COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, September 17, 2014 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 from the County of Los Angeles Department of Mental Health
2. Continue to apply the 'health neighborhood approach' to each of the Age Groups and the Intergenerational Group.
3. Agree on next steps.

MEETING NOTES

Department of Mental Health - Update	*Debbie Innes-Gomberg, PhD*, District Chief, Los Angeles County Department of Mental Health A. In June 2014, we started the Innovations planning process broadly and now have narrowed our focus. We have to pull back a little bit and think, "What is innovation? Is what we are proposing innovative in terms of the state's definition? What fits into the health neighborhood framework? Are there other innovative projects that we need to consider outside of health neighborhoods, particularly in light of other DMH initiatives? Here are a few questions to guide our thinking: a. Do the strategies fit within a Health Neighborhood framework? If they do not, that is okay. We do not want to make them fit into the framework that does not make sense because that is very confusing for folks. b. "What are the strategies we want to use to create health neighborhoods?" We want to be able to impact trauma in different ways. Different age group workgroups have talked about different strategies to do that. So our population-level outcome, maybe even our consumer-level outcomes, would be the reduction or prevention of trauma depending on the strategy. c. "What strategies are we proposing to reduce or prevent trauma?" Your strategies will differ depending upon your hypothesis, that is, the reason why you think trauma exists within your population/neighborhood, in the first place. B. **Community Capacity Building -** In every innovation project related to health neighborhoods, community capacity building is absolutely critical. An essential element for each health neighborhood that we will propose will have a community capacity building strategies meant to engage the community, not just find organizational anchors in the neighborhood. This includes the mental health and substance abuse community like DMH did with Innovation One projects, but also going beyond that and engaging the natural supports of the community that we select so folks that do this work ultimately will be responsible for community capacity building. This high level work will also be measured and tracked. C. **Purpose** - Innovation is less about time-limited funding for services and more about learning for the purposes of applying the knowledge to improve our service system and outcomes. Questions to help us think about this include:

a. "What approaches or strategies do we want to learn about?" We have a body of knowledge from our implementation of the Mental Health Services Act (MHSA) as well as from national and other county implementation of mental health services. That body of knowledge is known, but it may be that in Los Angeles there are very specific elements that would make the implementation of something different here versus if it was implemented in other counties.

b. "What do we want to learn?" That has to guide what we do.

c. "What is our hypothesis?" These may not be formalized or fully defined yet. If you want to learn how "x" impacts "y" you have some idea of how it will impact it and what the intervening variables are.

d. "What would we do differently based on the learning that we will get? "What is the application of your learning to our system?" The Oversight and Accountability Commission seems to be focusing a little bit more on these questions in terms of the innovations regulations. It does not mean necessarily that you have to continue to fund the programs that you deem successful but it does mean that you have to spread that learning in some way. So one of the things I want you to think about is, "How do you spread that learning?" "What would you anticipate?"

e. If the learning is positive and what you are proposing has a significant impact, what would you do with that information? How would you modify your system of care? Age groups are important in this process because they oversee those systems of care.

f. "How will it be applied?" Finally, chances are we will have some level of agreement about ideas that will come out of this meeting that will have to be then refined in the SLT standing committee. Chances are, in the next month or so, there will be more definition hopefully around the innovation 2 projects and your health neighborhood projects in particular. Then you can come back to the SLT and present an idea.

D. Proposal Approval Process:

a. In the coming months we want to get the preliminary leads for these projects together and have a phone conference with the Oversight and Accountability Commission staff to see if they agree that our projects are innovative. They can also help us continue to refine those learning questions.

b. After that we would do a 30-day public comment period.

c. Then a proposal would go to the Oversight and Accountability Commission.

d. We would let Richard Van Horn know so that he could get that on the agenda as quickly as possible and maybe by the end of the year we would have an approved plan that we could then move forward with.

FEEDBACK

1. **Questions:** Are we limiting the scope of what innovation is by just defining it based on a standard service principle? When you are talking about a neighborhood, is there a conflicting statement between the concepts of trauma versus neighborhood?

