COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, March 19, 2014 from 9:30 AM to 4:00 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. To deliberate and approve the allocation realignment within the MHSA Capital Facilities and Technological Needs Plan (CF/TN Plan).
2. To deliberate and approve the recommended goals and strategies for the MHSA Three-Year Program and Expenditure Plan.
3. To deliberate and approve the recommended budget and associated programs and services for the MHSA Three-Year Program and Expenditure Plan.
4. To formalize agreements that made consensus possible and/or key unresolved divergences.
5. To be clear about next steps.

MEETING NOTES

Meeting Opening	***Debbie Innes-Gomberg, Ph.D., District Chief,*** **Los Angeles County Department of Mental Health** A. Today is not the end of a planning process it is the beginning. This is an opportunity to use the information that we gathered, all the budget data, the plans we talked about, gaps and services, the desire to strengthen prevention and early intervention, community services and supports plan, and workforce education training. I can almost guarantee you that the plan you recommend to the Executive Management Team, to the Mental Health Commission and ultimately to the Board of Supervisors will not be a perfect plan, but it will meet our needs at this moment. This is the beginning of a process that we will continue to refine based on an analysis of program outcomes, budget, and claiming data, as well as your own experiences. B. The next item is a request that the Department is making related to our Capital Facilities and Technological Needs (CFTN) plan. While the CFTN plan is one plan, we bifurcated the two planning and approval processes in Los Angeles. The Technological Needs plan was approved by the state in May 2009. Our Capital Facilities plan was approved by the state in April 2010, however, the allocation is a joint one. Locally we decided that 70% would be dedicated to information technology or Technological Needs and 30% to capital facilities, which pays for county-owned buildings. C. In implementing our electronic health record we realized two things: we needed a little bit more money and we are not able to use all of our capital facilities money. Dr. Bob Greenless will discuss the proposal that you will vote on.
Proposal	***Robert Greenless, Ph.D., Chief Information Officer,*** **County of Los Angeles, Department of Mental Health** ***A copy of Bob Greenless' presentation was included in the SLT meeting packet.* **FEEDBACK** 1. **Question**: The $3 million, is that all you will need or do you need more? **Response:** We will probably need more than that ultimately.

	2. **Question**: Will the funding allocated for the peers to have computer access be spent before the reversion date? **Response**: That is a separate from the IBIS project. There are over a hundred computers right now. Because of the IBHIS project we have not had time to see if there is an opportunity to expand. 3. **Question**: Is there any consideration to the agencies that are experiencing the same problem with funding and trying to get this done by the May deadline? **Response**: I do not see an option there. We allocated, approximately $27 million to the agencies. That is something no other county has done. At this point we need to get IBHIS in or the rest will not matter very much. 4. **Question**: Will the reduction of the $3 million affect the providers in any way? a. **Response**: This is not a reduction. b. **Response**: Not that I am aware of. It cannot because the rules for construction are that construction money be used for county owned facilities not for providers therefore the switch is from county construction to information technology. In our initial discussions, we explored every avenue for using these efforts to support the contractors. This is why 70% of the money goes toward IT/TN because that was the part we could share with community agencies. 5. **Question**: Your slide shows that we have $57 of $100+ million we need. Where is the other $40 million you need to complete the IBHIS project going to come from? **Response**: From the regular IT budget. 6. **Question:** Will we have the funds to integrate into the new healthcare models that we are working on in Health Neighborhood? Is this fund going to be enough to do what we need to do to integrate that? **Response**: Basically we cannot do that unless we get IBHIS implemented. This helps us get the base in place to do that. ***Proposal: Support shifting $3 million from Capital Facilities to Technological Needs.*** ***VOTE:*** ***31 SLT Members Voted*** ***20 Strongly Agreed*** ***11 Agreed*** ***Proposal Approved***
Age Group Q&A and Deliberation	Rigoberto Rodriguez, Facilitator A. At the last meeting the SLT approved the goals that were presented with the exception of goal 8 for children. That was presented at the very end. Today you will be asked to approve goal 8. B. At the last meeting we identified the top three strategies that you felt would have the most impact in achieving those goals by age group and cross cutting age groups. Each age group discussed the strategies and reported their recommendations. The document titled "Proposed Priority Categories, Goals and Strategies"; resulted from that

recommendation that you issued last time. These goals, strategies, and categories all came from the multiple forums and deliberations that included not just the SLT but members of the public and SAACs.

