

CALIFORNIA MHSA MULTICULTURAL COALITION (CMMC)
Monday, March 25, 2013
9:30 A.M. – 4:30 P.M.

California Primary Care Offices
 1231 I Street, Suite 400, Sacramento, CA 95814

Jim Gilmer & Russell Vergara, Co-Chairs

GROUP MEMORY

Introductions

- **CMMC Members in Attendance:** John Aguirre; Michelle Alcedo; Rocco Cheng; Crystal Crawford; Viviana Criado; Jim Gilmer; Nga Le; Beatrice Lee; Jessica LePak; Gustavo Loera; Yvette McShan; Poshi Mikalson; Raja Mitry; Emma Oshagan; Christina Quiñonez; Mari Radzik; Perry Two Feathers Tripp; Russell Vergara; Gwen Wilson.
- **CMMC Members on Conference Call:** Jamila Guerrero-Cantor.
- **CMMC Members not in Attendance:** Sergio Aguilar-Gaxiola (Lina Mendez attended); Ahmed Ahmed; Leticia Alejandrez; Jack Barbour; Janet King (Kurt Schweigman attended); Jean Melesaine Leasiolagi; Masa Nakama; Gulshan Yusufzai.
- **Introduction and welcome:** New CMMC member Stephen Garrett.
- **Staff:** Stacie Hiramoto; Sandra Poole; Monique Pernell.
- **Visitors:** Sally Douglas Arce; Marina Augusto; Kimberly Knifong; Ricardo Moncrief; Alberto Erikson; Peter Best; Ruben Cantu; Vanessa Saavedra; Chris P.

Staff Updates/Announcements [Tab #1]

- From Stacie Hiramoto: Note content of meeting packet, which includes meeting calendars, decision-making process and conflict resolution materials, and rosters for leadership, committees, members and emerging leaders.
- From Sandra Poole: Request for members' bio information from whom she hasn't already received information.

Dec. 13-14, 2012 CMMC Group Memory & Summary and Evaluation Review [Tab #2]

- No changes or comments.
- Narrative evaluation report (deliverable) regarding December meeting handed out.

Update on the California Reducing Disparities Project (CRDP) [Tab #3]

[Report from Marina Augusto and Kimberly Knifong, Office of Health Equity (OHE)]

- Thank you for the opportunity; a lot has happened. We will provide you with much of the talking points and links that are on the web, including the six month report.

Status of consolidation:

- In July 2012, three offices consolidated into the Office of Health Equity (OHE): the Office of Multicultural Services (OMS), the Department of Mental Health (DMH) and the Office of Women's Health.
- These encompass large constituencies and stakeholder groups with concerns about health. Also included is responsibility for the Health for All Task Force and the Healthy Places Team. The California Department of Public Health (DPH) has over 200 programs.

- The functions related to county cultural competency plans moved to the Department of Health Care Services (DHCS).
- Although not responsible for that function, we are committed to that work and ensuring that plans remain intact.
- Monica Glass and Shawn Leslie met with OHE in a technical advisory capacity.
- Mandates for OHE arise from an interagency agreement with DHCS.
- What is the goal/role for OHE? What changes are there?
 - There are challenges related to the broadness of scope (noting that the statute that defines vulnerable populations includes the language, “not limited to...”);
 - There will be strategizing and promotion;
 - A goal of the highest level of health and especially mental health for those who are socially/economically disadvantaged and geographically isolated;
 - Encompasses the Health for All lens and recommendations;
 - To serve as technical advisors to other departments and look at disparities, which is a huge task for a small staff.
- Mental health is new to DPH – we are having to remind them of mental health and whole health; we are continually being advocates.
- What about money moves? There is a money and resources budget of \$19 million with seven different funding sources; the majority is MHSA (\$15-17 million) for CRDP; minimal funds to serve via DPH; we are restricted in what we can do.
- OHE has three units:
 1. Community Development and Engagement Unit – where OMS went, which is involved in a lot of work related to engaging constituent groups, stakeholders and many organizations, all of whom have high concern that priorities will fall through the cracks; it is involved in high level meetings with DPH; we don’t have our advisory committee formed yet so this work is helpful to us in broadening our perspectives, too;
 2. Policy Unit – Health for All Task Force and climate change policy work; climate change and adaptation – air quality focus;
 3. Health Research and Statistics Unit – this is exciting because of concerns regarding data; we are looking forward to looking at what is out there and influencing how data is obtained (questions, etc.).
- A deputy director will be hired.
- We are at a 50% vacancy rate so our emphasis is on building infrastructure and hiring.
- There was some attrition with the consolidation and there are some difficult classifications to fill; our focus is on background in mental health and cultural competency.
- Recruitment (started in August 2012) for the deputy director included a stakeholder process, previously part of advisory committees; all candidates are screened and then go before panelists that include community-based organizations. We are down to the top two candidates; the process then goes to DPH leadership. We anticipate a decision by April and then the recommendation goes to the governor’s office.
- Why so many levels of review? It is a governor or state health director appointed position (the fourth appointed position).
- There is another layer of interviews at the governor’s office (to be determined) and the position must be confirmed by the senate, which could be a year; the appointee would come on board but just not be confirmed.

