CALIFORNIA MHSA MULTICULTURAL COALITION (CMMC)

IN-PERSON MEETING

Tuesday –Wednesday, June 23rd – 24th, 2015

The Citizen Hotel
726 J Street
Sacramento, CA 95814

Conference Line
(800) 410-3590 Passcode: 7201208

AGENDA for Tuesday, June 23rd
10:00 a.m. – 4:00 p.m.

Co-Chair Russell Vergara
Facilitated by Elizabeth Kosier

10:00	I.	Introductions – Sharing Our Stories – Masa Nakama
10:30	II.	Review Meeting Notes from the Previous CMMC Meeting and Review of the Agenda Brief comments by the Project Director
10:45	III.	CMMC Committee Meetings - The Administration Committee - The Emerging Leaders Committee - The MHSA Assessment Committee - The Strategic Plan Committee Members of the public are welcome to sit in on any committee meeting.

11:45		GENERAL PUBLIC COMMENT
12:00		LUNCH
1:15	IV.	Update on the California Reducing Disparities Project William Porter, Kimberly Knifong, Ruben Cantu? No questions regarding Phase II will be entertained as the RFPs have not been released and the process has not been completed. However, questions regarding the Strategic Plan and general questions regarding the administration of OHE and the CRDP (as long as they are not directly related to procurement) are acceptable.
2:00	V.	Introduction to Toby Ewing, New Executive Director of the MHSOAC
3:00		BREAK
3:15		Presentation on a Special CalMHSA Project by Runyon Salzman and Einhorn – Lisa Smusz, Anna Vue, Cindy Cha
3:45		GENERAL PUBLIC COMMENT
4:00		ADJOURN
5:00		Pictures and Updated Biographies for the CMMC Website CMMC Members are welcomed to stay to have their picture taken for the CMMC website. There will also be opportunities to create or update your biography for the website.
6:00		Dinner

AGENDA for Wednesday, June 24th
9:30 a.m. – 3:00 p.m.

Co-Chairs Jim Gilmer and Russell Vergara
Facilitated by Elizabeth Kosier

8:30		BREAKFAST for CMMC Members
9:30	I.	Introductions and Sharing Our Stories – Poshi Mikalson
10:00	II.	Administration Committee Report Ahmed Nemr – Committee Co-chair
11:15	III.	Presentation by CalMHSA on Phase 2 of Their Statewide Projects – Ann Collentine/Stephanie Welch
11:45		GENERAL PUBLIC COMMENT
12:00		LUNCH
1:00	IV.	MAC Committee Report Michelle Alcedo and Gulshan Yusufzai – Committee Co-chairs
2:00	V.	Strategic Plan Committee Report Viviana Criado – Committee Chair Kathrine Elliott – Staff Consultant
2:30	VI.	Emerging Leaders Committee Report Mari Radzik – Committee Chair
3:00	ADJOURN	

CMMC

CALIFORNIA MHSA MULTICULTURAL COALITION

CONTENT SUMMARY

CMMC

CALIFORNIA MHSA MULTICULTURAL COALITION

MEMBERS

Sergio Aguilar-Gaxiola
John Aguirre
Ahmed Ahmed
Michelle Alcedo
Jack Barbour
Rocco Cheng
Viviana Criado
Jim Gilmer
Jamila Guerrero-Cantor
Shaista Jaffri
Janet King
Nga Le
Beatrice Lee
Jessica LePak
Yvette McShan
Poshi Mikalson
Raja Mitry
Masa Nakama
Emma Oshagan
Christina Quiñonez
Mari Radzik
Perry Two Feathers Tripp
Russell Vergara
Stephen Garrett
Gulshan Yusufzai

LEADERSHIP ROSTER

Jim Gilmer, Co-Chair
California MHSA Multicultural Coalition

Russell Veraga, Co-Chair
California MHSA Multicultural Coalition

John Aguirre, Co-Chair
Administration Committee

Ahmed Nemr, Co-Chair
Administration Committee

Mari Radzik, Chair
Emerging Leaders Mentorship Committee

Michelle Alcedo, Co-Chair
MHSA Assessment & Recommendations Committee

Gulshan Yusufzai, Co-Chair
MHSA Assessment & Recommendations Committee

Viviana Criado, Chair
Strategic Plan Committee

Contact: Stacie Hiramoto, MSW
1127 11th Street. Suite 925. Sacramento, CA. 95814, 916.557.1167

CMMC

CALIFORNIA MHSA MULTICULTURAL COALITION

Member Roster

Sergio Aguilar-Gaxiola+
sergio.aguilar-gaxiola@ucdmc.ucdavis.edu
(916) 703-9211
Racial or ethnic communities: Latinos
Provider of mental health services
Representative of another system: Education

John Aguirre
JohnA@itccinc.org
(559) 280-3864
Client/consumer Family member of a TAY
LGBTQ Communities

Ahmed Nmer**
aahmed@cbhi.net
(916)712-4764
Racial or ethnic communities: Arab/Muslim
Client/consumer Family member of a TAY

Michelle Alcedo
(415) 728-0195 or C (415) 994-3485
michelle@openhouse-sf.org
Racial or ethnic communities: Filipino
LGBTQ Communities: Older adults 60+

Jack Barbour
jmbarbour@earthlink.net
(310) 631-8004
Racial or ethnic communities: African-American
Provider of mental health services
LGBTQ Communities

Rocco Cheng+
RCheng@PacificClinics.org
(626) 962-6168 Ext.168
Racial or ethnic communities: Asian and Asian American
Provider of mental health services
Immigrant/refugee community

Viviana Criado**
viviana.criado@gmail.com
(760) 450-8609
Racial or ethnic communities:
Family member of a senior
Other underserved community: Older Adult

Stephen Garrett
stephenGarrett@victor.org
(760) 245-4695
Racial or ethnic communities: African American
Provider of mental health services

Jim Gilmer+
gilmerj@roadrunner.com
(805) 228-2386
Racial or ethnic communities: African American,
Latino, Filipino, Samoan Faith-based
Veterans/veteran

Jamila Guerrero-Cantor
guerrej2@lattc.edu
(310) 447-4145
Racial or ethnic communities:
Chicano/Latino
Representative of another system:
Community College
Representative of Cultural community:
Deaf and Hard of Hearing

Shaista Jaffri*
najmi_j@yahoo.com
(916) 517-3030
Racial or ethnic communities: Pakistani
Provider of mental health services

Janet King+
janetk@nativehealth.org
(510) 381-2684
Racial or ethnic communities: Native American
Family member of a senior
Provider of mental health services

Nga Le*
ngale08@gmail.com
(916) 261-1123
Racial or ethnic communities:
Representative of system: education
Immigrant/refugee community

Beatrice Lee**
beatricemlee@gmail.com
(925) 323-2489
Racial or ethnic communities:
Asian Pacific Islanders (Chinese)
Provider of mental health services
Immigrant/refugee community:
Asian Pacific Islanders

Jessica Elm
jessica.lepak@gmail.com
(415) 823-9920
Racial or ethnic communities:
American Indians and Alaska Natives
Client/consumer
Representative of another system: Child Welfare

Yvette McShan
yvettemcshan@yahoo.com
(510) 921-1250
Representative of system: Corrections
Racial or Ethnic Communities: African American
Primary Consumer

Poshi Mikalson+
LGBTQmentalhealth@att.net
(530) 908-9755
Provider of mental health services
LGBTQ Communities
Representative of system: Education

Raja Mitry
rmitry@sbcglobal.net
(415) 420-1289 Cell
Racial or ethnic communities: Arab-American
Provider of mental health services: TAY, Adults, Older

Masa Nakama*
mbnakama@gmail.com
(909) 389-8311 text only (Deaf)
Racial or ethnic communities:
Other Cultural community:
Deaf/Hard of Hearing, Late-Deafened, Deaf-Blind, Deaf Plus

Emma Oshagan
eoshagan@pacificclinics.org
(626) 840-9957
Racial or ethnic communities/ Armenian
Provider of mental health services

Christina Quiñonez*
geri_christina@yahoo.com
(323) 378- 8334
Racial or ethnic communities: Latino
Client/consumer/survivor: ex-patient community
LGBTQ Communities: Transgender services

Mari Radzik
Mradzik@chla.usc.edu
(323) 361-4770
Provider of mental health service
LGBTQ Communities Representative of another system: Adolescent Healthcare

Two Feathers (Perry) Tripp
tripp707@gmail.com
(707) 408-2244
Racial or ethnic communities:
California Indians/Native Americans
LGBTQ Communities

Russell Vergara
rbvergara@gmail.com
(714) 914-0305
Racial or ethnic communities/
Asian Pacific Islanders
Family member of an adult
Educator on mental health issues

Gulshan Yusufzai
gyusufzai@gmail.com
(916) 202-0707
Racial or ethnic communities:
South Asian, Middle Eastern
Client/consumer
Immigrant/refugee community

**REMHDCO Designated Representative
+SPW Designated Representative
*Emerging Leaders

PLEASE NOTE OUR NEW PHONE NUMBERS

Staff Contacts:

Stacie Hiramoto, MSW, Director
REMHDCO
1127 11th Street, Suite 925
Sacramento, CA 95814
shiramoto@remhdco.org
(916) 557-0907, Ext. 114

Michael Helmick
Associate Director
REMHDCO
1127 11th Street, Suite 925
Sacramento, CA 95814
mhelmick@remhdco.org
(916) 557-0907, Ext. 116

Alicia Castaneda
Program Assistant
REMHDCO
1127 11th Street, Suite 925
Sacramento, CA 95814
acastaneda@remhdco.org
(916) 557-0907, Ext. 104