C. What we are asking you to approve today is Children's goal #8 and the top 3 strategies per goal.

FEEDBACK

1. **Question**: (Older Adults) On goal 1, #2, goal 4, #1 and goal 5, #2—are those cost neutral?
    a. **Response**: The common denominator for older adults is that with the growing population older adults could use funding in every area. We looked at where we have existing initiatives where we could do something without funding. For instance, on goal 5, #2, provide training to service extenders and community volunteers, we have a service extender academy. We do not use any additional funding. We use our staff and then volunteers from some contract agencies that currently have service extenders. It could be done that way. Or it could be done where you pay another agency to come in and provide training. So I am just suggesting that, "Would funding be great? Yes". In the absence of funding there are avenues to make some of these things happen.

2. **Question**: On children's, it is not clear what is meant by goal 2, strategy #3, “implementation of the California reducing disparities project--recommendations to use EBP's.” Does that mean making the EBP's more culturally sensitive? Does it mean that whatever CRDP has come up with they will implement in the EBP's?
    a. **Response**: Some of the strategies were broad. The proposals have more detail in some of those.

    b. **Response**: This recommendation came out of the SAAC. In terms of further clarification I apologize. I do not have more than that.

3. **Question**: TAY did not include anything about making EBP's more culturally sensitive for the TAY group in all the goals and strategies (Goal 3, #2)
    a. **Response**: This is a synthesis of past meetings. The stigmatization includes all of those different cultural and ethnic disparities that would be addressed with EBP's.

    b. **Response**: Some can be addressed in the ways that you are implying. But some of it is really inherent in the EBP's. To do fidelity to the EBP you have to do what the developers say. So changing it is not in our power. What we can accomplish is to prepare the context in which the EBP's are provided so that they are as culturally relevant as possible.

4. **Question**: In the arena of aging, I look at goal 5, and my concern is the more fundamental issue of whether there is any process for supporting basic nutritional sufficiency for the aging population. How is that dealt with in terms of the programs listed here?
    Response: We thought about the Older Americans Act, which is separate from MHSA funding, as a way of mitigating that issue. I think a good point is being made that the mental health piece can prevent access, that you need the case management sometimes to help access the other resources. So the dollars are not necessary but the access is.

5. **Question**: Is there a way that the strategies that you do have can address that issue?
   Response: 'Increase number of FSP slots' because that is where it is and that will include the case management that helps somebody access that. That is a normal part of the FSP and the FSP pilot program.

6. **Question**: In the children, adult, and older adult the strategy is consistent. But I am seeing an inconsistency in the TAY. To give you an example, under goal 2, #1, consistency. They talk about education, to identify early symptoms indicative of mental health issues and to address stigma. The outreach and engagement efforts to parents and caregivers of ethnic and cultural groups ensuring linguistic capacity through expansion of the Promatores program and create the cultural equivalence of the Promotores model.
   a. **Response**: So if we added "cultural equivalent" that would address the concern.

   b. **Response**: Yes.

   c. **Response**: I think it was addressed for the outreach. We left the 'expand and adapt the Promotores model' as an outreach and cultural groups. So we referenced the cross cutting strategy and proposal that deals specifically with expanding and adapting Promatores not only to the Latino community but inclusive of all ethnic and cultural considerations.

   d. **Response**: We could be more explicit with the wording.

7. **Comment**: LGBT needs to be infused into these various levels.
   Response: If you look at page 1 under Children, at the very bottom, the footnote, this was one of the explicit recommendations that was made last time. Whenever we referred to cultural groups that we explicitly mention LGBT. We listed that at the beginning of the document, so it applies across the board from what the group agreed to last time.

8. **Question**: Under Children, goal 3, strategy 2, would that include an EBP like expanding PCIT? I see it here for children 0-5 specifically.
   Response: We did not specifically say PCIT but in the proposals for the PEI we collapsed PEI expansion and expanding integrated school health centers. We want to look at all of the EBP's that are currently utilized including PCIT. What we put in there is really to analyze and really to review the current EBP's to see and look at the outcomes. After that analysis we will look at which ones to expand.

