COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, July 17, 2013 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90010

REASONS FOR MEETING

1. To provide an update from the County of Los Angeles Department of Mental Health.
2. To inform the group about State budget legislative issues.
3. To issue a recommendation on extending the Innovation projects by year one.
4. To review the Office of Statewide Health Planning and Development (OSHPD) Workforce Survey.
5. To discuss the planning process for the MHSA Three Year Integrated Plan.

MEETING NOTES

Department of Mental Health - Update	*Marvin J. Southard, Director*, County of Los Angeles, Department of Mental Health A. Dr. Southard updated the SLT on his meeting regarding triage services and urgent care in the Antelope Valley and funding through SB 82. He discussed the County's veteran programs, the development of the health neighborhoods and application to the federal challenge grant which will focus on community engagement. **FEEDBACK** 1. **Question:** What do you mean by robust and less robust? a. **Response:** We do not know for sure. UCLA and Rand are writing the grants so that whatever is proposed applies generically to all jurisdictions. In LA we will implement something similar to the CPIC model used in various South LA neighborhoods. Community advisory groups representing faith and service organizations organize around a particular topic for that community. The topic in this proposal connects depression to another health issue. b. **Response:** The focus is on making it work. In the budget process one big change was the revision of the alcohol and drug benefit under Medicaid. The revision expands services for the historic Medicaid population plus adds a new cohort of individuals who will be entitled to a Medicaid benefit for substance abuse treatment for the first time. There are missing pieces that need to be filled in between now and the first of January. Questions include: 'Who are the providers? How will they be reimbursed? What sites will be available? What kind of medical necessity criteria will be established so that all the money is not used in the first two days?' Some issues are legislative, some policy and regulatory, and some require preparing our local work force and organizations. c. **Response:** I am working with SAPC in hopes of using the existing mental health provider network for more robust substance abuse services. The goal is that if you go to any of our mental health agencies you can access the full range of services from 'addiction only', to 'mental health only', and every shade of co-occurring at one place. The first of January is a statewide entitlement and a lot of work must be completed before that date. 2. **Question:** Is collaboration, particularly regarding substance abuse, a part of the planning that the state is doing or not?

	a. **Response:** The Alcohol and Drug Division became a part of the Department of Health Care Services on July 1st so the integration is taking place at the state level as we speak. The truth is that the intellectual work will probably need to be done at the local level and imported to the state. The state does not really have the capacity to provide the leadership. b. **Response:** In LA, the Department of Public Health and Department of Mental Health are working closely on this. We have the same vision on what needs to happen. That is not the case in every county. We try to make sure that LA's view prevails which is what happened in this drug benefit where this robust benefit was available both to the historic and expanded populations. 3. **Question:** What stakeholder input is happening with the drug benefit and integration with mental health? **Response:** As far as I know, none. 4. **Question:** That seems contrary to the way we do our planning. **Response:** This is not my system. It belongs to the Department of Public Health. I am part of 3 groups that have stakeholders on a statewide basis to move this forward. 'Alcohol and drug' is not a part of my portfolio. I try to be as helpful as possible because it matters to our clients. 5. **Question:** I have two major concerns; one is that we go with large providers who are not savvy about different cultural groups, and end up with only 12 step models and not using other evidence based models and substance abuse which in our diverse county— **Response:** That particular fear is probably not one you need to worry about because the paradigm is the Kaiser small business model and the benefits have already been decided. It is the implementation process that needs to be completed. 6. **Question:** That is my concern. You get huge mills that turn out people versus the smaller, licensed sober livings that have better outcomes for a lot less money. I am concerned about mental health providers doing substance abuse on a big scale when they haven not done it before. 7. **Comment:** The concerns are duly noted. 8. **Question:** I suggest that you advocate for the inclusion of stakeholders in that process and make sure that we get the smaller providers there. **Response:** I do.
State Budget, Legislation, & Related Issues - Update	*Susan Rajlal, Legislative Analyst,* County of Los Angeles, Department of Mental Health A. For the last two years the Department of Health Care Services (DHCS) had many opportunities for stakeholder input, including written input and public hearings in Sacramento. One reason they took an extra year to be transferred over to the DHCS was the amount of input. The DHCS website provides information on the type of input received. B. Two important things to report, the governor's plan to take part of our realignment funding and share it with Cal Works was rejected. We also have access to new money. C. The handout in the meeting packet shows the addition of $60 million to reach and serve the un-served and under served with mental health services as part of the implementation of health care reform--also Steinberg's community mental wellness bill. One area that still concerns us is LPS reform.

