. So I'm saying for two reasons; we need more to develop the plan. And then, you know, we've been focusing primarily on the time for engagement. But I would say just in the process of getting all the information together to develop the plan that would also speak to a fall deadline.

SANDI GALVEZ: Kathleen.

KATHLEEN DERBY: I'm also in favor of Pat's motion. And I just wanted to mention that I have to leave now. So I don't know if we're getting close to voting but I wanted to make sure you still had a quorum.

SANDI GALVEZ: Yeah. We're about to lose quorum.

So does anybody else want to speak to this or are we ready to take a vote.

ALVARO GARZA: Call the question.

SANDI GALVEZ: Pat.

PATRICIA RYAN: Well, my motion was -- was a month. And I think I would like to suggest or amend my own motion to make the date or deadline be extended to October 1st.

SANDI GALVEZ: So the motion on the table is to request a formal extension to October 1st to turn in the plan.

All those in favor? A show of hands.

ROCCO CHENG: 13.

SANDI GALVEZ: All those opposed. Any abstentions?

Have to figure out whether Rocco and I need to write something as Chair and Vice Chair, or if we just -- that's the message I wanted to deliver that the Committee has voted, that this is what we want to do.

The second order -- question I want to ask, so there is this issue on May 12th, that --

DEXTER LOUIE: The floor?

SANDI GALVEZ: Yes.

DEXTER LOUIE: I guess that request is a request that you make of OHE to ask for an extension. I don't believe we have the power to ask for an extension because we're only advisory to OHE.

So OHE may or may not take our advice, depending on what they find is the requirement that they need to come up with something.

Now, for those of who have been through the strategic planning processes, you know, it's never good enough. You just keep working on it until it's perfect, but you never get around to doing anything.

That's just a personal aside. Excuse me.

SANDI GALVEZ: Yes. I think that that's why we need to get further information how this request gets made. If it's -- how the request gets made. Take that advice from legal, how. But, the will of the group is that this request get made?

ALVARO GARZA: Yes.

JEREMY CANTOR: Right.

SANDI GALVEZ: So related to May 12th, how many folks from the Committee would not be able to attend May -- we're planning on going to this advocacy -- sorry, May 13th Advocacy Day. How many people would from the Committee would we miss if we had that date still on.

ROCCO CHENG: (Indicating.)

SANDI GALVEZ: So for sure, you know that they wouldn't be here? Or we just don't know because they're not here now.

ROCCO CHENG: Most likely they will not be here.

SANDI GALVEZ: Is there any input that can be made to see if we can find a two-date time around those dates that doesn't include May 12.

FRANCIS LU: May 13.

SANDI GALVEZ: Sorry. May 13th. Does not include May 13th. Maybe the 11th and 12th. I don't know if that.

DEXTER LOUIE: Mother's Day.

SANDI GALVEZ: Dexter.

DEXTER LOUIE: Just point of information, you know, we have a quorum. We have 24, 25 members. We have several absent already. So what's the critical mass that we're making this change?

SANDI GALVEZ: I think it's more than just a quorum issue. It's like, if we're missing an entire, kind of, representative group of the Advisory Committee, to me, that's problematic. It's not just a random, you know, group, you know, number of people that wouldn't be here, but a specific interest group that wouldn't be here. And I don't think that that's reflective on the body --

Francis.

FRANCIS LU: Right. So again, the staff might consider finding two other days. Another idea, possibly, might be, you know, to have an evening session on that 12th, especially if some of the people are going to be staying here in Sacramento anyway, is maybe have an evening session as another alternative.

SANDI GALVEZ: Is that allowed by Bagley-Keene if we do it in the evening? Is that fine? Would that be any problem?

KATIE BELMONTE: I don't know of any requirements for timing, as long as we're, you know, making a -- accessible to the public and noticing it within ten days.

SANDI GALVEZ: Okay. We will explore. Thank you, Francis. I think that's an option we can explore.

Are there any other issues that the Committee wants to discuss before we adjourn?

JAHMAL MILLER: So, thank you for last two days.

I want to thank again our staff for really working so diligently for the last two days and leading up to this meeting.

I thank all of you who for making yourself available to talk specifically with our newest team member, Tamu.

I think without the adjustment that we made, without the advice we received from Sandi and Rocco and many of you, I don't think that the last two days would have been as productive as they are. And, you know, speaking objectively in my Office of Health Equity position, when I think about possible compromises to the date, there's really only one reason. Because I'm gonna stick with the deadline. And there's really only one reason that I would want those of you to entertain addressing the deadline issue, and that's really being very sensitive to the issue we talked about stakeholder engagement. Because technically, yes, we can check the box off as far as what we've done to this point, as far as engagement and things of that nature. But for us to do it right, especially spearheaded and driven our advisors, that means a lot. So I thank you guys for that as well.

Sitting confirmations are coming up in April or May. So I really appreciate your role that the Advisory Committee has played into this point, once again to advance this strategic framework. I know we have something of great substance to be able to provide updates in the upcoming meetings that we have in preparation for that.

So not to sound cliché, but I really appreciate you guys and the hard work that you bring in the four -- six days that this group has assembled. So thanks.

RON CHAPMAN: Ditto. And thank you, and have a great evening. Thank you.

SANDI GALVEZ: And I guess I just want to say sentiments that are coming from the group, and we will definitely do our best as we -- since we can legally can -- the two of us -- speak with staff repeatedly and, you know, and work together to make the next meeting together as productive as possible (inaudible) and bringing back that spirit to our conversations.

Did you want to say something?

ROCCO CHENG: Just wanted to ditto all the comments. And I want to say thank you to all the Advisory Committee members for your dedication and stamina in the way that -- two long days that very heavy discussion exchange of ideas. Before this meeting could happen, a lot of work has been done by the OHE staff, including Connie's team, Marina's team, and a lot by Tamu by interviewing everyone. So thank you everyone.

And also, I would like to say thank you to our Madam Chair for hosting -- holding the meeting very effectively. So thank you.

And also the public for giving us your perspectives so we know that there's always someone observing, participating, and watching this process.

SANDI GALVEZ: Ditto.

So with that. I'll call the meeting to an end.

Thank you. Very much.

(The meeting concluded.)