CMMC

CALIFORNIA MHSA MULTICULTURAL COALITION

Committee Roster

6/12/2015

Administration Committee

1. Ahmed Nmer – Co-Chair
2. Jim Gilmer
3. John Aguirre – Co-Chair
4. Yvette McShan
5. Raja Mitry
6. Russell Vergara

Emerging Leaders Mentorship Committee

1. Jessica LePak
2. Mari Radzik - Chair
3. Poshi Mikalson
4. Masa Nakama
5. Stephen Garrett
6. Two Feathers Tripp

MHSA Assessment & Recommendation Committee (MAC)

1. Beatrice Lee
2. Christina Quinonez
3. Emma Oshagan
4. Gulshan Yusufzai – Co-Chair
5. Jamila Guerrero-Cantor
6. Michelle Alcedo – Co-Chair

Strategic Plan (CRDP) Committee

1. Jack Barbour
2. Janet King
3. Nga Le
4. Rocco Cheng
5. Sergio Aguilar-Gaxiola
6. Viviana Criado – Chair

CMMC

CALIFORNIA MHSA MULTICULTURAL COALITION

Emerging Leaders Roster

Shaista Jaffri
Mentor, Gulshan Yusufzai

Nga Le
Mentor, Beatrice Lee

Masa Nakama
Mentor, Jamila Guerrero-Cantor

Christina Quinonez
Mentor, Mari Radzik

Mentor, Jamila Guerrero-Cantor

Yvette McShan*
Mentor, Perry Twofeathers Tripp
*Promoted to Regular Member of the CMMC
At CMMC Meeting of 6/17/13

CMMC

CALIFORNIA MHSA MULTICULTURAL COALITION

2015 CMMC MEETING CALENDAR

IN-PERSON MEETINGS

March 25-26, Wednesday-Thursday
June 23-24, Tuesday-Wednesday
September 16-17, Wednesday-Thursday
December 15-16, Tuesday-Wednesday

EMERGING LEADERS CONFERENCE CALLS

2nd Tuesday at am to 9:00am

ADMINISTRATION CONFERENCE CALLS

3rd Wednesday at 4:00pm to 5:30pm

STRATEGIC PLAN CONFERENCE CALLS

3rd Friday at 10:00am to 11:30am

MAC CONFERENCE CALLS

3rd Friday at 3:00pm-4:30pm

RETREAT PLANNING COMMITTEE CONFERENCE CALLS

TBD

CMMC

CALIFORNIA MHSA MULTICULTURAL COALITION

What is the Purpose of the CMMC?

- The CMMC's primary goal will be to work toward the integration of racial, ethnic, cultural, and linguistic competence into the public mental health system.

- The CMMC will provide a new platform for racial, ethnic, and cultural communities to come together to address historical system and community barriers and work collaboratively to seek solutions to eliminate barriers and mental health disparities.

- The CMMC will be a new structure to bring forward diverse multicultural perspectives that have not been adequately represented in the mental health system or in previous efforts to obtain consumer and family member input to improve outcomes in programs and services.

- The CMMC will be pivotal in providing critical insights and assessments of systems (i.e. policies, procedures, and service plans) in moving toward a more culturally and linguistically competent system.

- The membership of the CMMC will provide input to the DPH, DHCS, and Mental Health Services Oversight and Accountability Commission (MHSOAC) regarding mental health policies, programs, and services related to the MHSA.

- The CMMC will work to foster the leadership of individuals from multicultural communities by establishing mentorship opportunities within the coalition.

CMMC DECISION MAKING PROTOCOL

Adopted at 3-21-2012 CMMC Meeting

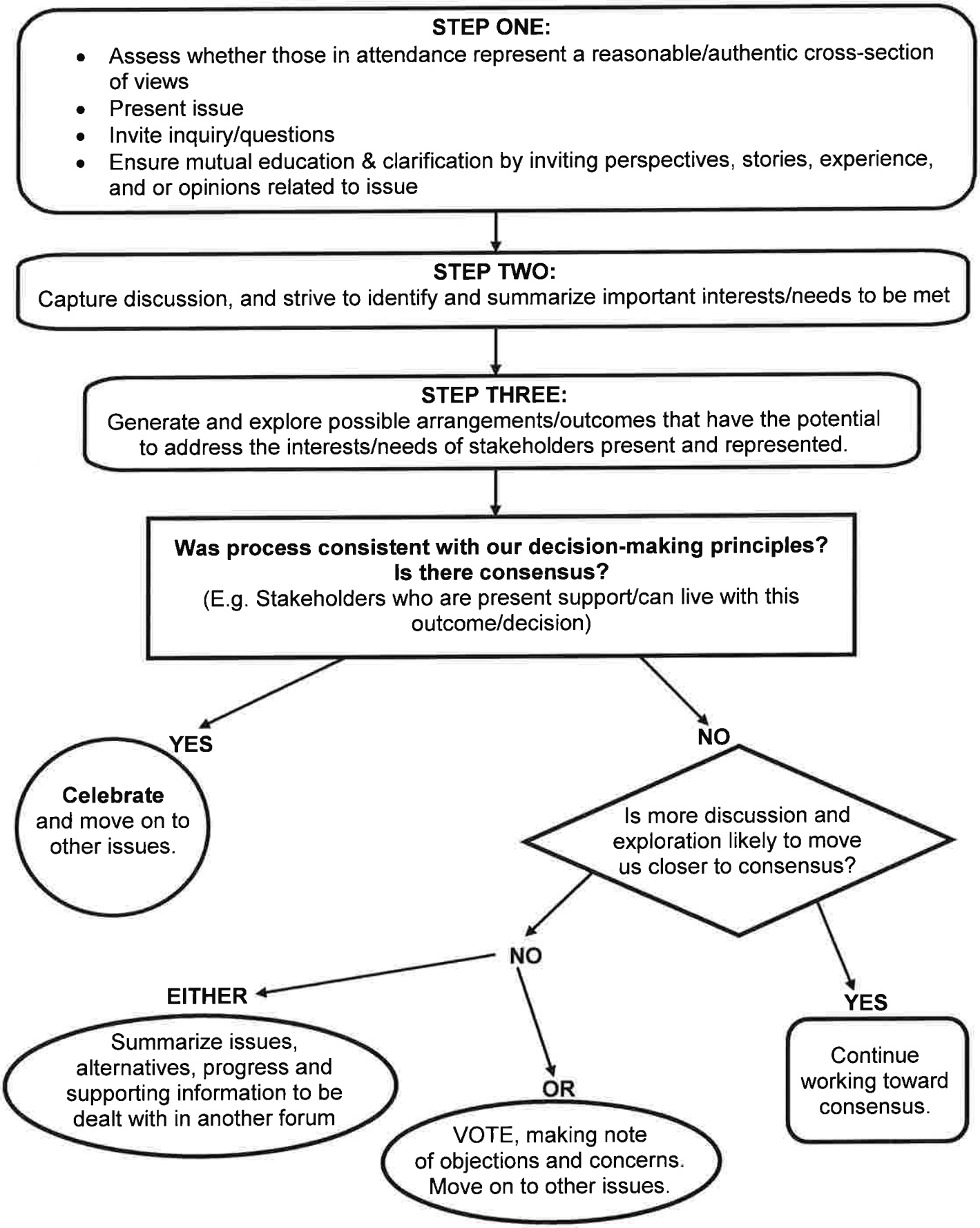
I. Decision-making Principles

[For use as a template that uses what is important to CMMC members collectively (below) to measure the strength and suitability of a proposed outcome]:

As a model of consensus building within our communities, CMMC strives to make decisions that demonstrate:

