COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, February 15, 2017 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. Provide an update on behalf of the County of Los Angeles Department of Mental Health.
2. Share information on State legislative and budget items.
3. MHSA 3-Year Program and Expenditure Plan Update.

MEETING NOTES

Department of Mental Health Update	**Jonathan Sherin, M.D., Ph.D., Director, County of Los Angeles, Department of Mental Health** Dr Sherin presented a diagram of how he is viewing the Department of Mental Health entitled "Sacred Interface"- The relationship of those who are receiving services and those that are providing services, known as the clinical trench. That is where the critical data exists, and we need to access that to make good decisions. This is where we need to focus our resources so that we can optimize/maximize the amount of healing. We need to set up intentional systems. Strategic way to improve the systems and the transfer of data (see diagram below). There are two sides, the Constituent Side, which includes the SAACs (community input) and SLT (formal advisory role) and the Provider Side, which includes the District Chiefs who are the ambassadors and control point within the Department. We need to turn up the volume on the flow of information in both directions so that we can maintain that fidelity.

<table>
<tr>
<td>Department of Mental Health Update (Cont.)</td>
<td>Dr Sherin will conduct <u>SAAC tours.</u> He hopes everyone can come out and to talk about what's happening. His role as a steward of DMH resources is to make sure that all the support is in place. Each SAAC needs to let DMH know what they need in terms of support. He wants each SAAC to identify a clinic that he should visit. In those clinics he plans to spend time in focus groups with providers that are directing offering care. To get the information from the Sacred Interface, you have to go to the source. What tools do they have and what tools do they not have to do the best work, he has to do that in a safe environment for them to speak. Begin to weave together these systems and be as intentional, strategic, tactical in delivering the care that we need to deliver throughout LA County that is driven by the need of the people we serve.

Discussion, Q&A

Leticia Ximenez- Are you planning to go to the Cultural Competency Committee and the Underserved Communities?

Dr Sherin: Yes, there is a long list of things to do and visit. I want to experience it first hand before that. I am working hard to help understand and promote the Health Agency and make it real. There are individuals from departments that are playing roles in the agencies, for all three departments. He thinks that is one of our strong suits, our wheelhouse, and he wants to bring it to the agency. He wants to drive cultural competency initiatives.

Richard Van Horn- Commissions don't receive a lot of training, and training is terribly inadequate. It is seen as troublesome, how is the Commission fitting in with your thinking?

Dr Sherin: I meet with the Commission in one form or another twice a month. We have a responsibility and opportunity to hold up the SAACs and to make those a place where voices are collected in a meaningful way. As far as training of the Commission- we should work together with the OAC, in a focused way.
On behalf of the Commission- we had conversations about getting more resources, we will have a number of new commissioners due to the changes, and therefore it is timely to look at training.

</td>
</tr>
<tr>
<td>Update-State Legislative and Budget Items</td>
<td>Susan Rajlal, Legislative Analyst, County of Los Angeles, Department of Mental Health

This is the end of bill season, meaning all the bills that will be introduced for this year for this session needs to be in the 17th. Currently we have 34 various bills being reviewed.
Assemblyman Adrin Nazarian will be the author of our bill that is related to MHSA. Only people in a full service partnership are able to receive housing subsidy. We want to change that; everyone should be able to be eligible. This is important to maintaining stable housing, and also to create flow. People should not have to stay in FSP to stay in housing. The bill number will be provided later.
A Peer Certification is bill being worked on, and is in need of an author. Time is short and we know there are a couple of other organizations that are working on similar bills, and if they get an author we will sign on as a co-supporter on that. We are attending the meetings in Sacramento with all the organizations that are working on making this a reality. We look forward to being creative, more collaborative and open to working in a different way so that we can get a bill passed.
Brief update on the ACA-

Conversation is changing - 60 days ago; we were going to replace Obamacare. A week ago, we

