COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

BOARD OF SUPERVISORS
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MARK RIDLEY-THOMAS
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DON KNABE
MICHAEL D. ANTONOVICH

DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

Reply To: (213) 738-2321
Fax: (213) 351-2026

December 1, 2009

The County of Los Angeles Department of Mental Health (LACDMH) hereby submits a request to amend its Mental Health Services Act (MHSA) Agreement to include an increased level of funding for Fiscal Year 2009-2010. The submission is for the review and approval of the LACDMH MHSA Innovation Plan (INN) consistent with the State Department of Mental Health Information Notice No. 09-02 released January 30, 2009. The total amount requested for the INN Plan is $20,293,924 for Fiscal Year 2009/2010.

Pursuant to the Welfare and Institutions Code Local Review Process requirements, a 30-day public comment period was completed on November 18, 2009 and a Public Hearing was subsequently hosted by the Los Angeles County Mental Health Commission on November 19, 2009. Please find a summary of substantive public comments and questions included in the Appendix of our submission.

Please direct any questions, comments, and/or revisions requests to:

Gladys Lee, LCSW
District Chief
LACDMH Planning Division

213 251-6801
GLLee@dmh.lacounty.gov

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

Mental Health Services Act (MHSA)

INNOVATION (INN) PLAN

Dr. Marvin J. Southard, DSW
Director of Mental Health

December 1, 2009

MHSA INNOVATIONS Plan

The Los Angeles County Department of Mental Health (LAC-DMH) strives to make Los Angeles communities better by partnering with consumers, families and community groups to create hope, wellness and recovery and by strengthening the capacity of communities to support recovery and resiliency. We improve the lives of thousands of people each year because we believe treatment works and recovery is possible. LAC-DMH serves approximately one-quarter of a million residents each year, making it the largest mental health service system in the nation. We provide a diverse spectrum of mental health services to all ages, including mental health assessments, crisis intervention, case management, and medication support in both residential and outpatient settings. Our diverse workforce includes psychiatrists, psychologists, social workers, medical doctors, clergy, and trained mental health consumers. Each year, LAC-DMH brings hope and recovery to hundreds of thousands of residents in all regions of Los Angeles County.

Los Angeles County is one of the nation's largest counties, with over 4,000 square miles, 88 different cities, and over 130 unincorporated communities. The County is home to over 10 million residents, a number exceeded by only eight states. One of the most diverse regions of the United States, dozens of languages are spoken by the County's residents.

Due to its large geographic size, Los Angeles County departments divide services into 8 regions called "Service Areas." The eight Service Area (SA) regions include: SA 1 (Antelope Valley), SA 2 (San Fernando), SA 3 (San Gabriel), SA 4 (Metro), SA 5 (West), SA 6 (South), SA 7 (East), and SA 8 (South Bay/Harbor).

California's voters passed Proposition 63 (Mental Health Services Act - MHSA) in the November 2004 General Election. Proposition 63 aims to improve and transform the delivery of mental health services and treatment across the State of California. LAC-DMH has developed several plan components under MHSA, including:

- Community Services and Supports (CSS) Plan;
- Workforce Education and Training (WET) Plan;
- Capital Facilities and Technology (CF/IT) Plan; and the
- Prevention and Early Intervention (PEI) Plan

The overarching goal of the above listed plans is to ensure the availability of services to children, youth, adults, and older adults most challenged by severe and persistent mental illness. LAC-DMH continues to work collaboratively with consumers, family members, parents, providers, other county departments, community groups and a number of planning bodies and organizations to ensure each plan is committed to the following concepts:

- Promotion of recovery for all who struggle with mental illness,

- Achievement of positive outcomes for all who receive mental health services,
- Delivery of services in culturally appropriate ways, honoring the differences within diverse communities; and
- Delivery of services in ways that address disparities in access to services, particularly disparities affecting ethnic, cultural and under-served communities

The MHSA Innovations (INN) Plan is the final MHSA plan to be implemented in LA County and is a plan focused on learning rather than service provision. The plan must focus on identifying new practices for the primary goal of learning and increasing the array of creative and effective approaches that can be applied to mental health services for specified populations. INN funding should be used to accomplish the following:

- The development of novel, creative and/or ingenious mental health practices and approaches that contribute to learning

- The development of mental health practices and approaches through a community informed process that are representative of the communities to be served, especially unserved, underserved and inappropriately served communities

- The development of new mental health practices and approaches that can be replicated and adapted to other populations and other counties if proven to successfully serve a specific population

In addition to these goals, LA County, in collaboration with its stakeholders has designed INN models that promote community collaboration, and service integration for consumers and their families. These models focus on wellness, recovery, and resilience, are culturally competent; and are driven by consumers, family members, parents, and caregivers. We believe that thoughtful and well-constructed models will enable us to increase the quality of services and to improve outcomes for those served.

County of Los Angeles—Department of Mental Health
Mental Health Services Act (MHSA) INNOVATIONS (INN) PLAN
EXHIBIT A

COUNTY CERTIFICATION

County Mental Health Director	Project Lead
Name: Marvin J. Southard, DSW	Name: Gladys Lee, LCSW
Telephone Number: 213-738-4601	Telephone Number: 213-251-6801
E-mail: msouthard@dmh.lacounty.gov	E-mail: gllee@dmh.lacounty.gov
Mailing Address: County of Los Angeles-Department of Mental Health Planning Division 695 So. Vermont Avenue, Floor 15 Los Angeles, CA 90005	

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Annual Update. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and California Code of Regulations (CCR), Title 9, Section 3410, Non-Supplant.

This Annual Update has been developed with the participation of stakeholders, in accordance with CCR, Title 9, Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Wok Plan are true and correct.

Signature	Date	Title Local Mental Health Director/Designee
	11/19/09	DIRECTOR

EXHIBIT B

INNOVATION WORK PLAN
Description of Community Program Planning and Local Review Processes

County Name: Los Angeles County
Work Plan Name: Los Angeles County Department of Mental Health MHSA Innovations Plan

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. *Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length -- one-half page)*

In designing a Community Program Planning Process for the Innovations Work Plan, Los Angeles County Department of Mental Health (LAC-DMH) sought to create a planning process that would invite innovative ideas and strategies that would lead the way to further recovery-oriented transformation in the public mental health system. Towards that end, we structured the process to be inquiry-oriented, flexible, adaptive, inclusive, and practical. The extensive and intensive planning process began in early May 2009 and picked up in earnest after the May 19th, 2009 election once funding for Innovations planning was assured.

On February 18, 2009, the Los Angeles County MHSA Stakeholder Delegates, a countywide, diverse, and representative group specifically created to ensure wide and meaningful public participation in ongoing MHSA planning, endorsed a process that would focus the Innovations Plan on three critical questions faced by the County as it seeks to transform the public mental health system towards a recovery-oriented direction. The three critical issues requiring attention through innovative strategies were as follows: 1) the fraying safety net of mental health, health and other social services for the uninsured, as a result of decreased funding and growth in the number of uninsured persons; 2) the fragmentation of mental health, health, and substance abuse services; and 3) the decreased capacity to serve uninsured clients potentially displaced from services as a result of shrinking County General Funds.

The Delegates also agreed to prioritize three populations greatly impacted by the above issues – the uninsured, homeless, and underrepresented ethnic populations (UREP), specifically African/African American, American Indian/Native American, Asian and Pacific Islander, Eastern European/Middle Eastern, and Latino communities.

On June 24, 2009, the Stakeholder Delegates approved a planning structure to focus on the critical issues and targeted populations for innovations. That structure included the following: 1) broad public input; 2) work groups focused on the target populations; and 3) the inclusion of consumers, family members, parents, and caregivers in formal decision making roles. A visual depiction of that structure is included as Attachment A,

and the components of the planning structure are elaborated in section 2 of this Exhibit B. Announcements and invitations to participate in this process were extended to the public by the following means: 1) the Planning Division staff's announcements at the regular Stakeholder Delegates meetings; 2) the Division of Empowerment and Advocacy which maintains close contact with consumers, family members, parents, and caregivers; and 3) the existing Los Angeles County Homeless Advisory Council; and 4) the five existing MHSA UREP subcommittees. Meetings were held in LAC-DMH offices or at St. Anne's Residential Facility, a centrally-located community facility.

In July 2009, three work groups began the planning process around the focal populations (uninsured, homeless, and UREP). Both the Homeless and UREP work groups were built upon existing MHSA Stakeholder subcommittees that worked together previously over the years; the Uninsured work group came together specifically for the Innovations Plan. These work groups would be responsible for vetting ideas to the next stages of consideration.

LAC-DMH then requested the submission of innovative strategies from the public. One hundred five public submissions were received and reviewed by one or more of the work groups. In fact, most of the submissions were reviewed by two or three work groups. Submissions were received from contract agencies (54), community organizations (31), DMH consumer and family groups (12), non-DMH consumer and family groups (3), schools or universities (2), and others (3). A complete list of the submitted strategies is provided as Attachment B. The work groups had the liberty to combine strategies or invent new ones, informed by all the submissions. In the end, the work groups authored some innovative strategies through a process that included holding each other to a high standard of innovation. Finally, each work group forwarded up to five of the best innovative strategies to the Integration Review Team. A visual depiction of the process up to this point is included as Attachment C.

At the end of August 2009, the Integration Review Team (IRT) examined the 15 proposed innovative strategies with an eye towards systems transformation. The IRT crystallized the learning goals that were within and across the three work groups and helped identify the strategies that spoke to those goals. The learning goals of the 15 strategies coalesced around the following four areas: 1) the leveraging of financial resources and maintaining sustainability; 2) the utilization of peer-run models; 3) the system-wide integration of mental health, health and substance abuse services; and 4) the engagement of ethnic community resources in the provision of services.

In early September 2009, the Integration Team considered the four learning areas and concluded that all of the strategies and learning questions were seeking to address the fragmentation of care experienced by many in the system. From there, the Integration Team developed the critical question to be answered by the Innovations Plan: What are the most effective models for integrating mental health, physical health, and substance

abuse services in our defined focal populations of uninsured, homeless, and UREP? To answer that question, the Integration Team proposed to test the following four integration models as the Innovations Plan: 1) Integrated Clinic Model; 2) Integrated Mobile Health Team Model; 3) Community-Designed Integrated Service Management Model; and 4) Integrated Peer-Run Model. Visual depictions of these processes and their outcomes are provided as Attachment D.

October 2009 was spent elaborating the four integration models consistent with the overarching learning question and the specific learning goals linked to the specific innovative strategies and developing the budget. The Plan was posted for public review on October 20th, 2009. The Delegates reviewed the Plan on October 21st, 2009 and again on November 18th, 2009, at which point they endorsed the Plan. The public hearing was held on November 19th, 2009, and the Commission moved to approve the Plan for submission to the State after the public was given an opportunity to provide their comments.

2. Identify the stakeholder entities involved in the Community Program Planning Process.

LAC-DMH utilized the following four primary structures for gathering input and developing the Innovations Plan: 1) Work Groups based on three Focal Populations; 2) Integration Team; 3) Integration Review Team; and 4) MHSA Stakeholder Delegates. The following paragraphs outline which stakeholders comprised each structure, the responsibilities of each structure, and how decisions were made. A visual representation of the process is provided as Attachment A.

Focal Population Work Groups – The three work groups were based on the County's decision to target Innovations Funds on addressing the needs of uninsured, homeless and underrepresented ethnic populations (UREP). Each work group was co-led by a community leader and a LAC-DMH department lead person. Each work group was charged with generating ideas for innovative projects, reviewing public submissions for innovative projects, identifying and developing up to five Innovative Strategies for consideration by the Integration Review Team (IRT), and electing up to three additional representatives to the IRT. Within the work groups, participation was open to everyone, but voting was restricted to those who had attended meetings consistently so as to ensure continuity in the development of the Plan. Participants included consumers, family members, parents, caregivers, homeless advocates and experts, cultural brokers, providers of mental health, physical health, and substance abuse care and services and others. At all workgroup meetings there were opportunities to participate in languages other than English (most commonly in Spanish and Korean).

Integration Review Team – The IRT consisted of the Integration Team plus up to three additional representatives elected by each of the work groups. The three representatives were chosen based on their ability and commitment to representing the

five innovative strategies from their work group. Priority was given to consumers, family members, parents, and caregivers. Of the 9 elected representatives, 6 were consumers, family members, parents, or caregivers. The IRT was responsible for developing and articulating the learning goals that were within and across the three work groups and helping to identify the strategies that spoke to those goals. The IRT also developed the details of each of the models along with content experts as needed. At all IRT meetings there were opportunities to participate in languages other than English.

Integration Team – The Integration Team consisted of two Innovations Plan co-chairs (one community lead and one LAC-DMH lead) and the co-chairs of each of the focal population work groups. The Integration Team was responsible for reviewing the outcomes of the Integration Review Team and integrating their recommendations into a cohesive Innovations Plan. The Integration Team meetings also had opportunities to participate in languages other than English.

MHSA Stakeholder Delegates – The Stakeholder Delegates is the primary recommendation-making body with regard to all MHSA planning. Many members of the Integration Team and work groups also participate in the Delegates process either as official representatives or alternates. Stakeholder Delegate meetings routinely have opportunities to participate in languages other than English.

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

The 30-day stakeholder review ran from October 20, 2009 through November 19, 2009. The public hearing was held on November 19, 2009, and interpreters were available for those speaking Spanish or Korean. Comments received during the review period and public hearing are included as Attachment J including those that were translated.

Innovation Work Plan Narrative

Date: November 25, 2009

County: Los Angeles County
Work Plan #: n/a
Work Plan Name: Overarching Concept to Innovations Plan

Purpose of Proposed Innovation Project (check all that apply)

INCREASE ACCESS TO UNDERSERVED GROUPS
√INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
PROMOTE INTERAGENCY COLLABORATION
INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

While all four of the above purposes apply, the Los Angeles County Department of Mental Health (LAC-DMH) selected "Increase the Quality of Services, including Better Outcomes" as the primary purpose for the entire Innovations Plan through a stakeholder process that determined that its highest priority was to successfully heal the system fragmentation that is a major impediment to service quality and good outcomes. We have developed four models of integration based on an extensive community participation process that generated learning goals and innovative strategies that are salient to the communities and providers in Los Angeles County. All four integration models were specifically designed to encourage community collaboration; to seek integrated service experiences for clients and their families; to focus on wellness, recovery, and resilience; to be culturally competent; and to be driven by consumers, family members, parents, and caregivers. Thoughtful and well-constructed project designs will enable us to increase the quality of services and to improve outcomes by learning how features embedded in these four models will best provide integrated mental health, physical health, and substance abuse care to critical groups.

All four proposed models have unique features that make them innovative and are detailed in the sections that follow. In addition, they share the innovation that comes from attempting to integrate physical health, mental health, and substance abuse services for specific vulnerable populations in a large, diverse urban environment and in a complex system of care. We believe that what we learn from these models can have broad applications in other similar urban environments such as Los Angeles.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length – one page)

LAC-DMH seeks to determine the effectiveness of four distinct models for integrating mental health, physical health, and substance abuse services in defined focal populations of the uninsured, homeless, and under-represented ethnic populations (UREP). Throughout our Community Program Planning Process, LAC-DMH heard from its stakeholders that current care is fragmented, ineffective, and does not fully meet the needs of communities. To address this concern, LAC-DMH and its stakeholders sought to identify innovative strategies that addressed system fragmentation, that were meaningful learning goals for systems transformation, and that also offered opportunities to deliver recovery-based services to the uninsured, homeless, and UREP populations.

Previous community research demonstrates that insufficient integration of mental health, physical health, and substance abuse services results in incomplete or inappropriate treatment for consumers. While Federal and State planning efforts look toward overcoming this historic and persistent fragmentation, mental health systems will be expected to play a major role. Despite these anticipated directives, there is a dearth of information regarding which integrative models will work best for populations with minimal resources and high mental health needs.

Towards this end, LAC-DMH and its stakeholders developed four models of integration based on an extensive community participation process that generated learning goals and innovative strategies that are salient to the communities and providers in Los Angeles County. All four integration models were designed specifically to encourage community collaboration; seek integrated service experiences for clients and their families; focus on wellness, recovery, and resilience; will be culturally competent; and driven by consumers, family members, parents, and caregivers.

The Four Integration Models

The **Integrated Clinic Model** combines physical health, mental health, and substance abuse services in a community-based site, such as a primary care clinic or mental health clinic, to more fully address the spectrum of needs of individuals who are homeless, uninsured, and/or members of under-represented ethnic populations (UREP). This strategy seeks to increase access to the aforementioned services to those for whom services are fragmented and resources limited. This strategy could potentially

Innovation Work Plan Narrative

transform access in Los Angeles County as it increases the capacity for physical health, mental health, and substance abuse programs in organizations and systems where people in the community already go. It also seeks to increase the quality of services, including better physical health and mental health outcomes, as providers work together to coordinate care across practices. The utilization of existing infrastructure and the leveraging of other programs will create an efficient and cost-effective system that promotes interagency collaboration between Los Angeles County departments and providers.

The **Integrated Mobile Health Team Model** is a client-centered, housing-first approach that uses harm reduction strategies across all modalities of mental health, physical health, and substance abuse treatment. This will be done in collaboration with the housing developers that have units available for this population in addition to accessing Federal housing subsidies and other housing resources. In this model, the primary goal is to address the fragmentation of services to the homeless population, many of whom are uninsured and are members of UREP. This model proposes to deploy a mobile, enhanced, integrated, multi-disciplinary team that includes physical health, mental health, and substance abuse professionals and specially-trained peers and that is managed under one agency or under one point of supervision. This model will develop individualized client care plans that contains physical health, mental health, and substance abuse client-centered treatment goals and objectives. Another unique feature of this model is that individuals will have access to the Integrated Mobile Health Team services through multiple points of entry, whether initially seeking assistance with physical health, mental health, substance abuse, or housing. It will increase access to services and leverage multiple funding sources including capital for housing development and Federal Qualified Health Center funding.

The **Community-Designed Integrated Service Management Model** (ISM) envisions a holistic model of care whose components are defined by the community itself and also promotes collaboration and partnerships between regulated entities, contract providers, and community-based organizations to integrate health, mental health, substance abuse, and other needed care to support the recovery of consumers with particular attention to under-represented ethnic populations. The ISM model consists of discrete teams of specially-trained and culturally competent “service integrators” that help clients use the resources of both “formal” (i. e., mental health, health, substance abuse, child welfare, and other formal service providers) and “nontraditional” (i. e., community-defined healers) networks of providers, and who use culturally-effective principles and values. The ISM Model services are grounded in ethnic communities with a strong foundation of community-based, non-traditional, and natural support systems such as faith-based organizations, voluntary associations, and other service groups. In this model, ISM teams will integrate formal and informal provider and community-based resources through the following: 1) community-specific outreach and education; 2)

Innovation Work Plan Narrative

community-specific enhanced engagement practices; 3) enhanced linkage and advocacy; and 4) harmonious intertwining of formal and non-traditional services and supports through facilitation of inter-provider clinical communication. ISM teams will work with each client to ensure service access, coordination, understanding, follow-up, and inter-provider clinical communication. The teams will consist of both service professionals and specially-trained peers who will meet regularly with clients and provide information, transportation, motivation, encouragement, and help with provider communication.

The **Integrated Peer-Run Model** supports people with mental health needs who also have additional health and/or substance abuse treatment needs to become well and stay well by providing new programs that are designed and run by people with lived experience of mental health issues. This model incorporates two innovative strategies: Peer-Run Integrated Services Management (PRISM) and Alternative Peer-Run Crisis Houses. PRISM is a client-driven, holistic alternative to traditional community mental health services that allows uninsured peers to secure needed physical health, mental health, and substance abuse options as part of a program designed to support and empower people to take responsibility for their own recovery. PRISM is based upon a "whatever it takes" philosophy in a context of personal choice. It consists of innovative specially-trained peer teams that share features of ISM teams in the Community-Designed ISM Model. As in the ISM model, the teams work with clients to ensure service access, coordination, understanding, follow-up, and inter-provider clinical communication. Also as with ISM teams, PRISM teams will meet regularly with clients and provide information, transportation, motivation and encouragement, and help with provider communication. However, unlike the teams in the ISM model, PRISM teams will consist entirely of specially-trained peers who will coordinate the provision of clinical services and coordinate and deliver peer-run/self help services. Peer-Run Crisis Houses are client-driven, holistic alternatives to hospitalization and are designed to provide a warm, safe, welcoming environment for uninsured people in psychiatric distress who are not a danger to others. These houses will be located in two places in separate service areas, and one of them will be dedicated to providing peer support to people in crisis who are being released from jail. Together, these strategies expand the range of peer-run options within the public mental health system.

The target populations for each of the above four models are the uninsured, homeless, and members of UREP with an emphasis on different combinations depending on the strategies used. Each model's description provides more detail on the numbers we project to serve and their demographic characteristics. As a whole, this Innovations Plan should provide critical services to a significant number of clients and their families with remarkable mental health, health, and substance abuse service integration needs, while also providing important data to help inform LAC-DMH's system transformation efforts.

Innovation Work Plan Narrative

Developing a new level of understanding of the dynamics of various integrative models will point the way to creating new care models that may greatly improve outcomes, reduce disparities for UREP populations, enhance service efficiency, increase consumer satisfaction, and carry the recovery-oriented skills and values of the public mental health system into the dimensions of physical health and substance abuse services.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)

A variety of studies demonstrate that integrated models of health service delivery provide better health outcomes, improved consumer satisfaction, and fiscal savings. Existing large-scale successful models of integrated health, mental health, and substance abuse services (such as the Veterans Administration Healthcare System and Kaiser-Permanente) deliver care through a unified administrative system, which has both acknowledged advantages (such as relative ease of service coordination, standards development, and resource allocation) and disadvantages (such as limitations of size and scope, and relatively more difficulty utilizing other existing community resources beyond the integrated system).

Successful integration of health care services has not been universal when it is attempted across multiple existing community agencies. While promising pilots have been attempted in a variety of settings, the degree to which we can usefully duplicate them has been limited by differences in funding, geography, ethnicity, and community resources.

In a large urban area like Los Angeles County, successful integration of health services would critically benefit people who are uninsured, homeless, and members of UREP; yet the only practical way to integrate care is through use of existing agencies and resources. Limited attempts to do so are hampered by separate funding streams, intra-agency disagreements regarding target populations, limited referral mechanisms and expertise, and poorly defined outcome measures. To date, no single existing model for service integration clearly overcomes all these challenges.

Therefore, the development of additional models specifically designed to overcome these limitations would be of great utility. What we learn could help intelligently guide both policy decisions and resource allocation for years into the future. Finally, each model pilot could provide important service benefits to many people while we answer fundamental questions for the future of health care delivery in the United States.

During our Community Program Planning Process, we identified four learning goals for our Innovations Plan, captured in the following questions:

1. Can one or more multi-disciplinary models of fully integrated health, mental health, and substance abuse services using existing providers be embedded

Innovation Work Plan Narrative

within Los Angeles County community systems and result in the accurate identification and appropriate treatment of poly-occurring health, mental health, and substance abuse for uninsured, homeless, and UREP populations?

2. Can specifically identified formal and non-traditional ethnic community resources be engaged and utilized to increase access and improve the quality of mental health services for consumers from UREP communities?
3. Can the integration of mental health, physical health, and substance abuse treatment services generate a structure that leverages funding streams and results in a sustainable, integrated, and multi-disciplinary care that meets the multiple needs of people with mental health disabilities?
4. Can peer-run strategies result in effective coordination of health, mental health, and substance abuse services, including self-help modalities, while supporting recovery and wellness and increasing cost effectiveness?

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length – one page)

Implementation/Completion Dates: 1/10 – 12/12
MM/YY - MM/YY

The system changes proposed in these four integration models are challenging, and the extent of the fragmentation and barriers will not be fully understood until attempted. All integration models have been carefully constructed with a two-year timeframe for reaching LAC-DMH's learning goals and with an eye toward replication if any of the models prove successful. We believe a two-year timeline is sufficient to determine if barriers can be eliminated, fragmentation of services decrease, and replication is feasible.

The lessons we learn will be shared with a variety of local, state, and national audiences such as LAC-DMH's Systems Leadership Team, MHSA Stakeholder Delegates, MHSOAC, CMHDA, and a variety of public policy forums. Each model will share its progress quarterly with the Systems Leadership Team's INN Workgroup, a body that provides oversight for adjustments and documentation of learnings. We believe that our lessons may influence future evidence-based practices that will be disseminated across multiple systems.The more specific learning measures and activities are outlined in each model's Timeline section, but the timeline below applies generally to our overall Innovations Plan:

Timeframe	Activities
Jan 2010	Estimated Plan Approval from CA Dept of Mental Health
Feb - Apr 2010	Competitive Bidding Process
May - July 2010	Contract Negotiations, Board Approval and Awarding of Contracts
Aug – Oct 2010	Start up and Staffing of Models
Nov 1, 2010	1st Quarterly Formative Evaluation and Reporting
Nov 2010 - Jan 2011	Service Provision continues

Innovation Work Plan Narrative

Feb 1, 2011	2nd Quarterly Formative Evaluation and Reporting
Feb - May 2011	Service Provision continues
June 1, 2011	3rd Quarterly Formative Evaluation and Reporting
June 2011 - Aug 2012	Service Provision continues
Sept - Dec 2012	Summative Evaluation/Final Report Share results and learnings with various local, state and national audiences.

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

All four models will be reviewed and assessed for their effectiveness in producing system change outcomes, and they will be evaluated using the following six domains:

1. **Integrated Care:** To what degree was the model successful in integrating mental health, physical health, and substance abuse services?

2. **Service Levels/Access:** Did the model provide appropriate service levels for each population needed to achieve superior outcomes in the mental health, physical health, and substance abuse arenas? What were the barriers identified and how were they overcome?

3. **Quality of Care:** Did the model provide higher quality of care and achieve superior outcomes in the mental health, physical health, and substance abuse arenas? What were the barriers identified and how were they overcome?