9. **Question**: This is regarding Workforce Education and Training as a suggestion/clarification that goes with all of the age groups. Dr. Southard explained almost all of the EBP's that we use with Older Adults--the majority are not culturally sensitive to the population served in East LA. My suggestion is that we put language in that encourages partnership with local universities with providers that are having community defined promising practices which could turn community defined promising practices into EBP's.
   a. **Response**: I think there is a rich opportunity here. On the one hand when we look at outcomes pre and post for EBP's for PEI we are seeing a huge reduction in symptoms particularly for the Latino population. I think the opportunity exists for possible WET regional partnership projects. That might be one avenue in which to think

about doing this. Our next Innovations project may be another.

b. **Response**: One final clarification is that Promatores/Community Workers is an EBP of prevention but not considered an EBP of early intervention. That makes things a little difficult.

10. **Question**: I found one group that we used to talk about--you did not put the blind in there.
    a. **Response**: That we have under "Persons with physical disabilities." Do you want me to make it explicit? Blind?

    b. **Response**: Yes.

11. **Question**: On page 24, on TAY drop in centers, this is excellent, but we need to address the impact for the street kids out there specifically in each SAAC. I know budget is limited but I suggest that we expand our horizons and make sure we have a drop in center at each SAAC area minimum.

12. **Comment**: Should some of these be in the PEI category as opposed to CSS? As an example, under TAY, goal 2, #1 about outreach and engagement; the reason we bring it up is because there is a heavy burden on CSS.

13. **Comment**: Where you see a check mark around the MHSA component sometimes we registered not so much where the money is going to come from but rather who brought it up and they thought it was PEI or CSS.
    a. **Response**: The staff should look to make sure that if we do get to the funding part that it might, especially on the CSS part, be fundable in other areas.

    b. **Response**: I think the intent is there and the desire is there.

14. **Comment**: I want to make sure that the Promatores model is not implemented to all of the ethnic groups and that characteristics of the outreach and engagement are taken into consideration the different characteristics of the different ethnic groups.
    Response: The Promatores model is actually a defined model which in its basic components the community people are educated in mental health or health if they are doing Promatores or health navigator work in health because it is and has been done with the health community and with the domestic violence community and the with AIDS community. The main issue is that we train people to be educators of the community. So that can be translated to any ethnic community. The key is bringing in cultural and linguistic components of that community in doing the presentations.

15. **Comment**: Models have consistencies in certain areas and communities however the adaptation is culturally relevant to the community you are serving. That community must define and adapt it so that it meets its cultural relevant. I want to be clear about that.
    Response: In January we gave you the definition of cultural competency. It is not an "if we do it" it is already required in terms of how we do the work.

16. **Question**: Is there a catalogue of all of the existing work plans that we can have reference to?
    Response : Yes.

17. **Question**: Is there a one for one correspondence between this document and the detailed document that we are going to have this afternoon?
    Response: Yes. We are asking you to approve the overarching skeleton, the bones, and then the meat is what we are going to get into in terms of resources and how to actually implement some of those strategies that you are prioritizing.

18. **Comment**: We never specified. We did not want to specify 0-5 because we want this program for 0-16 or 18 or whatever children are. Once you specify something you omit or exclude somebody else.

19. The SLT discussed adding a goal related to the client congress proposal to allocate 7.5% of the budget be spent on peer services. After discussion, emphasizing the importance of peer services and holding the Department accountable for supporting them, the group created a goal that focused on accountability to the development of peer services that was subsequently voted on.

20. **Question**: Regarding co-occurring disorders the strategy reads, "Provide ongoing workforce development to increase knowledge, skills, and abilities, in the provision of co-occurring disorder services." Maybe in an innovation kind of way say, not just training people but thinking out of the box and saying, "Create new groups that are ongoing at the various mental health clinics."
    Response: We have a couple of EBP's that incorporate substance abuse and co-occurring. Our challenge is one of training. Our social workers, psychologists and psychiatrists come to us with a very minimal amount of training to provide this. The primary thing that we are focused on is awareness with our staff and ensuring that they raise these questions and the training is what we use to support that.