</td>
</tr>
</table>

Update-State Legislative and Budget Items (Cont.)	started hearing we are going to repair the ACA. It's not perfect but we expect it to evolve. 43,600 clients in Los Angeles County received mental health treatment under Medicaid expansion. - Our intention is to work with parties who are writing proposals to help them see what is important in making changes. We are in the process of looking at what is important and what do we want to preserve. - Cassidy-Collins bill proposal - part of the bill included letting states determine if they want to keep the ACA as it is. States will be able to do so and get funding as a block grant but a 5% cut in funding right off the bat. - Governor Brown won't roll back any of the benefits that have been put forward and he will fight the repeal of the ACA. We need to be in touch with our elected assembly members of what the ACA has done for us. It is important to keep letting them know. - The latest we heard from Washington -- Replacement of ACA will be between 1 to 3 years. If we replace, but not have anything adequate in place, when the midterm elections are happening in 2 years, they may not get re-elected if they cannot do it in a way that provides coverage. The dialogue is beginning to be that you will receive healthcare in a different way. Less about coverage but more about receiving healthcare in a different way. **Discussion, Q&A** • **Jim Preis-** How much money is involved with the Affordable Care Act Medicaid programs, if it did stop, how much would it impact Department of Mental Health? o It would be 146mi annually. 20 billion to the State of CA. If 20 billion dollars disappeared we would have the biggest budget problem we've ever seen. • **Eugenie Lewis-** I would like to be involved in advocacy in the Affordable Care Act, Is there an organized vehicle maybe through SLT to promote advocacy? o Dr. Kay and Susan are facilitating a meeting that is open and trying, as a group, to put together some principles and thoughts on advocacy. Next meeting is in March and we will share that information with you as we develop it. If you would like information Susan will email it out. • **Tony Leggitt-** What was the legislator's name that you mentioned that did not have bill number? o Assemblyman Adrin Nazarian from the Van Nuys area. • **Patricia Russell-** What was the bill number? Is it possible for a summary of these bills and email it out to everyone? o Susan can email out a general list, and it is up for everyone to keep updating the information. Website that you can track the bills: www.leginfo.ca.gov.
MHSA 3 Year Program and Expenditure Plan	**Debbie Innes-Gomberg, Ph.D., Deputy Director, County of Los Angeles, Department of Mental Health** Public Hearing on Feb 23rd at Cathedral of our Lady of the Angels (555 W. Temple Street) from 11:30 am-3pm. Flyers are also available in Korean and Spanish. One of the big features of the 3 Year plan is the consolidation of Community Services and Supports Work Plans. Part of the plan is to expand FSP to include certain at risk populations that you help us operationalize. We will have a full picture for you at the next SLT meeting.

MHSA 3 Year Program and Expenditure Plan (Cont.)	Discussion, Q&A

	• **Tony Leggitt -** Are there 5700 new FSP slots that will be distributed, how many of those are net new or a mix of net new items? Can you please clarify?
	  o **Debbie Innes-Gomberg** - No update at this point. Half of the slots in the directly operated programs have significant vacancies; we will work on filling those vacancies before we expand them. In terms of the other question, we will be able to provide you specific details in the coming months regarding those programs.
	  o There will be an expansion of FSP slots- some of them from the migration of FCCS dollars to FSP-the other part is from FSP, the one-time $126M. We drafted a SCI, solicitation, in our contracts division now. That will start the increase in FSP slots that will allow providers to be able to provide the mental health support services for individuals being identified through whole person care. Whole person care starting in April- it will be the first phase.
	• **Jim Preis-**What is the source of funding for housing is the FSP dollars or the whole person care dollars? Will there be an increase in flex fund for this expanded FSP group?
	  o **Debbie Innes-Gomberg-**For that it would be flex funds just like a regular full service partnerships. $18,000 service dollars, $3,000 in flex. If you need higher amounts, let us know. In regards to the transition, the challenge is- we ask providers to augment or create a program. We are trying to do the best job as we can with that. “Do what you think is the best thing to do and we can always augment and change it.”
	• **Debbie Innes-Gomberg -** I would like to use the SLT, starting in April, to think about how the 3-year plan addresses Ethnic disparities. Disparities particularly in care. We are not making the strides in serving the Asian Pacific Islander populations, as we should. We want to put our best thinking together on how to reach the API community and address the disparities.
	• **Helena Ditko-** API populations seems disproportionately compared to other groups because they have the family support system due to their culture. We tend to look at as strength, but it should not be looked at as strength, since they are not receiving services due to the good family structures. We need to take a look at these populations.
	• **Lawrence Lue-** Commissions have heard the disparities that we need to address. The board priorities and jail diversion, some of these populations they aren’t appearing in for whatever reason. We don’t want to overshadow those populations that aren’t showing up. Hopefully we can engage them more, not just API, but all.
	• **Bruce Saltzar-** We need to reiterate our priorities for additional wellness centers programs for underserved populations and underserved geographic areas, which we identified as the biggest gap in the services. If we have additional CIRRS (RRR) dollars we need to look not just at FSP but for wellness centers programs and where we have deficiencies as well.
	• **Mariko Kahn -** For many of us serving the API populations for so long we often times spoken of these disparities, and it really is under the MHSA with the Innovations programs that we have begun to develop strong strategies that outreach not only to APIs but to other ethnic groups. We bring these statistics up constantly but to try to implement strategies that address the disparities is really the challenge. As the demographics of our population have grown to 19% in some districts, the utilization rate remains at 2% in PEI. For the severely mentally ill at most 4 or 5%. Analysis of all API clients in 2015- we have about 15,000 API clients and 78% of