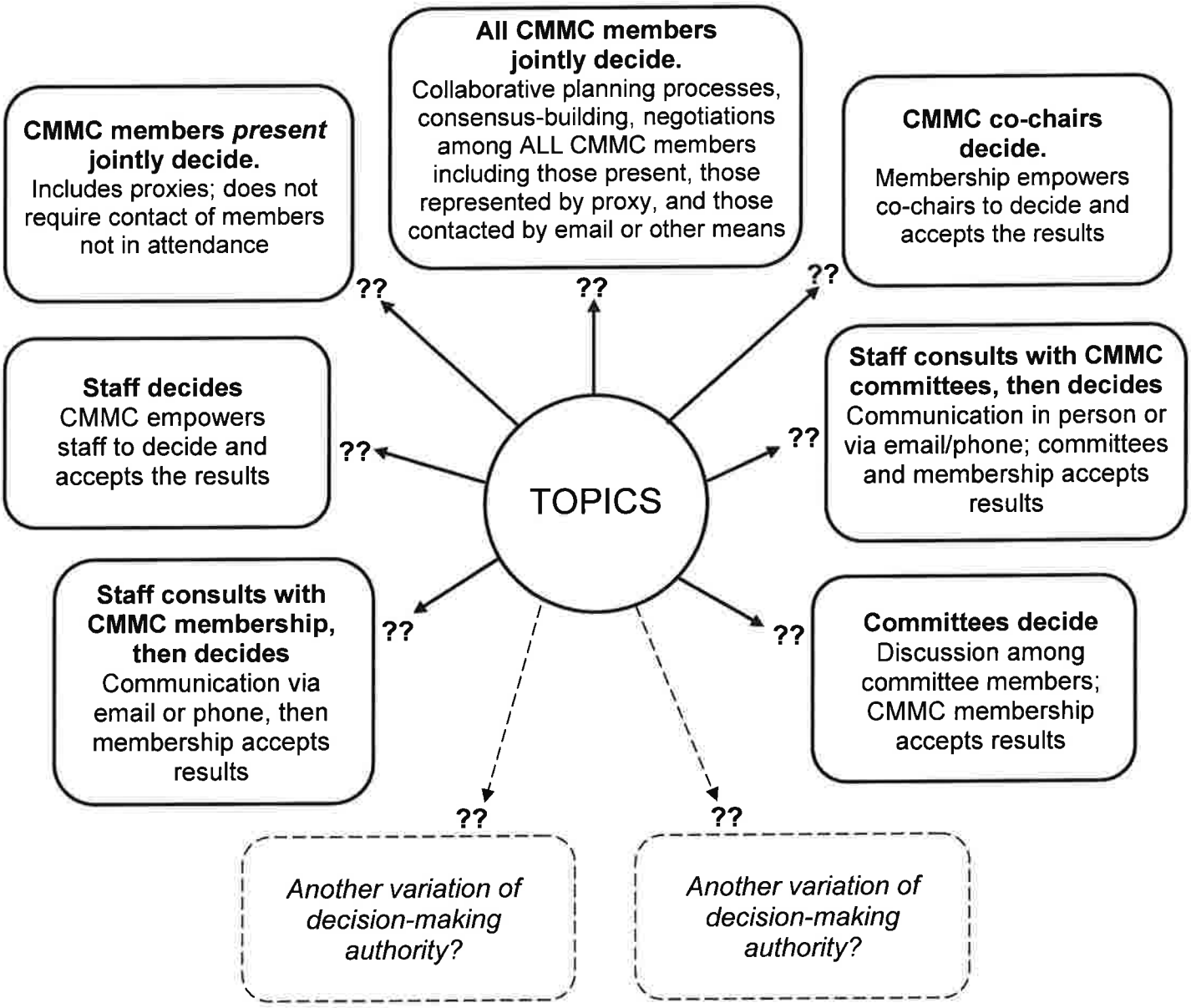
- ☐ *Inclusion and transparency*
- ☐ *Authentic opportunities for inquiry, expression of diverse cultural perspectives and personal stories, and clarification*
- ☐ *Being heard and understand even when viewpoints differ*
- ☐ *Respect for self and others, each other's strengths, and for different world views regarding time and communication*
- ☐ *Honoring CMMC committee efforts*
- ☐ *Focus on our common goal to transform cultural competency within the larger context in which CMMC operates*
- ☐ *Insight regarding the impact of decisions*
- ☐ *Action, implementation and closure*

I. CMMC Collaborative Consensus Based Decision-making Model



II. Delegation of Authority for Making Decisions

(Figuring out who has authority to make final decisions, including options as yet unidentified)

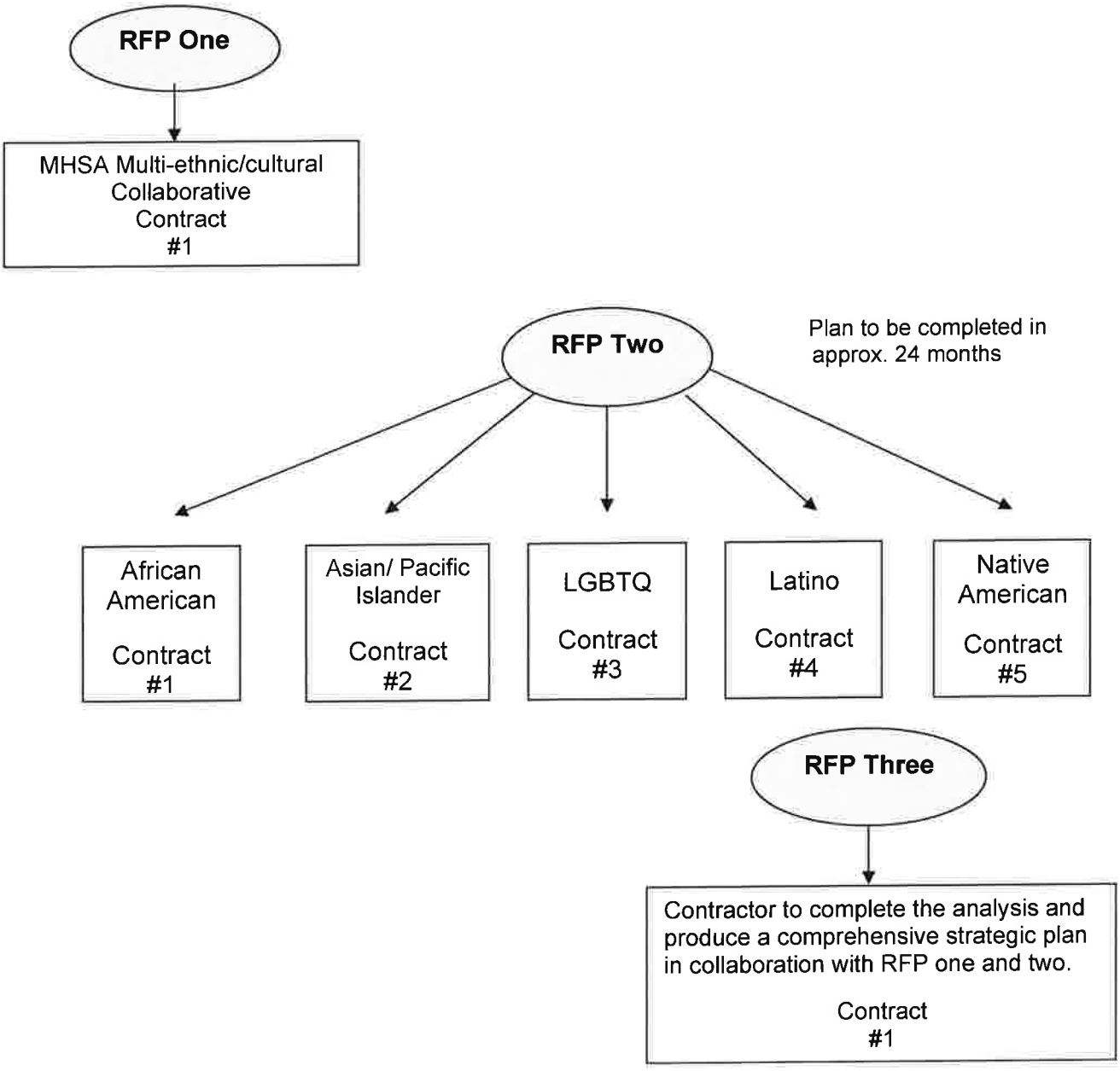


NOTES about decision-making:

- When using a consensus model for decision-making, while it is essential for participants to be heard and understood, it is also very important to ensure time well spent by avoiding repetitious or duplicative comments – ideally through self-enforced monitoring.
- Ultimately, if decisions are not made about a particular topic and CMMC finds itself at an impasse, it is important to acknowledge 1) that CMMC as a body will not influence what happens regarding that topic and 2) that individuals or agencies may still have an impact separate from any action by CMMC.

Prevention and Early Intervention & Office of Multicultural Services
Department of Mental Health

Reducing Disparities Project Design
(Modified 12/16/08)



Fact Sheet

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH EQUITY

CALIFORNIA REDUCING DISPARITIES PROJECT (CRDP)

Background and Purpose

In response to former U.S. Surgeon General David Satcher's call for national action to reduce mental health disparities, the former Department of Mental Health (DMH), with support from the Mental Health Services Oversight and Accountability Commission (MHSOAC), the California Mental Health Directors Association (CMHDA) and the California Mental Health Planning Council (CMHPC), created a statewide policy initiative to identify solutions for historically unserved, underserved, and inappropriately served communities. In 2009, the former DMH launched a statewide Prevention and Early Intervention effort, the California Reducing Disparities Project (CRDP), which focuses on five populations:

- African Americans
- Asians and Pacific Islanders (API)
- Latinos
- Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)
- Native Americans

The CRDP seeks to move away from "business as usual" and provide a truly community-focused approach to reducing disparities. The CRDP is divided into two phases. Phase I focuses on developing strategies to transform the public mental health system and identifying community-based promising practices in each of the five targeted populations. Phase II will focus on funding and evaluating the promising practices identified in Phase I, as well as advancing the strategies outlined in this plan. There has not been a project of this scope before; one that recognizes and elevates community practices and identifies strategies for systems change. Throughout this process, California will present this work on the national stage so that other states can learn from our efforts.

Phase I

Strategic Planning Workgroups (SPW)

Beginning in 2010, the CRDP funded the following five organizations to develop population-specific Strategic Planning Workgroups (SPWs):

- African American: The African American Health Institute of San Bernardino County
- Asian/Pacific Islander: Pacific Clinics
- Latino: The Regents of the University of California, Davis, Center for Reducing Health Disparities
- LGBTQ: Equality California Institute/Mental Health Association of Northern California
- Native American: The Native American Health Center

Each SPW is comprised of a broad representation of the diversity within their respective population group including, but not limited to, community leaders, mental health providers, consumer and family members, individuals with lived experience, and academia. The five SPWs worked to identify new service delivery approaches defined by multicultural communities *for* multicultural communities using community-defined evidence to improve outcomes and reduce disparities. Community-defined evidence is "a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community."[1]

Each of the five SPWs developed a Population Report that included recommendations for reducing

[1] National Latina/o Psychological Association, Fall/Winter 2008, National Network to Eliminate Disparities in Behavioral Health, SAMHSA, and CMHS, Larke Nahme Huang, Ph.D

disparities and removing barriers to accessing programs and services, along with an inventory of community-defined promising practices that could support efforts to reduce disparities. The Population Reports are available on the CRDP website.