21. **Comment**: Here is the first proposal. We will test for agreement. If there is an "E"--someone that blocks the second alternative--then we will vote on both of those. 60% or more is what carries forward the recommendation. The voting is now open. This proposal has two parts: one is adopt the children's goal #8 and the priority strategies, up to three strategies, that you heard from the each of the goals across the age groups. What we are asking you to adopt is the document.

22. **Question**: You are asking me to vote on this document that has goal 8 added that we did not have last time and with a missing page that we do not have?
    Response: That we have up here, yes.

23. **Comment**: If you want to change and add the revenue neutral peer services at this point you vote E.

24. **Question**: We suggested some inconsistencies and changes that need to be made. Are you saying that is included or not?
    Response: That is included in the strategies and what the people intended. It is a friendly amendment.

25. **Question**: Everyone knows that we are just voting on this document, goal #8, as the one that was expanded on and we want to make sure to get that included, but the caveat is that after this vote we will have openings, to discuss any

amendments.

Response: If someone blocks it.

26. **Question:** If somebody wants to make an amendment and the body agrees we can amend or add.
    Response: Correct. When we go into the second round of discussion.

27. **Comment**: We now open a second round. You can present an alternative proposal.

Proposal: Adopt the proposed goals and key strategies for all Age Groups.
VOTE: (42 voters)
15=A - 'Strongly Agree'
16=B - 'Agree'
2=C - 'Neutral'
3=D - 'Disagree'
6=E - 'Block'

28. **Question**: I want to get make to your interpretation on what 'A' means. You said it is "without changes." Definitely, before we made this vote you said that the things that the doctor and other people have brought up is included in the change, not in the document as written, right?
    a. **Response**: Right.

    b. **Response**: That's what my interpretation was when I voted. But you said there were no changes.

    c. **Response**: If you are an 'A' you strongly agree without any changes. If you have minor divergences you are a 'B'. 'C' you are neutral. 'D' you disagree. You disagree strongly but are still willing to not block the group from going forward. If you are a 'D' one thing that we ask is that what those key reservations are for the record. If you are an 'E' you are blocking because you have a major concern and then you want to propose something different from the group.

29. **Comment:** Before voting on the adult, to see handouts.
    a. **Response**: Can we have a chance to look at them and then exclude that from the vote right now so that we can look at them and vote on them later?

    b. **Response**: So you propose voting on all except adults.

    c. **Response**: Yes.

30. **Comment**: My problem was with the procedure mostly. I was thinking that we are voting on 3 things at the same time. They required 3 different votes. Like the 'adopt children's goal #8' is one vote. We need to vote on that separately. The age groups, that's another thing that we need to vote separately on. I think also the suggestions--the questions that we raised are also separate.

You propose voting on the 3 items separately.

31. Comment: Mark Parra pointed this out and I really missed this. Page 8 on the adults, goal 4 and the two strategies beautifully explain and puts on paper our whole discussion about cultural competence and EBP's and all of that. So my only suggestion is to perhaps scratch #2--is that if we could say that the adults go forward with 3 strategies would it be valid for all ages.

32. A member of the SLT initially proposed that the group add a goal that said, " the MHSA integrated plan include a benchmark of 7.5% of the overall funds for the peer services". Some members expressed the importance of including a benchmark for peer services, citing that it is important to hold the Department accountable. In addition, some noted that current budget allocations already exceeded the 7.5% benchmark. Others felt that the benchmark of 7.5% was problematic because of potential impact on services, the lack of clarity on how much 7.5% was, and setting a precedent for creating percentages for all services. The Executive Management team felt that this might be more of a compliance issue related to existing service and staffing expectations. A commitment was made to ensuring existing standards for peer services are adhered to.

33. After discussion, the SLT revised the proposal and voted on adopting that following statement, "The LA County MHSA three year program and expenditure plan include a clear commitment and accountability system for peer services."

Proposal: "The LA County MHSA three year program and expenditure plan include a clear commitment and accountability system for peer services."
VOTE: (34 Voters)
A=17
B=7
C=7
D=3
E=0
The Proposal passes

34. Comment: Before voting, the group reviewed the key points for inclusion in the age group strategies. Key points included emphasizing the importance of culturally competent EBP's. including the blind as part of the cultural groups, that we are clear that Promotores must have a cultural equivalent defined by the community, explicitly name or bring cultural competency in TAY in alignment with the rest of the document, be clear about LGBT across all levels, co-occurring disorders: making sure that as you look at that strategy that you look at Innovations or innovative ways that this could be embedded in groups, and a commitment to the importance of drop in centers for youth across all of the SAAC's.