	D. Although the bill that is going through this year it leaves lots of the areas related to LPS reform untouched because there is so much disagreement. Part of the money in Steinberg's bill includes $400,000 to be administered by CIMH. The goal is to get statewide consumer input and develop consensus guidelines for how to change 5150 and the welfare and institutions codes. Senator Steinberg says that it is his intention to remain the proteome until his last day in office. His priority for next year is continuing work on LPS reform and mental health legislation. E. I want to call attention to AB 85, which sets up the mechanism for counties to pay a share of what the state thinks there will be in savings with health care reform implementation. The counties believe the amount of money that the state is putting forth is probably inaccurate. $300 million will be taken from the realignment health sub-account. That does not include mental health, so we will not lose any money in that process. F. Lastly, we finally have a deputy director in the Department of Health Care Services with mental health background. Dr. Karen Baylor, currently the Director of San Luis Obispo County Behavioral Health, has been appointed. She will assume that position in September. The legislature is on holiday until the middle of August and then resumes with the bills that are still pending and getting them through and everything signed by September 10th. **FEEDBACK** 1. **Question:** What is LPS? **Response:** Lanterman Petris Short. That is the act that governs involuntary mental health treatment in California. That legislation is about 40 years old and ready for some reform. 2. **Comment:** Back in November of last year Dr. Shaner also spent some time on that particular piece of legislation. 3. **Question:** Is the addition of the $60 million to reach un-served and under-served for the whole state? Who will it be under? **Response:** Yes. Department of Health Care Services 4. **Question:** The money will go to DHCS and might be allocated to counties? **Response:** Yes.
One Year Extension to Innovation Projects - Recommendation	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division*, County of Los Angeles, Department of Mental Health *A copy of Debbie Innes-Gomberg's presentation was included in the July meeting packet.* *A copy of Mariko Kahn's presentation with her speaker notes was emailed to the SLT.* **FEEDBACK** 1. **Question:** When the Innovation component was put into the Act the intention was to create a 'learning community' with successful programs being integrated into the ongoing program with 5% always available for innovations. What level of change does DMH need

to see to say this program is so good that it deserves to be continued beyond the trial period?' Should it be a policy that the most successful innovation programs have first call on growth dollars as we move ahead?'

Response: In our quarterly learning sessions we will review the data, with providers and Department present, and ask 'what does the data show us?' For example, for PEI I gave a presentation to the SLT about pre and post differences as it relates to a specific outcome measure for specific practices. For Innovations, we have not answered, 'what's good enough?' If you get a 25% reduction on the YOQ (Youth Outcome Questionnaire) for the Trauma Focused CBT practice is that good enough? Is that what we expect? We do not know. For this, I want to bring together practice experts and general knowledge in the area of integrated care to start answering that question. The second question about growth is a policy issue to bring back to our Executive Management Team.

2. **Question:** Are we being asked to extend money that was unspent on Innovation because of the delay or are we being asked to take a piece of the ongoing funding that could be spent on anything and spend it on this?

   Response: Every year 5% of CSS and PEI are dedicated solely to funding innovation program. The request is to continue to rollover unspent funds that are eligible for innovation as well as taking the 5% component which is about $19 million a year for the next couple of years to fund this project for one additional year. The alternative is to wait for the 3 year integrated plan process, and come up with our next innovation project. We would have a couple of years when we would not do any innovation because of the time needed to create plans, sign contracts and then implement them.