California MHSA Multicultural Coalition

Another component of the CRDP is the California MHSA Multicultural Coalition (CMMC). The CMMC addresses a variety of mental health issues and provides state-level recommendations on all of the MHSA components and related activities. The CMMC's primary goal is to integrate cultural and linguistic competence into the public mental health system. The CMMC provides a new platform for racial, ethnic, cultural, and LGBTQ communities to come together to address historical system and community barriers and collaboratively seek solutions that will eliminate barriers and mental health disparities.

By creating and funding this coalition, the CRDP developed a new structure to bring forward diverse multicultural perspectives that have not been adequately represented in the mental health system or in previous efforts to obtain input from consumer and family member and individuals with lived experience. Individuals who have expertise in areas concerning multicultural communities, community members interested in improving the public mental health system, and service providers who work with racial, ethnic, cultural, and LGBTQ groups form the membership of the CMMC. The coalition includes representatives from each of the five CRDP SPWs and also represents the broader unserved, underserved, inappropriately served diverse communities in California.

The CMMC provided input and support to the SPWs in the development of the CRDP Population Reports for each of the target populations and the CRDP Facilitator/Writer of the comprehensive statewide Strategic Plan to reduce disparities.

CRDP Strategic Plan

The California Pan-Ethnic Health Network (CPEHN) collaborated with the SPWs to compile the five Population Reports into one comprehensive Strategic Plan. Still under development, the Strategic Plan will identify culturally appropriate strategies to improve access to services, quality of care, and mental health outcomes for the five CRDP target populations. When completed in 2014, the CRDP Strategic Plan will provide the public mental health system with community-identified strategies and interventions that will result in relevant and meaningful culturally and linguistically competent services and programs that meet the unique needs of the CRDP-targeted populations.

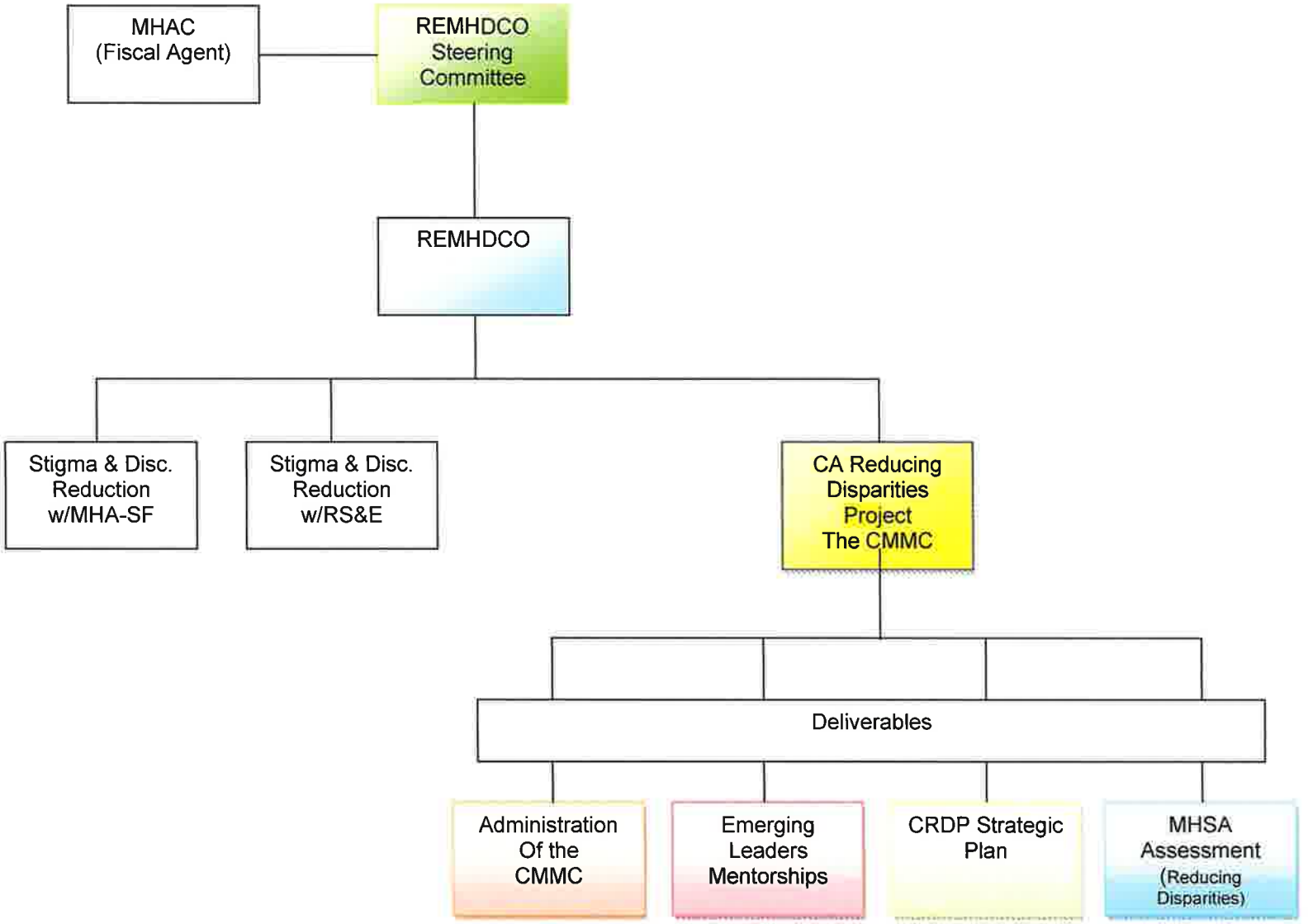
Phase II

Phase II of the CRDP, to begin in 2014, will provide four years of funding to implement the practices and strategies identified in the CRDP Strategic Plan. The focus of Phase II will be on demonstrating the effectiveness of community-defined evidence in reducing mental health disparities. Through a multi-component program, the CDPH plans to fund selected approaches across the five CRDP-targeted populations with strong evaluation, technical assistance, and infrastructure support components.

After successful completion of this multiyear investment in community-defined evidence, California will be in a position to better serve these communities and to provide the state, and the nation, a model to replicate the new strategies, approaches, and knowledge.

For updates and more information about the California Reducing Disparities Project, please visit the CDPH Office of Health Equity web site at: http://www.cdph.ca.gov/programs/Pages/CaliforniaReducingDisparitiesProject(CRDP).aspx

REMHDCO Organizational Structure



Mental Health Acronym List

AB 100: Assembly Bill 100

CalMHSA: California Mental Health Services Authority

CAYEN: California Youth Empowerment Network

CCCMHA: California Council of Community Mental Health Agencies

CCMH: California Coalition of Mental Health

CCPR: Cultural Competence Plan Requirements

CDE: California Department of Education

CFLC: Client and Family Leadership Committee

CiMH: California Institute for Mental Health

CLCC: Cultural and Linguistic Competence Committee

CMHDA: California Mental Health Directors Association

CMHPC: California Mental Health Planning Council

CMMC: California MHSA Multicultural Coalition

CNMHC: California Network of Mental Health Clients

CRDP: California Reducing Disparities Project

DHCS: Department of Healthcare Services

DMH: Department of Mental Health

ESM: Ethnic Service Managers

MHAC: Mental Health Association in California

MHSA: Mental Health Services Act

MHSOAC (aka OAC): Mental Health Services Oversight and Accountability Commission

NAMI: National Alliance on Mental Illness

REMHDCO: Racial and Ethnic Mental Health Disparities Coalition

OMS: Office of Multicultural Services

PEI: Prevention and Early Intervention

SAMHSA: Substance Abuse and Mental Health Services Administration

SPW: Strategic Planning Workgroup

WET: Workforce Education and Training

Tab 1

CMMC Meeting Notes

CALIFORNIA MHSA MULTICULTURAL COALITION (CMMC)
IN-PERSON MEETING MINUTES

Wednesday, March 25, 2015
9:30 A.M. – 5:00 P.M.

The Delta King
1000 Front Street
Sacramento, CA 95814

CMMC Members Present:

Jim Gilmer, Co-Chair
John Aguirre
Jack Barbour
Rocco Cheng, Ph.D.
Jessica Elm
Jamila Guerrero-Cantor
Janet King
Nga Le
Beatrice Lee
Yvette McShan
Lina Mendez, M.D.
Poshi Mikalson
Raja Mitry
Masa Nakama
Emma Oshagan, Ph.D.
Cristina Quinonez
Mari Radzik, Ph.D.
Brandon Ruiz-Williams
Perry Two Feathers Tripp
Gulshan Yusufzai

Public Present:

Annabella Agustin
Sally Douglas Arce
Crystal Crawford (conference call)
Katherine Elliott
Kevin Hoffman
Nicki King
Kimberly Knifong
Laura Leonelli
Ashley Mills
Jorge Monzon
Jose Oseguera
Dante Allen
C. Gallon (Interpreter)
S. Hester (Interpreter)

Staff Present:

Michael Helmick
Stacie Hiramoto
Betsy Kosier
Erin Reynoso

I. Introductions

Co-Chair Jim Gilmer welcomed everyone to the meeting. He invited the CMMC members and audience to introduce themselves.

Sharing Our Stories: Yvette McShan

Ms. McShan thanked God that she is living victoriously now. She is a former heroin addict of many years and spent time in every prison in California. She was also

diagnosed with a schizoaffective disorder; a therapist in the county jail helped her to beat her challenges. Years of therapy and her faith in God freed her from addiction.

Ms. McShan earned two degrees from Merritt College, in Substance Abuse Counseling and Human Services. She is close to completing a Bachelor's Degree from Holy Names College.