MHSA 3 Year Program and Expenditure Plan (Cont.)	those clients are served by the 4 major API agencies. About 11,000, almost 12,000 of the clients are being served by the API agencies, which means we are doing something right. We need to look at more systemic level. We look forward to working with DMH as the plan progresses and hopefully approved to reinforce the strategies that we have found to be successful. I have learned that DMH can be flexible and very forward thinking. I hope SLT will look at this as a move towards addressing these disparities. The other populations that need to be addressed are the First Nations since they are much smaller populations and what they have suffered is very deep. We need to offer more help and strategies. • **Helena Ditko -** One of the things people forget is that mental health does not know any ethnicity, race, gender or barriers. We need to keep in mind. • **Leticia Ximenez-** It is great that we are going back to what we learned in Innovations I being able to engage people and help people through the treatment and the discharge by collaboration with the faith leaders in their community. Really looking at how we can do that in integrating and use of Clergy breakfast, round tables, faith based advocacy council, etc. Also collaborating with the schools- best way to engage people through education. These mental health issues affect the academic performance. Engage not only people at the schools but with the families as well. • **Cynthia Jackson-** I notice that you are putting strategies that work, I would say the role of peers should be vital to this as well. • **Ana Suarez-** Since we are talking about populations. I want to remind people of the immigrant population, there are lots of dread, fear, and sense of trauma. There is a sense of trauma in the immigrant population. We need services for them-immigrant populations do not have Medi-cal. o **Dennis Murata-** We can offer them Mental Health First Aid training so when they come across and meet with these individuals that at least they have some background and the knowledge on how to deal with this. Legal advocacy organizations can benefit from Mental Health First Aid since they are directly dealing with these people. • **Carmen Diaz-**I want to second Ana's comment. My children are born and raised here, but they are feeling the dread as well even though they are citizens. Every population is feeling this. We need to educate of the teachers to tell the kids on what is going on. The main priority of focus is on helping parents. • **Sunnie Whipple-**What kind of support system are you thinking about? First Nations are at the bottom of the disparities. We have been fighting this fight for a long time. There is historical trauma with layer and layers. What type of help or recognition or advice that you can give us. • **Mariko Kahn**- the First Nations also have their own ISM and have come up with some strategies. Foster family care is under DCFS- they got a small grant $70,000. Used Korean media to do outreach and got over a hundred responses. Now we have 39 Korean families taking in foster children, prior to that there weren't any for them. o **Debbie Innes-Gomberg -** In the 3-year plan under outreach and engagement- take a look at Innovation1; start to apply that in all the programs. Identify strategies, the role of family in stigma reduction, the role of family and outreach. Innovation2- if organizations that are part of the American Indian culture are not on our master agreement list to become lead agencies for Innovations2 please let them know to get on that list. One of the strategies relates to generational historical trauma and this would be a perfect match and a way to reduce disparities as well as to increase visibilities in the community.