3. **Question:** I want see a presentation to the SLT on what was learned, what works, what does not work, and how we will integrate that into health care reform. I'm hoping we're going to have strong, solid data that will support us not only here, but also at the state level.

   Response: You will start to see some of that in the rest of today's presentations. As we move into the 3 year planning process--that is absolutely essential.

4. **Question:** You referred to a gap. My understanding was that if an Innovation program is effective and successful and we would not have a gap but that there would be funding available to continue it both from this 5% but also from other CSS growth dollars. The 3 year benchmark does not mean the end of the program and forcing groups to apply for funding again, rather that there would be some evaluation along the way. Is that true?

   Response: First, this is a time-limited project. If we determine something works then we need to determine how to fund it. It cannot be innovation. It has to be CSS or PEI. The gap referred to was the gap at the end of '13-'14 because we would not have a project and providers in place by July 2014.

5. **Question:** How many of the projects touch children and families?

   Response: The ISM model serves children. The IMHT model has the capacity to serve children. It focuses on the homeless population and the practicality is that there are not many children served at this point. The ISM is the Integrated Services Management model for the 5 underrepresented ethnic populations. That is the model that served the most children at this point.

6. **Question:** Your 4th year is your 3rd year right? It is the 3rd year of activity.

   Response: Yes.

7. **Comment:** I move that the SLT recommend to the Executive Leadership Team that all Innovation programs have a full 3 years of activity. That was the design and intent. It is to have 3 years to prove that something does or does not work. If at the end of the third year of full activity there are still unanswered questions I would want it to be at the discretion of the department director to say, 'this program still has some questions to answer' and we will make sure they continue for a fourth year.

8. **Comment:** I want to be clear on conflict of interest at this point in time. I ask that those with a financial interest or work in agencies that are being funded do not weigh in on whether you support or not because now we will issue a recommendation.

9. **Question:** Regarding the preliminary outcomes that show improvement in areas that you measured, do we have a 'control' group? Have we compared what has happened for clients in these innovation programs, with individuals who are in full service partnerships or non-integrated setting as it relates to the same outcome?
   Response: The metrics for innovation and FSP are different. There may be some opportunity, like BMI for example is collected at the FSP level and 'access to physician' or something along those lines--the metrics are different. But your point is a very good one. Maybe we can think more about a focus group that would drill down on that.

10. **Question:** Is your presentation just from one provider agency or do you work with other provider agencies for this ISM, for the API ISM?
    Response: For mine, which is the Cambodian, we are the lead agency. We work with 6 different community organizations including an FQHC.
    Response: What Mariko presented was a compilation of the work of ISMs. That includes multiple providers across the 5 UREP communities.

11. **Question:** Do you partner with other mental health agencies?
    a. **Response:** The data presented was across ISMs but Mariko's organization partners with FQHC and community, nontraditional providers.

12. **Comment**: I second Richard's motion as proposed. Second, we recently had a UREP groups leadership meeting. We found that these providers in the community are actually adapting their models based on the information they are gaining and the data to meet the needs of the community where they are. We are not waiting until the end of the model.

13. **Question:** Are we voting to continue what has been approved or can we make a recommendation that the groups, in terms of outreach and engagement, also include children and families?
    a. **Response:** The RSS has specified the target population. ISM, for example, there is an issue right now about the co-occurring disorders for children that are being served in that. We cannot change the focal populations. The funding is based--the amount of EPSDT versus the amount of federal financial participation versus the amount of MHSA--is all set in those contracts.

    b. **Response:** The ISMs are mandated to work with all age groups. Getting children into this program has been difficult for a number of reasons. One is fear in the community that if they are involved the child will be taken away from their home. We need to overcome that stigma and fear.