Ms. McShan owns her own business in which she represents African-American women, the homeless, and ex-cons. She encourages ex-cons to vote and believes in this kind of empowerment.

Ms. McShan belongs to an organization called Beyond Walls which counsels children whose parents are incarcerated. She has been a part of the CMMC for two years and also serves on the MHSOAC Client and Family Member Committee. She is proud to be a Pool of Consumer Champions member. She is proud of her successful daughter, who inspired her to go back to school. Ms. McShan believes in the strength of family.

She serves as well on the Mental Health Board of Stanislaus County.

II. Review Meeting Notes from the Previous CMMC Meeting and Review of the Agenda

Ms. Kosier directed the CMMC members to the calendar in their packets so that they could make note of upcoming meeting and teleconference dates.

Ms. Kosier stated that she would serve as meeting facilitator to keep the meeting on track. She reviewed the agenda.

Mr. Mitry pointed out an error in the printed June meeting dates. They will be Tuesday and Wednesday, June 23 and 24. Ms. Hiramoto suggested having the two-day meetings begin at 10:00 a.m. and end at 4:00 p.m. or something similar.

Mr. Gilmer requested the Coalition members to review the meeting notes during the course of the day.

III. Update on the California Reducing Disparities Project (CRDP) – Ruben Cantu

Mr. Cantu updated the CMMC on the town hall meetings and the Next Steps for the CRDP Strategic Plan.

- A total of about 264 people attended the town hall meetings; the largest were Los Angeles and Oakland. There was a good representation of diversity.
- Feedback concerned the following.
    - Moving away from business as usual to new methods
    - The need for better data collection standards and disaggregated data
    - Cultural competence and the workforce
    - The need to expand the workforce in general and in terms of representing the served populations

- Approaching cultural competence as cultural humility
- Sustainability of the projects after the four-year pilot program
- The intersection of identity
- Trauma for refugees and for communities of color on a daily basis
- In Humboldt County, issues for rural communities

- CRDP is also reviewing feedback received via email.
- The California Pan-Ethnic Health Network (CPEHN) developed a matrix for analyzing all feedback. Close to 500 specific comments were gathered.
- Next Steps are as follows.
  1. Updating, incorporating, and analyzing all feedback in the matrix
  2. Revising the Strategic Plan which they will share with the CRDP leads for their review
  3. Turning the document back to the state for final approval
  4. Making the document an actual report
  5. Posting the report on the website
  6. Sharing the report with all partners
  7. Planning a final conference to decide how to use the Strategic Plan as a tool to improve the system
  8. Developing a shorter Executive Summary for dissemination

Ms. Knifong added that an approval process would require California Health and Human Services Agency approval.

Q & A

Mr. Cantu and Ms. Knifong answered questions from the CMMC.

Question: Is there a particular month in which the conference might happen? Answer: Not as yet.

Question: Is there a possibility for the conference to handle questions as the town hall meetings did – to honor comments from the various communities? Answer: We would like to, but we are operating with limited resources. We will have conversations with CPEHN on this topic.

Question: Do we anticipate a roadblock to approval of the report? Answer: It is hard to predict, but if there are no significant changes to the document, the California Department of Public Health (CDPH) may spend less time in the approval process than it did approving the draft. We do not anticipate having to make huge changes.

(At that point Ms. Radzik assumed the Chair duties in the absence of the Co-Chairs.)

IV. Review of the MHSOAC Evaluation Projects Regarding Mental Health Disparities – Dr. Renay Bradley, Director of Research and Evaluation, MHSOAC

Dr. Bradley discussed the MHSOAC's plans to develop a statewide framework for continuously monitoring disparities in access to care.

- The Department of Health Care Services administers Cultural Competence Plans: county-level plans where the counties share information about their intentions to help reduce disparities and to provide culturally competent services to their target populations.
- The Office of Statewide Health Planning and Development (OSHPD) administers the Workforce Education and Training (WET) program, which provides services in a culturally competent manner.
- The MHSOAC provides oversight and accountability of the public community-based mental health system. It has a commitment to reducing disparities promoting cultural competence.
- The MHSOAC uses ongoing evaluation of the public community mental health system to enable identification of problems and solutions.
- In 2013 the MHSOAC adopted the Evaluation Master Plan which gives guidance for a five-year period, providing specific outcomes. Activities to achieve the outcomes include performance monitoring.
- However, the Master Plan does not include anything specifically focused on how to address the issue continuously of reducing disparities in access to care.

Questions and Comments

Question: When was the Master Plan developed? Answer: It was developed during 2011-12 and was adopted by the MHSOAC in March 2013.

Question: Is it available online? Answer: Yes, through the MHSOAC website.

Question: Is the Master Plan something that can be changed? Answer: Certain aspects of it are meant to be changed: the process through which the MHSOAC prioritizes different evaluation activities, as well as the specific evaluation activities.

Question: What is the Master Plan assessing if it is not looking directly at evaluations of disparities? It is meant to give the MHSOAC direction and guidance in regard to the evaluations done every year. It gives specific criteria for judging activities and clarifies the specific rules of the MHSA used as outcomes.

Question: Do you ever evaluate the rollout of the RFPs and possible disparities in deciding who receives the awards? Answer: I can speak to the RFPs or contracts generated through the Evaluation Unit. Certain resources are allocated to that unit each year. The process is generally in the Master Plan. We go through a prioritization process and come up with six activities, then identify subject matter experts for the evaluations. (The RFP process could possibly be done better.)

Question: Do you specify metrics in the RFPs? If the projects that are attempting to reduce disparities are having different outcomes, there must be at least some similarity in metrics that you can use for comparisons. Answer: As an entity, the MHSOAC has a mission to encourage the reduction of disparities. It does not provide direct services, rather it does evaluations. I don't have an indicator for disparities in access to care for all the different demographics. I agree that we need standard data collection instructions so that the counties give us consistency.

Question: Can you go directly to the communities as a better way of evaluating disparities? Answer: I am recording that suggestion. *How about looking at how other states are more successfully dealing with homelessness and employment for the incarcerated?*

Question: How do we initiate a recommendation to change the Master Plan to include reduction of disparities? Answer: That's what this is all about. The MHSOAC recognizes that this is an issue and has adopted it in its current year Work Plan. I want to work with the CMMC to figure this out.

Question: Would you consider disaggregating the API data and collecting LGBT disparity data? Answer: By all means. What we asked Dr. Aguilar-Gaxiola's team at UC Davis to do was to use currently available data to address this question of whether the MHSA has actually led to a reduction in disparities in access to care for different demographic populations. Could they do that with the available data? Probably not, largely because of the huge limitations with the data. A team at UCLA that examined performance monitoring found the same problems with the data.

Comment: I encourage attention to language that ensures appropriate, respectful outreach to groups experiencing disparity. Response: The MHSOAC has an evaluation that will start this coming fiscal year that is going to focus on outreach.

Question: The communities ask about the breakdown of race and ethnicity – where is that data for the Full Service Partnerships (FSPs)? Also, why didn't the MHSOAC say that they would not pay counties any more money until they supply useable data? Answer: Per the statute, the MHSOAC can point out performance issues to the Department of Health Care Services (DHCS); it is then DHCS's responsibility to address them. The MHSOAC has invested a lot of resources in DHCS's data collection reporting system by going out to counties, creating data dictionaries, providing training and technical assistance, etc. The MHSOAC's vision is to support DHCS so that they can move in a direction where they can adopt a statewide data collection and reporting system that actually meets the state's needs. We want to partner with the CMMC to develop the system. It may not be in place for another five to seven years. By next spring, we will go to the MHSOAC with a plan for obtaining data long-term, as well as short term activities.

Question: Within the framework you are developing, is there a component for looking at disparities within the MHSOAC itself? Answer: We have not developed the framework yet, but that is an idea that I would put forth.

Question: Is there any collaborative relationship between the MHSOAC and CalMHSA? Answer: The MHSOAC oversees CalMHSA, so they routinely report to us. We want to have a better understanding of what CalMHSA is doing with regards to the CRDP.

Comment: We would like the survey to include American Sign Language (ASL); it is a health resource for the deaf community. Response: As the MHSOAC develops the new system, it is the time to incorporate all appropriate languages including ASL.

Comment: A short-term suggestion would be for the MHSOAC to self-evaluate. Another short-term suggestion would be for the counties to use the County Cultural Competency Plan (a requirement for them) to collect some kinds of data. A third suggestion concerns qualitative data; there are providers out there who know what has worked for them and we should use their data.

Question: Is the Data Collection & Reporting (DCR) data that counties are required to collect part of what MediCal is requiring, or is it additional? Answer: What counties are required to submit to the federal government regarding MediCal is mostly billing information.

Question: Are there any plans to incorporate the immigrant populations that continue to arrive? Answer: There are, in the context of the Prevention and Early Intervention (PEI) and Innovation Regulations: the MHSOAC very much delves into that subject. The state routinely collects information on "The Big Five" ethnic populations – which does not allow the MHSOAC to break down to smaller, specific populations that are very relevant within the current mental health system – for example, the Hmong population.

Comment: Looking at them county by county, the breakdown of those small ethnic populations may be different.

Comment: the transgender population does not want to go to specifically transgender provider/therapists – everyone should be able to provide services for us. For gender data, UCSF has developed a tool in which organizations are encouraged in their documents to open up the gender question into two questions: (1) The gender that the person identifies with now, and (2) The gender given at birth.

Comment: Everyone sitting around this table knew the data was bad going into the project. Somehow all these resources were put into the project when we could have foreseen this outcome.