- Another OHE mandate is the development of a strategic plan – data, efforts, priorities, etc., with development guided by the advisory committee.
- Regarding the advisory committee – 180 applications are being reviewed and 20-25 members will be selected; the final selection is up to DPH leadership.
- OHE is still responsible for CRDP, the translation contract and contract, and some other contracts with allocated funds but not RFPs (requests for proposals).
- The California Health for All Task Force works with more than 18 state departments on social determinants to health: affordable housing, environmental design, access to healthy food, safe streets, etc.
- There is a lot of policy work.
- We are also looking at ways to address issues through RFPs and RFAs (Request for Applications) and how to determine them.
- We are working closely with University of California-Berkeley.

CRDP:

- Discussion later today about the status of the CRCP Strategic Plan.
- Background:
 - CRDP was developed by DMH to elevate community best practices from a grassroots perspective;
 - Five SPWs (strategic plan workgroups) were formed to function for two years at the grassroots level and get input on community-defined practices;
 - The work of these groups resulted in five population reports, which are mostly complete and posted on the OHE website (all except the final, final Asian/Pacific Islander report);
 - The stand alone reports go into the broader statewide CRDP strategic plan as a roadmap/blueprint to reduce disparities.
- We are not well resourced for such a complex effort; we realize the shortcomings but also it is one of the largest investments for racial, ethnic, multicultural communities in the nation.
- The counties would have liked to have worked hand-in-hand more, as well.
- Many deliverables depend on others, which was intended but causes challenges.
- This new model – bringing community voices in and linking partners – occurred with the DMH/OMS transition in the midst of it all.
- All contracts except CMMC were to be done December 2012. The SPWs and facilitator/writer (of the plan) wanted to continue with more time to complete deliverables, so we have done a no-cost extension and we are looking at other resources to pull forward to completion.
- We went to DPH with requests, including more dissemination of reports to other arenas. We are currently working on attaching funding to do so once the CRDP strategic plan is fully complete and vetted.
- We also brought on a public health medical officer for about three months, who reviewed everything and conducted key informant interviews, and gathered additional information for Phase 2 roll out.
- We developed schema for what the roll out would look like – a framework for moving forward and to take to the communities for input.
- There is a team of nine – the department, legal, a contracts person, 2-3 cultural competency consultants – for writing RFPs for the next phase.

- Timeline? Can't go out with the framework until the CRDP strategic plan is done, after the thirty-day public comment period and any necessary changes.