4. **Community Improvement:** To what extent did the integration of mental health, physical health, and substance abuse services translate into community improvements?

5. **Stakeholder Satisfaction:** How satisfied were primary stakeholder groups with the services? LAC-DMH will survey the satisfaction of primary stakeholder groups, including clients and providers.

6. **Cost:** How well did the model facilitate the leveraging of available Federal, State, and community resources? LAC-DMH also will review the actual cost of delivering integrated care according to the model.

We used the questions above to help us outline each model's specific project measurements and goals, and they are described individually in each work plan.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

In this Innovations Plan, LAC-DMH will leverage existing Federal and State funding, as well as community-based resources in order to maintain cost efficiency and maximize MHSA Innovations funding. Specific resources to be leveraged are listed within each model's description.

When constructing the budgets for each model, LAC-DMH sought to use the broadest and most general outline for budgeted services in the hopes that this flexibility will allow bidding agencies an opportunity to submit proposals that are truly creative and innovative. Cost estimates for each model were based primarily on the following three sources of data: 1) cost for outpatient services; 2) medication costs; and 3) data from stakeholders and subject matter experts for each specific model.

A generation ago, carving out the mental health system was an important step in providing much-needed attention and resources to vulnerable populations. Now, health care integration figures heavily in federal healthcare reform efforts and in the renewal of the 1115 waiver. The Los Angeles County Innovations Plan provides a remarkable opportunity to explore new frameworks of care for individuals who are uninsured, homeless, and members of UREP. We expect that it may shed light on methods for integrating mental health, physical health, and substance abuse services that can usefully inform much larger future integration policy and implementation. Perhaps the most important contribution of the proposed Los Angeles County Innovations Plan would be to help ensure that in this round of possible reintegration of some aspects of the carve out, adequate attention will be paid to the needs of underserved and vulnerable populations of individuals living with mental illness.

Innovation Work Plan Narrative

Date: November 25, 2009

County: Los Angeles County
Work Plan #: 1
Work Plan Name: Integrated Clinic Model

Purpose of Proposed Innovation Project (check all that apply)

INCREASE ACCESS TO UNDERSERVED GROUPS
√INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
PROMOTE INTERAGENCY COLLABORATION
INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

While all four of the above purposes apply, the Los Angeles County Department of Mental Health (LACDMH) selected "Increase the Quality of Services, including Better Outcomes" as the primary purpose for the entire Innovations Plan through a stakeholder process that determined that its highest priority was to successfully heal the system fragmentation that is a major impediment to service quality and good outcomes. We have developed four models of integration based on an extensive community participation process that generated learning goals and innovative strategies that are salient to the communities and providers in Los Angeles County. All four integration models were specifically designed to encourage community collaboration; to seek integrated service experiences for clients and their families; to focus on wellness, recovery, and resilience; to be culturally competent; and to be driven by consumers, family members, parents, and caregivers.

The Integrated Clinic Model seeks to increase the quality of care and services for uninsured people, including those who are homeless and/or members of UREP, by reducing the fragmentation inherent in the current system of care. This model will support the capacity of primary care or mental health clinics to integrate on-site mental health and substance abuse treatment services in an effective, culturally-relevant, and consumer-driven manner for individuals who are homeless, uninsured, and/or members of UREP. In this way, the model provides a "home" for people seeking integrated care.

While other efforts to integrate care exist, our Integrated Clinic Model is innovative for several reasons. First, we are attempting to integrate care in a large, complex urban environment and in a system that includes directly operated and contracted entities. Second, the model specifically targets the most vulnerable populations to test whether integrated care improves service quality to them. Third, for those primary care sites integrating on-site mental health and substance abuse treatment services, this model extends the definition and scope of the mental health care to support and treat serious mental illness within the borders of a primary care site. Fourth, for those mental health sites that will imbed physical health and substance abuse services, the model's

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innovation includes the opportunity to stabilize the client enough to determine whether he or she can change the health home to a physical health site with support (e.g. moving the client to a wellness center or to a primarily physical health site as a move along the continuum of care). Lastly, this Integrated Clinic Model's use of peers as staff is unique even among existing co-sited model design and systems of care.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length – one page)

The Integrated Clinic model combines physical health, mental health, and substance abuse services in community-based sites, such as primary care or mental health clinics, to more fully address the spectrum of needs of individuals who are homeless, uninsured, and/or members of underrepresented ethnic populations (UREP). This strategy seeks to increase access to the aforementioned services to those for whom services are fragmented and resources limited. This strategy can potentially transform access in Los Angeles County as it increases the capacity for physical health, mental health, and substance abuse programs in organizations and systems where people in the community already go. It also seeks to increase the quality of services, including better physical health and mental health outcomes, as providers work together to coordinate care across practices. The utilization of existing infrastructure and the leveraging of other programs will create an efficient and cost-effective system that promotes interagency collaboration between Los Angeles County departments and providers.

A significant number of uninsured people seeking primary care or mental health services has general medical problems that are affected by stress, challenges in maintaining healthy lifestyles, or mental health issues. Whether or not people are physically ill and even how ill they are is not the primary determinant of whether they decide to visit a physician. Studies have suggested that only 12-25% of health care use can be accounted for by disability or morbidity alone. Nearly 70% of all health care visits have a psychosocial basis. Only half of the population that suffers from diagnosable mental disorders seeks any form of mental health care. Of the half that do seek care, 50% receive it solely from their general physician, meaning that half of all the behavioral health care in the U. S. is provided by general medicine providers.[1]

Recently published studies indicate that persons with serious mental illness in the United States can expect to live an average of 25 years fewer than the general population. Such results underscore the pressing need to improve and facilitate access to coordinated and integrated physical health, mental health, and substance abuse care.

[1] Source: Strosahl, K. (2002). Identifying and capitalizing on the economic benefits of integrated primary behavioral health care. In Cummings, O'Donohoe & Ferguson (Eds.) The impact of medica! cost offset on practice and research: Making it work for you. NV: Context Press.

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In Los Angeles County, the need for improving access to and coordination of these services cannot be overstated. The Census 2008 American Community Survey found that 24.5% of the County's population, 2.1 million, is uninsured. Of the nearly 1 million patients served by Los Angeles County's primary care clinics in 2007, 63% (594,000) lived under the Federal Poverty Level. The majority seeking care in primary care clinics is uninsured, comes from UREP, and speaks a language other than English. These individuals face significant barriers to accessing services.

Unfortunately, the stigma surrounding mental illness is one powerful barrier to reaching treatment, distinct from barriers related to cost, fragmentation of services, and lack of availability of services. Additional barriers deter members of UREP, such as mistrust and fear of treatment, racism and discrimination, and differences in language and communication. The Integrated Clinic model can reduce the stigma or difficulty in accessing services associated with formal health and mental health settings by relying on the trusted community resources and established relationships of existing community-level health and mental health providers. Further, providing services in the same site and on the same day as the initial visit can prevent the missed appointments that currently occur in a more fragmented system.

The Integrated Clinic model is designed to serve the mental health, physical health and substance abuse needs of people who are uninsured, homeless, and/or UREP. The Integrated Clinic Model utilizes the "no wrong door" approach to services, meaning that clients can access the full suite of services by engaging a provider in any of the three disciplines at a single site. This model may also include the use of tele-medicine or tele-psychiatry. The Integrated Clinic model as structured here would provide services to an estimated 1,600 individuals over the course of a year at four planned clinic sites (400 individuals/year each).

The Integrated Clinic will offer:

- *Cultural Competence*: Targeted partners provide accessible, affordable, culturally-appropriate and non-discriminatory physical health or mental health care services to low-income families;
- *Wellness Focus*: Providers will offer coordinated services with a focus on wellness in all disciplines;
- *An Integrated Service Experience*: The model brings together systems with a common interest in providing care to the uninsured and medically indigent, restructuring the health care and mental health delivery system around an expanded network of public and private providers combining resources to improve the health and mental health outcomes of the underserved. This includes a capacity for peer involvement assisting clients with other services such as transportation, case management, linguistic support, and case management;

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- *Reduced Disparities in Access to Mental Health and Physical Health Services*: Community-based providers serve the medically indigent populations that normally fall through the cracks of our health care system. Within the community primary care clinic and mental health system, American Indian, African/African American, and Latino users are overrepresented relative to their proportion in the Los Angeles County population; and,
- *Reduced Stigma and Discrimination*: The model utilizes trusted community resources and non-traditional mental health settings. Integrating mental health services into the primary care setting can reduce the stigma associated with formal mental health settings. Integrating medical services into mental health settings will increase access of clients with serious mental illness into physical health care.

At the core of the Integrated Clinic Model is the "warm hand-off" approach. For example, a patient enters a community clinic for a primary care appointment and establishes a medical home. During the encounter with the patient, the primary care provider conducts a simple mental health screening. Finding symptoms of a potential mental health condition, the provider can then call on the clinic's mental health consultant to come to the exam room. Utilizing evidence-based assessment techniques and tools, the mental health provider then links the patient to the appropriate level of intervention matching the intensity of need. In another variation of the integration model where primary healthcare is embedded at a mental health site, screening and a warm hand-off approach is also utilized with the mental health provider performing the screening and hand-off to a physical health provider at the mental health clinic. This connection of services can reduce stigma in the mind of the patient and prevent the missed appointments that occur in a more fragmented system. This connection of services at the same site by the same team can also support the client's comfort level in accessing and being understood as a client with serious mental illness at the point of care for physical health.

Another core aspect in this model is care coordination. The objectives of care coordination are to facilitate access for high-risk populations and to promote coordination of social support and medical services across different organizations and providers, to ensure care and services at the appropriate level of care and to contain costs. Comprehensive care coordination enables people with special health or mental health care needs, especially those with chronic or complex conditions, to navigate through intricate care systems. Existing models of care coordination, including a number of chronic care and medical home partnerships, are demonstrating how health care can be delivered more smoothly and efficiently for people with chronic illnesses and complex needs. Care coordination and care management services to facilitate integrated access of mentally ill clients (particularly uninsured, homeless or a member of an underrepresented ethnic population) to mental health and healthcare resources is critical to ensuring access to physical health services. This intervention may serve to

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narrow the startling difference in life expectancy that exists today when serious mental illness is one of the diagnoses.

In addition to possessing the capacity to deliver mental health, physical health, and substance abuse services on-site, Integrated Clinic Models will also meet additional criteria for integrated care. Staff must include: peer staff, skilled care coordinators, benefits establishment coordinators, and licensed providers for health, mental health, and substance abuse treatment. The on-site care team may come from different agencies or may be staff hired within an agency for this particular integration purpose, but it must deliver integrated care including regular case conferencing, regularly updated unified care plan and follow up, and re-evaluated diagnosis and medications. Consumers, peer workers and family members, as appropriate, should be central to the initial care plan development, as well as ongoing revisions and updates to the plan. The Integrated Clinic Model must have the capacity to transmit necessary clinical and administrative information and link to high-level specialty mental health, specialty health, substance abuse, non-traditional services, and social services in the communities that they serve. Other required services and capacities are detailed in Attachment E.

Participating sites will leverage recent public and private investments into the clinics' technological infrastructure to assess the impact of this strategy on the mental health and physical health of the target population. Using disease management software, some clinics are already moving beyond the quality assurance efforts that are essential to ensure compliance by staff with protocols, practices, and documentation requirements. Such software efficiently and effectively advances quality improvement, tracks the effects of proven interventions on the uninsured individuals served, allows replication, and helps apply resources where they will do the greatest good.

Integrated Clinic Models will have the capacity to track clients through a database and use an electronic integrated care plan that is standardized to support data collection for outcomes as well as other quality improvement efforts. Team Case Managers will assist clients through the service structure as well as track clients through the system. In addition, a network of linked services (care as well as community-based organizations) will be pre-established and documented in this model.

The Integrated Clinic Model supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. The model is grounded in the following specific principles and values:

- Services are client-centered;
- Prospective care is planned, facilitated, and coordinated;
- Communication between providers is facilitated and enhanced;
- Networks for clinical, non-traditional, or community-based referrals are established;
- Peers are included in teams;
- Services are timely;

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- Care is safe;
- Data-driven outcomes are both systems-focused and client-centered;
- Services are efficient and quality-oriented;
- Services are culturally competent; and,
- Access to appropriate levels of care is provided.

A more detailed description of the Integrated Clinic Model can be found as Attachment E.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)

The Integrated Clinic Model changes an existing model of integrated care by applying it to specific, vulnerable populations in a large urban environment and complex care system. We expect that the model will help us understand how best to integrate mental health, physical health, and substance abuse care for uninsured, homeless, or under-represented ethnic populations in a complex urban environment such as Los Angeles. Specifically planned single-site focused coordination of health, mental health, and substance abuse care for uninsured people in Los Angeles County with significant mental health problems has not been previously attempted in a measured fashion.

Also, this model builds the capacity within the primary health care and mental health systems to better serve the mental health, physical health, and substance abuse needs of persons across the spectrum of need and acuity. In this way, we will learn if uninsured, homeless, or UREP clients can be served in places where they already seek one kind of care and with less reliance on referrals for services outside the agency. Further, with the focus on health care reform and expanding care for the uninsured, this strategy offers Los Angeles County policy and practical lessons on how to shape its system to best operate under reform.

The integration of primary care with mental health and substance abuse services is particularly important because it promises better outcomes in all areas. Through this model, the targeted population may achieve improved mental health status toward a wellness goal, improved physical health status, decreased utilization or need for crisis care, increased utilization of planned care through the clinic as medical home, and increased access for the those with mental illness. Better coordination of care is projected, as is better communication, planning, and shared clinical information between providers. The model may likely offer opportunities for skills enhancement among providers across systems and disciplines. Participating primary care staff members will almost certainly improve their understanding of mental health issues and interventions, and participating mental health members will improve their understanding of physical health issues.

On a broader scale, this strategy will provide insight into: 1) new intervention techniques; 2) the impact of integrated care on Los Angeles County's large and diverse population; 3) the relationship between physical and mental health costs and cost structures; and 4) the impact of current funding streams on the integration potential of the system.

Innovation Work Plan Narrative

Through our Community Program Planning Process, LACDMH and its stakeholders identified the following specific learning questions that would be answered by this model:

1. Can Los Angeles County expand and better coordinate services in order to improve health outcomes and better utilize limited public resources?
2. Can the capacity of the public mental health system be expanded to serve uninsured persons with high acuity levels?
3. Can integrated mental health and substance abuse services be provided at primary care settings?
4. Can integrated physical health and substance abuse services be provided at mental health settings?
5. How will persons of differing acuity levels access these integrated mental health and substance abuse services?
6. Will the imbedding of services at primary care settings decrease the stigma of clients receiving mental health services?
7. Will these persons achieve positive outcomes?
8. Can these services be delivered in a cost-effective way?

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Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length – one page)

Implementation/Completion Dates: 1/10 – 12/12
MM/YY - MM/YY

The proposed system changes in this model are challenging, and the extent of the fragmentation and barriers will not be fully understood until attempted. All integration models have been carefully constructed with a two-year timeframe for reaching LACDMH's learning goals and with an eye toward replication if any of the models prove successful. We believe a two-year timeline is sufficient to determine if barriers can be eliminated, fragmentation of services decrease, and replication is feasible.

The Integrated Clinic Model's learning goals include testing the boundaries of integrated sites' capacities to meet a wider range of physical, mental health and substance abuse needs beyond their usual capacity for the uninsured, homeless and members of UREP. To do this, we will need to develop the system's capacity to track clients as they move through the system; and then track clients, their acuity levels and interactions with peer providers during the process.

The lessons we learn will be shared with a variety of local, state, and national audiences such as LACDMH's Systems Leadership Team, MHSA Stakeholder Delegates, MHSOAC, CMHDA, and a variety of public policy forums. It is our intention that the information gained through this model will ultimately help LACDMH understand, shape and provide thoughtful definition to the future role and critical factors for specialty mental health in an integrated, person-centered health system. The timeline below applies generally to the Integrated Clinic Model:

Timeframe	Activities
Jan 2010	Estimated Plan Approval from CA Dept of Mental Health
Feb-Apr 2010	Competitive Bidding Process
May—July 2010	Contract Negotiations, Board Approval and Awarding of Contracts
Aug-Oct 2010	Start up and Staffing of Integrated Clinics Staff training Database and electronic care plan development Team orientation to the model MOU's and linkages for network finalization

Innovation Work Plan Narrative

	Menu of services and administrative structure and process finalization Begin to see clients
Nov 1, 2010	Clinics begin screenings, integrative processes and service delivery 1st Quarterly Formative Evaluation and Reporting Assessment of program, processes and preliminary data making adjustments as necessary Measure the number or percentage of patients screened by initial provider, referred to integrated partner, and referred outside to specialty care; measure acuity levels, peer involvement and other specific data.
Nov 2010-Jan 2011	Screening and integrated care and services continues
Feb 1, 2011	2nd Quarterly Formative Evaluation and Reporting Administrative and clinical staff meet for mid-program assessment with adjustment of program or processes as necessary. Measure the number or percentage of patients screened by initial provider, referred to integrated partner, and referred outside to specialty care; measure acuity levels, peer involvement and other specific data.
Feb-May 2011	Continue Integrated Services
June 1, 2011	3rd Quarterly Formative Evaluation and Reporting and adjustment of program or processes as necessary Measure the number or percentage of patients screened by initial provider, referred to integrated partner, and referred outside to specialty care; measure acuity levels, peer involvement and other specific data.
June 2011-Aug 2012	Continue Integrated Services One year assessment and reporting of program, CQI efforts and outcomes measures, with program adjustments as needed. Create vision for next steps for continuation of program or change recommendations. Measure the number or percentage of patients screened by initial provider, referred to integrated partner, and referred outside to specialty care; measure acuity levels, peer involvement and other specific data. Also, measure the number or percentage of patients transitioned to primary care plus wellness center health home as permanent medical home.
Sept-Dec 2012	Summative Evaluation/Final Report Assess results of evaluation and CQI efforts as basis for next steps in integration program and future efforts. Share results and learnings with various local, state and national audiences.

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

Given Los Angeles' geographic scope, population density, demographic diversity and mental health system's complexity (which includes numerous directly operated and contracted entities), LAC-DMH stands to learn a great deal about implementing integrated clinic models, including the following:

1. For those primary care sites integrating mental health and substance abuse care, to what extent can they provide care for the Seriously Mentally ill patient and when will those patients need to be referred out to specialty mental health centers?
2. How will use of peers be accepted and utilized in these integrated models in Los Angeles and what will be the impact?
3. For those primary care sites integrating mental health and substance abuse care, what type of client and level of mental illness acuity will be seen and treated in the primary care practice and which will be referred for care with the on site mental health provider?
4. For those mental health sites integrating physical health care and substance abuse services, what type of client and level of mental illness acuity will be seen and treated in the mental health practice and which will be referred for continued care in primary care?

These lessons, observations and data will help inform plans, designs and decisions of the Department of Mental Health to shape the future of specialty mental health as needed by our vulnerable homeless, uninsured and/or underrepresented diverse ethnic populations in Los Angeles. Below is a chart that broadly describes our measurement goals:

Current State	Desired State	Goals	Measures
Mental Health / Physical Health/ Substance Abuse services located in different settings resulting in fragmented care.	**Single sites provide integrated services for mental health AND physical health AND Substance abuse services.**	Determine the extent to which each program site provides mental health AND physical health AND substance abuse services.	Survey of program clients, providers, and administrators, and larger stakeholder community.
Mental Health care & Physical care are located at different sites resulting in	**Integrated Care at common site to improve access and create more**	Determine the extent to which every program provides common site for	Survey of program clients, providers, and administrators, and larger

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diminished access for clients with Mental Illness.	**efficiency in the patient/person centered system.**	mental health, physical health and substance abuse care and services.	stakeholder community.
Current programs often have a lack capacity for communication coordination and sharing of information.	**Clinical, operational and other pertinent information is available to all on-site providers involved in patient's care in a timely manner and supports prospective care planning and safety.**	Determine the extent to which each program changes or eliminates barriers to information sharing	Identification and inventory of barriers as baseline and determination of the degree of change or elimination of identified barriers through survey of program clients, providers, and administrators, and larger stakeholder community.
Many current programs lack capacity to fully integrate other community-based resources	**Community-based resources are integral service providers.**	Determine the extent to which each program increases the types and numbers of community-based partnerships and peer-provided services associated with integrated care sites.	Measure the number of community-based partnerships and peer-provided services at selected program sites at the beginning of the program and at 18 months.
Client must often go to multiple sites to receive care needed.	**Clients can receive necessary care at one site**	Determine the extent to which each program integrates and provides health, mental health, and substance abuse services at one site.	Survey of program clients, providers, and administrators, and larger stakeholder community.
Funding for integrated mental health, physical	**Funding for integrated mental health, physical**	Identify mechanisms for sustainable funding.	Identify, inventory, and track core cost elements of

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health and substance abuse programs is often difficult to sustain.	**health and substance abuse programs is ongoing.**	Identify care elements and cost of care elements for integrated care.	integrated care, reimbursement sources and flow over duration of project.

More detailed client outcomes measures for this model to support the above may include:

1. Screening tool usage (do primary care providers appropriately screen patients), and following referral protocols (do patients get referred to mental health when they screen positive) ;
2. Screening tool usage (do mental health providers appropriately screen patients), and following referral protocols (do patients get referred to PCP when they screen positive;
3. Pre- and post-tests (e. g., PHQ-9, Becks Anxiety Inventory, Brief Symptom Inventory, COJAK or other tools/in the case of warm handoff to physical health), screens may include no physical exam in last 12 months, Hx of Hypertension of diabetes, use of particular psychiatric medications etc.;
4. Patient satisfaction surveys;
5. Clinician satisfaction rates;
6. Medication usage;
7. Number of visits/utilization and level of care patterns;
8. Compliance with treatment goals; and,
9. Pre- and post-clinical indicators as appropriate.

All outcomes will be monitored through standardized reporting as required by the Innovation Plan oversight structure. Outcomes data and evaluation results will be shared as required by the Innovation Plan oversight structure and as appropriate to advance treatment of this population in primary care and other settings.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

MHSA funds will leverage local, State and Federal investments such as FQHC-330 funds, the State Expanded Access to Primary Care Program, and Los Angeles County's Public Private Partnership to serve the greatest possible number of people. Through benefits establishment, providers will ensure that MHSA funds are not used to supplant existing funding and coverage sources.

The estimated annual cost of the 4 proposed sites for implementation is $3,640,000 (i. e. $910,000 per site) Over two-years of initial MHSA INN funding this model will receive an estimated $7,280,000 of MHSA INN funding. These sites will serve an estimated 1,600 consumers annually (i. e. 400 per site) for outreach and engagement, assessment, treatment and/or referral services. Provision of outreach, engagement and assessment services may or may not result in ongoing treatment through the model but rather referral to other services. An estimated 20-25 percent of individuals receiving outreach and engagement services are expected to need on-going treatment for a full year (80-1 00 clients).

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Date: November 25, 2009

County: Los Angeles County
Work Plan #: 2
Work Plan Name: Integrated Mobile Health Team Model

Purpose of Proposed Innovation Project (check all that apply)

INCREASE ACCESS TO UNDERSERVED GROUPS
√INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
PROMOTE INTERAGENCY COLLABORATION
INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

While all four of the above purposes apply, the Los Angeles County Department of Mental Health (LAC-DMH) selected "Increase the Quality of Services, including Better Outcomes" as the primary purpose for the entire Innovations Plan through a stakeholder process that determined that its highest priority was to successfully heal the system fragmentation that is a major impediment to service quality and good outcomes. We have developed four models of integration based on an extensive community participation process that generated learning goals and innovative strategies that are salient to the communities and providers in Los Angeles County. All four integration models were specifically designed to encourage community collaboration; to seek integrated service experiences for clients and their families; to focus on wellness, recovery, and resilience; to be culturally competent; and to be driven by consumers, family members, parents, and caregivers.

One of the four service integration models is the Integrated Mobile Health Team Model which primarily seeks to increase the quality of services for individuals with a diagnosis of mental illness, and their families, who are homeless or have recently moved into permanent supportive housing (PSH) from homelessness through a specific set of strategies aimed at reducing the fragmentation of physical health, mental health and substance abuse care. This model proposes to use a mobile, enhanced, integrated, multi-disciplinary team which includes physical health, mental health, and substance abuse professionals. One of the main goals of the services provided through this model is to improve outcomes for individuals who have a mental illness and are homeless by assisting them to secure housing and to provide the supports necessary for them to retain their housing. Many of these individuals are uninsured, and are members of underrepresented ethnic and other groups.

While other mobile team models exist, our Integrated Mobile Health Team model is innovative for several reasons. First, we are attempting to integrate care in a complex urban environment that is geographically widespread and maintain those services even after individuals move into permanent supportive housing. Second, the Integrated

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Mobile Health Team will be managed under one agency or under one point of supervision, which is unusual in Los Angeles' complex system of multiple departments and agencies. Third, it will increase access to services and leverage multiple funding sources including Federal Qualified Health Center (FQHC) funding and capital for housing development which have not previously been tapped.

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Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length – one page)

To end homelessness for some of the poorest and most vulnerable Los Angeles County residents, many with multiple disabling conditions, LAC-DMH and its stakeholders have designed a model that will reach out to these individuals who are located throughout the county using an Integrated Mobile Health Team. This model is innovative in that it will operate in a complex urban environment under one agency or point of supervision, and the model includes innovative leveraging of various funding streams to establish sustainable funding. The Integrated Mobile Health Team will also continue to provide services to individuals to whom they have outreached even after they have moved into permanent supportive housing. The use of project-based service vouchers in partnership with permanent supportive housing developers is another innovative aspect of the Integrated Mobile Health Team Model.