14. **Comment:** We should focus on the new innovation programs and somehow make sure that you've got something that is targeted for children.
    a. **Response:** That would be something very different.

    b. **Response:** I want to clarify that some of the providers who have been successful of enrolling children are more the PEI population. Teenagers that may have a mental health issues in combination with substance abuse. Some children are being served. The younger children are the ones that we are having more difficulties with.

15. **Comment:** The ISMs are documenting the challenges and barriers to doing a follow up or extension of a program. You can then tailor

the RFP to address those specific issues and help overcome them.

16. **Question:** When you look at vulnerability with the populations how is that assessed? Is there consistency in terms of how that is assessed between agencies? Are they using the same type of vulnerability scale? Has any data been collected on decreased use of emergency rooms in that process?
    Response: The IMHT model (Integrated Mobile Health Team) does use the vulnerability scale. That was written into the RFS.

17. **Question:** Do agencies with like models use the same scales or different scales?
    Response: Only IMHT uses that scale. That is primarily because it is a homeless population. There are different variables here, focal population being one of them. The third question, we are tracking that. We did not have enough time to present all of that today.

18. **Comment:** One of the lessons learned is the importance of reaching out, especially to certain communities, on the basis of trauma and staying away from the labeling. The other piece from Exodus is that we have to involve the partners in the planning--not just plan it and say, 'would you like to partner?'
    Response: We are learning how best to do that.

19. **Question:** Do you work with the family so that those children are actually helped?
    Response: The answer is yes. ISM is yes, IMHT is yes, ICM is yes. The peer model--we're learning about that.

20. **Question:** I had a question for Exodus. I noticed in the sustainability slide that you got MediCal or some kind of benefit for 95% of your population. Do you exclude the uninsurable when doing enrollment or are you just not able to find the uninsurable? Is the Latino population getting excluded from this model?
    a. **Response:** Not at all, that was a projection--based on clients that are currently eligible for benefits that are accessing Healthy Way LA and in turn will roll into the Medicaid expansion. We realize that there is probably going to be a 5-7% population in any given time that are non-eligible for any kind of benefit.

    b. **Response:** The Latino ISM actually can probably be much more informative in terms of that question.

    c. **Response:** Latinos should be involved in the general ISMs and not just in the Latino one.

    d. **Response:** The ISMs were mandated to have 60% of our enrollees' indigent.

21. **Question:** What are we voting on? Is this an extension of time? Is it additional funding? Or is it both?

22. **Comment:** We started off with a proposal to extend funding by one year for the innovations project. That is the initial proposal. But what we are hearing is that another way to reframe that is giving the projects their full 3 years given the late start up.
    Response: Yes. Peer run started so late. Peer Run would go into another fiscal year that the other 3 models wouldn't if I understand that correctly. [Yes].

23. **Comment:** I want to restate that part of that motion was to give to the department director the determination of whether certain areas needed a longer period of time to determine what needed to be specifically looked into as a part of those individual moments--if there was a need for that and leave it to the director to make that determination.
    a. **Response:** Thank you. I would like to come back to the SLT if that were to happen.