Questions/Comments:

- Regarding health as the focus, isn't there an intersection between concern about health and mental health and where LGBTQ fits? I have a problem with California Multicultural Training. Answer: We are working with the research section's Healthy People 2020 regarding disparities and prevention of chronic disease; we are concerned about data that is not collected for the LGBTQ and other populations, and influencing data collection, gaps, and surveillancing.
- The Intertribal Council of California and California Rural Indian Health Board: the federal Office of Mental Health came out and did a training/briefing on proposed changes to class standards (15); this was put out directly to lots of state and Tribal agencies regarding what we're trying to achieve.
- Regarding CRDP's need for funding and how it is dispersed, there is very little time to consider and give input regarding future RFPs; is there a direct contact to improve communication? Answer: Regarding the quick turnaround, there is another opportunity to provide feedback during the thirty-day public comment period; comments go directly to Ruben; Ruben will present to DPH, walk through the feedback and seek clarification.
- Two questions: 1) regarding the advisory committee, will it be established in time to influence the strategic plan? And 2) will the strategic plan be out in time for CMMC to review it before the public comment period? Answers: 1) The advisory committee is not established; we are reviewing applications and then the recommendations go to DPH leadership. We anticipate invitations to go out in April. Other groups ask about the role of other groups with the advisory committee and that is in the queue for input from Legal. We don't know the parameters; the chair will be a non-state person and it will meet quarterly. A clarification regarding the formation of the advisory committee: it is not a prerequisite to finalizing the CRDP strategic plan; it is necessary for OHE strategic planning (two different strategic plans). 2) Regarding getting the CRDP strategic plan to CMMC before the public comment period: this is a hot button; DPH is much more stringent – it may need to go to agencies, not first but maybe now; there is no guarantee because of the political nature of CRDP and the \$60 million.
- Who is the legal counsel to OHE? **FOLLOW-UP: Marina Augusto will get that information.**
- Feedback regarding the advisory committee, its formation and the role of CMMC: Is there consideration of all the work done and carryover into populations being served – in lieu of set standards already in place? Is this creating another committee that will offset CMMC's role? Is the advisory committee diverse and inclusive and what is the application process? Answer: The advisory committee is in statute as a result of the push of many constituent groups; I agree with duplication of effort relative to mental health and communities and organizations; this advisory committee will have an inclusive health lens. I meet with leadership weekly; I do not know what interface there will be with other groups.
- Regarding the question related to CBNCS, training is already in existence; that is what is laid out in the budget authority. If you wanted to convene a group to influence the curriculum, maybe use the funding to do so.
- Regarding CMMC's opportunity to give input on the CRDP strategic plan: comments first, then comments to Ruben and then the strategic plan is changed, which is more desirable.

- Regarding the RFP framework, will the public have an opportunity to influence/comment on it? Answer: There will be public vetting of the framework through community forums – that is your time; once it goes back to DPH, the RFPs are theirs.
- CMMC advocates not doing business as usual; had OMG reaction to RFPs in the past. I advocate one more step – allow opportunity to make comments and clarifications to help organizations responding to RFPs for the first time.
- CMMC will get a presentation from OHE regarding the framework.

Discussion on the future of the CRDP: Phase I unfolded with the groundbreaking work of CRDP – the amazing energy and effort that made CMMC accomplishments to date possible. Phase I opened doors, yet is not a magic bullet – there is much more work ahead. In Phase II and beyond, CMMC continues contributing to the boundless potential of CRDP. Phase II offers the opportunity to walk through those opened doors authoritatively as advocates carrying the voices of many communities.

Question for discussion: *Imagining the future in concrete terms, how will CMMC collectively ensure that the work of all CRDP partners continues to coalesce on behalf of all un/underserved/inappropriately served communities?*

- Regarding contractors that have done previous work: does being included in the process pose a conflict of interest?
- Issues regarding California tribes and rural communities include disrespect, not being inclusive, and information being left out related to California Native people.
- Addressing unserved/underserved – there are no legal underpinnings, no definition.
- Using cultural brokers with key relationships with Tribal governments – government to government.
- Very excited about the wonderful work of the five population groups and the opening for other groups.
- I want us to look at other historically underserved communities in the same way.
- Have the same thing in place for emerging populations; there are a lot of Asian/Pacific Islander communities emerging; don't lose structure and responsiveness.
- Look at funding systems and how they perpetuate disparities; specific models.
- I would like to learn about the different groups around the table – history, historical trauma, beliefs, values and practices; it is the best way to ensure coalescence in the future. I want to learn from everyone and contribute to others' education. Emphasize historical trauma and the past; break the intergenerational transfer of trauma and experiences.
- More conversation about social determinants.
- We need to work on the data problem, not just with the Native population but also smaller populations, like Pacific Islanders.
- Emphasis on distinct differences between rural and urban Native populations – rural are without the same resources and urban Natives are invisible.
- Advocate a look at life span issues – specific trauma-related populations we are all serving and the intersection of trauma.
- Understand limited resources; come up with solutions to support DPH and OHE to continue.
- Continue focus on adequate service, not just general evidence-based practices; on culturally competent, community-defined services and treatment.