The Integrated Mobile Health Team is client-centered and uses a housing-first approach with harm reduction strategies across all modalities of mental health, physical health, and substance abuse treatment. This will be done in collaboration with the housing developers that have units available for this population in addition to accessing Federal housing subsidies and other housing resources. In this model, the primary goal is to address the fragmentation of services to individuals who are homeless and who have mental health, physical health, and substance abuse treatment needs. Currently, multiple providers from various agencies with different funding streams serve these individuals. The providers may be co-located but have different supervisors, their own policy and procedures, including separate charts and care plans. These practices result in fragmentation which is a barrier to providing the optimal supports necessary for these individuals to successfully move from homelessness into permanent supportive housing (PSH) and to maintain their housing.

To eliminate the fragmentation of services, the Integrated Mobile Health Team will be staffed with a multi-disciplinary team of mental health, physical health, and substance abuse professionals who work under one agency such as a Federally Qualified Health Center (FQHC) or one point of supervision. The Integrated Mobile Health Team will provide outreach and on-going services that are tailored to the specific needs of the individuals served whether they are living on the streets, in shelters or newly transitioned into PSH or living arrangements. They will travel with their supplies and will serve homeless individuals and their families where they reside or congregate such as on the streets and in shelters. This team will continue to serve these individuals and their families when they transition into PSH. A central feature of this model that will address the fragmentation of services is the development of one comprehensive client care plan that contains physical health, mental health, and substance abuse treatment

Innovation Work Plan Narrative

goals and objectives that are client-centered. Another unique feature of this model is that the access to services is based on the client's identified need, whether it is housing, physical health, mental health, or substance abuse. All of these needs can be addressed immediately by the multi-disciplinary Integrated Mobile Health Team that includes physical health, mental health and substance abuse professional and specially-trained staff including housing/employment/benefit establishment specialists and peer/family/parent advocates.

The Integrated Mobile Health Team will continue providing services to individuals who move from the streets and shelters into PSH units through the innovative use of a project-based service voucher. These vouchers will be committed to housing developers that are interested in building PSH and will be used to leverage housing capital to develop more PSH units. The project-based service vouchers will be dedicated to PSH units similar to the way that project-based operating subsidies are used to make the units affordable for a specific period of time. Developers will apply for project-based service vouchers for a specific number of PSH units dedicated to the MHSA focal population. LAC-DMH will make a commitment to the developer for a specific number of project-based service vouchers. The voucher indicates that the developer has access to integrated physical health, mental health, and substance abuse services provided by an Integrated Mobile Health Team. Funding will be tied to the housing units, but the service intensity will be based on the needs of the clients. In the event the client leaves the PSH project with the project-based service vouchers, the Integrated Mobile Health Team could continue to provide services regardless of their residence. We anticipate that over the next year approximately 400 PSH units will become available through the MHSA Housing Program and other housing development resources and that services will be needed by many of the individuals living in these units.

This model is designed to serve individuals with a diagnosis of mental illness, and their families, who are homeless and are living on the street, in a shelter, or have recently moved into PSH from homelessness. Some of these individuals will be the most vulnerable homeless individuals as defined by the Common Ground Vulnerability Index or other methods based on community priorities that determine that those living on the street or in shelters and who have multiple disabling conditions are the most likely to die in the next year. Individuals will have access to the Integrated Mobile Health Team services through multiple points of entry, whether it is physical health, mental health, substance abuse, or housing. It is estimated that a total of 900 individuals and their families will be served each year (300 per team). This includes individuals who receive outreach services only and those that are engaged in more on-going services.

The Integrated Mobile Health Team Model supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. The model is grounded in the following specific principles and values:

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- A housing-first model which will immediately assist individuals to transition from homelessness to housing by providing housing of the individual's choice without any prerequisites/conditions for mental health treatment or sobriety.
- Services are voluntary;
- Services are in the client's preferred language and are provided in a culturally competent manner;
- Services are designed to reduce the risk of harm associated with certain behaviors such as drug abuse;
- Services are driven by the client's own goals and interests;
- Holistic support including physical health, mental health, and substance abuse services, as well as services such as transportation, follow-up, encouragement, and communication is provided.
- Natural support systems of specific communities are actively strengthened, so that these supports can be part of the clients' recovery process; and,
- Outcomes data are collected and analyzed in order to inform efforts for systems change.

A more detailed description of the Integrated Mobile Health Team Model can be found as Attachment F.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)

The Integrated Mobile Health Team Model contributes to learning by changing existing integrated service models which remain fragmented because of separate funding streams, charts, care plans, and lines of supervision. This model will provide important information and data that will help us understand how best to integrate mental health, physical health, and substance abuse care for homeless individuals with these treatment needs. Mobile teams are not the innovation; previous multi-disciplinary teams have worked together but have been hampered by accountability to different agencies and/or supervisors. This model will explore the effectiveness of having one point of supervision or accountability for the multi-disciplinary mobile team, which is unusual in a complex system such as Los Angeles with multiple departments and agencies. Previous multidisciplinary teams also found that disparate funding streams were barriers to integrating care. Therefore, this model will test the efficacy of "braiding" a variety of existing funding streams (such as FQHC, Medical, Drug Med i-Cal, and veterans programs) so as to better integrate the funding of services and consequently, the services themselves over the long term.

This model also addresses the systemic need for increased permanent supportive housing units for clients with mental illness and their families. Borrowing concepts successfully used in Section 8 project-based rental subsidies, LAC-DMH plans to innovatively use project-based service vouchers to create a market that draws affordable housing developers and service agencies into a collaborative effort to increase the number of PSH units available. When partnered with Integrated Mobile Health Teams, project-based service vouchers can encourage the creation of both single-site and scattered-site permanent supportive housing.

Through our Community Program Planning Process, LAC-DMH and its stakeholders identified the following specific learning questions that would be answered by this model:

1. How do we decrease the fragmentation of and barriers to services provided to the homeless population including those recently transitioned into permanent housing that inhibit collaboration and integrated care?
2. How do we successfully design and manage a fully integrated physical health, mental health, and substance abuse service delivery model that best leverages existing funding for physical health and substance abuse services (in addition to mental health services) and braid several different funding streams to ultimately become financially sustainable?

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Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length – one page)

Implementation/Completion Dates: 1/10 - 12/12
MM/YY - MM/YY

The system changes proposed in this model are challenging, and the extent of the fragmentation and barriers will not be fully understood until attempted. Through a solicitation process, LAC-DMH will begin to find a qualified provider of these integrated services that can hire staff and develop and implement one integrated care plan addressing physical health, mental health, and substance abuse as indicated in the model. LAC-DMH anticipates that contractors with whom the LAC-DMH does not typically contract with for services, such as the Federally Qualified Health Centers, will be interested in implementing this innovative model. Also, LAC-DMH does not usually oversee contracted services that address physical health and substance abuse treatment needs, so we plan to work collaboratively with our partners at Department of Health Services and Department of Public Health, Alcohol and Drug Program Administration to develop, administer, and oversee the innovative Integrated Mobile Health Team Model.

A two-year timeline is sufficient to determine if barriers can be eliminated and fragmentation of services decreased by contracting with qualified provider(s), developing a truly enhanced integrated mobile health team, and to determine the feasibility of successfully braiding the funding and fully leveraging other funding resources. The proposed timeline will allow sufficient time for learning and will provide an opportunity to assess the feasibility of replication.

LAC-DMH anticipates that it will take the Integrated Mobile Health Team(s) a full 24 months of operation to address some of the more intractable barriers that have stymied past efforts to align charting, data collection, information sharing, and funding. Once the agreements and methods are in place for overcoming the barriers, they will be fully documented in order to replicate the approach widely.

The lessons we learn will be shared with a variety of local, state, and national audiences such as LAC-DMH's Systems Leadership Team, MHSA Stakeholder Delegates, MHSOAC, CMHDA, and a variety of public policy forums. The timeline that follows is a general outline of activities for the Integrated Mobile Health Team Model:

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Timeframe	Activities
Jan 2010	Estimated Plan Approval from CA Dept of Mental Health
Feb-Apr 2010	Engage in Competitive Bidding Process
May—July 2010	Contract Negotiations, Board Approval and Awarding of Contracts
Aug-Oct 2010	Start up and Staffing of Integrated Mobile Health Teams
Nov 1, 2010	1st Quarterly Formative Evaluation and Reporting Design one organizational chart that defines one point of supervision and there is one integrated set of policies and procedures. Establish a baseline of existing funding sources and the number of clients on benefits and projected amount of leveraging required for viability.
Nov 2010-Jan 2011	Outreach and Engagement
Feb 1, 2011	2nd Quarterly Formative Evaluation and Reporting Confirm that the Integrated Mobile Health Team is as is defined in the organizational chart and the team is following the one set of policies and procedures. Determine that the Integrated Mobile Health Team is actively seeking to maximize leveraging opportunities and is working to establish benefits for new clients.
Feb-May 2011	Integrated Mobile Health Team services provided
June 1, 2011	3rd Quarterly Formative Evaluation and Reporting Confirm that the Integrated Mobile Health Team's organizational chart and polices and procedures are effective and make modifications as necessary. Determine if there is an increase in leveraged funding (including benefits establishment). Budget is revised as needed to decrease MHSA revenue utilization as other funding increases.
June 2011-Aug 2012	Integrated Mobile Health Team services provided
Sept-Dec 2012	Summative Evaluation/Final Report Confirm that any revisions that are made to the organizational chart and the policies and procedures are re-evaluated for effectiveness and if successful, integrated into a best practice model.

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	Determine if there is a decrease in MHSA revenue utilization as a result of maximizing other leveraging resources. Share results and learnings with various local, state, and national audiences.

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Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

Current State	Desired State	Goal	Measures
Homeless people with physical health, mental health, and substance abuse needs receive fragmented care. Staff who provide physical health, mental health, and substance abuse services, even when "integrated" or "co-located," work under separate systems, supervisors, regulations, and other requirements.	Homeless people with physical health, mental health and substance abuse needs receive integrated services with single point of administrative supervision.	Eliminate fragmentation of physical health, mental health, and substance abuse needs for homeless individuals.	Review to determine that there is one organizational chart that defines one point of supervision and that there is one integrated set of administrative policies and procedures.
Funding for physical health, mental health, and substance abuse services comes from discrete and poorly coordinated funding resources and are not fully leveraged.	Funding for physical health, mental health, and substance abuse services are braided which will increase the leveraging possibilities	Maximize the coordinated use of all funding resources. Decreased use of MHSA funds and increased use of other State and Federal funding resources, including public benefits.	Measure the number, types and amounts of funding sources, as well as their usage, viability and leveraging potential by examining budget and financial statements.

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Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

The innovative funding mechanisms imbedded in this project will leverage MHSA dollars in order to reach and serve the greatest possible number of individuals, and they will also encourage the creation of more PSH. MHSA funding will be used to support outreach and engagement and on-going services by the Integrated Mobile Health Team. The team will work toward establishing benefits as quickly as possible to assure leveraging of other funding resources such as FQHC funding, Drug Medi-Cal, and Public/Private Partnership (for uninsured clients). The leveraging of FQHC funds will also be used to serve uninsured clients based on an enhanced reimbursement rate.

The innovative project-based service voucher will be used by housing developers to leverage housing capital for the development of more PSH units. The project-based service vouchers will be dedicated to PSH units in a manner similar to how project-based operating subsidies are used to make units affordable for a specific period of time. Developers will apply for project-based service vouchers for a specific number of PSH units dedicated to the MHSA focal population. LAC-DMH will make a commitment to the developer for a specific number of project-based service vouchers. The voucher will indicate that the developer has access to integrated health, mental health, and substance abuse services (among others) through an Integrated Mobile Health Team. Funding will be tied to the housing units, but the level of services would be based on the needs of the clients. In the event the client leaves the PSH project with the project-based service vouchers, the Integrated Mobile Health Team could continue to provide services regardless of the client's residence using other funding resources.

The projected cost of the 3 proposed integrated mobile health teams over 2 years is $8,714,238 (i. e. Year One: $5,220,024; Year Two: $3,494,214). Based on increased numbers of clients obtaining MediCal over the course of the program, the mix of MHSA/leveraged funding will change each year with the MHSA funds decreasing each year. The amount of funding dedicated to two peer/family/parent advocates per team is $240,000 per year. The total number of individuals served through the mobile health team model include individuals receiving outreach, engagement and screening services. Providing these services to individuals may or may not result in individuals becoming engaged in on-going services through the model.

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Date: November 25, 2009

County: Los Angeles County
Work Plan #: 3
Work Plan Name: Community-Designed Integrated Service Management Model

Purpose of Proposed Innovation Project (check all that apply)

INCREASE ACCESS TO UNDERSERVED GROUPS
√INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
PROMOTE INTERAGENCY COLLABORATION
INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

While all four of the above purposes apply, the Los Angeles County Department of Mental Health (LAC-DMH) selected "Increase the Quality of Services, including Better Outcomes" as the primary purpose for the entire Innovations Plan through a stakeholder process that determined that its highest priority was to successfully heal the system fragmentation that is a major impediment to service quality and good outcomes. We have developed four models of integration based on an extensive community participation process that generated learning goals and innovative strategies that are salient to the communities and providers in Los Angeles County. All four integration models were specifically designed to encourage community collaboration; to seek integrated service experiences for clients and their families; to focus on wellness, recovery, and resilience; to be culturally competent; and to be driven by consumers, family members, parents, and caregivers.

The Community-Designed Integrated Service Management Model (ISM) seeks to increase the quality of services by addressing the fragmentation inherent in the current system of care by building on the strengths of communities, especially underserved ethnic communities. This model envisions a model of care that is defined by the community itself and also promotes collaboration and partnerships between formal and non-traditional service providers, and community-based organizations to integrate physical health, mental health, substance abuse, and other needed care to support the recovery of consumers, with particular attention to underrepresented ethnic populations. In the following project description, "formal" providers are those that are traditionally recognized and funded through public and private insurance. "Non-traditional" providers are individuals who offer community-defined healing practices but do not have credentials that permit reimbursement from public or private insurance.

While similar programs may exist, our Community-Designed ISM is innovative for several reasons. First, we are attempting to integrate care in a large, diverse urban environment with complex systems of care. Second, the model differentiates specific needs and approaches for five distinct under-represented ethnic communities. Third, the model focuses on community self-direction for integrated service delivery. Fourth, we

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will also integrate peers into the model's mix of formal and non-traditional providers while we integrate physical health, mental health and substance abuse care.

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Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length – one page)

The Community-Designed Integrated Service Management (ISM) Model uses a multi-disciplinary, holistic team approach that is determined by the community itself to coordinate and integrate physical health, mental health and substance abuse care. It enhances the resources of the formal network of regulatory providers (e. g. mental health, health, substance abuse, child welfare, and other formal service providers) with culturally-effective principles and values. Services are grounded in ethnic communities with a strong foundation of community-based, non-traditional, and natural support systems such as faith-based organizations, voluntary associations, and other service groups. In this model, ISM teams will integrate formal and informal providers and community-based resources will be integrated through the following: 1) community-designed peer-based outreach and education; 2) community-designed peer-based enhanced engagement practices; 3) community-designed peer-based enhanced linkage and advocacy; and 4) harmonious intertwining of regulatory and non-traditional services and supports through facilitation of inter-provider communication.

This ISM Model strives to go beyond other models' uses of community strengths and partnerships by creating models of care specifically tailored to each of the five under-represented ethnic communities that also integrate health, mental health, and substance abuse services. In this way, there is the identification and differentiation of specific needs and approaches for each of the communities. Also, our approach emphasizes community-defined self-direction for integration of health, mental health and substance abuse services, as well as the interweaving of formal service providers with community-based resources and peers.

The ISM model contains discrete teams of specially trained and culturally competent "service integrators" that help clients use the resources of informal and formal networks of regulatory providers (i. e., mental health, health, substance abuse, child welfare, and other formal service providers), and who use culturally-effective principles and values. The ISM Model services are grounded in ethnic communities with a strong foundation of community-based, non-traditional, and natural support systems such as faith-based organizations, voluntary associations, and other service groups. ISM teams will work with each client to ensure service access, coordination, understanding, follow-up, and inter-provider clinical communication. The teams will consist of both service professionals and specially trained peers. These individuals will meet regularly with clients and provide information, transportation, motivation and encouragement, and help with provider communication. ISM team members will consist of professional and life-

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experienced consumers (peers), family members, parents, caregivers, cultural brokers and community members, particularly from communities being served.

In Los Angeles County, there are five distinct under-represented ethnic populations (UREP) subcommittees representing the mental health needs and concerns of their communities. These subcommittees include: African immigrant/African American (A/AA), American Indian (AI), Asian Pacific Islander (API), Eastern European/Middle Eastern (EE/ME), and Latino. By establishing these five UREP subcommittees as staples in various MHSA planning and stakeholder processes, LAC-DMH created a learning lab for the formal public mental health system to develop culturally competent approaches and services to reach marginalized ethnic communities. This ISM model Innovation Work Plan Narrative has been developed from the collective wisdom of the UREP groups regarding the distinct cultural norms of their communities and how these norms influence mental health needs and service approaches.

Each UREP community identified its own unique issues and common themes to address. For example, A/AAs are overrepresented in the mental health system, yet have poor outcomes. Uninsured individuals from the American Indian community receive mental health and substance abuse treatment services that may not be fully compatible with their belief systems and/or culturally-based healing practices. APIs, EE/MEs, and Latinos have experienced limited access to mental health services because services are not provided countywide in their language or within a comfortable cultural context. Many find mental health centers to be stigmatizing and do not trust them as institutions. Formal mental health, physical health, and substance abuse providers have not always recognized nor known how to tap into the inherent resources of ethnic communities and/or they superimpose their own geographic boundaries for service delivery that are incongruent with ethnic communities.

This Community-Designed ISM Model seeks to bridge the divide between ethnic communities and formal care providers by giving the communities themselves the opportunity to direct how mental health, physical health, and substance abuse services are integrated into trusted and established institutions of ethnic communities. While the general framework of the model will be consistent throughout the UREP communities, the combined network of care created by each ISM will be different depending on the specific needs and resources identified by the community served.

The Community-Designed ISM Model will serve the health, mental health, and substance abuse needs of under-represented ethnic populations who have limited access to culturally-appropriate services. These populations include: 1) families or individuals who have a history of dropping out of services; 2) families or individuals who are linguistically-isolated; 3) families or individuals who have not accessed services due to stigma; and 4) families or individuals who have not benefitted from services or have received inappropriate services. Families are a major focus because typically UREP communities identify family members as one unit and seek services for the whole unit.

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For example, a child may be brought in as the "problem," because it is less stigmatizing to say the child is the problem, when in fact there may be a parent with mental illness.

With the ISM Model, the point of entry to services can be through various sites including schools, places of worship, primary care clinics, or other community agencies. Over the course of two years, we propose serving 2,800 highly vulnerable families through this project.

		FY 10-11	FY 11-12	
UREP GROUP	GEOGRAPHIC TARGET	EST. # OF FAMILIES	EST. # OF FAMILIES	TOTAL # FAMILIES
African/African-American	Service Area 6	232	232	464
American Indian	Countywide	176	176	352
Asian/Pacific Islander	Countywide	320	320	640
Eastern European/Middle Eastern	Service Area 2 or 4	120	120	240
Latino	3 Service Areas w/ largest concentration of Latinos and lowest penetration rates	552	552	1,104

This model of integrated care recognizes that community-specific peer-based engagement requires ongoing, multiple contacts with the family. Capacities required of Community-designed ISMs will include an ability to understand, respect, and honor the specific cultures, traditions, and networks of each community. Community-specific peer-based outreach used by the ISM will include methods such as collaboration with community leaders, ethnic media, and informal “word-of-mouth” networks within the community. The community-designed peer-based enhanced service linkage and advocacy will connect families to formal services and community-based services, provide follow-up, and proactively facilitate communication and transportation. The elements of the model and the required capacities of Community-Designed ISMs are detailed in Attachment G.

The Community-designed ISM Model supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. The model is grounded in the following specific principles and values:

- Clients will receive holistic support that includes integrated physical health, mental health and substance abuse services, as well as other supports such as transportation, follow-up, encouragement, and communication.
- All services provided by organizations and staff are culturally and linguistically competent in planning and implementation. Emphasis is placed on the communities of each targeted population providing the information to ensure this.

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- ISM programs will use networks or collaboratives that are grounded in their respective communities in the delivery of services and will strive for a horizontal-based association. These collaborative may include grassroots, faith-based organizations, schools, and other entities.
- ISM programs will work within and actively strengthen the natural support systems of specific communities, so that these supports can be part of the clients' recovery process.
- ISM programs will rely on clients, family members, parents, and caregivers to inform service providers on what is helpful and needed to assist them toward recovery.
- ISM programs will promote the inclusion of consumers (peers), family members, parents and caregivers by training them to provide outreach, engagement, and linkage services.
- ISM programs will advocate for changes in the system of care that will better support the integration of services and improved outcomes for the client.
- ISM programs will collect and analyze outcome-based data to track and adapt integrated support plans that will strengthen system change.
- During the implementation period, the five UREP work groups can provide oversight capacity to ensure that the vision of this innovative model is maintained and proper balance and trust are kept among the participating agencies.
- ISM programs will collect and analyze their outcomes to track the cost effectiveness of the services, in particular whether or not the identified focal populations of uninsured, UREP, and homeless are being served in a compassionate and efficient manner.

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Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)

LAC-DMH is adapting an existing model for application in five distinct, diverse urban communities. The significance of these models of care is that they will illuminate, via outcome measures, the extent to which the model will facilitate culturally informed peer-based services; measure the degree, nature and success of service integration; and provide feedback on which services prove to be the most effective for each ethnic community in developing culturally-competent models of care.
.
The Community-Designed ISM Model contributes important information and data that will help us understand how best to integrate mental health, physical health, and substance abuse care for diverse ethnic populations. A key innovation of this model is that it allows the communities themselves to leverage their inherent strengths and direct the integration of physical health, mental health and substance abuse services into their existing models of community self-care, rather than having it imposed upon them from outside their communities. Implementation of the Community-Designed ISM can potentially transform the formal mental health system overall by anchoring the integration of mental health, physical health, and substance abuse services in the resources of the diverse UREP communities and through the use of community providers as the starting point for developing a family care plan. In addition, this model can provide important insights into how to lessen the stigma of seeking mental health services and how to deliver culturally competent services.

Through our Community Program Planning Process, LAC-DMH and its stakeholders identified the following specific learning questions that would be answered by this model, organized by UREP subcommittee:

African/African-American (A/AA):

- Is an A/AA-specific integrated service model within the public mental health system able to address multiple needs of A/AAs by providing services in a culturally competent, holistic and cost-effective manner?
- Are we able to provide sustainable services over a extended period of time by developing leaders in the A/AA community through training and coordination?
- Do we increase the likelihood that A/AA consumers will complete services and sustain increased levels of wellness (thereby reducing their need for intensive services for extended periods of time) through providing a community/holistic service approach?

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American Indian:

- What DMH policies create barriers in implementing AI mental health/non-traditional healing services?
- What mechanism can be developed to address credentialing of, and quality of services provided by AI non-traditional practitioners?
- How can AI non-traditional healing be incorporated into a client's treatment plan so that AI non-traditional practitioners are able to bill for services?
- Can identification of AI non-traditional healers and development of a referral system of such individuals lead to cost-effective methods to provide culturally-based recovery services?

Asian Pacific Islander:

- What kind of program or approach is conducive for APIs to utilize mental health services (i. e. wellness activities, substance abuse counseling) in a way that meets the linguistic diversity and geographic spread of APIs in Los Angeles County?
- Can a countywide wellness approach effectively meet the linguistic diversity and geographic spread of API consumers in Los Angeles County?
- Can a countywide wellness approach effectively engage grassroots organizations and community groups in a way that is mutually beneficial for both entities?
- What kind of wellness activities aid in the recovery process for API consumers?
- What kinds of wellness activities satisfy the needs of family members?

Eastern European/Middle Eastern:

- Can a culturally competent Community-designed one-stop referral and outreach center meet all the physical health, mental health, and substance abuse needs of the Eastern-European/Middle-Eastern communities?
- Can this culturally competent, Community-designed one-stop referral and outreach center be replicated to meet the physical health, mental health, and substance abuse needs of other culturally diverse communities?

Latino:

- Can a culturally competent Community-designed ISM for Latino communities decrease barriers to access for monolingual, underserved, unserved, and inappropriately served Latino communities that are homeless, uninsured/indigent, and/or undocumented?

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Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length – one page)

Implementation/Completion Dates: 1/10 – 12/12
MM/YY - MM/YY

The proposed system changes in this model are challenging, and the extent of the fragmentation and barriers will not be fully understood until attempted. All integration models have been carefully constructed with a two-year timeframe for reaching LAC¬DMH's learning goals and with an eye toward replication if any of the models prove successful. We believe a two-year timeline is sufficient to determine if barriers can be eliminated, fragmentation of services can decrease, and replication is feasible.

We expect to learn via outcome measures the extent to which the model will facilitate culturally informed peer-based services; measure the degree, nature and success of service integration; and provide feedback on which services prove to be the most effective for each ethnic community in developing culturally-competent models of care.

The lessons we learn will be shared with a variety of local, state, and national audiences such as LAC-DMH's Systems Leadership Team, MHSA Stakeholder Delegates, MHSOAC, CMHDA, and a variety of public policy forums. The timeline below applies to the Community-designed Integrated Service Management model:

Timeframe	**Activities**
Jan 2010	Estimated Plan Approval from CA Dept of Mental Health
Feb-Apr 2010	Competitive Bidding Process
May—July 2010	Contract Negotiations, Board Approval and Awarding of Contracts
Aug-Oct 2010	Start up and Staffing of ISM Teams. Monitor and review the number and types of participating community-based partner providers.
Nov 1, 2010	1st Quarterly Formative Evaluation and Reporting. Identify, monitor, and address barriers (both internal and external to the Department) to implementation of model and develop a plan to ameliorate barriers.
Nov 2010-Jan 2011	Outreach, Engagement, Linkage, Education and Training. Evaluate and explore the essential components leading to successful facilitation of culturally informed peer-based

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	outreach, engagement, linkage, education and training to ethnic communities.
Feb 1, 2011	2nd Quarterly Formative Evaluation and Reporting. Determine and measure the extent to which ISM programs provide service integration management through survey of participating clients, providers and administrators.
Feb-May 2011	ISM Services Provided to Families
June 1, 2011	3rd Quarterly Formative Evaluation and Reporting Measure the extent to which consumers are completing services (measure rate of recidivism); evaluate how effective non-traditional community-based providers within each ISM have been for each ethnic group; assess if barriers to implementation of model and access to services have been reduced; are the physical, mental and substance abuse needs of the communities being met through the individual models.
June 2011-Aug 2012	ISM Services Provided to Families Gather information on the number of non-traditional community-based partners who are providing services to clients.
Sept-Dec 2012	Summative Evaluation/Final Report Share results and learnings with various local, state and national audiences.