MHSA 3 Year Program and Expenditure Plan (Cont.)	• **Mirtala Parada-Ward** is the lead of ISM programs- culturally sensitivity and competency. What came out of this process is the incorporation of non-traditional practice and engaging these groups. Our biggest success is around the outreach and engagement piece. The program allows providers to think outside the box. To bill for services that we weren't able to bill for, so we can properly engage these groups. Possible solution would be to expand some of the ISM groups to some of those despaired groups. The outreach piece is the most significant piece. Going out to the community, doing the grass roots work and utilizing health promoters, non-traditional practices such as yoga, developing partnerships with other community programs to help with the outreach. • **Ana Suarez**-I want to respond to Sunnie, I want to encourage any agencies that have expertise in ethnic outreach to sign up for the UREP, now UsCC for the master agreement list. That is another way to reach the communities. If you are not on the list you are not going to be invited to the bidder's conference so you won't be able to bid. **UPDATE FROM AGE GROUP LEADS ON WORK GROUPS:** **ADULT - Debbie Innes-Gomberg, Deputy Director, Adult System of Care.** Adult Workgroup met twice so far. The focus was on 4 things: ▪ Making sure we have a service continuum that is continuous and makes sense ▪ Identifying a level of care metric ▪ Identifying outcome measures for R3 ▪ Starting a discussion on benchmarking where we want to be for specific programs. Went from Non-FSP to CIRRS to now its final name: RRR - Recovery, Resiliency, Reintegration or R^3. 4 service areas- ▪ Field Based Services where mental health and supportive services are delivered in the field. It could be in a person's home, a community location such as a park, or a substance use disorder facility, etc. ▪ Clinic Based Services- Creating comprehensive mental health supportive services including the use of evidence-based practices. It requires a dedicated staff, and asking providers to start looking at. Practices using cognitive behavior therapy. ▪ Wellness Services. Services geared toward recovery, whole health, integrations back into the community, and increasing meaningful supports as well as the use of time. Client's responsibility toward movement in recovery, meaningful use of time and purpose. Creating purpose, and the interventions and support will be around achieving that. ▪ Client Run Centers- Peer Run Centers. There is an opportunity to leverage peer support in a way that is a bit different than how we have been doing it. Bring peers out into the community. **Approach to services:** using strategies to improve self-coordination. The more someone can self-coordinate, the more likely they are able to move and advance in their recovery. We talked about adjusting the intensity and frequency services as they move along in recovery. ▪ Using strategies to improve self-coordination ▪ Adjust frequency and intensity of services

MHSA 3 Year Program and Expenditure Plan (Cont.)	▪ How to integrate peers into all services? **Specialized populations:** Identified some specialized populations ▪ Co-morbid medical conditions ▪ Co-morbid substance use conditions ▪ Those experiencing trauma **Level of Care Measurement:** The level of care measurement that we are going with is the use of the determinants, which also incorporates the milestones and recovery. In next meeting we will look at the number of determinants that would correspond with the level. Devoted a training contract that will start in 2 weeks. Frequency – monthly has been helpful in the pilot. Consider decreased frequency as client gets better (after attaining a specific level of care) Create messaging around the value of measuring level of care **Outcome measure selection:** • OQ reviewed • IMR reviewed • Reviewed analysis of OQ vs. IMR • Dave Pilon recommended reviewing the CIOM (Clinically Informed Outcome Measurement System) **Other discussion:** Recommended additional training on FSP and training on the service continuum (RRR) **Actions:** • Dave, Paul, Kara, TJ and CIOB meeting on web-service development for where to enter LOC • Members to review outcome measure options **Discussion, Q&A** • **Carmen Diaz-**What services are there for parents who have a mental health diagnosis, who is having problems with child protective services and children are not in the system yet. I keep getting calls and I don't know what to tell them. o **Debbie Innes-Gomberg**- we are looking into mental health services that we can provide family members. • **Carl McKnight-** We talk about homelessness a lot, but we never talk about how to prevent it. We can use that model to prevent it. Once they are housed, in particular in the FSP programs, are there any ideas or support to bring support of employment into FSP to keep them from relapsing or not being housed anymore? o **Debbie Innes-Gomberg-**absolutely, the Dartmouth model is probably most closely aligned with assertive community treatment or with FSP. I would like to see it in Adult System of Care implemented in throughout FSP as well as R3. • **Carl McKnight-** that was my thought; it would be nice to have it throughout the system of care.