- We have been in existence for two years – it is time to assess the progress we have made; also have OHE share how they see CMMC within the CRDP context post strategic plan – role and responsibilities in order to ensure strategic goals.
- I appreciate prior comments; LGBTQ is new at the table and inclusive in language; it is important to continue LGBTQ language not subsumed under multicultural category; sexual orientation is different from sexual identity. I would like to see CMMC support more of Phase 1 into other groups – allow more intersection of LGBTQ and other communities; not just look at promising practices – more information gathering and engagement.
- Doors will close without continued community engagement; assess our strategies – make sure they are responsive still as communities evolve. The intersection of identities, including age diversity as well – older adults, LGBTQ populations within ethnic and racial communities, and not just the responsibility of the LGBTQ community.
- Want to look at people who are homeless and parolees; the voice in the community is not their voice – it's the voice of service providers. It is okay to bring voices in that won't access services – they need their own voice.
- I would like CMMC to be an advocate for contract structures for small groups that are culturally competent in providing for their communities; I don't want that to be a barrier. Also, it helps us to think of ourselves as role models – articulate our challenges of advocating for our communities; to role model how to talk about different advocacy issues among our communities; we need to articulate how.
- Also, how do we deal with our own ways we communicate with each other in our advocacy approaches? Nikki King talked in general terms about how to help small ethnic-oriented culturally competent providers without some of the barriers within the state contracting process – an incubator system to support them and get through the difficulties of the start-up process. Public comment came in through the CRDP process; the biggest concern is that we never heard anyone address community infrastructure – eliminating duplication, simplifying the RFP process; we need collective impact to unify activities, create access, etc.
- Who are the CRDP partners in the future? CMMC, SPWs – clarifying roles; how can these ideas be integrated?
- At this juncture, it is important to have a very clear idea of structure, roles and responsibilities in place. There has been underutilization of CMMC that hindered our development; we need to use this group appropriately – how to interact with OAC (MHSA Oversight and Accountability Commission), etc.
- On the macro level, three years is not enough time for CRDP; it leads to marginalization and horizontal hostilities; I want this to stay statewide and avoid competition in communities. There is lots more work; get beyond 1%.
- There is an opportunity to restructure ourselves; opportunity to be part of the population focus as plans get implemented.
- Regarding CMMC being underutilized and focus on SPWs: I hope the SPWs haven't gotten in the way; our work was very different. As we move forward, it's another place for advocacy and to make sure the SPW work and cultural competency doesn't get dusty on the shelf. Identify distinct needs; SPWs add to CMMC and CMMC has to identify important work it can do.
- I like the idea of clarifying the future role. I understand one role of CMMC to determine, by evaluation, how the CRDP strategic plan rolls out and stays true to the vision and the plan. That is still our role.

- Embrace the cultural competency aspect in the work we will do and the importance of embracing different cultures into our meetings.
- Inclusion of teeth in the strategic plan – such as systems to respond. How to integrate guidelines into community master plans?
- There is a lot in the strategic plan that speaks to policy and systems change; CMMC can have a role with transitions and structures. Example: gender lens recommendation from 25 women’s groups to OHE – a very effective document that asked, “Can you do this?” This was good because it gets memorialized and there is follow-up.
- Capacity building – CiMH does it from the county perspective; what role could CMMC do? For community based organizations, support, training, recommendations to help build resources.
- Data components – ideas are welcome from the field.
- Community-defined practices – input, a white paper to inform the state; workforce issues; where are the points of entry for CMMC?
- Building infrastructure – what are different models for RFPs, RFAs that reflect doing business differently? CMMC can be a resource for models.
- What community-based organizations are using to grow community-based practices and what is used for community involvement?
- How can you replicate and sustain models?
- It can’t just be more consultation; provide beyond us; deliberate, concrete steps resourced by CRDP and others can benefit from what we’re extracting from this effort to see how changes are occurring at all levels. Envisioning.
- Who we are and what we are doing; structure of CMMC and public affairs/policy papers. Any possibility of taking CMMC on the road to become more visible and to partner and expand potential for reciprocal information exchange?
- Not quitting until plans are in place.