	24. **Comment:** Here is the motion at this point: Provide that full 3 year time frame for the implementation. If there is the need for additional time that would come back to the SLT and then issue any recommendation to the director of the department. Any other need for clarification? 25. **Comment:** Remember that the next cycle of these is a whole new set of Innovation programs. None of that money has been spent and none of that money is going to be spent until the new cycle begins. 26. **Comment:** It passes as consensus. No one is opposing it. The group has supported that recommendation. **SLT Recommendation:** Each Innovation model will have 3 full years of implementation and, at the end of that time, should the Department feel the need for additional time to achieve learning objectives, the Department could make a recommendation to the SLT to continue learning for a specified period of time.
OSHPD Workforce Survey - Feedback	*Angelita Diaz-Akahori, Psy.D., Workforce Education and Training Division*, County of Los Angeles, Department of Mental Health FEEDBACK 1. **Question:** Did you mention the blind? a. **Response:** No we did not. 2. **Question:** We have some African communities that are facing great challenges. The American government chose fit to bring some of these communities here as immigrants. We want to meet their needs. 3. **Question:** Why do you not have Eastern European? a. **Response:** The Eastern European on which part? b. **Response:** Page 2 on the mental behavioral health work force diversity, you do not have Eastern European in the list. c. **Response:** Could you add that? 4. **Comment**: On the first page on the general work force shortage the number one priority or position is to prescribe medication, which we would agree with. It includes psychiatrists and psychiatric nurse practitioners. On page 2 when you list the 'hard to fill' and 'hard to retain' positions starting with the highest need I do not see psychiatric nurse practitioners. It might be the second highest priority after psychiatrists. I would make the same comment when for stipends on page 4 and loan assumption program on page 5. 5. **Question:** It seems to me on the language issue we should say 'other needed languages'. That is very general. **Response:** But they need to be "needed". There may not be anyone that we need in French but we might need Ethiopian or Somali. 6. **Comment:** When we say 'other needed language' on the one hand it could seem really broad but if we define 'needed' in more specific terms like--there is this concept of threshold language where a certain percent of the population speaks.

Response: Threshold would not be far enough down because, for example, Thai is not a threshold language but we have a huge Thai population. Swahili is not a threshold language but we have a Swahili population. We can designate which languages those are but it seems to me that we do not want to privilege some and not others.

7. **Comment:** Is there a way of determining 'need' in regards to language other than threshold languages?
   Response: So maybe what we do is do the threshold languages and then 'other significant language'.

8. **Question:** How did you come up with those 8 languages? What criteria did you use?
   Response: Based on the data on the consumers being serviced in our system.

9. **Comment:** Can we use the same system to determine 'other needed?'
   Response: Yes, 'other needed' and we can come up with the criteria for the other languages.

10. **Question:** We need people who specialize in stigma reduction. Stigma is a huge issue in our department. People working on stigma reduction should be included, probably on page 2, but that whole area is a huge area that needs to be addressed.

11. **Comment**: I want to make sure that my recommendation did not get lost in all of this. There are like 5 languages--African--that the UREP group is working on.

12. **Comment:** What I'm hearing is that need to be clear about the criteria that we use to identify languages other than the threshold languages. We may need to have some thinking around that. How we determine 'needed' is something we'll need to drill down on.

13. **Comment:** The real problem regarding stipends is that in California we have to allocate sufficient resources to lower the costs of attending these collegiate and post collegiate doctoral and masters costs. The fact that a psychiatrist has to come out with a $150,000 debt is the major problem.

14. **Comment:** I suggest that in the category of 'other' we add 'training Katie A. Core practice model that was enacted by the state earlier this year.'
   Response: I think those are categorical types for programs and funding that are probably covered under those programs. This is primarily the MHSA wet dollars. That is a totally different program and funding.

15. **Comment:** One of the concerns by DMH staff was that stipends are awarded but then the recipient following their education will pay back the money and not provide the services to the county. That is almost like a loss. I attended the other work group held at DMH headquarters that talked about the real need for psychiatrists. When you do not have a full complement of people to do the evaluation or the initial assessment then access to services is delayed significantly.
   Response: The issue about the priority of needing more licensed clinical staff has been outlined here with the 'hard to fill and retain' position and the first page, the 'existing and future work force shortages'. It is been addressed there. The question about the stipend that some individuals are returning their stipend money back; yes it is true but it is a very small percentage, maybe 1 or 2 of those individuals that are receiving stipends and we give out 102. It is a very small number. The majority are following up with their commitment in an underserved or unserved community as well as bilingual and bicultural consumers.