Comment in response: Resources were committed to this project very early on, but they did document very specifically the limitations within the data system. This has allowed us to take a step back and begin more planning.

Comment: Multiple partners are important in this effort. The Office of Health Equity (OHE) was also involved. Response: If there are others, please let me know.

Comment: MHSA dollars flow directly to the counties from the state – we cannot stop that money from flowing.

Comment: As this process continues, people are dying in the Muslim community. In Sacramento, over 70,000 Muslims are constantly facing this problem and not having answers.

Comment: I would emphasize for the record that Dr. Bradley has charged the CMMC with partnering to discern what is needed in both the short term and the long term. You have some serious work to do because the short term plans need to be developed before the fall.

GENERAL PUBLIC COMMENT

Comment: The CMMC did produce a report including the findings. It took about three hours to realize that the data would not be useful for looking at disparities. The report includes recommendations. Also, of the reports produced by Dr. Aguilar-Gaxiola's group, the Cultural Competence Plan displays all the data collected from the counties; 23 are missing race and ethnicity data. Response: I want to think about what to do moving forward so we don't continue to struggle with these same issues for the next 10 years.

Ms. Hiramoto reminded the CMMC members that one of the reasons for having this meeting was so that they could attend the MHSOAC meeting tomorrow. Accordingly she encouraged them to stay through the 4:00 meeting time for that topic. Although great things are happening in ethnic communities at the local level, Ms. Hiramoto personally felt that no one is paying attention to the statewide issue of whether disparities are being reduced. CMMC members need to be in attendance at the meetings to express what they want the MHSOAC to look at.

V. CMMC Emerging Leaders Committee – Dr. Mari Radzik

Dr. Radzik reported on the following.

- The committee has a new Emerging Leader: Brandon Ruiz-Williams. He is a recent graduate of Gallaudet University, earning a B.A. in Social Work. He now works with the National Black Advocates to create programs devoted to identity development, community engagement, and leadership skills for black deaf youth. Ms. Guerrero-Cantor is his mentor.
- Over lunch, Ms. Elliott presented a training opportunity to the committee: helping with data analysis process of the State of the State Report. All the members present wanted to participate.
- Mr. Tripp raised the topic of the Phase 2 RFPs that had been released for the CRDPs. He asked if the CMMC had any wish to explore these opportunities.

VI. Presentation from the Little Hoover Commission Regarding Their Report, *"Promises Still to Keep: A Decade of the Mental Health Services Act."* Pedro Nava – Chair of the Little Hoover Commission

Mr. Nava had his much-valued staff introduce themselves: Carole D'Elia, Jim Wasserman, and Tamara Koehler.

Mr. Nava reported on the following.

- By statute, people with a mix of political views serve on the Commission. The strength of the report is that they take what the CMMC brings and compile a report that gathers support from the diverse Little Hoover Commission.

- $13 billion in taxes has been collected from California's millionaires to support the Little Hoover Commission.
- Because of mental illness, there is a fine line for many of us between operating in this world and finding ourselves in a different reality.
- When the MHSA was initially authorized, the money went to the Department of Mental Health. They were taking too long to develop their plans, so the Legislature amended the MHSA to send the money basically to the counties. However, they left out guidelines for what the counties were supposed to do with the yearly funds.
- More money is going to be coming through the MHSA pipeline as time goes on. There needs to be more accountability. The CMMC has helped to elevate the importance of that conversation. The irony is that the very body the CMMC negotiates with for its contracts is the body that does not necessarily want to hear from the CMMC about what they are doing wrong.
- The OHE is going to want to hear from the CMMC on the best way to use the MHSA funds.
- Assembly Member Sebastian Ridley Thomas has a select committee that will be examining Prop 63 and mental health funding.
- In the report, the Little Hoover Commission made some recommendations:
    - More oversight by the Legislature
    - Examination of how the counties characterize their funding and put it into their various programs
- It looks as if the $1 billion dollar/year outflow of money for this aspect of mental health funding is going to continue.
- The CMMC has an opportunity to define the people who have been the most needy in the communities to help the counties defend their funding.

Questions and Comments

Comment: The Little Hoover Commission is recommending that the MHSOAC be given more authority. I am concerned about that because I, as well as the counties, don't feel that they have done a good job; also, there isn't the diversity on the MHSOAC that we would like to see. Response: There definitely needs to be improvement at the MHSOAC. But we don't want to recommend a new entity – that comes with a whole host of problems. The idea is to make the MHSOAC better.

Comment: Thank you for saying that we have the power for the counties to defend themselves. Response: The risk is for the counties – they are in the red. The CMMC has the credibility to tell the counties you can help them with what's coming.

Question: What solution or future do you see regarding the data collection problem? Answer (Ms. D'Elia): The recommendation is for the MHSOAC to work with DHCS, which actually has the data. We added that potentially some of the $87 million used

across the 12 different state entities could be used for a data system. The challenge is that the counties must be on board, and they have developed all different sorts of data systems.

Ms. Hiramoto suggested for CMMC members attending tomorrow's MHSOAC meeting to listen to the panel's discussion, to see whether the government, the counties, and the providers even mention the word "disparities." She expressed concern about whether ethnic communities are being fairly or adequately served. She also pointed out that the MHSOAC had proposed that the Little Hoover Commission's recommendations be adopted.

Question: How will the report be disseminated; and is a response expected from the MHSOAC? Answer (Ms. D'Elia): The MHSOAC will have a presentation tomorrow and eventually a task force. The Little Hoover Commission has been meeting with the Legislature and the appropriate Committee Chairs of both houses regarding the content of the report. Every member of the Legislature and all those involved in the public process receive a copy of the report. It is available on the Little Hoover Commission website.

Question: While I appreciate the paradigm shift that we now have the power over the counties, my experience is that I get pushback, lip service, and a lack of cooperation from them. Regarding the missing data – this goes beyond MHSA. The data that needs to be gathered needs to be done across the board; the MHSOAC does not have the authority to mandate this. Would you recommend legislation that mandates the data collection? Answer (Mr. Nava): I do think you are going to see movement in that direction. Members of the Legislature who are interested in this issue now know what the problems are. I recommend that your leadership meet with Sebastian Ridley Thomas and Assembly Member Salas; make those alliances.

Comment: Dr. Bradley stated earlier that between the DCHS and the MHSOAC it will be between five and seven years for the data system to be up and running. At a meeting several months ago, they said the cost would be $500 million to establish it.

Ms. Hiramoto announced that Assembly Member Roger Hernandez is carrying a bill that addresses the issue of reducing disparities and representation of underserved communities. A seat on the Commission would be dedicated to a person who is an expert in reducing disparities. This gives the CMMC the opportunity to speak to the Legislature about why this is needed.

Mr. Nava agreed: the report and bill create the opportunity to speak to "witnesses." People will be paying attention. We also should take a look at what the California Association of Counties does with respect to the legislation – we don't want them to oppose it. CMMC members can generate letters of support for the legislation and ask their Boards of Supervisors to take a support position.

VII. MHSA Assessment and Recommendations Committee Report – Gulshan Yusufzai

Ms. Yusufzai reported on the State of the State.

- The topics of focus were Women and Transition Age and Older Adults.

- The Committee has done five key informant interviews for both topics, and two interviews that covered both.
- The committee decided upon the following methods of dissemination:
    - Email blast with upcoming graphic design
    - Poster presentation
    - Panel presentation

Comments

Mr. Gilmer stated that he had utilized the report on penetration rates in his advocacy work for Ventura County. The MHSA Director had disseminated the report to the Board of Supervisors and the Mental Health Board, along with information about the CRDP. The reports are on point when it comes to issues of reducing disparities; he wished there were an opportunity for more vocal groups to advocate using that information.

Dr. Radzik suggested referring to the five State of the State reports as a conference rather than a presentation. Ms. Reynoso agreed. Dr. Radzik suggested that experts in the room could do pieces of the conference throughout the day to ease the workload.

Dr. Oshagan warned the members against generalizing the results. It is a starting point; we need more quantitative studies to be able to describe the needs and problems in those communities.

Ms. Elliott noted that yearly conferences such as the Latino Behavioral Health Conference and the American Psychological Association (APA) provide opportunities for the CMMC to submit an abstract and present its work. Ms. Elliott is always available to provide support.

Ms. Knifong had spoken with OHE Deputy Director Jahmal Miller about having OHE host the State of the State reports; he was enthusiastic. He would like the reports posted on the revamped OHE website.

Ms. Reynoso confirmed for Ms. Arce that the reports are posted on the REMHDCO website.

Ms. Yusufzai asked when the reports can be approved. Ms. Knifong stated that she believed they do not have to go to OHE. Mr. Miller is ready to post them as final.

Mr. Mitry wanted to make sure that the CMMC reviewed them to find any necessary corrections. He had noticed a fact sheet inaccurately indicating that Middle Eastern and Southwest Asian communities are regarded as one. Ms. Reynoso responded that the committee was currently revising that report.

Ms. Guerrero-Cantor noted that the State of the State reports are exploratory and qualitative. She had an idea to involve key agencies and leaders (including Gallaudet for the deaf community), asking them to check out the reports and be a part of the dissemination.

Mr. Gilmer appreciated the committee underlining the exploratory aspect of the work. Because the reports are living documents of sorts, the CMMC could create a blog for its

website. This could attract people to the emerging research and information, and they might add to the document.

Ms. Yusufzai agreed that getting more input would be advisable.

Ms. Hiramoto cautioned the committee to remember not to overload the staff. Ms. Yusufzai understood, and said that the committee would discuss the issue and report back to the CMMC.