35. Comment: On page 8, besides EBP can we add community defined practices and promising practices.

36. Question: What are Community-Defined Evidence (CDEs) and Promising Practices (PPs)?
Response: There is Evidence Based Practice, Community Defined Evidence and then Promising Practice. Typically it is the EBP's that we end up using because of all of these studies, experimental and quasi-experimental designs

	behind the evidence. In our community there is history, community wisdom and other forms of evidence that we can use. Promising Practices have some degree of studies behind them but not necessarily the most "scientifically" rigorous, quasi-experimental, etc.? ***Proposal 3: To adopt the proposed goals and key strategies for all age groups.*** ***Vote :(34 voters)*** ***A=17*** ***B=10*** ***C=4*** ***D=0*** ***E=0*** ***We have adopted this framework for the 3 year integrated plan***.
Budget Plan, Q & A, and Deliberations	*Dennis Murata, Deputy Director,* Program Support Bureau A. The most important recommendation today is the one that we just made. If we are not clear about the goals and strategies then it is difficult to allocate resources. Some strategies may or may not have money to be implemented the first year, second year, or third year. We are committed to achieving those goals and implementing those strategies. B. We are asking you to make 2 more recommendations. The first recommendation is around the broad budget. When we started this process in September and October we were informed that there was no new money. However, about a month ago the department put forward a proposal around the unspent dollars for CSS to the Ad Hoc Group. We want to focus specifically on the amount of funds that are available through CSS for the next three years. Having consulted with members of the EMT and being an EMT member himself Dennis will present three options on how to distribute the money from the unspent dollars from CSS for each of the age groups. Then we will deliberate and agree to one of those options. C. There are no additional unspent dollars for PEI or WET. The budgets have to conform to CSS fundable strategies. The final point as we move into the budget is conflict of interest. The Conflict of interest rule states that a person cannot be involved directly in making a decision around public funds that benefit them or an organization that they work for or with directly. D. How Conflict of Interest is applied to a multi stakeholder body is yet another question. First, one is not in conflict of interest when, for example, through ad hoc planning processes through small work groups, or if you give recommendations around general priorities or even a general breakdown of a budget. For this next part we are in the clear. No one has conflict of interest. E. What we do have is a commitment to a whole system. We do have interests in terms of specific constituencies and age groups. We want that to be part of this conversation. However, after we reach an agreement around the distribution of resources by age group we will go back into small groups and at the small group level you can continue to give your opinion around the relative allocation of resources for your age group. When we bring those proposals back to the large group we are then going to be very strict about the conflict of interest policy.

F. At our SLT Ad Hoc group the Department and the EMT put forward a proposal. Basically there is $90 million available for the next 3 years of unspent CSS dollars. The task was then to think of that $90 million and allocate it by about $30 million per year for the next three years.

G. Whatever strategies we identify to be funded through these dollars should be services and programs that become funded through ongoing dollars in year 4, instead of onetime dollars. There are a couple of interests we have to balance. We do not want to fund something with one-time dollars that we then have to dismantle in year three.

H. That $90 million is an accumulation of dollars over many years. The bulk of those unspent dollars came to us either last year or the year before. We had a big boost of CSS dollars. There were some dollars held up in the state reserve. Those dollars were one-time. They are not sustainable. It is not something we are going to get every year.

I. Rather than having a free for all and saying, "Okay, which strategies do we fund or not?" we thought it more effective to first ask, "What percent of those dollars can be allocated by age group?" We will then ask you to go back to your groups and to deliberate on the proposals and bring your strategies and amounts in conformity with the amount.

J. This one it is titled comparison of CSS and PEI. This was based on last fiscal year. You will see the first few row shows number of clients served, their percentage, as well as the net dollars for CSS. In this case net dollars are 100% MHSA dollars. Gross dollars include those net dollars and any revenue that would draw down from Medi-Cal. So that's for CSS and PEI.

K. The key thing we wanted to highlight is that depending on the age group and type of program some of these dollars are heavily leveraged. For example, if you take a look at kids under CSS, $1 net buys an additional $5.30 approximately. The $30 million are net dollars. Those are not gross dollars.