16. **Question:** Are you listing the work force occupation by order of need?'
   Response: Yes. These are statewide WET funded programs. There are two different stipend programs offered; one under our plan and the other under the state. We do not provide any recommendations. We also do not get any information back in

	terms of those individuals that have gotten the stipend and their work commitment. So what we're requesting from the state is please be able to forward the names of those individuals; both the MFTs, the psychiatric nurse practitioners and psychologists. 17. **Question:** Are we trying to expand capacity for clinicians' knowledge of 0-5 work? **Response:** It is on page 2, the mental health 'hard to fill, hard to retain.' It is also in question 3, second row. 18. **Question:** Occupational Therapists in 0-5 work are very important. Is there a thought about expanding their capacity within the Department? a. **Response:** The problem was bringing them aboard into the department within our public mental health system. The other thing too was the amount of equipment and specialty that they bring in. Also, we have very select programs; 0-5. b. **Response:** Well there are a lot of different providers doing 0-5, not just the department but in the provider network. Letting some 0-5 specialists in occupational therapy would enhance all of those programs--not just within the department but outside the department as well. 19. **Question:** Under your shortages you have family therapists but I do not see individual therapists. **Response:** When you are talking about bringing in therapists and clinicians you are really talking about individual, family, and group. It would be quite difficult in trying to bring in that type of specialty, we are approaching this in a generalist way. 20. **Question:** Have we got to the part where you have loan forgiveness if people commit themselves for a year? **Response:** Noted. These programs are state level programs. 21. **Question:** What about increasing the work force in terms of doctoral degrees? **Response:** It is on page 1, #3. It is also on page 2, #3 as well.
Three Year Integrated Plan Planning Process - Discussion	*Dennis Murata, MSW, Deputy Director, Program Support Bureau,* County of Los Angeles, Department of Mental Health FEEDBACK 1. **Comment:** We want to form an Ad Hoc team. This ad hoc group would meet between now and August to take feedback from several sessions on the three year implementation planning process. Part of the discussion happened when Antonia came here and will be reflected in her response. The group generated some ideas around principles for structuring the 3 year implementation planning process. We also engaged the EMT and the agenda design committee for their ideas; all of this to do some lead thinking on the 3 year implementation planning process. No decisions have been made. We want this ad hoc team to help us integrate information from various sources and then weigh in on two specific items. 2. The first is 'what are the principles that we need to use for this planning process for this 3 year integration plan?' The principles would include the latest data--what are the other kinds of values and principles that we have used that have worked? The other is identifying parameters: For examples, parameters coming through the state office OAC with regards to the definition of integration. Or internally, when do we want to complete the integration planning process so that we can work backgrounds and start structuring a process?

3. **Comment**: This ad hoc team would meet July and August and prepare a recommendation for Debbie and Dennis who would take that recommendation, consult with EMT and bring it back to the SLT at the September meeting. That way we are coordinating across various bodies and then putting forward our best set of principles and recommendations around parameters. As soon as we hear from the OAC what the regulations and guidelines we can hopefully accelerate the process.

4. **Question:** I am a little confused because we spent all of this time going through this whole process and were just waiting for this report that supposedly was going to incorporate most of that. We reviewed proposed principles, given feedback, why do we have this work group before seeing draft report?
   Response: We do have a divergence in terms of this report. We only met once when Antonia was here. That report has never been brought back to you formally for comment. We need to finish that process. I think this ad hoc team is an opportunity for us to integrate that and give feedback.

5. **Comment:** That report is a living document. They want to know not only what it has to do with all of the ad hoc work group meetings that they've had--the SLT. But they also want to know, 'how does that tie into the 3 year plan?' If you need to make a correction--we're talking about the planning process for the 3 year plan. We're not talking about a 3 year planning process which is different for what we did with PEI and CSS where it took 2-3 years. This plan must happen and be implemented July 1st. What we are discussing today will be incorporated into this report that the CEO is doing. What we usually do is DMH and SLT come up with a general outline and some sort of process. How do we incorporate county wide interest, SACC interest, how do we incorporate all of these things in terms of stakeholder input into this process?
   Response: For example, we voted like 3-4 months ago. We never saw the votes still. What's happening with that?