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Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

Each UREP ISM has specific outcomes and evaluation measures that are relevant to their individual communities. What follows is a description of the outcomes and evaluation measures for each group as they pertain to the group's previously stated learning questions for the model.

African/African-American UREP Outcomes:

1. Creation of community partnerships and collaborations with community based organizations and groups to whom clients were referred; and,
2. Consistent participation in mental health treatment and supportive services to completion.

African/African-American ISM Evaluation Measures:

1. Development of partnerships: count of community partners and community-based agencies who referred clients to ISM; and,
2. Consistent participation and completion:
   a. Consistent Participation means no more than one missed appointment for every four scheduled appointments.
   b. Completion means that client and ISM team's mutually agreed-upon termination of regular services.

American Indian UREP Outcomes:

1. Development of strategies addressing barriers to identifying and credentialing non-traditional practitioners to provide culturally competent quality services; and,
2. Increase the number of consumer referrals to non-traditional practitioners by developing a referral system linking consumers to credentialed healers.

American Indian ISM Evaluation Measures:

1. Development of a final report identifying systemic barriers and policies preventing credentialing of non-traditional practitioners. This final report will include:
   a. Articulation and implementation of strategies to overcome barriers;
   b. Number of practitioners credentialed; and,
   c. Number of credentialed practitioners receiving referrals as a result of the project.
2. Increase in consumer referrals to non-traditional practitioners: count of consumer/family referrals linked to non-traditional practitioners through newly

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developed referral system for physical health, mental health and substance abuse treatment options.

Asian Pacific Islander UREP Outcomes:

1. Increase access for marginalized API ethnic groups that are not currently served or are underserved;
2. Provide cost-efficient and culturally-effective mental health and substance abuse services through partnerships between community-based organizations and public mental health providers;
3. Increase satisfaction from community organizations about working with public mental health providers;
4. Increase family member involvement in the client's recovery for more sustained periods of time;
5. Increase the number of consumers who become more integrated into their community, find meaningful job opportunities, and learn useful skills or develop new interests; and,
6. Increase the number of consumers, family members, parents, and caregivers who take leadership or instructional roles in the wellness programs.

Asian Pacific Islander ISM Evaluation Measures:

1. Increase access for marginalized API ethnic groups that are not served or are currently underserved or inappropriately served. For API families that are not served, underserved or inappropriately served increasing the total number of community-utilized points of entry (e.g., primary care offices, places of worship, schools, etc) and referrals to culturally appropriate and sensitive physical, mental health and substance abuse treatment options;
2. Increased collaborations and partnerships between API community-based organizations and public mental health organizations, measured with a baseline and chart each new partnership;
3. Better recovery rates for the consumer, measured by:
    a. Tracking the progress of consumers using specific parameters;
    b. Tracking the satisfaction of family members, parents, and caregivers on the progress of the client; and,
    c. Setting up parameters to measure various categories like job placement, new skills learned, etc. and monitor this in each client.
4. Higher satisfaction from clients, family members, and collaborative agencies measured through surveys of clients, family members and collaborative agencies to monitor what they feel is successful and what is not.

Eastern European/Middle Eastern UREP Outcomes:

1. Increased access to culturally sensitive physical, mental and substance abuse treatment options;

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2. Increased client awareness of mental health issues through culturally appropriate peer-based outreach and education; and,
3. Increased community partnerships between grass roots/cultural organizations and mental health agencies.

Eastern European/Middle Eastern ISM Evaluation Measures:

1. Increase access to culturally sensitive physical, mental health and substance abuse treatment options. Measurement of Access: For EE/ME families that are not served, underserved or inappropriately served, increasing the total number of community-utilized points of entry (e.g., primary care offices, places of worship, schools, etc.).
2. Increased EE/ME community awareness of mental health issues, measured through surveys of randomly-selected EE/ME community individuals regarding mental health issues.
3. Creation of community partnerships between service organizations and mental health agencies, measured through a count of agencies that referred clients and agencies to whom clients were referred.

Latino UREP Outcomes:

1. Increased access to services for uninsured and/or indigent families served; and,
2. Increased community partnerships between grass roots/cultural organizations and mental health agencies.

Latino ISM Evaluation Measures:

1. For Latino families that are unserved, underserved, or inappropriately served, increase the total number of community-utilized points of entry (e.g., primary care offices, places of worship, schools, etc) and referrals to culturally appropriate and sensitive physical, mental health and substance abuse treatment options; and,
2. Creation of community partnerships measured through a count of agencies that referred clients and agencies to which clients were referred.

The following chart outlines the measurement goals and measures that apply universally to the model regardless of specific UREP group:

Current State	Desired State	Measurement Goals	Measures
Relative exclusion of community-based resources	**Community-based resources are integral service providers**	Determine the numbers and types of participating community-based partner providers at the beginning of the program over the	Measure the number and types of participating community-based partner providers at the beginning of the program over the following 18 months through

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		following 18 months	survey of program clients, providers, and administrators, and larger stakeholder community.
No culturally competent service integration capacity to: 1) help clients to access and communicate with a network of formal and non-traditional Mental Health/Substance Abuse/ Health services that are often located in different settings, and 2) support communication and coordination among those service providers.	**Care is integrated across the network of formal and non-traditional** Mental Health/Substance Abuse/ Health services.	Determine the extent to which ISM programs provide service integration for formal and non-traditional mental health AND substance abuse AND physical health care services within ethnic communities.	Measure the degree, nature, and success of service integration management through survey of program clients, providers, and administrators, and larger stakeholder community.
Limited culturally competent outreach and education to UREP communities	**Culturally-informed peer-based outreach, engagement, linkage, education, and training to UREP communities**	Determine the extent to which ISM teams facilitate culturally informed peer-based outreach, engagement, linkage, education, and training to their targeted UREP community Increase in the number of formal and non-traditional programs providing integrated and culturally-informed peer-based services	Measure the extent to which ISM teams facilitate culturally informed peer-based outreach, engagement, linkage, education, and training to their targeted UREP community through survey of program clients, providers, and administrators, and larger stakeholder community. Assessment by community leaders regarding the linguistic and cultural appropriateness of the peer-based outreach, engagement, linkage, education, and training
Regulatory interpretations create **barriers to the inclusion of non-traditional healing services**	Regulatory interpretations **facilitate access to services provided by non-traditional practitioners**	Identify barriers and strategies to address and measure their impact in inhibiting access to nontraditional services Develop and measure the	Measure the degree to which non-traditional practitioners are integrated into mental health, health and substance abuse treatment through survey of program clients, providers,

Innovation Work Plan Narrative

		effectiveness of methodologies to facilitate non-traditional practitioners to accept referrals from a newly developed referral system	and administrators, and larger stakeholder community.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

In this model, LAC-DMH is leveraging the inherent resources of Los Angeles' diverse communities such as established trust and relationships with ethnic communities and intimate knowledge of culturally-relevant approaches to a families' physical health, mental health and substance abuse care. We envision that these resources include, but are not limited to, the following:

- Free or reduced rent for community space;
- 12-Step recovery groups;
- Volunteers from faith-based, cultural, and community groups;
- Mentorship programs;
- Community resources such as Boys and Girls Clubs, food banks, clothing barns, etc.; and,
- Free or reduced ancillary care such as Planned Parenthood or free health clinics.

The total amount of MHSA INN funding required for the ISM model is 15,997,800 over two years of initial INN funding. This estimate provides funding for five distinct ISMs for each of the five UREP groups, including African/African-American, ($2,652,770), American Indian ($2,010,158), Asian/Pacific Islander ($3,647,740), Eastern European/ Middle Eastern ($1,370,246) and Latino ($6,316,886). The amounts proposed for each UREP group are based on a weighted compilation of (1) poverty population (40%) ; (2) prevalence rates (30%) ; and (3) penetration rates (30%). In an effort to address stigma within ethnic communities and include community members in serving consumers, funding for this model will also be used for outreach, engagement and education activities through ISMs for each ethnic population. The total number served through the ISM model will include individuals receiving outreach, engagement, education and screening services. Provision of these services to individuals may or may not result in on-going services through the model.

Innovation Work Plan Narrative

Date: November 25, 2009

County: Los Angeles County
Work Plan #: 4
Work Plan Name: Integrated Peer-Run Model

Purpose of Proposed Innovation Project (check all that apply)

INCREASE ACCESS TO UNDERSERVED GROUPS
✓ *INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES*
PROMOTE INTERAGENCY COLLABORATION
INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

While all four of the above purposes apply, the Los Angeles County Department of Mental Health (LAC-DMH) selected "Increase the Quality of Services, including Better Outcomes" as the primary purpose for the entire Innovations Plan through a stakeholder process that determined that its highest priority was to successfully heal the system fragmentation that is a major impediment to service quality and good outcomes. We have developed four models of integration based on an extensive community participation process that generated learning goals and innovative strategies that are salient to the communities and providers in Los Angeles County. All four integration models were specifically designed to encourage community collaboration; to seek integrated service experiences for clients and their families; to focus on wellness, recovery, and resilience; to be culturally competent; and to be driven by consumers, family members, parents, and caregivers.

The Integrated Peer-Run Model seeks to increase the quality of care and services for the uninsured who may also be homeless and/or members of under-represented ethnic populations (UREP) by using a peer-driven model to identify, obtain, and coordinate mental health, physical health, and substance abuse care, thus reducing the fragmentation inherent in the current system of care. Two distinct strategies for peer support are imbedded in this model, and they offer a broader range of peer-run options for the public mental health system.

While other examples of peer-run models exist, this Integrated Peer-Run Model is innovative in important respects. First it combines two service strategies—Peer Run Integrated Services Management (PRISM) and peer-run crisis houses-- to expand the potential of peer-run services and apply them to Los Angeles' large and complex urban environment. Second, the Peer-Run Integrated Services Management (PRISM) utilizes peer support to address physical health, mental health and substance abuse issues across systems in a more integrated and coordinated way, and the peer-run crisis houses involve a creative team work approach to stabilization and community linkeage to a spectrum of services.. Together, these service strategies expand the possibilities for peer staffing, including administration and supervision by peers and are designed to

Innovation Work Plan Narrative

be utilized by peers from diverse cultures, including traditionally underserved communities.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length – one page)

The Integrated Peer-Run Model supports people with mental health needs who also have health and/or substance abuse issues to become well and stay well by providing new programs that are designed and run by people with lived experience of mental health issues. This consumer-led, Integrated Peer-Run Model also has the capacity to effectively coordinate other forms of peer supports for the consumers' family members, parents, children, and caregivers. Other peers such as Family Specialists, Parent Partners, and Caregivers are able to help the consumers' family members, parents, and caregivers through critically important peer-to-peer relationships.

This model incorporates two innovative strategies: Peer-Run Integrated Services Management (PRISM) and Alternative Peer-Run Crisis Houses. PRISM is a client-driven, holistic alternative to formal public mental health services that allows uninsured peers to secure needed physical health, mental health, and substance abuse options as part of a program designed to support and empower people to take responsibility for their own recovery. PRISM utilizes a "whatever it takes" philosophy in a context of personal choice. It is innovative in that it is a team approach that involves peers helping peers. Alternative Peer-Run Crisis Houses are client-driven, holistic alternatives to hospitalization and are designed to provide a warm, safe, welcoming environment for uninsured people in psychiatric distress who are not a danger to others. These houses will be located in two places in separate service areas, and one of them will be dedicated to providing peer support to people in crisis who are being released from jail.

Together, these strategies expand the range of peer-run options within the public mental health system. In both strategies, people in recovery from mental health, physical health, and/or substance abuse issues will develop reciprocal relationships with uninsured people like themselves who are dealing with similar issues and who may be in crisis or dealing with trauma. Both strategies are culturally competent in that the adults involved will be supported by peers who are similar to them linguistically and ethnically, and by peers who respect and value cultural differences.

There are two differences between Alternative Peer-Run Crisis Houses and PRISM. The Alternative Peer-Run Crisis Houses are intended to provide safe and healing environments where people can move through their psychiatric distress in a relatively brief time (up to 15 days) and then engage in further services if desired, which might include referral to the PRISM team. PRISM will help consumers find housing (including collaborative housing if preferred), volunteer opportunities, and jobs in the community.

Innovation Work Plan Narrative

In addition to the problems associated with the fragmentation of services, people experiencing a mental health crisis — whether insured or uninsured — lack alternatives to institutional and more costly options such as hospitals and urgent care centers. The Peer-Run Alternative Crisis House provides a cost-effective alternative within the public mental health system to provide support to people experiencing a mental health crisis. The public mental health system has not effectively and fully integrated peer-run programs into the array of public mental health services and supports for uninsured people with mental health issues. In this regard, the proposed Integrated Peer-Run Model can help ascertain the extent to which peer-run strategies result in effective coordination of care, high-quality care, and increased cost effectiveness.

The peer-run strategies are designed to serve uninsured adults with a mental health issue seeking support (PRISM) and uninsured adults with a mental health issue experiencing a crisis (Alternative Peer-Run Crisis Houses). The uninsured adults must also have either a physical health or substance abuse issue; and they also may be members of UREP and/or homeless. We anticipate that approximately 300 individuals will receive services annually through PRISM and 216 individuals will receive services annually through the Alternative Peer-Run Crisis Houses.

PRISM and the Alternative Peer-Run Crisis Houses possess similar elements. Both will be staffed by teams including but not limited to Peer Administrators/Managers, Peer Supervisors, and Peer Specialists (including Family Specialists and Parent Partners). “Team” refers to a set of peers who work in a coordinated fashion in order to achieve a common goal: to effectively integrate mental health, physical health, substance abuse, and other services in order to support people in their personal journey toward recovery. “Team” does not presuppose that all team members are supervised by the same person. Creative modes of coordination and accountability are encouraged, such as sub-contracting with other peer-run programs as the need arises. Team members conduct outreach and engagement activities to a broad range of entities to ensure multiple points of entry for uninsured persons, including but not limited to county jails, emergency departments, faith-based communities, family groups, parent groups, peer-run programs, self-help groups, and urgent care centers.

Staff in both strategies must be sufficiently diverse and skilled to provide peer support to the following: 1) uninsured adults with mental health, physical health, substance abuse issues who may also be homeless; 2) uninsured adults who may be from UREP communities; 3) uninsured adults from Gay/Lesbian/Bisexual/Transgender/Questioning/ Intersex, Deaf or Hard-of-Hearing, and Blind or Visually-Impaired communities; and 4) family members, parents, and caregivers with children who may be uninsured and themselves wanting support. In addition, programs will demonstrate the following capacities: 1) ability to sustain trusting reciprocal relationships with peers; 2) capacity to link to and secure desired services within time constraints; 3) willingness to advocate for peers, including advocating to obtain free services and/or appropriate assessments for individuals seeking professional services; 4) experience in ways to enhance health,

Innovation Work Plan Narrative

including but not limited to preparing nutritious food and participating in appropriate exercise; 5) demonstrated knowledge of and linkage to self-help services; 6) openness to spiritual beliefs and practices; and 7) experience with supervising peers. A detailed description of the Integrated Peer-Run Model is provided as Attachment H.

The Integrated Peer-Run Model supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. The model is grounded in the following specific principles and values:

- Peer specialists in a peer-run model will be responsible for designing and administering programs and securing services.
- Safety concerns will be addressed in both training and supervision of the peer specialists who work in this model.
- The peer-run model is consumer-driven and focused on developing trusting relationships with peers that support and enhance recovery.
- The systems-level transformation will be the successful integration of mental health, physical health, and substance abuse interventions within the context of a peer-run model that is both creative and cost effective.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)

The Integrated Peer-Run Model brings three important innovations to peer-run strategies in the context of the Los Angeles County public mental health system. The first is the use of an Integrated Service Management (ISM) team approach to peer-run strategies. The ISM team that is supervised, administered, and implemented by peers for the coordination of mental health, physical health, and substance abuse services is new. Second, the model combines two peer-run strategies, PRISM and the Alternative Peer-Run Crisis Houses, to work in tandem to offer consumers a broader array of peer-run supports. The third type of innovation is the integration of multiple forms of peer supports. The Integrated Peer-Run Model seeks to effectively coordinate and deliver different types of peer supports in the consumers' recovery. Peer support can come from consumers in recovery, parents, family members, and caregivers. This model utilizes peer support to coordinate physical health, substance abuse, and mental health care across systems in an integrated way.

During our Community Program Planning Process, LAC-DMH and its stakeholders identified the following specific learning question that would be answered by this model:

- Can peer-run strategies result in effective coordination of health, mental health, and substance abuse services, including self-help modalities, while supporting recovery and wellness and increasing cost effectiveness?

In addition, the Integrated Peer-Run Model will allow us to develop answers for the following learning questions:

- Will a peer-run crisis house, as an alternative to hospitalization, prove effective in reducing psychiatric distress quickly and safely in a complex urban environment?
- Will the expansion of possibilities for peer staffing, including administration and supervision by peers, demonstrate a creative model for addressing physical health, substance abuse, and mental health issues across systems in a coordinated way?

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length – one page)

Implementation/Completion Dates: 1/10 – 12/12
MM/YY - MM/YY

The system changes proposed in these four integration models are challenging, and the extent of the fragmentation and barriers will not be fully understood until attempted. All integration models have been carefully constructed with a two-year timeframe for reaching LAC-DMH's learning goals and with an eye toward replication if any of the models prove successful. We believe a two-year timeline is sufficient to determine if barriers can be eliminated, fragmentation of services decrease, and replication is feasible.

Because of the "learn-as-we-go" nature of this project, quarterly progress reports will allow adjustments to be made quickly as needed. The lessons we learn will be shared with a variety of local, state, and national audiences such as LAC-DMH's Systems Leadership Team, MHSA Stakeholder Delegates, MHSOAC, CMHDA, and a variety of public policy forums. The timeline below applies generally to our overall Innovations Plan:

Timeframe	Activities
Jan 2010	Estimated Plan Approval from CA Dept of Mental Health
Feb - Apr 2010	Competitive Bidding Process
May - July 2010	Contract Negotiations, Board Approval and Awarding of Contracts
Aug – Oct 2010	Start up and Staffing of Peer-Run Models Training of culturally diverse staff in resources, including multiple self-help peer-run resources, team building, reporting methods and safety issues with input from mental health professionals and consultants to this model
Nov 1, 2010	1st Quarterly Formative Evaluation and Reporting Presentation of training materials and report on methods for addressing any barriers to developing links to integrating health, mental health and substance abuse services
Nov 2010 - Jan 2011	Outreach and Engagement Provision of training and consultation on jail linkages as well as community engagement with ongoing feedback to PRISM and the

Innovation Work Plan Narrative

	crisis houses on outcomes
Feb 1, 2011	2nd Quarterly Formative Evaluation and Reporting Report on outcome measures Summary of challenges and successes with regard to creative use of peer specialists (people in recovery, family members, parent partners) in integrating health, mental health and substance abuse services in a culturally competent manner
Feb - May 2011	Integrated Peer-Run Services Provided Adjustments to strategies as needed with ongoing training and consultation on scope of peer support and cultural competency with ongoing feedback to PRISM and the crisis houses on outcomes
June 1, 2011	3rd Quarterly Formative Evaluation and Reporting Report on outcome measures and use of peer specialists as team members, including any supervisory or administrative issues that have been addressed and resolved in addressing crises and integrating health, mental health and substance abuse services
June 2011 - Aug 2012	Integrated Peer-Run Services Provided Adjustment to strategies as needed with ongoing training and consultation on scope of peer support and cultural competency as well as ongoing feedback to PRISM and the crisis houses on outcomes
Sept - Dec 2012	Summative Evaluation/Final Report Report on Outcome measures Summary of challenges and successes with regard to staffing, supervision and administration peer-run crisis houses as an alternative to hospitalization and PRISM as a client-driven peer-run approach to the integration of health, mental health and substance abuse services Share results and learnings with various local, state and national audiences.

Innovation Work Plan Narrative

Project Measurement
Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

Current State	Desired State	Goals	Measures
Mental Health / Physical Health/ Substance Abuse **services coordinated by peers is non-existent.**	**Peers coordinate the provision of integrated services** for mental health AND physical health AND Substance abuse services, including self-help.	Determine the extent to which peer-run strategies can coordinate integrated health, mental health and substance abuse services with self help.	The number of clients who are successfully referred to health services and substance abuse services as well as other community supports.
No collaborative structure that enables the coordination of multiple forms of peer supports.	**Peer-run strategy will coordinate multiple peer-run supports and self-help programs.**	Determine the extent to which peer-run strategies will increase access to and the use of peer-run and self-help programs and will increase client quality of life.	Survey number of peer-run and self-help programs used by service recipients Clinically Informed Outcome Measure (CIOM) - to measure client perception of increased quality of life. Survey program participants and their family members, if available, to access satisfaction with services received.
Lack of alternatives to more institutional and costly options such as hospitals and urgent care	Peer-Run Programs **provide cost-effective alternatives** to consumers in crisis.	Determine the extent to which peer-run crisis house is an effective alternative to higher levels of	The number of clients served by the peer-run model who do not present at a psychiatric emergency room,

Innovation Work Plan Narrative

centers		care such as urgent care centers and hospitals.	psychiatric inpatient facility or jail within 2 months of assistance at the PRISM or peer-run crisis house. Compare the cost of crisis house services with the cost of higher levels of care if peer-run crisis house is not utilized

Innovation Work Plan Narrative

Leveraging Resources (if applicable)
Provide a list of resources expected to be leveraged, if applicable.

In this model, LAC-DMH is leveraging the inherent resources of the peer-based support networks within Los Angeles. We envision these resources in include, but are not limited to, the following:

- Donated or volunteered professional services (provided in-kind);
- Free or reduced rent for community space; and,
- Free or low-cost food, clothing, and access to other needed programs.

The annual cost of PRISM (serving an estimated 300 consumers annually) will be $1,460,000, or a total cost of $2,920,000 for two years. The Alternative Peer-Run Crisis House (serving an estimated 216 consumers annually) will cost $975,000 per year, or a total cost of $1,950,000 for two years.

EXHIBIT D

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Los Angeles

Work Plan Name

Overarching Concept to Innovation Plan

Annual Number of Clients to Be Served (If Applicable)
4,416 Total

Population to Be Served (if applicable):

The LAC-DMH Innovations Plan is proposing four innovative models to serve individuals and families who are uninsured, homeless and from under-represented ethnic populations with mental health, physical health and/or substance abuse problems.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

All models address the problem of fragmentation of health, mental health and substance abuse services and seek to learn how to improve the quality of services and achieve better outcomes for individuals with significant mental illness who are uninsured, homeless and from underrepresented ethnic populations (UREP).

Model I - Integrated Clinic Model combines physical health, mental health and substance abuse services in community-based sites, such as primary care or mental health clinics, to better address the spectrum of needs of the target population. This strategy seeks to improve access to the aforementioned services to those for whom services are fragmented and resources limited. (Estimated 1,600 to be served annually)

Model 2 - Mobile Health Team seeks to increase the quality of services for individuals with a diagnosis of mental illness and their families who are homeless or have recently moved into permanent supportive housing. This model proposes to use a mobile, enhanced, integrated, multidisciplinary team managed under one agency. It will leverage multiple funding sources including Federal Qualified Health Center (FQHC) funding and capital for housing development. (Estimated 900 to be served annually)

Model 3 - Community Designed Integrated Service Management (ISM) will build on the strengths of UREP communities by integrating community-based and non-traditional services with more formal clinical services to improve quality of care to UREP families. It will include community defined outreach, engagement, education, linkage and advocacy. (Estimated 1,400 to

be served annually)

Model 4 - Peer-Run Model will support a Peer-Run ISM to coodinate and deliver integrated clinical and self help mental health, physical health and substance abuse services (estimated 300 to be served annually) and a Peer-Run Crisis House as an alternative to higher levels and more costly crisis services (estimated 216 to be served annually).

All models include peers in their strategies.

EXHIBIT D

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Los Angeles

Work Plan Name

Integrated Clinic Model

Annual Number of Clients to Be Served (If Applicable)
1,600 Total

Population to Be Served (if applicable):

Target populations will include uninsured and/or homeless, and /or members of UREP. Individuals served will be eligible for specialty mental health services and could benefit from primary health care and/or substance abuse treatment services. Data from Los Angeles County, WRMA Sacramento, and the California State Department of Mental Health indicate an estimated population with Serious Emotional Problems (SEP) and Serious Mental Illness (SMI) at 706,388 individuals in Los Angeles County. Of these, 326,913 individuals live below 200% of the federal poverty level according to its 2008 report. The target populations may be selected based on the density of uninsured, homeless and/or UREP, utilization patterns, and other available data.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The Integrated Clinic model seeks to increase the quality of care and services for the uninsured, including those who are homeless and/or members of under-represented ethnic populations (UREP) by reducing the fragmentation inherent in the current system of care. This model will support the capacity of primary care or mental health clinics to integrate on-site mental health, physical health, and substance abuse treatment services in an effective, culturally-relevant, and consumer-driven manner for individuals with significant mental illness who are homeless, uninsured, and/or members of UREP. In this way, the model provides a "home" for people seeking integrated care. The Integrated Clinic Model uses a multi-disciplinary team approach to address the client as a whole avoiding the silos, duplication, and fragmentation inherent in the current system of care; leverages an existing untapped framework of community-based providers with the potential to offer a spectrum of community-driven and client-focused primary care, mental health, and substance abuse services; emphasizes the whole person approach to health services, including critical enabling services (e. g. transportation, linguistic support, care management, etc.) which are the hallmark of the community-based care; ensures culturally and linguistically competent care through a model designed to provide accessible, affordable, culturally appropriate and non-discriminatory care to the underserved; and, works to reduce the myriad barriers to care for under-represented populations.