L. One recommendation was to distribute it by age group. What we are proposing in this chart here, if you a take a look there are three options. We could do the allocation, and this is the yellow piece, of what that actual net dollar percentage is by age group for CSS. That's the yellow option there. That will show you how much of, let's say, $20 million will be distributed by age group.

M. When you take a look at kids, it may only represent 6.2% for kids for CSS but the bulk of PEI are for children in terms of the net and gross dollars. It is hard to separate that. Even though they are different plan components when folks come into service these are services that are available to them period. That's why we thought maybe another option would be to combine those two amounts and then take a look at what that percentage distribution would be. That's the green section there. That would show you what that allocation would be based on $20 million.

N. The third option is looking at the client or consumer distribution by age group. We are willing to hear other options as well. We are talking about $30 million. So why am I talking about $20 million? The Board priorities are roughly $10 million. We took that money off the top. That is why the balance would be $20 million to distribute.

FEEDBACK

1. The SLT asked questions of clarification that included discussion of Board Priorities (Laura's Law, IMD Step Down, and Staffing and service for SB82), which groups benefitted the most from the priorities, and the use of CSS dollars only. Dennis also provided context for why the proposals used actual claiming numbers from both CSS and PEI. The group asked about the impact of the Affordable Care Act, and the impact of the leveraging of dollars by age group.

2. The group voted on 5 different funding models
   a. Net CSS dollars
   b. Combined PEI and CSS models
   c. CSS Clients
   d. 14.18%. 12% for TAY, 60% for adult, and 13.92% for older adult.
   e. 10% Children, 14% TAY, 63% for Adult, 13% for Older Adult

Round One:
Proposal: Vote on the top two budget frameworks
A=7 (Net CSS Dollars)
B=8 (Combined PEI and CSS models)
C=9 (CSS Clients)
D=18 (14.18%. 12% for TAY, 60% for adult, and 13.92% for older adult)
E=14 (10% Children, 14% TAY, 63% for Adult, 13% for Older Adult
Our top 2 are D and E.

Round Two:
Proposal: Vote for either proposal D or E
Option D=19
Option E=11

3. The SLT discussed the merits of Option D and Option E. Some members felt that Option D gave too much to children and not enough to TAY, some felt that the Adult System of Care needed more resources given the cuts it had taken over the years. Some felt that TAY were covered by both Child and Adult funding. Others chose E because they felt children have EPSDT and have more help.

4. The SLT voted for consensus on both proposals D and E, and neither passed.

VOTE:
Option D: A: 62 percent, B: 0 percent, C: 7 percent, D: 17 percent, E: 14 percent
Option E: A: 45 percent, B: 7 percent, C: 14 percent, D: 10 percent, E: 24 percent

5. The SLT then went to a vote on the two proposals:

VOTE:
D=16 (57%), E=12 (43%)

6. In order for one proposal to be selected, it must garner 60% of the vote. Neither proposal garnered 60%. The SLT was then asked to provide an alternative proposal.

7. The SLT proposed 13% Children, 13% TAY, 61% Adults, 13% Older Adults.

VOTE:
Proposal: 13% Children, 13%, TAY 13%, 61% Adults, 13% Older Adults.
A: Strongly Agree = 9 (35%)
B: Agree = 7 (27%)
C: Agree with Reservations = 6 (23%)
D: Disagree but will not block = 4 (15%)
E: Block = 0 (0%)
We have consensus on this.

8. Based on consensus reached by SLT, the CSS dollars per fiscal year, broken down by age group is: $2.6 million for Children, $2.6 million for TAY, 12.2 million for Adults, $2.6 million for Older Adults.

9. The group was provided with a packet that included all proposals that were submitted by age group, a one page document that provided budget information for CSS proposals including the Board Priorities, cross-cutting strategies, and age group strategies.

10. The SLT divided into smaller working groups by age group. Each age group was asked to allocate resources to the strategies they wanted to prioritize. The group was asked to provide a breakdown by Fiscal Years 1,2 and 3. Each age group was required to align their budget with the allocation of CSS money that they were given.

11. The group was unable to finish their deliberations and continued their work in a Special Session of the SLT on Tuesday, March 25, 2014.