[Find summary of emerging themes and areas of convergence in meeting summary accompanying these notes.]

Strategic Plan Committee Report [Tab #5]

Strategic Plan status – Kimberly Knifong, OHE:

- Steps and timing: nothing is certain. This is the third review by DPH – more stringent, because of review and desire to be able to stand by the product; working closely with Ruben Cantu. Some revisions just went to the contract monitor.
- The package goes to leadership and may have to go to the California Department of Health and Human Services (thirteen programs).
- There are a few formatting items, probably until this Friday, and edits to DPH; then to DPH leadership with one-day turn around, and then it will be ready to either go to agencies or public comment. There will be an additional 2-3 weeks if there is agency review and edits.

Strategic Plan Committee:

- There has been a committee meeting every week regarding deliverables, the review tool for the strategic plan and developing a review of the strategic plan process for CMMC meeting to include discussing and providing input. Ruben Cantu’s job description in the packet (Tab #5) explains what the plan is supposed to have in it.

- The CRDP strategic plan will be sent with the review tool and a request to return input before CMMC meets face-to-face to discuss the plan. We will send out a meeting wizard to get a meeting scheduled. If you cannot attend, a call-in number will be provided.
- At the review, we will not go over the same questions; new questions will be discussed to achieve consensus. Individual responses will be confidential but the collective response will be from CMMC. It will be critical to review the plan and be ready to discuss.
- ACTION ITEM: Approve deliverables.
 - Feedback – deliverable #3e: add community-based organizations.
 - Page 2 – more details desired by the state – networks, list serves, websites.
 - **FOLLOW UP: How will it happen? Viviana will send a follow-up email request by April 12th to all CMMC members; Jim Gilmer will help.**
 - Indigenous avenues – word of mouth, faith-based organizations.
 - QUESTION: I am wondering about summaries to community folks that are user-friendly; related to deliverables and the strategic plan. How?
 - Dissemination versus promotion – need to differentiate.
 - Put language in there related to county and state website links; require county website links.
 - A kick-off by CMMC – locally responsive; local SPWs who worked on it.
 - Need to leverage resources – dovetail with taking CMMC on the road.
 - RFP needs to allow flexibility and parameters.
 - I like the kick-off idea and internal communicator – for stakeholders here; add intermediate levels of communication; have to check with Ruben.
 - These details are enough; no exact organization but specific media/avenues.
 - Schools and universities to incorporate into curricula.
 - Public comment: submit comments; please be mindful.
 - Deliverable – definitions/distinctions between mental health and psychological health/well-being.
 - What constitutes primary prevention has to be flushed out before entering the medical model.
- **DECISION: Deliverables approved.**

Emerging Leaders Committee Report [Tab #6]

- We have been meeting monthly by phone.
- We are working toward two deliverables:
 1. Arranging a meeting with Rusty Selix about the history of the MHSA act for the Emerging Leaders who are the next generation of influence;
 2. Two components – a module of training either interactive or scholarly (training/shadowing) with funding for travel by car, train or bus; accommodating and helping Emerging Leaders learn about your agency and what you do.
- At the June 2013 CMMC meeting, there will be an overview presentation by Emerging Leaders.
- We are trying to start with a needs assessment; one question will be to get feedback on their experience and needs.
- QUESTION: How will you evaluate the mentor/mentee relationship? Answer: That is coming; mentee self-evaluation is best.
- Need clear focus on what is expected and what is offered.