2. **Comment**: We can guide and add to that other knowledge and information but the general public does not perceive trauma as we perceive trauma. If we do not put it in terms that they can understand then they will not engage the concept, they will not act on it, and we have done nothing to educate them and elevate the issue. There are things out there that help define this such as the wellness project in Santa Monica or neighborhood action councils. There are a lot of things out there that would fit into the scope of what we are doing where you can get this kind of information that is measureable and understandable for the community.

    a. **Response:** We need enough specificity for the Oversight and Accountability Commission and SLT and broad, community-friendly thinking and terminology. We also need to build in the expectation that the successful bidders have the flexibility to really outreach, engage, and educate the communities that they are going to be creating these health neighborhoods for.

    b. **Response:** Can we add the word 'empower?' This implies the community can do things when we walk away from them.

    c. **Response:** There is a body of knowledge that we have and then there is what we do not know or have not done yet. Thinking about the last 10 years now and how DMH has engaged underserved communities, the work we have done and the work that Gladys Lee did at one point around bringing in community based providers. We did orientations around the mental health system and MHSA. We need to build on that work and what was successful with that work and we need to go beyond that. During the outcomes discussions consider "How do we measure the success of community capacity building?" We need to think about the measurement strategies that would demonstrate an entity was successful in that regard.

    d. **Response:** The Neighborhood Action Councils have measurements, as do the 14 Best Start communities. You can talk to Coleen Mooney from the South Bay Development Center about that or people that are working with the well-being project in Santa Monica. They are working with Rand, USC, and other groups to define what well-being is and have developed measures and indicators. It captures the community's thinking and has several different indicators of well-being, not just the service model. You will find it unique to understand that the most important thing is social connection out of those indicators.

3. **Comment:** Once you begin this work of impacting systems of care through health neighborhoods, it means that we will not marginalize these efforts as we did the Children's Planning Council after all those years and it went away. Community engagement went away. It is there forever after you do a genuine engagement. So we will be building not only systems of care but communities of care in full partnership. That is going to have to underpin how these things launch as well.
    Response: Part of the role of the SLT is to ensure that we do that and also ensure we do that with innovation 1 and everything else. You are right; there is nothing worse than not incorporating work that has already been done.

4. **Comment:** When we think about the causes and the implementation, we should be trying to keep this fairly well focused on what is modifiable within the scope of the projects themselves. On the other hand, in somewhat contradiction to what I just said, you also have to think of, no matter what recommendations you make, "What other sectors would need to be involved besides mental health?" Implicitly, that is going to happen.
    Response: We must keep in mind mental health can only do so much. We are only a part of the solution.

	5. **Comment:** We have a system and we have service delivery. Now we are talking about population capacity building. They have to happen simultaneously and in unison, neither is in a silo by itself. I really think that we need to understand this dual purpose that we are working. We have got to have a safety net where it needs to be and at the same time we are trying to build the capacity so we do not need as big a safety net. **Response:** Your comments and suggestions help me to address "What happens after this proposal gets submitted? How similar is it to the work that was done with innovation 1?" We are going to continue to frame and further define the elements of these health neighborhoods as it relates to children, TAY, adults, older adults, and the intergenerational groups. There is this tension between proposing something that is doable, time limited, and being really innovative. I think we are proposing things that are very innovative and stretch the comfort and knowledge levels of what we have particularly done in this department and in the county. 6. **Comment:** I think the struggle is always that we understand there are rules and guidelines that all systems and agencies must protect and we always try to balance it against what the county council and the auditor-controller says. I think what we need to do is bring them in as a partner and say, "Okay, tell us how we can do it and what you are comfortable with." That way they are not driving the debate or discussion. They are partnering with us in how we can make them feel comfortable and still do what we need to do. Traditionally you do not do that, you usually go and say this is what we want to do and you go to them and they tell you that you cannot do that. They never tell you how you can do it. They always say you cannot do it because that is the thinking of that part of the system. That is not conducive to the innovation. That relationship needs to be changed. **Response:** We will talk with Vince further about the suggestion about bringing in the CEO and county council earlier into the process to really guide what is possible. 7. **Comment:** Dr. Southard from one of the times when he said, "It is all going to be about relationships. We cannot be successful, any of us, in any of this work unless we form the relationships." I think it may be on the bottom of the list. But it is something we need to think about as we move forward.
Health Neighborhood Approach	1. **Question:** In the context of this overarching health neighborhood perspective and trauma we all know what we think of when we think of mental health outcomes. Does the definition of a mental health outcome change in the context of the work that we are doing now? What is the parameter around what we consider to be a mental health outcome? **Response:** When you think about evaluation you have to think about the program, its goals, objectives, strategy and all of that. Right now we would be looking at not only population level outcomes but also the outcomes associated with each component of a health neighborhood. With trauma being the primary mental health issue that we would be addressing there would be a measure of trauma in some way. By the time we submit to the Oversight and Accountability Commission we will have to have a well-articulated approach to evaluating. 2. **Question:** Trauma is a broad term because there are different levels and drivers of trauma. Are we going to provide communities with trauma informed issues? Are we going to let the community define what trauma is happening and what they are interested in doing and help them define and understand it and look at strategies? What are we looking at? Are we talking about debilitating