Ms. Mikalson pointed out that if the committee will not have an opportunity to change the information in the reports, they should not ask for community feedback. If they do ask, they should make clear what they are asking for and what they will do with it.

Dr. Oshagan noted that we cannot compare the State of the State reports with the CRDP Strategic Planning Workgroup (SPW) reports. Obviously you cannot base conclusions or results on interviews of three people. The reports raise questions about the communities and point to the issues that we should now look at for further study.

VIII. Review of CalMHSA RFP *"Reaching California's Diverse Communities to Achieve Mental Health and Wellness"*

Ms. Hiramoto directed the members to the memo she had prepared. The RFP was available on the web. She proceeded to describe the RFP.

- The anticipated total available funding is up to $7.5 million subject to fund availability.
- CalMHSA will give up to six awards.
- The length of the program period is two years.
- CalMHSA will post the webinar.

Ms. Hiramoto felt that OHE's RFP community input process is more robust than CalMHSA's, which gets its input mainly through its own Special Advisory Committee.

Comments

Comment: *This RFP appears to be written for the agencies already funded in Phase 1. Often those agencies came to us at the last minute, offering a paltry payment, if anything, for our subject matter expertise. Subcontracts should have been required as part of the contracts because of the contractors' lack of knowledge of all diverse communities.*

Phase 2 looks to be business as usual. Those of us from different communities can attest that the green ribbon does not necessarily resonate with us. One of the requirements of Phase 2 is to give stipends to local people; they will get over $1 million, while the local community members will get a $50 or $100 stipend to do their work for them.

The member described the less than successful experience working with both the contractor and CalMHSA in Phase 1. Part of the disparity of our communities is that not only are we unserved and unreached; it is also

that the big organizations get the funding and throw crumbs to the diverse communities so that they can say they reached us.

The timeframe of a month showed that since CalMHSA has already written the Phase 1 RFP response, it's not hard to write Phase 2 because they know they are getting the money.

Questions regarding the RFP were allowed until March 24. We won't know the answers to the questions until after the Letter of Intent is due; and by then we will have two weeks to write the article. One of the questions had been "Can this be regional?" – running a statewide social networking campaign for our communities was a lot to ask.

Comment: *CalMHSA is requesting people to come up with 30% matching funds: the first year would be 10% cash/20% in-kind, and the second year would be 20% cash/10% in-kind.*

Mr. Gilmer asked if there were any actions the CMMC wanted to take. A member suggested complaining to the MHSOAC – they could have made requirements about the way the RFP was written. Ms. Hiramoto confirmed that the MHSOAC can evaluate proposals.

Mr. Gilmer stated that the CMMC wants to position itself in the future to be at the front end of policy and decision-making. He encouraged the CMMC members to express their angst and advocacy at the MHSOAC meeting. Beyond that, members could have continued discussion with the program officers and others at CalMHSA.

Comment: *I suggest a workgroup session prior to the MHSOAC meeting to present a uniform dialogue.*

Comment: *Remember the quote: "There is no such thing as a single-issue struggle."*

Comment: *There are three more RFPs that counties are supposed to draw up. Perhaps the current RFP could be used as an opportunity to brief the MHSOAC on the idea that the next three should be vetted by diverse communities and by the affected stakeholders.*

Comment: *CalMHSA can pull the current RFP until they sign a contract.*

IX. CMMC Administration Committee Report – Raja Mitry

Mr. Mitry reported on the following action items.

- **Approval of the policy on CMMC stationery.** The new policy allows a member to remove his or her name from letters involving an issue requiring a vote of the entire CMMC, on a case-by-case basis. Ms. Hiramoto specified that such letters would be sent to members 12 hours prior to a deadline.

  Ms. Mikalson suggested extending the timeframe to 24 hours.

  Mr. Mitry informed Mr. Tripp that the policy did not extend to the website.

  Ms. Hiramoto clarified that this policy and the one below apply to times between CMMC meetings when the organization cannot wait. Ms. Kosier pointed out that

in a fast-turnaround circumstance, you do the best you can in a consensus-building process – recognizing that the time factor is working against you.

The CMMC members approved the proposed policy regarding the stationery including the change from 12 to 24 hours.

- Approval of the policy on voting by email. This policy had also been discussed at the December meeting and during the Administration Committee monthly calls in January and February. It specified the process regarding responses by members.
- Mr. Tripp pointed out that the organization needed to consider its voting and approval practices – should it follow Robert's Rules of Order or consensus-building practices?

  Ms. Lee suggested voting via Doodle Poll.

  Mr. Aguirre pointed out the voting via email did not allow for interaction. He suggested teleconference calls.

  Ms. Hiramoto brought up the example of the letter about the OHE's existing policy stating that people could weigh in on their RFPs only until close of business today. The Strategic Plan Committee had quickly put together a letter opposing that policy.

  Mr. Gilmer felt that the CMMC was being true to the consensus model; the CMMC always brings large issues to the entire group.

  Ms. Kosier stated that when someone is not present at a meeting, and the CMMC has a discussion, in essence that person is abstaining. The CMMC should take care not to confuse the voting process with the consensus-building process. Consistency will be critical.

  Ms. Mikalson suggested developing a method of transparency as well as clarifying a minimum amount of time for which the notice would be given. Methods of transparency could be to **cc** (not **bcc**) all members in the email so that they could **Reply All**; or to give opinions via Doodle Poll. Members would have at least 24 hours to state opinions for the consensus.

  No one voiced an objection to these suggestions.

- A third item was to review the new CMMC Year 5 deliverables. Mr. Mitry noted that all five of the CRDP partners had received extensions to their original contract in Phase 1. Instead of finishing at the end of June 2015, the CMMC will now be able to operate until at least December 2015.

  Mr. Gilmer requested the members to read and review the deliverables, to be discussed at the next meeting.

X. CMMC Strategic Plan Committee Report – Nga Lee

Ms. Le reported that the focus of the committee has been around the development and implementation of a plan for the achievement of Task 4 of the deliverables.

Ms. Elliott reported that the committee is moving to a more comprehensive and cohesive report format for the deliverables. At the same time the committee is engaging in many timely activities that fulfill the deliverables but are not in the report format. The committee is looking for ways to document work already done, showing it in the final report.

Ms. Knifong suggested an option to submit relevant information (and part of the deliverable) to the Office now, allowing them to tweak the draft solicitations to final, to be submitted later as a full comprehensive report.

Ms. Hiramoto acknowledged the Strategic Plan Committee for organizing and being the focal point for the CMMC to make comments at the town hall meetings.

Ms. Reynoso reported on the town hall meeting that had been held in five locations around the state. The CMMC had approved the letter and the talking points; representatives from the CMMC attended every meeting and advocated for their communities.

Mr. Mitry commented that he had not heard about the approved talking points; he had submitted comments as an individual. Ms. Lee responded that the committee had done much of its work during the monthly conference calls; they could now create another conference call to get CMMC member feedback.

Ms. Le stated that the committee had created a recommendations letter calling for an extension of the comment period to April 8 for the CRDP Phase 2 Draft RFPs. Ms. Reynoso announced that OHE had responded via email; they had agreed to extend the comment deadline.

Ms. Mikalson commented regarding the committee's recommendation in the letter to OHE to simplify the legal language – it is very important to anyone who may be applying to see the exact "legalese."

XI. Director's Report – AB 253 (Hernandez)

Ms. Hiramoto spoke about AB 253 – a "spot" bill –staking out certain code sections so that later the new language can be presented into the bill. Senator Hernandez and staffer Erica Martinez care very much about reducing disparities in mental health. Senator Hernandez would like to see two new seats on the MHSOAC: one representing veterans and one for a person with knowledge of reducing disparities.

Mr. Gilmer requested copies to be sent electronically to CMMC members.

Ms. Hiramoto announced that Ms. Reynoso was moving on to a position outside the CMMC, and that Michael Helmick was being promoted to fill her position.

Ms. Reynoso thanked Ms. Hiramoto and the rest of the staff. She said that her experience at CMMC has been amazing. She is going to work in Tobacco Control.

Mr. Helmick said that it was a privilege to work with the CMMC and the two Associate Directors. He is looking forward to learning much more going forward.

Mr. Mitry expressed concern that AB 253 should include advocacy for the families of veterans.

Ms. Gulshan asked about the deliverables for the next year; Ms. Hiramoto replied that the CMMC has almost the same deliverables as the original contract, but the time was extended to December, and there were additional deliverables that would allow, for example, participation in the dissemination of the Annual Report.

XII. Discussion of Agenda Items for the MHSOAC

Ms. Hiramoto directed the members to the MHSOAC Meeting Agenda in the packets.

A. Item 4A – Scope of work for the Client Stakeholder Contract Request for Proposal

Ms. Hiramoto stated that the MHSOAC had an original proposal for an entity to survey stakeholders statewide, getting their opinion on how the MHSA is going. REMHDCO was concerned that the proposal sought no input specifically from underserved communities. Ms. Hiramoto has raised the issue wherever possible, but the MHSOAC has not responded in any effective way.

The contract is up for renewal. Ms. Hiramoto suggested for the CMMC members to request that the successful bidder work in a respectful and effective way with underserved communities.

Mr. Mitry shared an experience from the Bay Area in which an interested member of the Middle Eastern community had not been contacted by the contractor.

B. LULAC Report

Ms. Hiramoto had sent copies of the League of United Latin-American Citizens (LULAC) report to the CMMC members. It concerned the lack of services that the Latino community in Ventura County experiences. The county had responded with a rebuttal, to which LULAC had responded with a memo.