- It is hard as a mentor without objective goals. Develop the needs assessment, have goals, define a process of what it involves. It is a beginning and the committee has done great.
- Are mentees learning anything?
- Basic: mentors teach how to be an effective CMMC member – prepared, doing follow-up, etc.
- **FOLLOW-UP: Stacie Hiramoto volunteered to pull information together about roles of mentors and convey it in a variety of ways.**
- We don't talk to each other enough – it's a process on both sides.
- There is accountability all ways – mentees to mentor and to CMMC; personal, social and organizational level.
 - We need to ensure that Emerging Leader mentee input is included.
 - Think about what you want as an Emerging Leader – you shape CMMC.
 - Rules and procedures – group decisions about how things are conducted.
 - Focus on what we've done and what we want in the future.
- Initially, meetings were confusing. In the mentor/mentee relationship, I looked to other CMMC members that can help also.

MHSA Assessment & Recommendations Committee (MAC) Report

Report/discussion:

- We are working on our deliverables – State of the State (2) and a special report.
- We decided we needed a writer.
- We did a draft outline of State of the State (2) as a follow-up to State of the State (1) and the writer pulled us back to look at qualitative interviews and to make a list of who to interview.
- We developed categories of populations not brought in.
- Disaggregating data is crucial; I am very hopeful regarding the research unit of the Department of Public Health.
- Regarding the scope of State of the State (2), the goal is to do it by June this year. We hope to provide a model for further communities.
- Some SPW reports flesh out bi-racial, multi-racial communities, some do not.
- We need to decide categories.
- The third category jumps out – and overlaid with the groups listed after the categories.
- We have heard an outcry from CMMC members and their communities.
- Look at risk factors that affect communities and the population growth.
- QUESTION: Are resources available? Answer: We have a contract with the writer.
- QUESTION: What are we doing with the interview information? Answer: Convey the information; it might launch the next phase of CRDP.
- Regarding the special report:
 - A score card for populations we serve
 - Talk about a year three report – at the June meeting
 - Also talk about the dissemination of this material.

MAC Recommendations for the special report: [Non-prioritized]

First page:

- Un/underserved populations not in the first CRDP phase BUT are current CMMC members

- Un/underserved populations not in the first CRDP phase AND are not current CMMC members
- Un/underserved populations from the first CRDP phase (5) BUT could benefit from additional planning resources
- Special “needs”

Second page:

- Russian community
- Armenian community
- Arab community

- Deaf/hard of hearing
- Disabled – developmental and cognitive disabilities, autism spectrum
- Blind

- Rural/isolated urban
- Refugees/immigrants
- Women
- Older adults – aging who do not identify as “older”; aging single; aging single males

Administration Committee Report [Tab #7]

Discussion about deliverables:

- Helpful to have a graphic organizational structure to clarify roles and responsibilities regarding CRDP (dovetail with earlier conversation) and our future vision; evaluate whether we need to clarify.
- **DECISION: Deliverables approved.**

Discussion about forming an ad hoc Public Affairs Committee:

- Ad hoc because no deliverables, no money.
- We request that people on the committee develop policies and procedures for the committee and then bring back recommendations for approval by CMMC members.
- **DECISION: Agreed.**
- There is a lack of clarity regarding what MHSA covers – would the Public Affairs Committee deal with this? More dialogue related to the intent of the act.
- A large part of CRDP is getting branding down; the more we become an orchestra, the more transformational.

Conflict of interest policy:

- **FOLLOW-UP:** Two Feathers Tripp will send information/sample to Stacie by Wednesday, April 17, 2013.

Conflict resolution process:

- **FOLLOW-UP:** Jim Gilmer, Raja Mitry and Betsy Kosier will work on this. Betsy Kosier will initiate with an email to Jim and Raja.

Committee attendance policy:

- **FOLLOW-UP:**

Public Comment

- I recently visited an Oakland school mental health department; they told us that kids now ask for mental health services – a sign of diminishing stigma.

- At a Public Health Association meeting, one facility called The Village talked about raised self-esteem of kids.
- As a federal money recipient, this comes under Title VI protected classes; there may be some synergy there for community-based organizations (how monies can be used/are used).
- From CMMC member: Start thinking about the agenda for the next CMMC meeting:
 - Branding
 - Visioning.