trauma which is just related to an individual? Are we talking about trauma as it relates to historic trauma that drives how a community thinks and feels about other things in its environment? We need to be much clearer about this. How broad is it? How narrow is it?

Response: The way we have been answering that question right now is by asking each of the age groups is to round out that concept of trauma. Here is the challenge that I have seen: you are toggling between two levels, this health neighborhood platform which is admittedly fairly abstract and big, but that is what you need in order to achieve population level outcomes, and the more specific strategies that are of interest to each of the age groups. For example, there is a whole discussion on the jail diversion model. So what we wanted to do today is focus your work in a way where you can then be more specific by what you mean by things like trauma, etc., but that are specific to the strategy or strategies that you are trying to crystallize, that you can test out through a health neighborhood model or separately.

Response: That is part of the challenge of the opening question "Can a health neighborhood approach prevent or reduce trauma for a whole population?" What health neighborhood? What type of trauma? What approach? What target population? Sometimes what I think we need to try to consider is if innovation really is a version of creativity. Part of the definition of creativity is to hold two opposing thoughts at the same time. Another thing that I would like to offer as an alternative question is "What is trauma's contribution to promoting community wellbeing?" If you look at the underpinnings of trauma and all that ties to it in terms of resilience and response to trauma, the need for social connection, concrete services, and response to trauma, the need for a community to rally and look at who is creating trauma, what institutions, individuals, organizations are creating trauma, who is experiencing trauma, who is impacted by trauma and who responds to trauma? It is the anchoring vehicle in another way of looking at well-being. It puts us in the business of assuming we can impact general population well-being as well.

3. **Question:** The public health model is based on the issue of exposure level; exposed, unexposed, and what the nature of that exposure was. When you are thinking of the public health/prevention approach, it is really trying to identify the circumstances and basically targets for reducing potential exposures to trauma. Where are the places where you are going to be exposed and how can we reduce those exposures in some way. That is very different than the treatment issue. But the treatment issue is linked to it because clearly people who are traumatized--it becomes a contagion. Circumstances of people who feel threatened operating in ways that produce more trauma for other people. There is an interaction that takes place but at its base it is the question of, "What are the reasons and the targets where exposures are taking place?"

4. **Comment:** On one end we have crisis response to the people with the greatest need. On the other hand we have prevention. The movement that tells us where we are is how we decide to measure this trauma. It is the indicator that goes back and forth, whatever we choose as to how to identify that. But it is not about one or the other. It is, "How do we bring this into a whole model that accomplishes the population level results?"

5. **Comment:** Sometimes trauma organizes a society. There is a tribe of Indians that I am descended from South America. One of the tribes is very chauvinistic. Women and children have no voice. The men have a voice and the elders have multiple voices, one is theirs and the others are in their head. For you to become the chief or a medicine man or the VIP people you have to hear more than one voice in your head. How do you get a voice? You get a voice by having a trauma, a near death experience, a loss of a loved one,