Mr. Gilmer, a member of that LULAC chapter, stated that the Oxnard Multi-Cultural Mental Health Coalition had addressed this issue collectively. They are requesting seed money to do a mini-CRDP in their community. Elaine Crandall, the new Mental Health Director, will speak at tomorrow's meeting.

Ms. Hiramoto encouraged CMMC members to support the LULAC report and to say that it applies to other communities and other counties.

C. Little Hoover Commission Round Table Discussion

Ms. Hiramoto noted that this item was critical. The MHSOAC was going to discuss the recommendations; its staff was generally supportive. However, many institutional powers were not supportive and do not want changes or oversight.

While the MHSOAC's record on cultural competence and reducing disparities is not stellar, compared to DHCS the MHSOAC is easier to educate and work with.

Ms. Hiramoto felt it important for CMMC members to state that the findings of the Little Hoover Commission ring true. It is an unprecedented opportunity to get more oversight and accountability back with Proposition 63.

Mr. Gilmer added that this item was critical because of PEI funds. When PEI money came into the communities, hopes were high that communities of color would be engaged in the funding process. However, when the money actually arrived, it was not distributed well in the communities. There is now hope for reactivation; that would be a big win – PEI is a huge force within the MHSA.

Ms. King asked if it would be appropriate tomorrow to bring up the two MHSOAC seats; Ms. Hiramoto responded that it would not.

Ms. Mikalson requested any CMMC members attending the MHSOAC meeting to comment that there is no LGBTQ representation on the Little Hoover Commission panel; Mr. Mitry noted that other populations are not represented either.

Mr. Ruiz-Williams felt that the transgender population should specifically be represented on the panel. Ms. Mikalson commented that getting representation from any part of those communities is a challenge; that is why we end up lumping together sexual orientation and gender identity.

D. Public Comment Period

a. Introductions

b. Locations of MHSOAC Community Forums

Ms. Hiramoto stated that the community forums are held in order for MHSOAC Commissioners to listen to community needs. However, the CMMC, REMHDCO, and the people on the original Cultural and Linguistic Competence Committee have been concerned that only clients and family members from mainstream perspectives were attending the forums.

Concern remains about the venue locations that the MHSOAC is picking for future forums; they are not following the recommendations of their Advisory Committee. The mode is also crucial: the MHSOAC has been told repeatedly that small focus groups are better than meetings with hundreds of people present.

Ms. Kosier asked the CMMC members what they wanted to do regarding the CalMHSA RFP. Ms. Hiramoto responded that it would be wise to address this during the Public Comment period before lunch.

Mr. Gilmer stated that RFPs should be community-driven: diverse communities should be structured into the front end of the decision-making process. This RFP shows some inconsistent areas including the matching requirement. In addition, when RFPs go out with a short turnaround time period of 30 days, it is typically because the requestor knows who will be at the table in front of them.

He continued that representatives of diverse communities need to be leading the effort – as awardees of the proposal, as part of media campaigning, as part of marketing, and so on.

Ms. Hiramoto said that another bullet point for tomorrow would be to compare this process with OHE's process: open community meetings all over the state to find out what the communities wanted. CalMHSA had not done vetting with the public in general, let alone diverse communities.

Mr. Gilmer added more bullet points: the 30-day timeframe is not feasible, and there is a need to regionalize – diverse communities are spread out around the state.

Ms. Mikalson stated that the "ask" should be that the CMMC wants the RFP to be pulled. Mr. Gilmer agreed.

Mr. Tripp mentioned the need to advocate for training and technical assistance.

Mr. Aguirre mentioned that many agencies cannot handle the burden of matching funds.

Ms. Kosier highlighted other points that had come up during the meeting. CMMC members are encouraged to:

- Work with Dr. Bradley to identify what needs to happen with regard to evaluation.
- Speak to legislators about the Little Hoover Commission Report.
- Generate letters of support from within the communities to affirm the Hernandez bill.
- Let the MAC Committee know about other opportunities for poster sessions or conferences.

Mr. Mitry suggested forming a workgroup to meet with Dr. Bradley. Ms. Hiramoto will send an email on this subject.

Jorge Monzon, a television producer and medical interpreter, stated that he would join the CMMC in addressing the RFP; he concurred that it needs to be revised.

ADJOURN

Mr. Gilmer adjourned the meeting at 5:10 p.m.

Tab 2

Committee Notes

CMMC Emerging Leaders Committee Call Agenda

Tuesday, April 14, 2015
9:00 am – 10:30 am
Conference Line: (800) 410-3590 - Passcode: 7201208#
Facilitator: Mari Radzik

In Attendance: Michael Helmick, Mari Radzik

Not in Attendance: Jessica LePak, Poshi Mikalson, Masa Nakama, Stephen Garrett, Two Feathers Tripp

9:00 am — Roll Call & Changes to the Agenda

We recently welcomed our new Emerging Leader: Brandon Ruiz Williams. He will be quite an asset! Hopefully mentors will be able to help him figure out what subcommittee he can serve on soon.

9:10 am — Review and Approve March 10th Minutes

The minutes are approved.

Mari will look into action item 6AI and she will look into past tasks and provide an update on their status. Please make time in the next agenda to check-in regarding these updates.

9:20 am — Debrief Data Analysis Training

Nothing else has been sent over from Katherine except for the review document which could be possibly used as a training opportunity and a deliverable item. Currently, we are not sure that we can use the training that Two Feathers provided since it was from a previous quarter. We were asked to not turn it in when it was originally ready, but are awaiting confirmation from the OAC to find out if we may use that training or not. Two Feathers sent in everything that we needed from him including the summary. Katherine's description has a record of attendees, record of CMMC members, as well as information on data collection, data analysis, and the collection process.

- Which Emerging Leaders will help Katherine?
  There was an email sent out to Emerging Leaders to find out who might be interested in helping her.
- Next Steps?
  Due to the new contract, we need to present evidence of what we have accomplished thus far, such as emails that we have sent out.
  Mari will email Katherine on next steps and with whom to reach out to.
  Michael will scan the review from Katherine to Mari so that Mari has a PDF of the review document. This seems like a great training opportunity.
  Another possible opportunity for next period: the Mac Data State Reports; we would like to hold a state-wide conference to disseminate information which might also be a good opportunity to generate more publicity. The conference might be a good opportunity for Emerging Leaders to be a part of. It is going to be an in-person conference and we may piggyback onto the OAC CRDP Strategic Planning Conference (most likely in Los Angeles) in order to do those. We are open to holding our conference either the day of, the day after,

or the day before their conference is held. As of right now, there is a tentative time frame of July or August of 2015. It will be hosted by CPEHN. This is on phase two of the strategic plan. All of the RFP process needs to be completed before they can move forward with the conference. This seems like a great opportunity to present our information! The Mac Committee is the subcommittee that is running it. Michael will bring this up during their conference call and will update Mari on if they are open to the idea. They originally wanted to have two; one in Los Angeles and one in Sacramento but it looks like they will only be able to do the one in Los Angeles. Michael will follow up with Ruben Cantu.

9:50 am Update on Deliverables

Mari will follow up. She sent an email to Katherine in regard to next steps for Data Debrief Training for Emerging Leaders

10:15 am Upcoming Dates of Importance

OAC CRDP Conference: pending on where it is, we will need to coordinate travel for Emerging Leaders. Michael should know more about the conference after he attends the next Mac Committee

Next CMMC meeting is June 23rd and June 24th.

- **Next CMMC Emerging Leaders Conference Call**
  Tuesday, May 12, 2015
  9:00 am – 10:30 am

10:30 am Adjourn

CMMC Emerging Leaders Committee Call Agenda

May 12, 2015
9:00 am – 10:30 am
Conference Line: (800) 410-3590 - Passcode: 7201208#
Facilitator: Mari Radzik
Attendance: Mari Radzik,
Not in attendance: Jessica Elm, Masa Nakama, Stephen Garrett, Two Feathers Tripp
Staff: Michael Helmick

9:00 am Roll Call & Changes to the Agenda

9:10 am Review and Approve April 14th Minutes

9:20 am Data Analysis Training

- Which Emerging Leaders will help Katherine?
- Next Steps?

1. We need to get a hold of the people who have yet to respond and figure out what group they want to be a part of.
2. Action item: Michael will contact the Emerging Leaders to ask that whoever has not given choice, please do so.
3. Katherine will start setting things up so that the projects can get started the weekend after Michael returns from vacation.

9:40am Committee for Brandon Ruiz-Williams

1. Need to figure out what committee Brandon would like to be on.
2. We need to reach out to him with a description of each of the committees. Need to connect with Jamila to see if it would be best for her to connect with Brandon, or how best to connect with him.

10:00 am Update on Deliverables

1. Our new contract started in February.
2. In the next deliverable the mentorship plans for the Emerging Leaders.
    a. We need to figure out what we will use for it and what we will be doing for it.
    b. We might try to set up mentorship conference calls to figure out where we are being helpful and where we are not being helpful so that we can make improvements. It would be nice to get them involved in ways other than having them attend CMMC meetings.

10:15 am Upcoming Dates of Importance

- **Next CMMC Emerging Leaders Conference Call**
  Tuesday, June 10th, 2015
  9:00 am – 10:30 am
- **CMMC In-person Meeting**
  Tuesday, June 23rd-Wednesday June 24th, 2015
  Times: TBD

1. The next CMMC meeting is June 23, 2015 and June 24, 2015. The first day plan is to have a half day meeting, and then the second day would be an entire day—but that will be determined once a venue has been chosen.
2. For the next agenda: Is this time a good time to have conference calls? What might be a better time?

10:30 am Adjourn