| **MHSA 3 Year Program and Expenditure Plan (Cont.)** | • **Ruth Hollman**-wasn't there a request for services that came out for the Dartmouth model and the only people that were allowed to apply for it was FSP providers?
  o **Mary Romero-** It was through the TAY division.
• **Ruth Hollman-** It is seems like the people that can benefit from employment support services are not at the level of being stabilized, so it seemed a little odd that those were the only people that can apply for it.
  o **Debbie Innes-Gomberg-**Transition Age Youth Bureau have been working with someone that worked in Alameda County who got phenomenal results with IPS and now is the director of Stanislaus County. They have researched this quite a bit. Mary, do you have anything to add to this? Through our contact with Stanislaus County we looked at services for FSP first since it seems most appropriate at this time.
• **Patricia Russell**- As far as talking about co-morbid and including substance abuse training, I was wondering if there was any way to connect it all. Is there a pragmatic way of training people about co-occurring disorders? They need to know about both, and they need to interact with both.
  o **Debbie Innes-Gomberg**- we have a huge opportunity this next year with SAPC? We will be relying on our contacts to be able to create and build on the training that exists now and to create integrated services. I do have to say we have interns are now being trained, they are coming in with some of those models built in, maybe training for the older clinicians.
• **Jim Preis-**As you develop these outcomes, are you going to attach dollar amounts to them? Can we capture the value or economic value? We can make the argument the value of the service of not only the human terms but in economic terms as well.
  o **Debbie Innes-Gomberg**- that is a wonderful suggestion.
• **Ruth Hollman-** The OQ outcome questionnaire is that for clients?
  o **Debbie Innes-Gomberg**-yes it is client questionnaire.
• **Ruth Hollman**-Depending on your setting, it may be ok to give this out monthly in a clinic setting. When you get more towards wellness and in wellness or peer environments- doing it more than every 6 months affects the integrity of program milieu.

CHILD – Kanchana Tate, Mental Health Clinical Program Manager, Children's System of Care
Reconvening the work group on Feb. 27th, 2pm-5pm @ 600 Commonwealth Conference Room 8. The purpose would be to look at RRR (Recovery, Resilience & Reintegration), and finalize the discussion that we started at last work group meeting on the target population, frequency of services, look at outcome measures, and to set benchmarks.

TRANSITION AGE YOUTH – Mary Romero, LCSW, Clinical Program Manager III and Belen Fuller, LCSW, Program Manager II
Two committee meetings were held, The discussion was on the non-FSP, R3, level of care, service array, level of care, tools for level of care. We agreed on outcome measures, MORS scores will be used for 18 years and above. We had a good discussion on using the Comprehensive Assessment Adolescent Severity Inventory but we don't want it to be complicated for the providers but need to work out details, i.e. frequency of scoring and other things. Meeting on Thurs. Feb.10-11: 30 pm at 550 S. Vermont. 4th |

MHSA 3 Year Program and Expenditure Plan (Cont.)	floor conference room—focus will be on Outcome measures. **OLDER ADULT – Martin Jones, LCSW, District Chief** We met with provider networks a week ago and talked in details of MORS, determinants and level of care. A couple of our providers were part of a pilot project, so we feature a presentation around how to actually use the MORS and determinants together to actually identify a level of care. We agreed to move forward with MORS and level of care training for our provider network. We are in process of calendaring meeting of outcome measures and other tools that will be part of the R3. We need to talk about not having free standing wellness centers, how to best utilize the RRR and make it a comprehensive program.
Update from Prevention and Early Intervention	**Lillian Bando, Program Manager III, MHSA Prevention and Early Intervention** • MH Commission Public Hearing is next week but we needed to start on the work now in order to get these programs moving for a start date of July 1st. • We are expanding the ability to providers for community outreach services. Prior year's allocation was low. Providers can use unspent non-Medi-Cal dollars to utilize up to 25% PEI allocations for COS. Submitted COS plans at end of January, but it is a rolling submission. We went out to 134 agencies and found that the staff has difficulty reaching out to the community to schools, religious organizations, head start, community organizations, and other government organizations. They can also provide prevention only services. They can get training, and provide Mental Health First Aid, PPP (positive parenting program). There are one-time presentations on a variety of proposals to be implemented in libraries, where a child is being occupied in an activity while the parents can receive education on specific topics. • We are looking at other community based programs that are currently being conducted. A number of them don't reach the level of becoming a community defined practice; we can provide technical assistance to them. We are working with a few organizations under community outreach services. They can do education and training, mental health promotion about certain topics, such as anger management, stress reduction, safe dating, depression, coping skills, and life skills. These are very specific to our communities. We have number of curriculum available. • Prevention only programs are being considered, and won't be part of COS; they will be bid out or implemented in another way. We are looking at short-term education, promotion, and existing curriculum. We are developing short videos. It would be specific for ethnic groups/underserved communities. • **Debbie Innes-Gomberg-** In addition to the things we will be doing in PEI, we are looking at Trauma related initiatives as the goal of Innovation 2. The RFS is close to going out. It is with County Counsel. The unintended consequence of Innovation 2 taking so long to implement is that the department is taking a look at becoming more trauma informed. There is an effort to align our efforts with PEI. • **Dennis Murata-** what we have been implement now, these are thing that any communities will need. We hope these types of strategies would have a much broader application. Starting in a more expansive way • **Carmen Diaz-** I notice we don't have anyone from the deaf and hard of hearing group. Maybe we can get vignettes on trauma for the deaf and hard and hearing group.