	and the Guarani's believe that once you go through a trauma a voice of an ancestor or one of the God animals comes into your head. In that way the resilience to the trauma is actually what organizes a society. There is a guy named Bruce Anderson who talks about the core gift. It is kind of the same thing. The core gift is born out of a trauma and that is what produces resilience. 6. **Comment:** I am so glad we are talking about trauma. I remember during the first planning process when I was the chair of the trauma committee and people were saying, "That is not mental health. There is no diagnosis of trauma." So I am really glad we are talking about trauma. With that being said I think there is trauma and there is resilience from trauma. We are not going to end all traumas in the world and maybe we do not want to end all traumas in the world. But the idea is the building of resilience. I was reading the minutes from the "I-Care" meeting yesterday and was struck by the statement that relationships are the foundation of everything. The root cause of not having resilience, of having more trauma and stress and all of these things that make us sick are a lack of relationships. I think we have to look at getting to that root cause when we talk about prevention. A big part of that prevention is creating relationships that enable us to have resilience against the things that go on in life.
Large Group Discussion	**CHILDREN'S GROUP** 1. We landed on the principle on, "How do we actually build connections within discreet neighborhoods?" The core learning question is, "What are the ways we deepen the connections among community members if we are trying to actually assume that part of our success is how well we do that?" Then we start getting very concrete about neighborhood businesses, Laundromats, the micro level of existing neighborhood watch and residents on into schools and other community institutions. Reducing isolation among the community institutions themselves is part of how you reduce the isolation among the residents. So we wrestled with questions of, "How do you get by from representatives of those entities to even want to have a conversation about trauma, mental health and looking at neighborhood environmental factors that are contributing to poor outcomes with kids and so forth?" That was our first level of conversation. Then we went back and looked at some of our proposals that identified some of the higher risk populations. Do we look at youngest kids, prenatal, and on into school age? Part of the problem of always centering this organizing effort on existing institutions is that the institutions' culture and interests will drive how that group operates as opposed to a group that comes together through other kinds of nexus or places to congregate. We did a lot of questioning of taking trauma and mental health and well-being as a centerpiece for educating folks but to motivate people to come out of the isolation they are in. We talked over and over about a village concept. We are creating concepts of learning from those principles of families owning everybody's kids and the well-being of the community; It is not just about DCFS. I do not know if we are ever going to find the tipping point to actually return to that. That was my existential thought about no matter what we do with these innovation programs and the hunger to get it to return, is it possible given the lifestyles, interests, and other competitive things or just the level of social conditions that are so overwhelming. How do you overcome that? Nonetheless, it would be good enough to select certain areas of focusing these kind of concepts, organizing families and members to really engage in trauma--Best Start LA, in other words, focuses on child development a lot, they say, "your target is birth to 5". Part of getting in the game this round with us would be that you have got to deal with mental health issues and tie trauma into it as the

theme. We do not know beyond that exactly how that works, but that would be our piece of the investment.

2. **Question:** What is the defined entity or place you begin your work? With what group of people/organizations? We talked with Magnolia and other places that have centers as well as other ways they do outreach. But then the other issue that came up was that, Are we then, as we move forward, partnering with the existing communities that have the wealth of history of already being more sophisticated, how they have already organized, i.e. the Best Start communities or are we going to go into communities that really have no history? High need, but have yet to be organized. These are practical questions.

3. **Comment:** If your idea is that, "Let's expand and strengthen social connections in ways that will generate well-being, i.e., reduce trauma" your strategy would be what? What kinds of collaborative strengthen and expand social connections?

4. **Question:** If it is the collaborative then in what way is it collaborative, when you think about prevention, secondary prevention, and intervention--or is the strategy to strengthen the family and the family's social connections as a way of getting to the expansion of social connections?

5. **Comment:** Along the idea of the village and wanting everybody to be socially connected and really making a campaign similar to what we do in suicide prevention and letting people know it is okay to talk about these issues and it is okay to ask people how they are doing instead of being socially isolated. This can be one strategy. Maybe a social marketing campaign within the neighborhood that begins to circulate these messages but on a community level.

TAY GROUP

We kind of went backwards. We really had an opportunity to actually have someone who is in the TAY age range to share and have a rich discussion about bringing our strategies, what we were talking about in the past couple of meetings really relate to life. The first question was the health neighborhood approach. Definitely TAY must be involved in participating in developing healthy neighborhoods and in the strategies to really work with TAY and the community especially with shared experiences. Carmichael is going to talk to you about the strategies we discussed. One of them is the circle of influence, the 5 people that you hang around the most are the most likely to influence who you become; we want to really target that circle of influence with positive social connections.