While other efforts to integrate care exist, our Integrated Clinic Model is innovative for several reasons. First, we are attempting to integrate care in a large, complex urban environment and in a system that includes directly operated and contracted entities. Second, the model specifically

targets the most vulnerable populations to test whether integrated care improves service quality to them. Third, for those primary care sites integrating on-site mental health and substance abuse treatment services, this model extends the definition and scope of the mental health care to support and treat serious mental illness within the borders of a primary care site. Fourth, for those mental health sites that will imbed physical health and substance abuse services, the model's innovation includes the opportunity to stabilize the client enough to determine whether he or she can change the health home to a physical health site with support (e.g. moving the client to a wellness center or to a primarily physical health site as a move along the continuum of care). Lastly, this Integrated Clinic Model's use of peers as staff is unique even among existing co-sited model design and systems of care.

EXHIBIT D

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Los Angeles

Work Plan Name

Integrated Mobile Health Team

Annual Number of Clients to Be Served (If Applicable)
900 Total

Population to Be Served (if applicable):

Individuals/Families with a diagnosis of mental illness who are homeless including but not limited to those living on the streets and in shelters or those who have recently moved into PSH from homelessness. Some will be the most vulnerable individuals as defined by the Common Ground Vulnerability Index or other methods based on community priorities. a.Individuals/Families who have multiple disabling conditions and are living on the street b. Indiv/Families with multiple disabling conditions, living in shelters/transit. housing c. Formerly homeless indiv/families who have multiple disabling conditions living in PSH.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The Integrated Mobile Health Team Model is a client-centered, housing-first approach that uses harm reduction strategies across all modalities of mental health, physical health, and substance abuse treatment. In this model, the primary goal is to address the fragmentation of services to the homeless population, many of whom are uninsured and are members of UREP. This model proposes to deploy a mobile, enhanced, integrated, multi-disciplinary team that includes physical health, mental health, and substance abuse professionals and specially-trained peers and that is managed under one agency or under one point of supervision. This model will develop individualized client care plans that contains physical health, mental health, and substance abuse client-centered treatment goals and objectives. Individuals will have access to the Integrated Mobile Health Team services through multiple points of entry, whether initially seeking assistance with physical health, mental health, substance abuse, or housing. It will increase access to services and leverage multiple funding sources including capital for housing development and Federal Qualified Health Center funding.

While other mobile team models exist, our Integrated Mobile Health Team model is innovative for several reasons. First, we are attempting to integrate care in a complex urban environment that is geographically widespread and maintain those services even after individuals move into permanent supportive housing. Second, the Integrated Mobile Health Team will be managed under one agency or under one point of supervision, which is unusual in Los Angeles' complex system of multiple departments and agencies. Third, it will increase access to services and leverage multiple funding sources including Federal Qualified Health Center (FQHC) funding and capital for housing development which have not previously been tapped.

EXHIBIT D

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Los Angeles

Work Plan Name

Community-Designed Integrated Service Management Model

Annual Number of Clients to Be Served (If Applicable)
1,400 Total

Population to Be Served (if applicable):

The Community-Designed ISM is designed to serve the health, mental health, and substance abuse needs of under-represented ethnic populations that have limited access to culturally-appropriate services and/or will be potentially displaced from services due to funding gaps. In addition, these populations include: 1. Families/individuals who have a history of dropping out of services; 2. Linguistically-isolated individuals/families; 3. Families that have not accessed services due to stigma; and, 4. Families that have not benefitted from services or have received inappropriate services.

The Los Angeles County Department of Mental Health (LAC-DMH) is committed to working alongside ethnic and cultural communities that have been historically on the periphery of the mental health system. These communities, referred to as UREP (Under-Represented Ethnic Populations), provide LAC-DMH with a wealth of resources and information on how to best serve currently unserved, underserved, and inappropriately served ethnic populations with the goal of bettering their mental health outcomes and overall well being. In Los Angeles County, there are five distinct UREP subcommittees representing the mental health needs and concerns of their communities. These include African Immigrant/African American (A/AA), American Indian (AI), Asian Pacific Islander (API), Eastern European/Middle Eastern (EE/ME) and Latino.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The Community-Designed Integrated Service Management Model (Community-Designed ISM) addresses the fragmentation inherent in the current system of care by building on the strengths of a community, especially underserved ethnic communities. Collaboration and partnerships between regulated entities, contract providers and community-based organizations will integrate health, mental health, substance abuse, and other needed care to support the recovery of consumers, with particular attention to under-represented ethnic populations. With the ISM model, the point of entry to services will be through various sites including schools, places of worship, primary care clinics, or other community agencies. The Community-Designed ISM model: 1) uses a multi¬disciplinary, integrated service management team consisting of professional and life-experienced consumers, family members, parents, caregivers, cultural brokers and community members, particularly from communities being served; 2) draws upon the resources from a network of regulatory providers (i. e., mental health, health, substance abuse, child welfare, and other formal service providers) working with a foundation of community-based, non-traditional, and natural support systems; 3) coordinates the integration of the regulatory providers and community-based resources through: (a) Community Specific Outreach and Education; (b) Community Specific Enhanced Engagement practices; (c) Enhanced Linkage and Advocacy (d) Harmonious Intertwining of Regulatory and Non-Traditional Services and Supports; 4) Culturally-effective principles and values and, 5) Reduction of identified barriers to service delivery for under-represented populations.

While similar programs may exist, our Community-Designed ISM model is innovative for several reasons. First, we are attempting to integrate care in a large, diverse urban environment with complex systems of care. Second, the model differentiates specific needs and approaches for five distinct under-represented ethnic communities. Third, the model focuses on community self-direction for integrated service delivery. Fourth, we will also integrate peers into the model's mix of formal and non-traditional providers while we integrate physical health, mental health and substance abuse care.

EXHIBIT D

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Los Angeles

Work Plan Name

Integrated Peer-Run Model

Annual Number of Clients to Be Served (If Applicable)
516 Total

Population to Be Served (if applicable):

1. Uninsured adults with a mental health issue seeking support 2. Uninsured adults with a mental health issue experiencing a crisis 3. Sub-Populations Uninsured with mental health, health, substance abuse issues (may be homeless), Uninsured from UREP communities; Uninsured GLBTQI, Deaf or Hard-of-Hearing, Blind, Visually Impaired communities; Family members, parents/caregivers with children

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

The Integrated Peer-Run Model supports people with mental health needs who also have additional health and/or substance abuse treatment needs to become well and stay well by providing new programs that are designed and run by people with lived experience of mental health issues. This model incorporates two innovative strategies: Peer-Run Integrated Services Management (PRISM) (estimated 300 to be served annually) and Alternative Peer-Run Crisis Houses (estimated 216 served annually). PRISM is a client-driven, holistic alternative to traditional community mental health services that allows uninsured peers to secure needed physical health, mental health, and substance abuse options as part of a program designed to support and empower people to take responsibility for their own recovery. PRISM is based upon a "whatever it takes" philosophy in a context of personal choice. It consists of innovative, specially-trained peer teams that share features of ISM teams in the Community-Designed ISM Model. As in the ISM model, the teams work with peers to ensure service access, coordination, understanding, follow-up, and communication. Also as with ISM teams, PRISM teams will meet regularly with peers and provide information, transportation, motivation and encouragement, and help with provider communication. However, unlike the teams in the ISM model, PRISM teams will consist entirely of specially-trained peers who will coordinate the provision of clinical services and coordinate and deliver peer-run/self help services. Peer-Run Crisis Houses are client-driven, holistic alternatives to hospitalization and are designed to provide warm, safe, welcoming environments for uninsured people in psychiatric distress who are not a danger to others. These houses will be located in two sites/ service areas, and one of them will be dedicated to providing peer support to people in crisis who are being released from jail. Together, these strategies expand the range of peer-run options in the public mental health system.

While other examples of peer-run models exist, this Integrated Peer-Run Model' is innovative in important respects. First, it combines two service strategies -- Peer Run Integrated Services Management (PRISM) and peer-run crisis houses -- to expand the potential of peer-run services and apply them to Los Angeles' large and complex urban environment. Second, the Peer-Run Integrated Services Management (PRISM) utilizes peer support to address physical health, mental health and substance abuse issues across systems in a more integrated and coordinated way, and the peer-run crisis houses involve a creative team work approach to stabilization and community linkage to a spectrum of services. Together, these service strategies expand the possibilities for peer staffing, including administration and supervision by peers and are designed to be utilized by peers from diverse cultures, including traditionally underserved communities.

(Exhibits E and F)

MHSA Innovation (INN) Plan Overview of the Budget and Budget Narrative

The following pages contain the LACDMH Innovation Plan Budget and Budget Narratives. The planning and development process for the budget involved a review and analysis of current programs that contain similar elements that served as a template regarding each model. The next step included multiple consultations with community mental health contract providers, internal program heads and other program professionals that could provide input regarding the establishment of estimates for the *number of clients served* per model.

When reviewing the LACDMH Innovation Plan Budget, the following concepts apply:

- The primary goal of the Innovation Plan is to use the broadest most nonspecific outline for budgeted services to be provided in these conceptualized four models

- LACDMH hopes to maintain the highest level of flexibility in reviewing proposed budgets and plans for leveraging within proposals submitted by agencies during the competitive bidding process

- Flexibility will allow agencies the opportunity to submit proposals that are truly creative and innovative

All subsections including Personnel Expenditures, Operating Expenditures and Revenues are all meant to be estimates based on anticipated expenses and macro assumptions regarding revenue.

EXHIBIT E

Mental Health Services Act
Innovation Funding Request

County: Los Angeles

Date: 11/25/2009

	Innovation Work Plans			FY 09/10 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name			Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1		**Integrated Clinic Model**		**3,640,000**				
2		**Mobile Health Team Model**		**5,220,024**				
3		**Community Designed Integrated Service Model (ISM)**		**7,998,900**				
	3.1	African/African-American ISM	$1,326,385					
	3.2	American Indian ISM	$1,005,079					
	3.3	Asian/Pacific Islander ISM	$1,823,870					
	3.4	Eastern European/ Middle Eastern ISM ISM	$685,123					
	3.5	Latino ISM	$3,158,443					
4		**Peer-Run Model**		**2,435,000**				
	4.1	PRISM	$1,460,000					
	4.2	Alternative Crisis House	$975,000					
5								
19								
20								
26	Subtotal: Work Plans			$19,293,924	$0	$0	$0	$0
27	Plus County Administration			$1,000,000				
28	Plus Optional 10% Operating Reserve							
29	Total MHSA Funds Required for Innovation			$20,293,924				
	Funds from Approved/Received CPP Dollars			**$0**				
	Total Request for INN Funding			**$20,293,924.00**				

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Los Angeles

Fiscal Year: 2009/10

Work Plan #: 1

Work Plan Name: Integrated Clinics Model

New Work Plan ☑

Expansion ☐

Months of Operation: 1/10-12/12
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			2,040,000	$2,040,000
2. Operating Expenditures			1,760,000	$1,760,000
3. Non-recurring expenditures				$0
4. Training Consultant Contracts				$0
5. Work Plan Management			200,000	$200,000
Expenditures	**$0**	**$0**	**$4,000,000**	**$4,000,000**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. Federal Financial Participation			360,000	$360,000
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$360,000**	**$360,000**
4. Total Revenues	**$0**	**$0**	**$360,000**	**$360,000**
C. Total Funding Requirements	**$0**	**$0**	**$3,640,000**	**$3,640,000**

Prepared by: Ansara J. Lewis

Date: 11/24/2009

Telephone Number: 213 251-6836

MHSA Innovation (INN) Plan Budget Narrative: Integrated Clinics Model

A. EXPENDITURES

Personnel Expenditures: Salaries and benefits for estimated FTEs including costs associated with personnel for data collection, evaluation and reporting

Operating Expenditures: Estimated costs associated with the day-to-day operations of the project/plan. Includes building or office rent/lease, utilities, supplies, insurance or fees, travel and/or transportation, on-going medication and/or medical supplies, perishable furnishings (such as pillow cases, towels, masks etc.), ongoing costs such as food or like supplies, mileage, expenses for travel, and client supportive services.

Work Plan Management: Estimated cost for Community Mental Health Contract Providers to provide sufficient oversight and internal management of their contracted project. This includes the responsibility to provide requested data, outcomes, and reports

B. REVENUES

Federal Financial Participant: Estimated possible revenue from FFP. Estimates are based on data secured from current programs with similar elements to this model

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Los Angeles

Fiscal Year: 2009/10

Work Plan #: 2

Work Plan Name: Mobile Health Team Model

New Work Plan ☑

Expansion ☐

Months of Operation: 01/10-12/12
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			3,640,830	$3,640,830
2. Operating Expenditures			2,310,000	$2,310,000
3. Non-recurring expenditures			300,000	$300,000
4. Training Consultant Contracts			0	$0
5. Work Plan Management			0	$0
Expenditures	**$0**	**$0**	**$6,250,830**	**$6,250,830**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. Federal Financial Participation			852,246	$852,246
b. Federal Qualified Health Center			178,560	$178,560
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$1,030,806**	**$1,030,806**
4. Total Revenues	**$0**	**$0**	**$1,030,806**	**$1,030,806**
C. Total Funding Requirements	**$0**	**$0**	**$5,220,024**	**$5,220,024**

Prepared by: Ansara Lewis

Date: 11/24/2009

Telephone Number: 213 251-6836

MHSA Innovation Plan Budget Narrative: Mobile Health Team Model

A. EXPENDITURES

Personnel Expenditures: Salaries and benefits for estimated FTEs including costs associated with personnel for data collection, evaluation and reporting

Operating Expenditures: Estimated costs associated with the day-to-day operations of the project/plan. Includes building or office rent/lease, utilities, supplies, insurance or fees, travel and/or transportation, on-going medication and/or medical supplies, perishable furnishings (such as pillow cases, towels, masks etc.), ongoing costs such as food or like supplies, mileage, expenses for travel, and client supportive services and Fixed Assets such as a possible vehicle.

Non-recurring Expenditures: Estimated One time cost. Items including fixed assets such as vehicles, office equipment, computers, desks, chairs and communication devices such as phones etc for base location.

B. REVENUES

Federal Financial Participant: Estimated possible revenue from FFP. Estimates are based on data secured from current programs with similar elements to this model

Federal Qualified Health Center: Estimated revenue from FQHC

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Los Angeles Fiscal Year: 2009/10

Work Plan #: 3

Work Plan Name: Community Designed Integrated Services Model (ISM)

New Work Plan ☑

Expansion ☐

Months of Operation: 1/10-12/12
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			4,639,000	$4,639,000
2. Operating Expenditures			2,639,999	$2,639,999
3. Non-recurring expenditures			319,956	$319,956
4. Training Consultant Contracts			0	$0
5. Work Plan Management			399,945	$399,945
Expenditures	**$0**	**$0**	**$7,998,900**	**$7,998,900**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$7,998,900**	**$7,998,900**

Prepared by: Ansara Lewis/Tara Yaralian Date: 11/24/2009

Telephone Number: 213 251-6836 / 251-6814

MHSA Innovation Plan Budget Narrative: Community Designed Integrated Services Management (ISM) Model

A. EXPENDITURES

Personnel Expenditures: Salaries and benefits for estimated FTEs including costs associated with personnel for data collection, evaluation and reporting

Operating Expenditures: Estimated costs associated with the day-to-day operations of the project/plan. Includes building or office rent/lease, utilities, supplies, insurance or fees, travel and/or transportation, on-going medication and/or medical supplies, perishable furnishings (such as pillow cases, towels, masks etc.), ongoing costs such as food or like supplies, mileage, expenses for travel, and client supportive services to purchase non-traditional and other supports that are specific to each ethnic group model

Non-recurring Expenditures: One time cost. Items including fixed assets such as vehicle, office equipment, computers, desks, and communication devices such as phones

Work Plan Management: Estimated cost for Community Mental Health Contract Providers to provide sufficient oversight and internal management of their contracted project. This includes the responsibility to provide requested data, outcomes, and reports

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Los Angeles

Fiscal Year: 2009/10

Work Plan #: 4

Work Plan Name: Peer-Run Model

New Work Plan ☑

Expansion ☐

Months of Operation: 1/10-12/12
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures			1,208,200	$1,208,200
2. Operating Expenditures			556,500	$556,500
3. Non-recurring expenditures			111,450	$111,450
4. Training Consultant Contracts			437,100	$437,100
5. Work Plan Management			121,750	$121,750
Expenditures	**$0**	**$0**	**$2,435,000**	**$2,435,000**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$2,435,000**	**$2,435,000**

Prepared by: Ansara J. Lewis

Date: 11/24/2009

Telephone Number: 213 251-6836

MHSA Innovation Plan Budget Narrative: Peer Run

A. EXPENDITURES

Personnel Expenditures: Salaries and benefits for estimated FTEs including costs associated with personnel for data collection, evaluation and reporting

Operating Expenditures: Estimated costs associated with the day-to-day operations of the project/plan. Includes building or office rent/lease, utilities, supplies, insurance or fees, travel and/or transportation, on-going medication and/or medical supplies, perishable furnishings (such as pillow cases, towels, masks etc.), ongoing costs such as food or like supplies, mileage, expenses for administrative costs, travel, and peer client supportive services for health, mental health and SA

Non-recurring Expenditures One time cost for two houses. Items include office equipment, computers, desks, printer/copier and communication devices such as phones, and fax machines

Training Consultant Contracts
Consultation and Training with local, national and statewide experts

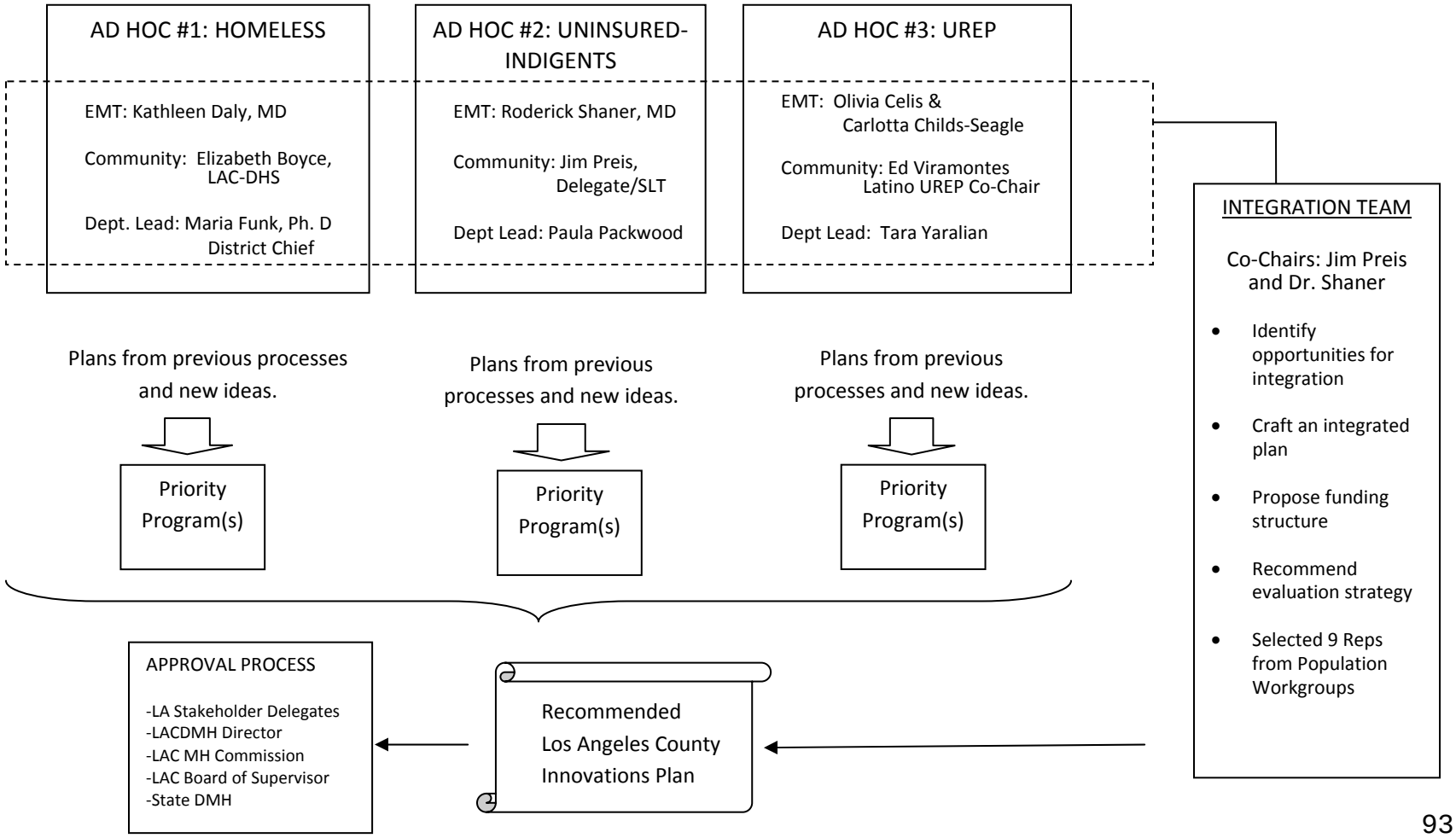
Work Plan Management: Estimated cost for Community Mental Health Contract Providers to provide sufficient oversight and internal management of their contracted project. This includes the responsibility to provide requested data, outcomes, and reports

Attachment A

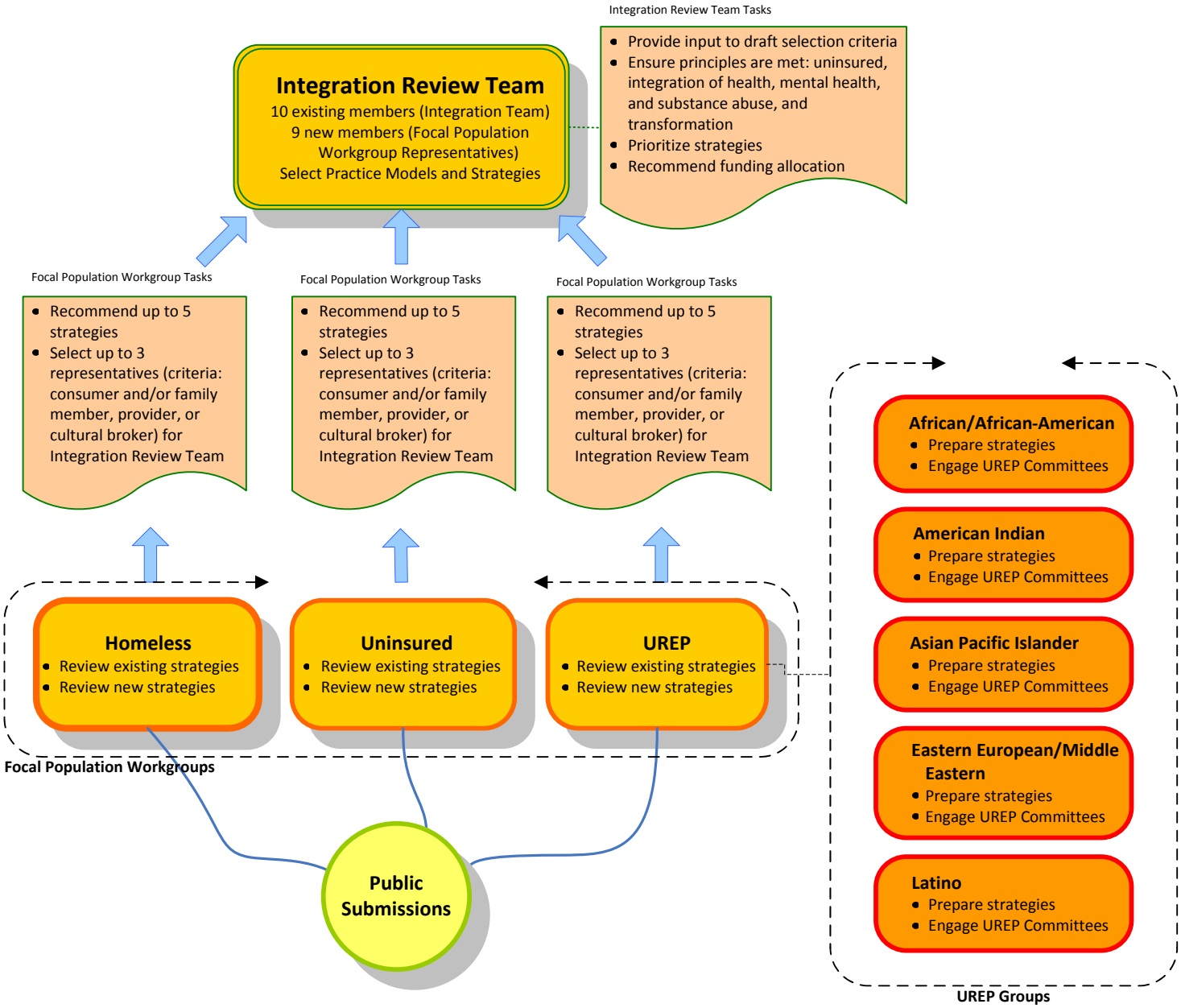
MHSA INNOVATIONS (INN) PLAN: COORDINATION DIAGRAM