6. **Comment:** When she came here we formed these 3 groups. At the end of the feedback there were lists and you voted. That voting process was not a final vote. It was to get a sense of what the priorities were within each of the categories.
   Response: But we' have never seen it. When are we going to see it?

7. **Comment:** We need to get that back to this group so you can look at the results, not as a final tally, but to then inform your recommendations around principles, priorities, etc moving forward into the integration plan.

8. **Comment:** This is the last piece in terms of finalizing that report. What they want to include in that report is the tie to the 3 year planning process for that.
   Response: That makes a lot of sense. My concern is; are we going to have a work group that will do the work without the benefit of all of the work we did before.

9. **Comment:** What we will focus on is how to we ensure that the stakeholder input happens throughout this process? For this tiny process--do we want to repeat what we did with CSS or PEI? We probably want to do something in between.
   a. **Response:** I thought the report was supposed to inform this process.

10. **Comment:** If that is what you are waiting for--the review of the draft--it is not going to help us with the 3 year plan. Since a large amount of this goes through the SLT we have to ensure that adequate representation from the SAACs, not representation from service areas, but from the SAACs as well as some of the key stakeholder county-wide group as well. That was one of the recommendations of EMT. Those vacant slots or slots where folks have not participated, we need to make sure that they are filled by SACC members as well as other interests.

11. **Comment:** Maybe it is unrelated. But it is so frustrating. It is been so long. I do not know if we're ever going to see the report before—
    Response: You will.

	12. **Question:** But again is it going to be too late. **Response:** No, it will not be too late. The details of how that is going to influence our planning process--I do not think it will be so much compared to other guidelines that were set. What concerns me is us setting up something and then we see the guidelines and then they are going to want a whole bunch of local process that may change our entire design. 13. **Comment:** The smaller work group needs to think about the relationship between the roles and responsibilities of the SLT and the SAACs. What the SLT and the SAACs need to do that work, what data they need, what information they need, and then how that gets filtered back up for synthesis at the SLT level. 14. **Question:** It is just not the SAACs. It is also countywide interests: probation, older adult--there is also discussion in terms of the UREP groups which are not specific to a SAAC—they are decentralized--that we need to discuss. How do we ensure that that input is provided? 15. **Comment:** Next Thursday the OAC will vote on the requirements for the 3 year plan. The only regulations that apply to this are regulations affecting the Mental Health Services Act money--the Mental Health Trust fund. I will guarantee you that the move that will come shortly after this--and may not go until the next year--but will say 'one county, one plan'. Since we blended a lot of MHSA dollars with other dollars and other sources and leverage etc; there really is as far as Dr. Southard is concerned a unified county plan. So that may not be in the requirements that you get August 1st. My advice to this cluster is that is going to work, for which I will volunteer, is to look at this as a single plan for the entire county behavioral health program; everything we have responsibility for. 16. **Comment:** Within DMH though. **Response:** Yes. 17. **Comment:** When looking at the entire continuum of care it would be foolish not to see how the MHSA 3 year plan does not integrate or integrate with the larger system of care. For example, as we start planning for health care reform for the first few years we're going to have folks who are covered 100% by the federal government. How does that impact our current services and then also 'how does that impact expenditures in terms of MHSA?' because there will be no MHSA dollars involved but they will be diverting resources to seal that population. We have to think of all those things as a system. **Response:** We want to think 'one county, one plan' so that we do not have divisions working by the time we get that into regulations because it will get in there. 18. **Comment:** Let me make clear that the Mental Health Commission is fully in support of the philosophy that Richard just outlined: One plan covering the entire resources of LA County. 19. **Comment:** To the degree that it is in our budget we support that. **Response:** The commission also is responsible for approving the budget, prior legislation and reporting to the board as well as the department. We have that responsibility and have had it for years.
Public Comments	