A. **Learning Question:** "Can a healthy neighborhood that provides TAY safe and anonymous pathways to connect with community services and social supports utilizing nontraditional outreach and engagement practices and peer support increase positive social connections to really equip TAY to deal with trauma?" Our group discussed that we cannot prevent any traumatic events but we can try to at least inform TAY on how to deal and cope with trauma.

B. **Strategies**:
   a. If you have a troubled gang member you are going to find an experienced and troubled gang member to relate to them. You are going to match apples with apples.
   b. This includes language, to engage TAY we need to keep it simple and talk normal. Another strategy is social media. We are not going to send an expert from DMH to talk to somebody who is a TAY. You are probably going to send someone who is an expert at being a TAY to correlate with them. If Drew went to someone like my brother and I, you would not catch us. If

I went I could talk to my brother, I could relate to him. You could also go out in pairs to increase that relatedness.

c. Events to connect and develop relationships, perhaps at schools and parks. What if you recruit the TAY and talk to them simply and say, "Talk to someone if you are experiencing bullying", something along those lines to catch their attention that asking for help for what we understand impacts mental health is not dumb. You are not going to be ostracized or stigmatized. It is perfectly normal. There is nothing wrong about asking for help. If you stay after school for tutoring you were made fun of. It is more about educating and informing about support and resources. Parks would be a good place to start because there are a lot of activities there for basketball, baseball, etc. A lot of parents and like-minded people are going to talk together and say, "This is really helpful."

d. Family occupation and motivation. I use this everyday to talk to people. First I talk about family, second occupation, recreation, motivation and after I get that motivation I say, "Look, what if I found a way to help you out?" You could talk to somebody. Would this be of interest to you?" I am going to pick their brain without them knowing it. At the end, I am going to show them a way where I am painting a picture and they can get the help that they want. To talk to the TAY you are going to get people who were ex-gang members, nerds, abused (physically, sexually or verbally), etc. The TAY is going to talk to someone who has been abused, like them, and they will feel understood and comfortable.

ADULT GROUP

We talked a lot about social isolation being a root cause. Based upon the conversations that we had, the proposals we have seen, and the folks at the table, we really wanted to focus on a couple of target populations. We think social isolation have to do with all of these. Trauma is also caused by incarceration, the experience of being homeless, and we put UREP in here but we are really talking about underrepresented populations, specifically immigrant populations and refugees. We know that these factors intermingle and are root causes of trauma. The discussion we had goes to really needing some experts in these areas to help us devise our strategies and really flesh out our learning questions. The group has agreed that they are interested in participating in a further conversation. We may bring a couple of experts to the table, particularly to help us flesh out some of our strategies once we are able to find our learning questions. It is tough to do it in such a short period of time.

Learning Questions:

A. **Homelessness:** "Does housing, first, and employment, second, lead to the decrease of social isolation and increase community connections for individuals?" This is going to lead us to some of our more specific strategies, very specifically who those community partners are going to be to make this more innovative and very specific strategy.

B. Incarcerated Population: "Can trauma be reduced by diversion?" and looking at different kinds of innovative diversion strategies. Very specifically we were looking at petty, non-violent, drug related crimes, the re-traumatization, and how it basically plays on itself and continues the cycle. So how do we interrupt that cycle? What kinds of interventions can we use?

C. **Question:** Did you get to whether you are going to use a health neighborhood approach or not? Do any of the strategies not fit the health neighborhood framework?

Response: We expect each of them will. We talk about the role of community and the role of partner agencies. So we think that is key to the health neighborhoods.

INTERGENERATIONAL GROUP

We started with the concept that we need to change the system. The system has always been focused on the identified patient. We feel very strongly that we need to go to the concept of family, family systems, and the family as a unit. Everybody has his or her idea of what a family is. We do not want to restrict any communities' concept of family. Whatever the community feels is a family is fine.

Learning Questions:

A. How does strengthening the family strengthen the neighborhood? Does strengthening the family build resilience in a trauma exposed neighborhood? Is strengthening the family a way to prevent future traumas? As we started to discuss this we really talked about a continuum of care. We felt strongly that prevention builds resilience and that we need to improve relationships at all levels of a community whether it is departments, community based organizations or families. How do we use these strengths from all of the age groups? We feel that the family is all ages. That is why we are intergenerational. Our point of view was that the family is made up of individuals. So treatment and recovery need to be bi-directional. When the family is healthy the individuals are healthy. When the individual is healthy the family is healthy. If you want a healthy family you are going to have healthy neighborhoods.