COORDINATOR: GLADYS LEE

PROJECT MANAGER: DARLESH HORN



Innovations (INN) Plan: Strategy Selection Process



MHSA-INNOVATIONS (INN) STRATEGIES SUBMISSION LOG

Strategy	Submitter	Homeless	Uninsured	UREP	ID#
AAA Centered Faith-Based and Holistic Services Project	AAA UREP			x	01
AAA Neighborhood Family Enrichment Project	AAA UREP	x	x	x	02
ACE Study-Based System of Primary Medical Care, Supportive Services, and Health Education	Peggy Edwards	x	x		03
Advocacy to Increase Ease/Flexibility of attempting employment for persons with disabilities	AFSCME	x	x	x	04
Alano Clubs - Supportive Services Co-located		x	x	x	05
Brief Cognitive Behavioral Therapy for Homeless Women with Post-Traumatic Stress Disorder: Training and Feasibility for LACDMH	USC School of Social Work	x	x	x	06
Building a best practices model to serve adults with dual diagnosis: a partnership with the Tierra del Sol Foundation	Tierra del Sol Foundation	x	x	x	07
Cell Phones/Radios for the Homeless	Roland Moses	x	x	x	08
Child Development Center for Parenting and School Readiness				x	09
Community Relations, Education and Outreach (CREO)	Mental Health America of Los Angeles		x	x	10
Consumer and Family	James Randall			x	11
Core Gift Coorporation with Sol Adventurers Foundation	Stars, Inc	x		x	12
Cross-Sector Collaborative Project	Black Los Angeles County Client Coalition (BLACCC)	x	x	x	13
Dedication to Education Street Team Mentor Program	Inner City Industry (ICI)	x	x	x	14
Developing an Evidenced Based Practice for Ethnic Psychotic Elders	Heritage Clinic		x	x	15
DPSS/DMH Collaboration to Transition GR NSAs to SSI	DPSS	x	x	x	16
Dr Floyd McGregor's Chill Out CBT Anger Management Program	CONNECTING - it works! Inc		x	x	17
Early Intervention First Break TAY	Choices Recovery Services	x	x	x	18
Eat & Meet Life Skills Program	Peggy Edwards		x		19
Embedding Health Care to Engage High Risk Homeless Individuals	Mental Health America of Los Angeles	x	x		20
Family Empowerment for Families with Special Needs Children	Jeffrey Foundation			x	21
Field Based FSP Services Utilizing a Full-Sized Van	Choices Recovery Services	x	x	x	22
FSP Diversion Pilot Project	Mental Health America of Los Angeles	x	x		23
Health Integration Project	Pacific Clinics		x		24
HIP-Harmonious Integration Plan	API UREP			x	25
Hope and Home	Foothill Family Service	x	x	x	26
Housing Centered Income Maximization Project for homeless mentally disabled individuals		x	x	x	27
Integrated Care for Consumers with Co-Occurring Disorders	Tarzana Treatment Centers	x	x	x	28

MHSA-INNOVATIONS (INN) STRATEGIES SUBMISSION LOG

Strategy	Submitter	Homeless	Uninsured	UREP	ID#
Integrated Dual Disorder Treatment Quality and Access Improvement	Don Parrington	x	x	x	29
Integrated Healthcare, Mental Health, SA Services to Homeless Mentally Ill	SF Valley Community Mental Health Center	x	x	x	30
Integrated Primary and Behavioral Healthcare for Mental Health Consumers	Didi Hirsch Mental Health Services	x	x	x	31
Integrated School Health Center	Mandy Johnson		x	x	32
Integrated Supportive Housing Management	Mollie Lowery	x	x		33
Integrating Behavioral Health into the Medical Home	Community Clinic Association of LA	x	x	x	34
Integrating Mental Health into Perinatal Care: Addressing Depression in Pregnancy and the Postpartum	Children's Health Outreach		x	x	35
Integrating Mental Health Screening, Referral and Brief Treatment into Primary Care	Tarzana Treatment Centers	x	x	x	36
Just In Reach	Eimago/Union Rescue Mission	x			37
Korean Family Health Project	Asian American Drug Program			x	38
Latino Family Access Centers	DMH-Ana Suarez/Sam Chan		x	x	39
LGBT Aging In Place Initiative	LA Gay & Lesbian Center	x		x	40
Life Source	Life Source	x	x	x	41
Life Works	LA Gay & Lesbian Center	x	x	x	42
Long Beach TAY Collaborative	Long Beach TAY Collaborative	x	x	x	43
Low Barrier Drop In Center for Homeless TAY	Step up on Second	x	x	x	44
Marketing Fiscal Sources for DMH programs to School Officials	Community Family Guidance Center	x	x	x	45
Mary Lind COD Integration Strategy	Mary Lind Recovery Centers	x	x	x	46
Medication-Assisted Therapy with Vivitrol for Alcohol Dependent, Trauma-Exposed COD Individuals	Tarzana Treatment Centers	x	x	x	47
Mental Health and Integrated Care Management of Uninsured in public sector utilizing Medical Services Organization	Paula Packwood	x	x	x	48
Mental Health Prevention in Emergency Department Setting	Tarzana Treatment Centers	x	x	x	49
Mental Health's Sustentacularability Strategy Plan (MHSSP)	Rev. James Steele	x	x	x	50
MHSA Innovations Countywide Fun for Services in Permanent Supportive Housing	Shelter Partnership	x			51
Mobile Brief Responsive Counseling	Didi Hirsch Mental Health Services	x	x	x	52
Multidisciplinary And Integrated Mobile Health Team	Peggy Edwards	x	x		53
Multidisciplinary Mobile Team for Chronically Homeless in Hollywood	Saban Free Clinic	x			54
Multi-Family Group	DMH-James Randall			x	55
Older Adult UREP Peer Support Project	DMH-Older Adult Programs Admin			x	56
Ourtreach, Linkage and Education-OLE	Latino UREP			x	57
Para Los Ninos Mental Health Collaborative Care Model	Para Los Ninos	x	x	x	58

MHSA-INNOVATIONS (INN) STRATEGIES SUBMISSION LOG

Strategy	Submitter	Homeless	Uninsured	UREP	ID#
Parents and Child Care Providers Working Together for the Future	Child Care Resource Center (CCRC)	x	x	x	59
Peer Recovery Collaboration		x	x	x	60
Peer-Run Respite House	Project Return		x	x	61
Pilot Integrating Health, Mental Health and Supportive Services to Head Start Families	Kedren Community Health Center		x	x	62
Primary Care-Based Telepsychiatry	DMH-Older Adult Programs Admin		x	x	63
Project to Access and Sustain Permanent Housing (PAS)	Mollie Lowery	x	x		64
Project-Based Service Vouchers (PBSV)	Skid Row Housing Trust	x	x	x	65
Promoting Mental Health through Healthy Relationship Skills	California Healthy Marriages Coalition		x	x	66
PROTOTYPES Center for Innovation and Integration	Prototypes	x	x	x	67
Reach Out to At-Risk, Trauma Exposed Families	Armenian Relief Society of West USA	x	x	x	68
Recovery After Initial Schizophrenia Episode (RAISE) Program	DMH-James Randall			x	69
Regenerative Transitional Behavior Therapy (RTBT-T)	Diane McNeal	x	x	x	70
Outreach and Referral Center for Multicultural Mental Health Services	EE/ME UREP	x	x	x	71
Responding to Domestic Violence: The "Whole Person" Approach	Children's Institute		x	x	72
Salud Y Familia Media Campaign	LA Child Guidance Clinic			x	73
School Based Mental Health and Substance Abuse Prevention	Tarzana Treatment Centers		x	x	74
Secure Attachment for Family Engagement (SAFE)	Vista Del Mar Child and Family Services		x	x	75
Seeking substance abuse treatment for individuals receiving Section 8 housing	AFSCME		x	x	76
Sober Living House - Supportive MH Services		x	x	x	77
SPA 6 Restoration Center (S6RC)	Special Service for Groups	x	x	x	78
Steps to Success	Laurel Bear, Rosalie Finer-Alliant Int.	x	x	x	79
Stop LGBTQ Family Violence	LA Gay & Lesbian Center	x	x	x	80
Strength Through Access and Resources (STAR)	Family Service		x	x	81
System Development: Mental Health, Substance Abuse, and Health Program	LBHI			x	82
Teachers and Life Coaches (TLC)	Antelope Valley Partners for Health	x	x	x	83
The Restoring Urban Traditional Healing (RUTH) Project	AI UREP	x	x	x	84
The SHARE Program	SCHARP	x	x	x	85
The Three R's - Building Relationships, Resiliency & Recovery	LA Child Guidance Clinic			x	86
Therese Haviland's CBT Langauge Arts Therapy	Therese Haviland			x	87
Trauma Informed Afterschool Program for Middle School Students	Didi Hirsch Mental Health Services		x	x	88
Trauma Systems Therapy for Substance Abusing Adolescents and Transitional Age Youth	Children's Institute	x	x	x	89
Understanding and Addressing Homelessness in the Context of Trauma	Children’s Hospital	x			90

MHSA-INNOVATIONS (INN) STRATEGIES SUBMISSION LOG

Strategy	Submitter	Homeless	Uninsured	UREP	ID#
Video Conference Technology Field based Psychiatric Services	Choices Recovery Services	x	x	x	91
Volunteer Companions	Step up on Second	x	x	x	92
Vulnerability Index Full Service Partnership Initiative		x			93
Vulnerable Veterans Initiative	Peggy Edwards	x			94
Web Based Interactive Behavioral Modification and Treatment Intervention	Institute for Multicultural Counseling & Education Services, Inc	x	x	x	95
Wellness on Wheels	Children's Institute	x	x	x	96
WIN Services for Families Outside the Network	Westside Infant Family Network	x	x	x	97
Youth Outreach Trailer to deliver PEI Mental Health Services	Choices Recovery Services	x	x	x	98
Advancing the Transition to Adulthood Among Older Youth and Young Adults with MH Needs and Fragile Community Connectedness (Advancing Pathways to Success)	Kathy Millet	x	x	x	99
Hire Staff to Assist Under-Age (less than 60) Hoarders	DMH - EAD	x	x	x	100
Peer-Run Crisis Residential Program	DMH - EAD	x	x	x	101
Procovery	DMH - EAD	x	x	x	102
Peer Support Strategies For Consumers	DMH - EAD	x	x	x	103
Collaborative Care Strategy for Consumers	DMH - EAD	x	x	x	104
Provide Support for People with Mental Health Problems	Ruth Hollman	x	x	x	105

COUNTY OF LOS ANGELES— DEPARTMENT OF MENTAL HEALTH
MHSA INNOVATIONS PLAN
Identifying Critical Question, Integration Models and Innovative Strategies

Critical question to be answered by Los Angeles County INN Plan: What are the most effective models for integrating Mental Health, Physical Health, and Substance Abuse services in our defined focal populations of Uninsured, Homeless, and Under-represented ethnic populations?

Model 1: Integrated Clinic Model

Model 2: Integrated Mobile Health Team

Model 3: Community-Designed Integrated Service Management Model

Model 4: Integrated Peer-Run Model

All models will integrate mental health, health and substance abuse services.

Innovative Strategies

1. Integrate health and substance abuse services in mental health setting.
2. Integrated services in primary care setting.

Innovative Strategies

1. Enhanced and integrated mobile teams.
2. Project-based service vouchers
3. Integrated team mobile services.

Innovative Strategies

1. Neighborhood Family Enrichment Project
2. Referral System for Traditional Healers
3. Countywide Approach to Provide a Wellness Program
4. Culturally-Competent Community-Defined Outreach and Referral Services Center
5. Outreach, Linkage, and Education Collaborative

Innovative Strategies

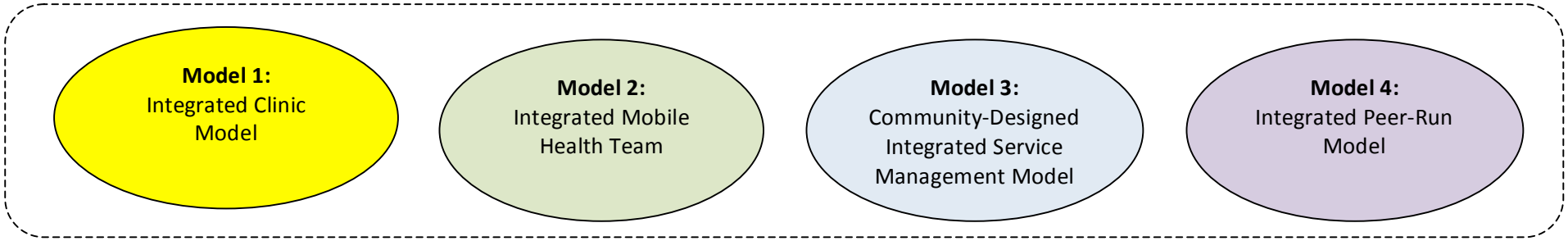
1. Peer Bridgers Brokering Integrated Services
2. Peer support for successful transition from jail into the community
3. Peer/family crisis alternative services

Cross-Cutting Innovative Strategies (can be integrated in one or more models):

1. Peer Bridgers brokering integrated services.
2. Wellness Promoters integrating health, mental health and substance abuse.
3. Tele-psychiatry

COUNTY OF LOS ANGELES— DEPARTMENT OF MENTAL HEALTH
MHSA INNOVATIONS PLAN

Identifying Learning Goals, Critical Question, and Integration Models



Critical question to be answered by Los Angeles County INN Plan: What are the most effective models for integrating Mental Health, Physical Health, and Substance Abuse services in our defined focal populations of Uninsured, Homeless, and Under-represented ethnic populations?

Learning Goals

Area One
System Integration of Mental Health, Health and Substance Abuse

Learning Goal: Can a multi-disciplinary model of fully integrated health, mental health, and substance abuse services be embedded within the public mental health system that results in the accurate identification and appropriate treatment of poly-occurring health, mental health and substance abuse disorders?

Area Two
Leveraging Financial Resources and Sustainability

Learning Goal: Can the integration of mental health, physical health, and substance abuse treatment services generate a structure that leverages funding streams and results in sustainable, integrated and multi-disciplinary care that meets the multiple needs of people with mental health disabilities?

Area Three
Community-Defined, Culturally Competent Model of Care with Underrepresented Ethnic Populations

Learning Goal: Can ethnic community resources be engaged and utilized to increase access and improve the quality of mental health services for consumers from UREP communities?

Area Four
High Quality and Cost-Effective Peer-Run Models

Learning Goal: Can peer-run strategies result in effective coordination of health, mental health, and substance abuse services including self-help modalities, while supporting, recovery and wellness and increasing cost-effectiveness?

Innovative Strategies (15)

ATTACHMENT E

Innovations Plan – Detailed Description of Integrated Clinic Model

County of Los Angeles – Department of Mental Health

I. Vision

The Integrated Clinic model seeks to increase the quality of care and services for the uninsured, including those who are homeless and/or members of under-represented ethnic populations (UREP) by reducing the fragmentation inherent in the current system of care. This model will support the capacity of primary care or mental health clinics to integrate on-site mental health, physical health, and substance abuse treatment services in an effective, culturally-relevant, and consumer-driven manner for individuals who are homeless, uninsured, and/or members of UREP. In this way, the model provides a "home" for people seeking integrated care.

The Integrated Clinic Model:

1. Uses a multi-disciplinary team approach to address the client as a whole avoiding the silos, duplication, and fragmentation inherent in the current system of care;
2. Leverages an existing untapped framework of community-based providers with the potential to offer a spectrum of community-driven and client-focused primary care, mental health, and substance abuse services;
3. Emphasizes the whole person approach to health services, including critical enabling services (e. g. transportation, linguistic support, care management, etc.) which are the hallmark of the community-based care;
4. Ensures culturally and linguistically competent care through a model designed to provide accessible, affordable, culturally appropriate and non-discriminatory care to the underserved; and,
5. Works to reduce the myriad barriers to care for under-represented populations.

II. Innovations

While other efforts to integrate care exist, our Integrated Clinic Model is innovative for several reasons. First, we are attempting to integrate care in a large, complex urban environment and in a system that includes directly operated and contracted entities. Second, the model specifically targets the most vulnerable populations to test whether integrated care improves service quality to them. Third, for those primary care sites integrating on-site mental health and substance abuse treatment services, this model extends the definition and scope of the mental health care to support and treat serious mental illness within the borders of a primary care site. Fourth, for those mental health sites that will imbed physical health and substance abuse services, the model's innovation includes the opportunity to stabilize the client enough to determine whether he or she can change the health home to a physical health site with support (e.g. moving the client to a wellness center or to a primarily physical health site as a move along the continuum of care). Lastly, this Integrated Clinic Model's use of peers as staff is unique even among existing co-sited model design and systems of care.

III. Target Population

Target populations will include uninsured and/or homeless, and /or members of UREP. Individuals served will be eligible for specialty mental health services and could benefit from primary health care and/or substance abuse treatment services. Data from Los Angeles County, WRMA Sacramento, and the California State Department of Mental Health indicate an estimated population with Serious Emotional Problems (SEP) and Serious Mental Illness (SMI) at 706,388 individuals in Los Angeles County. Of these, 326,913 individuals live below 200% of the federal poverty level according to its 2008 report. The target populations may be selected based on the density of uninsured, homeless and/or UREP, utilization patterns, and other available data.

IV. Need Addressed

As documented in the September 2009 Integration Policy Initiative report by the California Institute of Mental Health and the Integrated Behavioral Health Project, "The failure to address the need for primary and behavioral health care coordination and integration has resulted in grave consequences for individuals and families including chronic medical conditions and early mortality in individuals with serious mental illnesses. The other side of the primary care/behavioral health interface is the significant number of people in primary care that need behavioral health services. Primary care is usually the first health care contact for individuals and is intended to provide comprehensive care. Integrating care at these sites will improve access while eliminating the stigma often experienced while seeking care at mental health only sites.

Recently published studies indicating that persons with serious mental illness in the United States can expect to live an average of 25 fewer years than the general population, have underscored the pressing need to improve and facilitate access to coordinated and integrated physical and mental health care and services. The ability to detect and treat mental health or substance use issues in the primary care setting and to screen for and even treat the identified need for physical health services in the mental health setting may improve the quality of care received from both systems of care in facilitating treatment of the whole individual.

The potential for increased quality of care and service and improved clinical outcomes is inherent in an integrated care model. Using a common care plan and noting clinical findings, medications and treatments in a common medical record increases the providers' capacities to recognize, treat and refer clients more appropriately and comprehensively. Safer care and improved individual client outcomes will be the benefits of providers understanding of the whole spectrum of health issues affecting a client, including medications, plan of care, etc. The timeliness of the "warm handoff" technique as well as the embedded systems of care will strengthen the drive toward efficiency and patient-centered care.

V. Program Elements, Process and Services

Element Set 1: Service Provider Management Team

1. The service provider management team will be responsible for the following:
    a. Identifying a lead Project Director to coordinate operations;
    b. Verifying licensure for the delivery of mental health, physical health and substance abuse services;
    c. Billing third party payer sources for mental health, physical health and substance abuse services;
    d. Establishing and meeting pre-defined systems-focused and client-centered outcomes, for each client and for the program overall; and,
    e. Accessing INN funding allocated for service provision by Integrated Clinic Model

2. Capacities:
    a. Train staff/others who will be screening clients and providing referrals;
    b. Establish and document appropriate clinical and community network for referral and supportive services; and,
    c. Track clients through a database and use an electronic integrated care plan.

Element Set 2: Staffing, Services Provided and Administrative Structure

1. Staffing
    a. Integrative Care will be provided by an on-site care team with multi-disciplinary staff. The on-site care team works to facilitate communication among service providers to ensure that the range of services available is identified and shared systematically among the team. Staff must include, at a minimum, licensed providers for mental health, physical health, and substance abuse, and skilled care coordinators/case managers, peer staff, and benefits establishment counselors. The onsite care team may also include the following staff members:
        - Primary care physician;
        - Psychiatrist;
        - Depression care manager;
        - Licensed Clinical Social Worker;
        - Nurse Practitioner;
        - Certified Substance Abuse Counselor;
        - Clerical Support;
        - Billing Clerk; and,
        - Promotores or other ethnic support or peer counselors.

2. Services Provided
    a. This model brings together at one site systems with a common interest in providing care to the uninsured and medically indigent, restructuring the health care and mental health delivery system around an integrated and

expanded network of public and private providers combining resources to improve the mental health and physical health outcomes of the underserved. This includes potential for peer involvement assisting clients with other services such as transportation, case management, linguistic support, and case management. The Integrated Clinic Model would provide services to an estimated 1,600 individuals over the course of a year at four planned clinic sites (400 individuals/year each). At a minimum, required on site services would include: specialty level mental health care, physical health care, and substance abuse treatment services with referrals for other specialty services. Other services available on site may include the following:

- Pharmacy-Prescriptions and medications (dispensary) will be available on site;
- Ancillary-Lab work would be drawn at site;
- Non- traditional sources, social services and hospital linkages;
- On-site benefit establishment including DPSS staff or linkage;
- Individuals requiring highly specialized services not available in the integrated clinic can be appropriately linked to necessary programs. The referral network must be defined and documented; and,
- Remote services provided onsite, which may include integration of tele-psychiatry and/or tele-medicine.

3. Administrative Structure
    a. Supervision of Care team -On site care team may come from different agencies, but must deliver integrated care under the management of the project director.
    b. Team process will include regular case conferencing, regularly updated unified care plan and follow up, and periodic re-evaluation of diagnosis and medication.
    c. Access, outreach and availability-Individuals could receive services at the clinic through referrals or as a walk in at a center that provides mental health, physical health and substance abuse care.
    d. Data availability and assessment-Data based referrals

4. Capacities
    a. Location at a geographically appropriate site for convenient service delivery to the identified target population, as identified by available data sources
    b. Demonstrated linkage capacity, including information transfer, to mental health, specialty physical health, substance abuse, non-traditional services, and social services providers in the communities that serve the target population

c. Cultural Competence: Clinic and agencies to which they refer clients must provide accessible, affordable, culturally-appropriate and non-discriminatory services to low-income families;
d. Ability to track and report on services and linkages
e. Screening tool will be used at the integrated care clinic as well as the referring agencies, it must be robust enough to determine acuity level and document basis of dollars used for other than mental health services

Element Set 3: Client Flow

The Integrated Clinic Model utilizes the “no wrong door' approach to services, meaning that clients can access the full suite of services by engaging a provider in any of the three disciplines. At the core of the Integrated Clinic Model is the “warm hand-off' approach. For example, a patient enters a community clinic for a primary care appointment and establishes a medical home. During the encounter with the patient, the primary care physician conducts a simple mental health screening. Finding symptoms of a potential mental health condition, the physician can then call on the clinic’s mental health consultant to come to the exam room. Utilizing evidence-based assessment techniques and tools, the mental health provider then links the patient to the appropriate level of intervention matching the intensity of need. In another variation of the integration model where primary healthcare is embedded at a mental health site, screening and a warm hand-off approach is also utilized with the mental health provider performing the screening and hand-off to a physical health provider at the mental health clinic.

1. Critical components
    a. Tracking of clients will be done through a database. Database (to track client information from DMH and DHS or primary care provider);
    b. Care coordinators/Case managers assist clients through the service structure as well as tracking clients through the system;
    c. Case conferencing (would include on-site and off-site service providers);
    d. Electronic integrated care plan that is standardized for all would help collect data for outcome; and,
    e. Possible development and implementation of an Encounter Data Sheet.
2. Funding and Leveraging of Resources
    a. Leveraging with FQHC and Public Private Partnership (PPP) funding for uninsured mental and physical health care with substance abuse funding and MHSA for mental health care as indicated under Innovations project plan funding; and,
    b. Also leverage with third party payer funding for greater percentage of clients as they work with the benefits establishment coordinator.

VI. Principles and Values

The integrated clinic model supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR section 3320. The model is grounded in the following specific principles and values:

1. Client Centered Care and service;
2. Prospective care planning and facilitation as well as coordination;
3. Provider to provider communication;
4. Pre established network for clinical, non traditional or CBO referral;
5. Peers included in teams;
6. Timeliness;
7. Safety;
8. Data driven outcomes both systemic and client centered;
9. Efficiency while quality oriented;
10. Cultural competence'
11. Improvement in access to care at appropriate level of care and service; and,
12. Wellness Focus: Providers will offer coordinated services with a focus on wellness in all disciplines.

Additionally, the model utilizes trusted community resources and non-traditional mental health settings. Integrating mental health services into the primary care setting can reduce the stigma associated with traditional mental health settings. Integrating physical services into mental health settings will increase access of clients with serious mental illness into physical health care.

VII. Outcomes and Contribution to Learning

1. Service level and system change outcomes:
    a. clinician satisfaction survey;
    b. medication usage;
    c. screening tool usage;
    d. referral process adherence;
    e. tracking and data adherence to process and data and reporting compliance;
    f. follow up for chronic illness treatment and for mental illness protocols;
    g. timeliness and access standards compliance; and,
    h. use of unified electronic patient care plan with frequent scheduled team conferencing and update.

2. Transformative learning questions -Global questions;
    a. Can an integrated structure for mental, physical and substance abuse care decrease fragmentation and improve timeliness and efficiency in the system as evidenced by the following: 1) improved clinical outcomes; 2) improved utilization patterns with decrease in emergency room usage and inappropriate or frequent hospitalizations; and 3) improved timeliness of access to all of these systems of care

b. Can an integrated system of care increase the capacity of the system to track care and outcomes and embark on a continuous quality improvement process between and among systems of care as evidenced by the following: 1) data systems available to support tracking of project participants, utilization patterns across systems and patient outcomes; and 2) structure for assessment of barriers and to support CQI
c. Can provider levels of competency around appropriate referrals to mental health or physical health care be demonstratively improved by training and coaching on the referral protocol established by the model

3. Transformative Learning Questions – Los Angeles County specific.
   a. Through our Community Program Planning Process, LACDMH and its stakeholders identified the following specific learning questions that would be answered by this model:
   b. Can Los Angeles County expand and better coordinate services in order to improve health outcomes and better utilize limited public resources?Can the capacity of the public mental health system be expanded to serve uninsured persons with high acuity levels?
   c. Can integrated mental health and substance abuse services be provided at primary care settings?
   d. Can integrated physical health and substance abuse services be provided at mental health settings?
   e. How will persons of differing acuity levels access these integrated mental health and substance abuse services?
   f. Will the imbedding of services at primary care settings decrease the stigma of clients receiving mental health services?
   g. Will these persons achieve positive outcomes?
   h. Can these services be delivered in a cost-effective way?