Update from Prevention and Early Intervention (Cont.)	**Eddie Lamon**- is what you are talking about in writing? No. **Lawrence Lue**- Sounds like the resources are still being channeled primarily through the existing contracts and it varies according to their ability to have left over PEI funds? Who do they contact if they are interested in these videos? How to access these presentation, who do they contact? Information is not generally available. **Lillian Bando**- we would be able to identify which agencies are offering those presentations and be able to provide what the COS services are in the directory. In regards to agencies that wanting training- they can adapt or adjust for their specific community and get trained on. People in community can learn about these. If it is training across service area for communities on a broader level. We need to redo website so it is useful. We also need to take advantage of social media too. - We are in the process of compiling a directory offering different types of programs, etc. - Call Lillian-213- 251-6710; voicemail message does not work sometimes. You can always email me at lbando@dmh.lacounty.gov or email mhsapei@dmh.lacounty.gov if you have questions on PEI. **Mariko Kahn**-As an agency that applied to convert some of our dollars, we have not received funding yet. All of the agencies that are applying are going to use a strength-based approach because we are in the community and we are going to let folks know. Eventually once we set up more classes/workshops we can funnel that to DMH. We aren't there yet, once it is up and running, information will be more available. - Resource on trauma vignettes on website: www.nctsn.com they have huge amounts of resources, done with providers all throughout the country. We should look into those and how can we utilize those vignettes. **Leticia Ximenez-** to the comment on Alhambra faith leaders, we are offering free topics, training to public specifically for faith leaders in the community. I can give you information on that. **Eugenie Lewis**- question on curriculum you mentioned. Are you saying the curriculum will be available to agencies, or community groups that are not contracted with DMH? Or is it for those contracted with DMH? - It is open to public and training will be for DMH agencies. **Ari Winata**-thinking about how huge the Department of Mental Health is the issues of communication are huge. I would like to suggest a spokesperson to refer, answer and assist all the people in the community to get treatment. The website has been in process for a couple of years, we need someone to answer questions. Someone to represent DMH, from every angle of communities. **Debbie Innes-Gomberg**- that makes a lot of sense. Creating a bureau that is public facing. Using social media increase our presence. We need to be able to get out there. ISD contracted with a developer, and working with different departments. We saw a mockup of website and much more thoughtfully lay out with the access # being more prominent. **Eddie Lamon**-I just want to say, what I found out what works is 2-1-1. If you can describe what you need, they can direct you to what you want. **Leticia Ximenez**- Remind people that we have a navigator in each service areas. Each service areas have

Update from Prevention and Early Intervention (Cont.)	navigators to help the community access and link people to services. We also have outreach and engagement people in the service areas. We also have a brand new item-health neighborhood faith base liaison. These are staff that connects people to different services. Leticia to send out the list. • **Helena Ditko**-1-800-854-7771, has great information and hard to remember all 8 service areas. • **Gabriel-**I wanted to respond to the vignettes on trauma. You may not be in victim of shooting but still traumatic even just living in that kind of area. o **Dennis Murata**- I want to remind everyone that it is everyone's responsibilities. It needs to be more than web based, or social media, it has to be all our efforts. We all need to do Outreach, trainings, anti-stigma, training, expansion of Promotores, etc. o **Debbie Innes-Gomberg**- in light of our earlier conversation around reducing disparities. Just received an email, on March 30th, all day presentation/conference on advancing mental health disparities. Information being forwarded to you today.
Public Comment and Announcements	**Mark -**March 3rd- 4th, Peer Action 4 Change Self Help Conference. The Conference will feature people from the State presenting workshops; Also presenters from Oakland present. Flyers are being handed out.
Adjourn	11:44 am