B. We focused on strategies that would change the system to help families be stronger and more resilient. We came up with a starting list.

    a. Coalition building including the current systems of care, sharing community resources such as our faith based organizations, developing a continuum of services to be more inclusive and less siloed, use of a team approach, not just a mental health team approach but a team approach using all levels of the community, and move away from focusing on mental health services but use the community resources to provide services that ultimately we think are going to improve mental health anyway.

C. Possible hypothesis is "If the family, however you define it, is treated as a whole using the strengths of a community, will the neighborhood show reductions in the effects of trauma such as substance abuse, mental health issues, homelessness, unemployment, social isolation, etc.?" We also wanted to see that trauma can have positive effects on a community, not just negative.

D. When trauma happens how do we identify what is positive and negative about trauma? How do we develop strategies to increase the positive effects such as resilience? We did not have enough time to develop all of the lists. But we looked at: "How do the families and people who have been helped go back to help their community and neighborhood?" We believe it is their responsibility to help others. That is part of the sustaining efforts that we want to see a health neighborhood have. It is not enough that you get help. How are you as a result going to help somebody else? Trauma can organize people to improve their situation.

OLDER ADULT GROUP

We had a particular model around older adults that does actually fit into this model or platform. We have two other platforms that will not necessarily fit into this particular model. With the health neighborhood platform we begin talking first about the definition of trauma and trying to reconfirm consensus among the group that we did because trauma, in one way, is a bit subjective. On the other hand there are different severity levels in terms of looking at trauma.

	Strategies: A. We really want to reduce the level of isolation among older adults in a particular low income, high crime communities. We looked at enhancing those social relationships through community partnerships but also other innovations and strategies such as neighborhood councils for older adults where they are able to speak and be respected again, as the elders and have a contributory voice to their community. Also, looking for mentorship and volunteer opportunities for older adults, we talked about various strategies to strengthen the connectedness of older adults in their particular community. B. We also looked at safety as one aspect and looking at the structure of the family or the support system. We talked about abuse reports through Adult Protective Services, whether it is fiduciary, physical or neglect, and wanting to have some impact on reducing the number of reports. Our overall concept really has to do with restoring the connectedness, the role, the meaning, the voice, and empowering the older adults in a specific community where the voice has been maybe overshadowed in some way. C. There was also some discussion of looking at safety in terms of preventing falls. For instance, if an older adult falls and they break their hip or are injured they become even more isolated, cannot go out, and so we have to think about the connectedness between physical health issues and also other social and mental health issues. D. **Question:** You mentioned that there were some strategies that were outside of a health neighborhood. Which ones were those? a. **Response:** LGBT: We are looking at LGBT older adults in a particular selected community such as Long Beach or Hollywood, and looking at providing some services, outreach and engagement, linkage and cross training of staff in mental health services to this particular underserved and inappropriately served community. We did not necessarily look at it in terms of a health neighborhood; it would be a stand-alone project. For LGBT, "How might a specialized 'breaking barriers' type of team help to increase access, provide additional safety and things of that nature versus that traditional system that we already have right now? b. Wellness Centers: Quite a few older adults utilize adult wellness centers that generally do not have older adult programming. Older adults could benefit from a broader array of services that are tailored to their specific needs. We want to do some learning around those issues. "How would an older adult wellness center differ from what we traditionally see in an adult setting? What improvements and enhancements might we see as a result of that?" E. **Comment**: A big point was made that we really need to focus on building resilience, especially in people with multiple physical and emotional vulnerabilities. Clearly that happens enormously among socially isolated people and others as well. One of the points that came up that I made was that I thought that because we are talking about people who are vulnerable to accidents, to being exploited to the standpoint of people taking advantage of their economic resources or physically abused, etc. that perhaps bundling interventions through the support structure of creating better connectedness to community resources might be an avenue to do this where you can develop multiple messages because you are dealing with these same individuals having these multiple needs.
Next Steps	A. Rigo to meet with age group leads and discuss next steps to prepare for October SLT meeting. B. Possible SLT standing committee meeting prior to the October SLT meeting.
Public Comments & Announcements	