4. Client level outcomes
   a. patient satisfaction surveys
   b. medical and psychiatric clinical measures of improvement
   c. utilization patterns pre and post at appropriate level of care
   d. compliance with treatment goals and strategies

VIII. Project Measurement

Current State	**Desired State**	Goals	Measures
Mental Health / Physical Health/ Substance Abuse services located in different settings resulting in	**Single sites provide integrated services for mental health AND physical health AND Substance**	Determine the extent to which each program site provides mental health AND physical health AND substance abuse	Survey of program clients, providers, and administrators, and larger stakeholder

fragmented care.	**abuse services.**	services.	community.
Mental Health care & Physical care are located at different sites resulting in diminished access for clients with Mental Illness.	**Integrated Care at common site to improve access and create more efficiency in the patient/person centered system.**	Determine the extent to which every program provides common site for mental health, physical health and substance abuse care and services.	Survey of program clients, providers, and administrators, and larger stakeholder community.
Current programs often have a lack capacity for communication coordination and sharing of information.	**Clinical, operational and other pertinent information is available to all on-site providers involved in patient's care in a timely manner and supports prospective care planning and safety.**	Determine the extent to which each program changes or eliminates barriers to information sharing	Identification and inventory of barriers as baseline and determination of the degree of change or elimination of identified barriers through survey of program clients, providers, and administrators, and larger stakeholder community.
Many current programs lack capacity to fully integrate other community-based resources	**Community-based resources are integral service providers.**	Determine the extent to which each program increases the types and numbers of community-based partnerships and peer-provided services associated with integrated care sites.	Measure the number of community-based partnerships and peer-provided services at selected program sites at the beginning of the program and at 18 months.
Client must often go to multiple sites to receive care needed.	**Clients can receive necessary care at one site**	Determine the extent to which each program integrates and provides health, mental health, and substance abuse	Survey of program clients, providers, and administrators, and larger stakeholder community.

		services at one site.	
Funding for integrated mental health, physical health and substance abuse programs is often difficult to sustain.	**Funding for integrated mental health, physical health and substance abuse programs is ongoing.**	Identify mechanisms for sustainable funding. Identify care elements and cost of care elements for integrated care.	Identify, inventory, and track core cost elements of integrated care, reimbursement sources and flow over duration of project.

More detailed client outcomes measures for this model to support the above may include:

1. Screening tool usage (do primary care providers appropriately screen patients), and following referral protocols (do patients get referred to mental health when they screen positive) ;
2. Screening tool usage (do mental health providers appropriately screen patients), and following referral protocols (do patients get referred to PCP when they screen positive;
3. Pre- and post-tests (e. g., PHQ-9, Becks Anxiety Inventory, Brief Symptom Inventory, COJAK or other tools/in the case of warm handoff to physical health), screens may include no physical exam in last 12 months, Hx of Hypertension of diabetes, use of particular psychiatric medications etc.;
4. Patient satisfaction surveys;
5. Clinician satisfaction rates;
6. Medication usage;
7. Number of visits/utilization and level of care patterns;
8. Compliance with treatment goals; and,
9. Pre- and post-clinical indicators as appropriate.

All outcomes will be monitored through standardized reporting as required by the Innovation Plan oversight structure. Outcomes data and evaluation results will be shared as required by the Innovation Plan oversight structure and as appropriate to advance treatment of this population in primary care and other settings.

IX. Projected Costs

The budget proposes to serve an estimated 1,600 clients at 4 sites at an average cost of $910,000 per site per year.

X. Timeline

ATTACHMENT E

Innovations Plan – Detailed Description of Integrated Clinic Model

County of Los Angeles – Department of Mental Health

Timeframe	Activities
Jan 2010	Estimated Plan Approval from CA Dept of Mental Health
Feb-Apr 2010	Competitive Bidding Process
May—July 2010	Contract Negotiations, Board Approval and Awarding of Contracts
Aug-Oct 2010	Start up and Staffing of Integrated Clinics Staff training Database and electronic care plan development Team orientation to the model MOU's and linkages for network finalization Menu of services and administrative structure and process finalization Begin to see clients
Nov 1, 2010	Clinics begin screenings, integrative processes and service delivery 1st Quarterly Formative Evaluation and Reporting Assessment of program, processes and preliminary data making adjustments as necessary Measure the number or percentage of patients screened by initial provider, referred to integrated partner, and referred outside to specialty care; measure acuity levels, peer involvement and other specific data.
Nov 2010-Jan 2011	Screening and integrated care and services continues
Feb 1, 2011	2nd Quarterly Formative Evaluation and Reporting Administrative and clinical staff meet for mid-program assessment with adjustment of program or processes as necessary. Measure the number or percentage of patients screened by initial provider, referred to integrated partner, and referred outside to specialty care; measure acuity levels, peer involvement and other specific data.
Feb-May 2011	Continue Integrated Services
June 1, 2011	3rd Quarterly Formative Evaluation and Reporting and adjustment of program or processes as necessary Measure the number or percentage of patients screened by initial provider, referred to integrated partner, and referred outside to specialty care; measure acuity levels, peer involvement and other specific data.
June 2011-Aug 2012	Continue Integrated Services One year assessment and reporting of program, CQI efforts and outcomes measures, with program adjustments as needed. Create vision for next steps for continuation of program or change recommendations. Measure the number or percentage of patients screened by initial provider, referred to integrated partner, and referred outside to specialty care; measure acuity levels, peer involvement and other specific data. Also, measure the number or percentage of patients transitioned to primary care

	plus wellness center health home as permanent medical home.
Sept-Dec 2012	Summative Evaluation/Final Report Assess results of evaluation and CQI efforts as basis for next steps in integration program and future efforts. Share results and learnings with various local, state and national audiences.

ATTACHMENT H

Innovations Plan – Detailed Description of Integrated Mobile Health Team Model
County of Los Angeles – Department of Mental Health

I. Vision

To reduce fragmentation and increase quality of services, a mobile, enhanced, integrated, multi-disciplinary team including physical health, mental health, and substance abuse professionals and other specialized staff managed under one supervisor will leverage multiple funding sources including capital for housing development and Federal Qualified Health Center (FQHC) funding to reduce homelessness and improve outcomes for individuals who are homeless, many of whom are identified as vulnerable, uninsured and from underrepresented ethnic populations and other groups.

II. Innovations

While other mobile team models exist, our Integrated Mobile Health Team model is innovative for several reasons. First, we are attempting to integrate care in a complex urban environment that is geographically widespread and maintain those services even after individuals move into permanent supportive housing. Second, the Integrated Mobile Health Team will be managed under one agency or under one point of supervision, which is unusual in Los Angeles' complex system of multiple departments and agencies. Third, it will increase access to services and leverage multiple funding sources including Federal Qualified Health Center (FQHC) funding and capital for housing development which have not previously been tapped.

III. Need addressed

Homeless persons with mental health needs typically have a complex array of additional needs, including physical health and substance abuse care. Often their care, if accessed at all, is fragmented as a result of being provided by different agencies from various systems with several funding sources. To address consumers' multiple needs more adequately, a wide array of services should be provided in an integrated manner, breaking down barriers between systems and providers, with the goal of achieving permanent housing.

Homeless people with mental illness are more likely to have higher rates of morbidity and mortality than people with mental illness who live in stable, permanent housing. This difference is the result of a lack of access to healthcare, dental care, mental health care, drug/alcohol treatment, and a result of the adverse conditions experienced living on the streets. Even homeless people with mental illness who have moved into housing often become unstable and frequently lose that housing because they lack access to appropriate, accessible, and integrated services.

Permanent supportive housing (PSH) is recognized as the preferred solution for people who experience chronic homelessness and mental illness. PSH enables the client to first become housed and then receive the services necessary to address their mental

illness and other disabling conditions. It is virtually impossible to adequately treat mental illness, physical health, and substance abuse issues while the individual remains homeless. Initial findings from Los Angeles (LA) County's Project 50 reveal that of the targeted most vulnerable and long-term homeless individuals, only 4% were receiving mental health services prior to housing; this figure increased to 91% after being housed and receiving some degree of integrated supportive services. Moreover, it has been demonstrated that PSH is cost-effective, reducing the use of city and county resources including such as costly crisis/emergency services.

Even with the current stock of PSH, the services tend to be minimal and generally do not include physical health and substance abuse services; if they do the services are fragmented. A Shelter Partnership report on special needs housing in Los Angeles found that "of the 42 permanent housing projects surveyed, the vast majority (88%) reported that they provide supportive services. In 50% of these developments, the levels of services funding and staffing are below what Shelter Partnership determined to be the 'consensus standards' for permanent supportive housing."[1]

Therefore, to more effectively end homelessness for the poorest and most vulnerable residents in Los Angeles County, we must outreach to these individuals who are located throughout the County using an integrated mobile health team and concurrently increase the stock of affordable, service enriched housing. There are financial resources available for the capital development and operating subsidies necessary for developing PSH, both scattered site and project-based, but there is no dedicated funding source for supportive services. This gap has been identified by affordable special needs housing developers as a disincentive to developing more PSH for those with mental illness and other co-occurring disorders.

IV. Target Population

0. Access to services
   This model is designed for individuals with a diagnosis of mental illness, and their families, who are homeless including those living on the streets and in shelters or have recently moved into PSH from homelessness. Some of these individuals will be the most vulnerable individuals as defined by the Common Ground Vulnerability Index or other methods that determine those living on the street who are most likely to die in the next year or other methods based on community priorities.
   a. Individuals who have multiple disabling conditions and are living on the street and their families.

[1] "Survey of Special Needs Housing Projects Funded by the Housing Authority of the County of Los Angeles (HACOLA)," Shelter Partnership, www.shelterpartnership.org

b. Individuals who have multiple disabling conditions and are living in shelters or transitional housing and their families.
c. Formerly homeless individuals who have multiple disabling conditions and their families who have moved into PSH.

With an enhanced integrated service model, the point of entry is through whichever need the client identifies, whether it be housing, physical health, mental health, or substance abuse.

1. Numbers to be served
It is estimated that a total of 900 individuals and their families will be served each year (300 per team). This includes individuals who receive outreach services only and those that are engaged in more on-going services. The individuals to be served may include but are not limited to individuals targeted through the following programs:
    a. Project 500 – an expansion of the highly successful Project 50 which targeted the 50 most vulnerable, chronically homeless people in Skid Row;
    b. MHSA Housing Program – a project that provides funding for the development of new permanent supportive housing units. It is estimated that over the next year 425 new units will become available.
    c. Supportive Housing Alliance – an advocacy group comprised of supportive housing developers estimates that over the next year 211 PSH units will become available (there may be some overlap with the MHSA Housing Program units referenced above).

V. Program Elements

1. Integrated Service Management Team
Multidisciplinary health team (mental health, physical health, and substance abuse professionals and other specialized staff) who work under one agency such as a Federally Qualified Health Center or under one point of supervision.
    a. Staff from multiple disciplines, including but not limited to:
        i. Physical Health
        ii. Mental Health
        iii. Substance Abuse
    b. Team staff members, including but not limited to the following:
        i. Medical physician
        ii. Psychiatrist
        iii. Psychiatric social worker
        iv. Nurse practitioner
        v. Certified substance abuse counselor
        vi. Clerical support
        vii. Billing clerk
        viii. Benefit establishment/housing/employment specialists)

ix. Peer advocate/Family advocate/Parent Partners

2. Funding

Innovative funding mechanisms will leverage MHSA dollars in order to reach and serve the greatest possible number of people, and they will be developed to encourage the creation of more permanent supportive housing. MHSA funding will be used to support outreach and engagement and on-going services by the integrated mobile team. The team will work toward establishing benefits as quickly as possible to assure leveraging of other funding resources such as FQHC funding, Drug MediCal and Public/Private Partnership (for uninsured clients)

The model tests the feasibility of leveraging of Federal resources available through an FQHC to provide services to uninsured clients given the FQHC's rate structure.

The model will determine gaps in allowable FQHC service funding for a fully integrated mobile health service model, and the MHSA funds needed for leveraging.

Once individuals move from the streets and shelters into PSH units, the integrated mobile health team will continue providing services through the use of a project-based service voucher. These vouchers will be committed to housing developers that are interested in building PSH and will be used to leverage housing capital to develop more PSH units. The project-based service vouchers will be dedicated to PSH units similar to project based operating subsidies that are used to make the units affordable for a specific period of time.

Developers will apply for project-based service vouchers for a specific number of PSH units dedicated to the MHSA focal population. DMH will make a commitment to the developer for a specific number of project-based service vouchers. The voucher indicates that the developer has access to integrated health, mental health, and substance abuse services (among others) through a mobile team.

Funding will be tied to the housing units, but the service intensity would be based on the needs of the clients.

In the event the client leaves the PSH project with the project-based service vouchers, the mobile team will continue to provide services regardless of their residence.

3. Services Provided
    a. All mental health, physical health, and substance abuse services identified will be fully integrated into one client care plan that contains physical, mental health, and substance abuse client-centered treatment goals and objectives.
    b. May include tele-health or tele-psychiatry, connections to faith-based community services, peer support programs, and non-traditional approaches that match individual client interests.
    c. Service intensity is moderated according to the needs of the client.

4. Process of Providing Services:
    a. This is a client-centered, housing-first approach, using harm reduction strategies across all modalities of mental health, physical health and substance abuse treatment.
    b. Conducts outreach, engagement and service delivery in the streets, shelters, and in PSH that are tailored to the specific needs of the population served whether they are on the streets, in shelters or recently moved into PSH.
    c. Provides a bridge between the client and other supportive service providers who will then become the main source of on-going support and services, when appropriate.

5. Process of Providing Housing
    a. Housing needs are based on client choice and immediately addressed without “readiness criteria. ”
    b. Specially trained housing specialists that are part of the multi-disciplinary team will collaborate with the housing developers that have units available including those with project-based service vouchers, in addition to accessing Federal housing subsidies and other housing resources.
    c. Assist clients with completing any necessary housing applications, locating housing, and any other supports necessary to obtain housing.

6. Principles and Values
    a. Housing First - Immediately assists individuals to transition from homelessness to housing by providing housing of the individual’s choice without any prerequisites/conditions for mental health treatment or sobriety.
    b. Services are voluntary and focus on creating community.
    c. Multi-lingual and culturally competent – services are in the client’s preferred language are provided in a culturally-congruent manner.
    d. Harm reduction – strategies that are designed to reduce the risk of harm associated with certain behaviors such as drug abuse.
    e. Client-centered – services driven by the client’s own goals and interests.

f. Holistic support – assists the client with health, mental health, and substance abuse needs, but also with other services such as transportation, follow-up, encouragement and communication. A holistic approach will assist clients in attaining and completing services in a linguistically and culturally competent manner.
g. Community-based natural support systems – The mobile teams work within and actively strengthen the natural support systems of specific communities, so that these supports can be part of the clients' recovery process.
h. Advocacy – Includes efforts to change systems in order to better support the integration of care and improved outcomes for the client. Collect and analyze outcome-based data in order to inform efforts for systems change.

VI. Outcomes

Service level outcomes:

1. Reduced homelessness
2. Improved mental health and physical health
3. Increased number of PSH units for the homeless with mental illness
4. Increased housing retention
5. Reduced medical and psychiatric ER visits and other high-cost services
6. Reduced medical and psychiatric hospitalizations
7. Increase benefits establishment
8. Reduced incarcerations
9. Increased involvement in self-help, peer support, and community building activities. Increased self-sufficiency through public benefits, income support, education, vocational training, and connections to employment opportunities

System change outcomes

1. Over time, the model will achieve financial sustainability by leveraging funding through MediCal, Drug MediCal, FQHCs, and other existing programs.
2. Provision of integrated physical health, mental health and substance abuse services under one point of supervision and the braiding of several different funding streams.

Transformation learning questions:

1. How do we design and manage an integrated health, mental health and substance abuse service delivery model that best leverages existing funding for physical health and substance abuse services (in addition to mental health services) that ultimately can become financially sustainable?
2. What barriers exist within public systems that inhibit collaboration and integrated care?
3. What funding gaps exist among existing public service systems that must be addressed to assure high-quality care for homeless mentally ill clients?

4. What program design features increase the effectiveness of the program to engage the hardest-to-reach consumers?
5. Will housing developers have more interest in accepting hard to serve individuals with multiple intense needs who are homeless and mentally ill if integrated services are available to support their transition or and retention of PSH?
6. What program features are necessary to increase the supply of PSH?
    a. To increase the number of developers willing to develop PSH
    b. To increase the number of PSH units
    c. To increase the number of service providers involved in PSH projects
    d. To increase the range and integration of services available to consumers
7. What program features are necessary to encourage mental health services providers to create new partnerships with PSH developers?
8. How can housing developers and service providers work together to better meet the needs of mentally ill, homeless consumers?
9. What are potential mechanisms to bring this type of integrated mobile health team to scale and to sustain it over time?

VII. Projected costs

The attached budget delineates the spending plan for three integrated mobile health teams each serving 300 clients a year which includes those who are outreached to but not engaged in services and those engaged and receiving on-going services. Based on increased numbers of clients obtaining MediCal over the course of the program, the mix of MHSA/leveraged funding will change each year with the MHSA funds decreasing each year.

1. Projected cost for three integrated mobile health teams over two years is $8,714,238 (i. e. Year One: $5,220,024; Year Two: $3,494,214).
2. Portion of cost per year for three teams dedicated to two peer/family/parent advocates per team: $240,000 per year.

VIII. Implementation Timeline

Timeframe	Activities
Jan 2010	Estimated Plan Approval from CA Dept of Mental Health
Feb-Apr 2010	Engage in Competitive Bidding Process
May—July 2010	Contract Negotiations, Board Approval and Awarding of Contracts
Aug-Oct 2010	Start up and Staffing of Integrated Mobile Health Teams
Nov 1, 2010	1st Quarterly Formative Evaluation and Reporting Design one organizational chart that defines one point of supervision and there is one integrated set of policies and procedures. Establish a baseline of existing funding sources and the

	number of clients on benefits and projected amount of leveraging required for viability.
Nov 2010-Jan 2011	Outreach and Engagement
Feb 1, 2011	2nd Quarterly Formative Evaluation and Reporting Confirm that the Integrated Mobile Health Team is as is defined in the organizational chart and the team is following the one set of policies and procedures. Determine that the Integrated Mobile Health Team is actively seeking to maximize leveraging opportunities and is working to establish benefits for new clients.
Feb-May 2011	Integrated Mobile Health Team services provided
June 1, 2011	3rd Quarterly Formative Evaluation and Reporting Confirm that the Integrated Mobile Health Team's organizational chart and polices and procedures are effective and make modifications as necessary. Determine if there is an increase in leveraged funding (including benefits establishment). Budget is revised as needed to decrease MHSA revenue utilization as other funding increases.
June 2011-Aug 2012	Integrated Mobile Health Team services provided
Sept-Dec 2012	Summative Evaluation/Final Report Confirm that any revisions that are made to the organizational chart and the policies and procedures are re-evaluated for effectiveness and if successful, integrated into a best practice model. Determine if there is a decrease in MHSA revenue utilization as a result of maximizing other leveraging resources. Share results and learnings with various local, state, and national audiences.

ATTACHMENT G

Innovations Plan – Detailed Description of Community-Designed Integrated Service Management Model

County of Los Angeles – Department of Mental Health

I. Vision

The Community-Designed Integrated Service Management Model (Community-Designed ISM) addresses the fragmentation inherent in the current system of care by building on the strengths of a community, especially underserved ethnic communities. Collaboration and partnerships between regulated entities, contract providers and community-based organizations will integrate health, mental health, substance abuse, and other needed care to support the recovery of consumers, with particular attention to under-represented ethnic populations.

The Community-Designed ISM model:

1. Uses a multi-disciplinary, integrated service management team consisting of professional and life-experienced consumers, family members, parents, caregivers, cultural brokers and community members, particularly from communities being served;

2. Draws upon the resources from a network of regulatory providers (i. e., mental health, health, substance abuse, child welfare, and other formal service providers) working with a foundation of community-based, non-traditional, and natural support systems;

3. Coordinates the integration of the regulatory providers and community-based resources through: (a) Community –Designed, Peer-based Outreach and Education; (b) Community -Designed Peer-Based Enhanced Engagement practices; (c) Community-Designed Peer-Based Enhanced Linkage and Advocacy (d) Harmonious Intertwining of Regulatory and Non-Traditional Services and Supports;

4. Is rooted in culturally-effective principles and values and,

5. Identifies the barriers to service delivery for under-represented populations and strives to reduce them.

II. Innovations

While similar programs may exist, our Community-Designed ISM is innovative for several reasons. First, we are attempting to integrate care in a large, diverse urban environment with complex systems of care. Second, the model differentiates specific needs and approaches for five distinct under-represented ethnic communities. Third, the model focuses on community self-direction for integrated service delivery. Fourth, we will also integrate peers into the model's mix of formal and non-traditional providers while we integrate physical health, mental health and substance abuse care.

III. Need Addressed

The Los Angeles County Department of Mental Health (LAC-DMH) is committed to working alongside ethnic and cultural communities that have been historically on the periphery of the mental health system. These communities, referred to as UREP (Under-Represented Ethnic Populations), provide LAC-DMH with a wealth of resources and information on how to best serve currently unserved, underserved, and inappropriately served ethnic populations with the goal of bettering their mental health outcomes and overall well being. In Los Angeles County, there are five distinct UREP subcommittees representing the mental health needs and concerns of their communities. These include African Immigrant/African American (A/AA), American Indian (AI), Asian Pacific Islander (API), Eastern European/Middle Eastern (EE/ME) and Latino. By establishing these five UREP subcommittees as a staple in various MHSA planning and stakeholder processes, Los Angeles County created a learning lab for the formal public mental health system to develop culturally competent approaches and services successful at reaching marginalized ethnic communities. As a result, these five UREP groups provide their input about the distinct cultural norms of their communities and how these norms influence mental health needs and service approaches. Hence, development, planning, and implementation of Mental Health Services Act (MHSA) services builds upon this collective wisdom by ensuring all MHSA programs embody culturally-competent approaches endorsed by and effective for the communities they aim to serve.

IV. Target Population

1. Access to services
   The Community-Designed ISM is designed to serve the health, mental health, and substance abuse needs of under-represented ethnic populations that have limited access to culturally-appropriate services and/or will be potentially displaced from services due to funding gaps. In addition, these populations include:
   1. Families/individuals who have a history of dropping out of services;
   2. Linguistically-isolated individuals/families;
   3. Families that have not accessed services due to stigma; and,
   4. Families that have not benefitted from services or have received inappropriate services.

   With the ISM model, the point of entry to services can be through various sites including schools, places of worship, primary care clinics, or other community agencies.

2. Numbers to be served

Over the course of two years, we are proposing to serve 2,800 highly vulnerable families through this project:

		FY 10-11	FY 11-12	
UREP GROUP	GEOGRAPHIC TARGET	EST. # OF FAMILIES	EST. # OF FAMILIES	TOTAL # FAMILIES
African/African-American	Service Area 6	232	232	464
American Indian	Countywide	176	176	352
Asian/Pacific Islander	Countywide	320	320	640
Eastern European/Middle Eastern	Service Area 2 or 4	120	120	240
Latino	3 Service Areas w/ largest concentration of Latinos and lowest penetration rates	552	552	1,104
Total		1,400	1,400	2,800

V. Program Elements
The following sections describe each of the five elements of the ISM model.

A. Element Set 1: Integrated Service Management Team
The team consists of professionals, paraprofessionals, and peers with the professional, cultural, and linguistic skills and resources to integrate mental health, primary care, and substance abuse services.

1. Licensed Staff from multiple disciplines, including but not limited to:
   - Health
   - Mental Health
   - Substance Abuse
   - Nursing
   - Homeopathic physician
   - Chiropractor
   - Acupuncturist

2. Professionals that provide culturally defined services, including but not limited to:
   - Case managers
   - Non-Traditional Healers
   - Community based health practitioners
   - Nutritionists
   - Teachers/instructors
   - Health and fitness trainers
   - Herbalists
   - Culturally sanctioned tribally recognized professionals

3. Peers and/or life experience workers, including but not limited to:
   - Wellness Promoters
   - Promotoras
   - Peer Bridgers
   - Parents
   - Family members

4. Cultural brokers and resource extenders, including but not limited to:
   - Churches/religious leaders
   - Community-based business leaders
   - Volunteers/voluntary organizations

B. Element Set 2: Integrated Care Network

The network consists of formal and community-based non-traditional providers that will break down the silos created by services and treatments dictated by compartmentalized funding.

1. Formal providers including mental health, health, and substance abuse service providers

2. Community-based non-traditional providers include, but not limited to:
   - Faith-based organizations
   - Voluntary associations
   - Community-based organizations providing an array of services including but not limited to legal assistance, social and family support services, immigration services, recreational services, and educational and vocational services.

C. Element Set 3: Integrated Care Model

Community-Designed Peer-Based Engagement and Education recognizes engagement as an ongoing, multiple contact process and the importance of culturally-appropriate education to increase awareness and decrease stigma.

Capacities:

a. ISM will conduct community-designed peer-based enhanced engagement and education with current and/or potential consumers and family members. This type of engagement would:
b. Understand, respect, and honor the specific cultures, traditions, and networks of each community;
c. Address multiple challenges (e. g., lack of knowledge of existing services and treatment options, high rates of recidivism, and stigma) that impair these communities from accessing and maintaining services;
d. Serve UREP members who are also homeless, uninsured, LGBTQ, deaf and hard of hearing, and blind and visually impaired, among others;
e. Provide educational services about mental illness and health issues, including substance abuse;
f. Provide screening to formal and community services;
g. Provide culturally competent referrals for the appropriate level of care required by clients/family members;
h. Outreach, engage and provide appropriate referrals and linkage to client/family members from all non-stigmatizing community accepted location(s) (e. g., Church, school, community based organization, primary care clinic, etc) ;
i. Develop strong working relationship with community organizations and leadership;
j. Provide training, education, and coaching to community organizations and leaders;
k. Use success stories to help de-stigmatize mental illness; and,
l. Use settings and locations that would appeal to ethnic groups and not be identified as a treatment clinic.

D. Community-Designed Peer Based Outreach and Education

Capacities

a. Conduct community-designed peer-based outreach through collaboration with community-specific organizations and other community leaders;
b. Use ethnic media by identifying the media outlets by specific community and maintaining relationships with them;
c. Conduct community forums and town hall meetings;
d. Recognize and leverage the word-of-mouth capabilities of current and former clients and family members to reach other community members; and,

e. Prioritize the use of properly translated materials to increase family members' access to information and education.

E. Community Designed Peer-Based Enhanced Service Linkage and Advocacy Capacities
   a. Assess the various mental health, physical health, substance abuse and other needs of consumers and develop integrated care plans;
   b. Link individuals to formal services and community-based services;
   c. Follow up to ensure that the client and/or family member was able to access the services, such as providing transportation or giving encouragement;
   d. Facilitate communication among service providers to ensure that the range of services is identified and knowledge of these resources is shared;
   e. Facilitate communication among service providers to develop trust and a collaborative spirit; and,
   f. Conduct advocacy, if needed, to assist families to secure needed qualified services and break down institutional barriers.

F. Element Set 4: Process
   ISM Client Flow Process
   a. Clients may already be in the system at every level of treatment and recovery;
   b. Potential clients may enter the system through a variety of entry points including community programs that are not specific to mental health;
   c. Potential clients will be screened by the ISM teams to identify client needs beyond determining acuity levels;
   d. ISM will collect appropriate information on each client or family member such as how they entered the ISM program, identifying markers, types of services provided, etc. ;
   e. ISM will track key outcome data such as recidivism rate, focal populations served, areas of improvement, how services were delivered, etc. ;
   f. ISM will survey client satisfaction periodically to provide feedback to the organizational participants so they can improve, change, or prioritize service delivery; and,
   g. ISM will encourage communication from clients and family members to ensure that services are appropriate and helpful.

G. Element Set 5: Principles, Values, Standards
   a. Holistic Support – The ISM model will use a holistic, community-designed peer-based, culturally competent approach to ensure clients are appropriately served. This approach means assisting the client with health, mental health, and substance abuse needs, and also with other services such as transportation, follow-up, advocacy, encouragement and

communication. A holistic approach by the ISM will assist clients in attaining and completing services in a culturally-competent manner.

b. Culturally and Linguistically-Competent Services - Ensure that all services provided by organizations and staff are culturally competent in planning and implementation. Emphasis is placed on the communities of each targeted population providing the information to ensure this.
c. Network Approach – ISM programs will use networks or collaboratives that are grounded in their respective communities to deliver services. This approach may integrate the services at a single site, an existing network of providers, or a community-based network. The network or collaborative will strive for a horizontal-based association. These collaborative may include grassroots, faith based organizations, schools, and other entities.
d. Community-Based Natural Support Systems - ISM programs will work within and actively strengthen the natural support systems of specific communities, so that these supports can be part of the clients' recovery process.
e. Peer-Driven Services – ISM programs will rely on clients, family members, parents and caregivers to inform service providers on what is helpful and needed to assist them towards recovery. Peers and staff will strive to work with one another to develop a trusting relationships that foster true partnership and equality so mutual goals can be reached.
f. Advocacy — ISM programs will advocate for changes in the system of care that supports the integration of services and improved outcomes for the client, as well as advocate on behalf of families to break down institutional barriers
g. Data driven outcomes – ISM programs will collect and analyze outcome-based data to track and adapt integrated care plans that will strengthen system change.
h. Oversight mechanism – The ISM model recognizes that past systems of care often resulted in disparity when one agency or organization became too powerful. Often this done out of necessity to centralize functions or in the name of cost efficiency. During the implementation period, the UREP Work Groups can provide oversight capacity to ensure that the vision of this innovative model is maintained and proper balance is kept among the participating agencies. Trust takes time to develop, and balance in the presence of great changes must be nurtured and protected.
i. Cost Effectiveness – ISM programs will collect and analyze their outcomes to track the cost effectiveness of the services, in particular whether or not the identified focal populations of uninsured, UREP, and homeless are being served in a compassionate and efficient manner.

VI. Services Provided

1. Services will be fully integrated into one family care plan that contains physical, mental health and substance abuse family-centered treatment goals and objectives.
2. Services may include ethnic specific services such as non-traditional healers, connections to faith-based community services, herbalists, culturally-sanctioned tribally-recognized professionals, peer support programs, and other community-based non-traditional approaches that match ethnic specific interests and needs.
3. Service intensity is moderated according to the needs of the family.
4. Process of Providing Services
    a. This model is a family-centered, community-designed approach, using culturally and holistically derived strategies across all modalities of mental health, physical health, and substance abuse treatment.
    b. ISM will conduct culturally-effective and competent community-designed peer-based outreach, engagement and service delivery in the communities where under-represented families reside.
    c. ISM will provide a bridge between the family and other formal and community-based supports that will then become the main source of ongoing support and services when needed.

VII. Principles and Values

One of the cornerstones of Mental Health Services Act (MHSA) planning efforts in Los Angeles County is to empower UREP groups to work in concert with LAC-DMH to expand services to include culturally and linguistically-competent approaches. UREP communities endorse the following over-arching principle for establishing effective services for ethnic communities: “To provide effective mental health treatment to UREP communities, the public mental health system must adopt culturally competent and holistic strategies anchored in and supported by UREP communities that complement and enhance formal mental health services.”

Approaches endorsed by LAC-DMH UREP cultural brokers and community partners include:

a. Community-designed peer-based outreach and engagement that is “focused”, “accountable” and defined by community experts.
b. Successful linkage and/or continuous follow-up until linkage is established.
c. Collaboration with community partners and cultural brokers to sustain community services.
d. Coordination of service.
e. Community education and training.
f. Inclusion of spirituality and holistic (mind, body, and spirit) approaches to service.
g. Advocacy.
h. Deletion of geographic boundaries to service provision.
i. Building community capacity to provide on-going services that complement public services and,

j. Leveraging community strengths and resources to maximize all resources.

By employing theses approaches across MHSA Plans and planning efforts, UREP groups believe the public mental health system will expand its capacity to appropriately serve UREP communities.

VIII. Outcomes and Evaluation

A. System Change Outcomes
Implementation of the ISM potentially transforms the formal mental health system overall in LA County for UREP communities. If fully successful, implementation of UREP-specific ISMs will create the following system change outcomes:
   1. The integration of mental health, physical health, and substance abuse services through a community-designed model of care that is anchored in the resources of the diverse UREP communities and uses community providers as a starting point for developing family care plan and,
   2. Development of holistic, culturally-relevant family care plans that adds mental health as a component rather than a primary focus of recovery.

B. The effectiveness of the ISM in producing system change outcomes will be evaluated using the following six domains:
   1. **Integrated Care**: It is anticipated that the learning achieved in this domain will include successful strategies used to integrate mental health, health and substance abuse services.
   2. **Service Levels/Access**: The ISM is expected to contribute to learning by identifying appropriate service levels for each population needed to achieve superior outcomes in the mental health, physical health, and substance abuse arenas. ISMs are expected to reveal potential barriers to access to care, service retention, development of appropriate referrals systems and community capacity building for UREP populations.
   3. **Quality of Care**: ISMs will inform Department of the most effective strategies to be used to maximize the quality of care for UREP Populations.
   4. **Community Capacity Building and Overall Improvement**: ISMs are designed to help determine the extent to which the integration of mental health, health and substance abuse services for a UREP population translates into community improvements as it relates to capacity building and the provision of culturally competent and community defined services which increases access to services and service retention.
   5. **Stakeholder Satisfaction**: ISMs will survey the satisfaction of three primary stakeholder groups, (including UREP consumers, community-based agencies and community partners and the current providers of mental health care) in providing culturally-competent, community-designed services to UREP communities.

6. **Cost**: ISMs facilitate leveraging of community resources to build culturally competent services for UREP consumers. In addition, ISMs will review the actual cost of delivering integrated care in an effective and culturally competent manner.

C. System Change Evaluation: To evaluate system change using these six domains the ISMs will address the barriers of the current mental health system as follows:

Current System	**Desired System**	**Measures**	**Goals**
Excludes community-based resources	Community-based resources are integral service providers	Increase the number of community-based partner providers Increase the types of community-based partner providers	Number of community-based partner providers at the beginning of the program will increase within 18 months. Types of community-based partners will increase within 18 months.
Mental Health/Substance Abuse/ Health services located in different settings resulting in fragmented care.	Programs provides mental health AND substance abuse AND health care.	Every program provides mental health AND substance abuse AND health care.	Survey of all programs for an increase in integration efforts of Mental Health/Substance Abuse/ Health services
Little to no culturally competent peer-based outreach and education to UREP communities	Programs provide culturally-informed peer-based outreach, engagement, linkage, education and training to UREP communities	All ISMs provide culturally informed peer-based outreach, engagement, linkage, education, and training to their targeted UREP community	Increase in the number of programs providing outreach, engagement, linkage, education, and training to their targeted UREP community Assessment by community leaders regarding the linguistic and cultural appropriateness of the outreach, engagement, linkage, education, and training.
DMH policies create barriers to the inclusion of non-traditional healing services	DMH services include services provided by non-traditional practitioners	Develop strategies to address barriers to the inclusion of non-traditional healing services	Identify barriers and strategies to address barriers Credential Non-traditional practitioners to accept referrals from a newly developed referral system

C. ISM Specific Learning Questions and Projected Outcomes

Each UREP ISM has specific outcomes that are relevant to their individual communities and seek to answer specific learning questions. These are as follows:

A-1a. **African/African-American (A/AA) UREP Learning Questions**:

1. Are we able to provide sustainable services over an extended period of time by developing leaders in the A/AA community through training and coordination?

2. Do we increase the likelihood that A/AA consumers will complete services and sustain increased levels of wellness (thereby reducing their need for intensive services for extended periods of time) through providing a community/Holistic service approach?

C-1b. **African/African-American (A/AA) UREP Outcomes:**

1. Creation of community partnerships and collaborations with community based organizations and groups to whom clients were referred; and,
2. Consistent participation in mental health treatment and supportive services to completion.

C-1c. **African/African-American A/AA ISM Evaluation:**

1. Development of Partnerships: Count of community partners and community-based agencies who referred clients to ISM; and,
2. Consistent participation and completion.
   a. Consistent Participation: No more than one missed appointment for every four scheduled appointments.
   b. Completion: Client and ISM team's mutually agreed upon termination of regular services.

C-2a. **American Indian Learning Questions**:

1. What mechanism can be developed to address credentialing of, and quality of services provided by non-traditional practitioners?
2. Can identification of non-traditional healers and development of a referral system of such individuals lead to cost-effective methods to provide culturally-based recovery services?

C-2b. **American Indian UREP Outcomes:**

1. Development of strategies addressing barriers to identifying and credentialing non-traditional practitioners to provide culturally competent quality services and,
2. Increase the number of consumer referrals to non-traditional practitioners by developing a referral system linking consumers to credentialed healers.

C-2c. **American Indian ISM Evaluation:**

1. Development of a final report identifying systemic barriers and policies preventing credentialing of traditional practitioners. This final report will include:
   a.) The articulation and implementation of strategies to overcome barriers.
   b.) The number of practitioners credentialed and,
   c.) The number of credentialed practitioners receiving referrals as a result of the project.
2. Increase in Consumer Referrals to Non-traditional Practitioners: Count of consumer/family referrals linked to non-traditional practitioners through newly developed referral system for physical heath, mental health and substance abuse treatment options.

C3a. Asian Pacific Islander Learning Questions:

1. What program or approach leads to higher utilization of mental health services (i.e. wellness activities, substance abuse counseling) for APIs?
2. Can a countywide wellness approach effectively meet the linguistic diversity and geographic spread of API consumers in LA County?
3. Can a countywide wellness approach effectively engage grassroots organizations and community groups in a way that is mutually beneficial for both the community-based organizations and the public mental health agencies?
4. What kind of wellness activities aid in the recovery process for API consumers?
5. What kinds of wellness activities satisfy the needs of family members?
6. Will wellness activities and community partnerships provide good entry points for potential clients to enter the public mental health system?
7. What type of approach results in higher consumer and family satisfaction about services from the public mental health system?
8. Does education about mental illness increase access to care by lowering barriers in API populations?
9. Does a countywide, culturally and linguistically appropriate, community collaborative approach decrease the fragmentation in delivery of services producing better client participation in treatment and family member support?

C-3b. **Asian Pacific Islander UREP Outcomes**:

1. Increase access for marginalized API ethnic groups that are not currently served or are underserved.
2. Provide cost efficient and culturally effective mental health and substance abuse services though partnerships between community-based organizations and public mental health providers.
3. Increase satisfaction from community organizations about working with public mental health providers.
4. Increase family member involvement in the client's recovery for more sustained periods of time.
5. Increase the number of consumers who become more integrated into their community, find meaningful job opportunities and learn useful skills or develop new interests and,
6. Increase the number of consumers and family members who take leadership or instructional roles in the wellness programs.

C-3c. **Asian Pacific Islander ISM Evaluation:**

1. Increase access for marginalized API ethnic groups that are not served or are currently underserved or inappropriately served. Measurement of Access: For API families that are not served, underserved or inappropriately served increasing the total number of community-utilized points of entry (e.g., primary care offices, places of worship, schools, etc) and referrals to culturally appropriate and sensitive physical, mental health and substance abuse treatment options.
2. Increased collaborations and partnerships between API CBOs and public mental health organizations. Measurement: Develop a baseline and chart each new partnership.
3. Better recovery rates for the consumer. Measurement:
    a. Track the progress of consumers using some specific parameters.
    b. Track the satisfaction of family members on the progress of the client and,
    c. Set up parameters to measure various categories like job placement, new skills learned, etc. and monitor this in each client.
4. Higher satisfaction from clients, family members, and collaborative agencies. Measurement: Surveys of clients, family members and collaborative agencies to measure the levels of satisfaction. Monitor what they feel is successful and what is not.

C 4a. Eastern European/Middle Eastern Learning Questions:

1. Can a culturally-competent, one-stop referral and outreach center meet all the physical, mental and substance abuse needs of the Eastern-

European/Middle-Eastern communities and can it be replicated for other culturally diverse communities?

C-4b. **Eastern European/Middle Eastern UREP Outcomes:**

1. Increased access to culturally sensitive physical, mental and substance abuse treatment options.
2. Increased client awareness of mental health issues through culturally appropriate outreach and education and,
3. Increased community partnerships between grass roots/cultural organizations and mental health agencies.

C-4c. **Eastern European/Middle Eastern ISM Evaluation:**

1. Increase access to culturally sensitive physical, mental health and substance abuse treatment options:
   a. Measurement of Access: For EE/ME families that are not served, underserved or inappropriately served increasing the total number of community-utilized points of entry (e.g., primary care offices, places of worship, schools, etc).
2. Increased EE/ME community awareness of mental health issues.
   a. Measurement of Increased Awareness: survey of randomly selected EE/ME community individuals regarding mental health issues.
3. Creation of community partnerships between service organizations and mental health agencies.
   a. Measurement of creation of community partnerships: count of agencies who referred clients and agencies to whom clients were referred.

C-5a. **Latino UREP Learning Questions**:

1. Can a culturally-competent ISM decrease barriers to access for monolingual, under-served, unserved, and inappropriately served Latino communities that are uninsured and/or indigent.

C-5b. **Latino UREP Outcomes:**

1. Increased access to services for uninsured and/or indigent families served
2. Increased community partnerships between grass roots/cultural organizations and mental health agencies

C-5c. **Latino ISM Evaluation:**

1. For Latino families that are unserved, underserved, or inappropriately served - increase the total number of community-utilized points of entry (e.g., primary care offices, places of worship, schools, etc) and referrals to

culturally appropriate and sensitive physical, mental health and substance abuse treatment options and,

2. Creation of community partnerships: count of agencies that referred clients and agencies to whom clients were referred.

IX. Funding/Leveraging

The total amount of MHSA funding required for the ISM model is 15,997,800 over two years. This amount funds each individual UREP-specific ISM as follows:

ISM Proposed Funding (In Millions of Dollars) by FY, UREP Group and Service Area

UREP GROUP	FY 09-10	FY 10-11	TOTAL FUNDING	FY 09-10 EST. # OF FAM	FY 10-11 EST. # OF FAM	TOTAL # FAM	SAs
African/African-American	$1,326,385	$1,326,385	$2,652,770	232	232	464	SA 6
American Indian	1,005,079	1,005,079	2,010,158	176	176	352	CW
Asian/Pacific Islander	1,823,870	1,823,870	3,647,740	320	320	640	CW
Eastern European/ Middle Eastern	685,123	685,123	1,370,246	120	120	240	SA 2 or 4
Latino	3,158,443	3,158,443	6,316,886	552	552	1,104	3 SAs
Total	$7,998,900	$7,998,900	**$15,997,800**	1,400	1,400	2,800	

Cost Per Services for All Groups

Service	Annual Cost Per Family	% of Annual Cost Per Family	Total # of Families	Total Cost
Medication	$2,700	23.63%	2,800	$3,780,000
Mental Health	2.250	19.69	2,800	3,150,000
Health	1.800	15.75	2,800	2,520,000
Substance Abuse	1.800	15.75	2,800	2,520,000
Client Supportive Services (Flex Funding)	1.927	16.86	2,800	2,697,800
Peer-Based O/E, Education & Linkage	900	8.31	2,800	1,330,000
Total	**$11.427**	100.0%	2,800	**$15,997,800**

The amounts proposed for each UREP group are based on a weighted compilation of the following data: poverty population (40%), prevalence rates (30%); penetration rates (30%).

The ISM model will leverage MHSA funds with community resources. MHSA funding will be used to support:

(a) Integrated care and support (e.g., health, mental health, substance abuse, screenings, assessment, tracking and follow-up);

(b) Community-designed peer-based outreach, engagement, and education (e.g., education, training, technical assistant, follow-up by consumers, parents, family members, promotores, and community members).

(c) Community-designed peer-based enhanced service linkage and advocacy (e.g., transportation, linguistic support and follow-up by consumers, parents, family members and promotores) and,

(d) Development of formal and informal network of providers.

IX. Implementation Timeline

Timeframe	Activities
Jan 2010	Estimated Plan Approval from CA Dept of Mental Health
Feb-Apr 2010	Competitive Bidding Process
May—July 2010	Contract Negotiations, Board Approval and Awarding of Contracts
Aug-Oct 2010	Start up and Staffing of ISM Teams. Monitor and review the number and types of participating community-based partner providers.
Nov 1, 2010	1st Quarterly Formative Evaluation and Reporting. Identify, monitor, and address barriers (both internal and external to the Department) to implementation of model and develop a plan to ameliorate barriers.
Nov 2010-Jan 2011	Outreach, Engagement, Linkage, Education and Training. Evaluate and explore the essential components leading to successful facilitation of culturally informed peer-based outreach, engagement, linkage, education and training to ethnic

	communities.
Feb 1, 2011	2nd Quarterly Formative Evaluation and Reporting. Determine and measure the extent to which ISM programs provide service integration management through survey of participating clients, providers and administrators.
Feb-May 2011	ISM Services Provided to Families
June 1, 2011	3rd Quarterly Formative Evaluation and Reporting Measure the extent to which consumers are completing services (measure rate of recidivism); evaluate how effective non-traditional community-based providers within each ISM have been for each ethnic group; assess if barriers to implementation of model and access to services have been reduced; are the physical, mental and substance abuse needs of the communities being met through the individual models.
June 2011-Aug 2012	ISM Services Provided to Families Gather information on the number of non-traditional community-based partners who are providing services to clients.
Sept-Dec 2012	Summative Evaluation/Final Report Share results and learnings with various local, state and national audiences.

ATTACHMENT G

Innovations Plan – Detailed Description of Community-Designed Integrated Service Management Model
County of Los Angeles – Department of Mental Health

Community-Designed Peer-Based
Outreach/Engagement/Education

(e. g. education, training, TA, follow-up by consumers, parents, family members, promotores, and community members)

Integrated Care and Support

(e.g. Health, Mental Health, Substance Abuse, screening, assessment and tracking and follow-up)

Underserved
Ethnic Populations

AAA; AI; API; EE/ME; Latino

Peer-Based Enhanced Services
Linkage and Advocacy

(e. g. transportation, linguistic support and follow-up by consumers, parents, family members and promotores)

Integrated Service Management (ISM) Team

Integrated Community Network:
Formal and Community Based Supports

Principles and Values

Holistic support; culturally and linguistically competent services; network approach; community based natural support systems; peer driven services; advocacy; data driven outcomes; oversight mechanism; cost effectiveness

ATTACHMENT H

Innovations Plan – Detailed Description of Integrated Peer-Run Model
County of Los Angeles – Department of Mental Health

I. Vision

A. An Integrated Peer-Run Model supports people with mental health needs who may also have health and/or substance abuse issues to become well and stay well by providing new programs that are designed and run by people with lived experience of mental health issues. This model targets uninsured adults seeking services through two innovative strategies: Peer-Run Integrated Services Management (PRISM) and Alternative Peer-Run Crisis Houses.

B. PRISM is a consumer-driven, holistic alternative to formal services that allows uninsured peers to secure needed health, mental health and substance abuse options as part of a program designed to support and empower people to take responsibility for their own recovery. PRISM utilizes a "whatever it takes" philosophy in a context of personal choice. It is innovative in that it is a team approach that involves peers helping peers.

C. Peer-Run Crisis Houses are consumer-driven, holistic alternatives to hospitalization and are designed to provide a warm, safe, welcoming environment for uninsured people in psychiatric distress who are not a danger to others. These houses will be located in two places in separate service areas, and one of them will be dedicated to providing peer support to people in crisis who are being released from jail.

D. In both strategies, people in recovery from mental health, health and/or substance abuse issues will develop reciprocal relationships with uninsured people like themselves who are dealing with similar issues and who may be in crisis or dealing with trauma. E. Both strategies are culturally competent in that the adults involved will be supported by peers who are similar to them linguistically and ethnically and by peers who respect and value cultural differences.

II. Needs and Problems Addressed

The Integrated Peer-Run Model addresses three types of problems in the public mental health system.

1. The first is the fragmentation of mental health, health, and substance abuse services for uninsured people with mental health needs who may also have health and/or substance abuse issues. Providing services in an integrated manner through PRISM and the Peer-Run Alternative Crisis House can better address these multiple needs.
2. The second is a systems problem. People experiencing a mental health crisis—whether insured or uninsured—lack alternatives to institutional and more costly options, such as hospitals and Urgent Care Centers. The Peer-Run Alternative Crisis House provides a safe place to successfully resolve a crisis for people who choose not to go into a mental hospital. It is also

potentially a more cost-effective alternative within the public mental health system to provide support to people experiencing a mental health crisis.

3. The third problem is also a systems problem. The public mental health system has not effectively and fully integrated peer-run programs into the array of public mental health services and supports for uninsured people with mental health issues. The proposed Integrated Peer-Run Model can help ascertain the extent to which peer-run strategies can be fully integrated as part of the array of services and supports.

III. Target Population

A. The primary target populations to be served by this model are:
   1. Uninsured adults with a mental health issue seeking support (i. e., PRISM)
   2. Uninsured adults with a mental health issue experiencing a crisis (i. e., Alternative Peer-Run Crisis Houses)

B. Sub-Populations
   1. Uninsured adults with mental health, health, substance abuse issues who may also be homeless;
   2. Uninsured adults who are from UREP communities;
   3. Uninsured adults from GLBTQI, Deaf or Hard-of-Hearing, and Blind or Visually Impaired communities;
   4. Family members, parents/caregivers with children who may be uninsured and themselves wanting support.

C. Number of people to be served
   1. PRISM will serve 300 unduplicated consumers per year.
   2. Alternative Peer-Run Crisis Houses will serve 216 unduplicated consumers per year.

IV. Innovation

The Integrated Peer-Run Model brings three important innovations to peer-run strategies in the context of the Los Angeles County public mental health system.

1. The first is the use of an Integrated Service Management (ISM) team approach to peer-run strategies. The ISM team that is fully supervised, administered, and implemented by peers in terms of the coordination of mental health, health, and substance abuse services is new.
2. The second innovation is bringing together two peer-run strategies under one model. In this case, PRISM and the Peer-Run Alternative Crisis House will work in tandem to offer consumers a broader array of peer-run supports.
3. The third type of innovation is the integration of multiple forms of peer supports. The Integrated Peer-Run Model seeks to effectively coordinate and deliver different types of peer services to support the consumers' recovery. Peer support can come from consumers in recovery, parents, family members, and caregivers. This model can generate a better

understanding of the most effective to coordinate multiple forms of peer support.

V. Definition of Roles

A. Peer specialists ("bridgers", advocates, supporters) will primarily support their peers in addressing expressed needs. The peer relationship, based on reciprocity, individual choice, and personal responsibility will inform the process of identifying and obtaining self-help options and professional services.
B. "Peers" can also refer to other individuals who have lived experience with mental health issues (family members, parents or caregivers).
    1. An individual whose family member(s) has had mental health issues can function as a Family Specialist to a family member in crisis.
    2. A parent/caregiver with children who have had mental health issues can function as a Parent Partner with parents/caregivers who are in crisis and also have children who have mental health issues.

VI. Program Elements

The PRISM Team Strategy and the Peer-Run Crisis House teams focus on supporting peers in crisis or psychiatric distress in identifying what will be most helpful to them in the present and in building hope and confidence in their ability to reach the goals they set for the future.

A. Program Element Set One: Teams
    1. PRISM teams and Crisis House teams include, but are not limited to:
        i. Peer Administrators/Managers
        ii. Peer Supervisors
        iii. Peer Specialists (including Family Specialists and Parent Partners)
    2. "Team" refers to a set of peers that work in a coordinated fashion in order to achieve a common goal: to effectively integrate mental health, health, substance abuse and other services in order to support people in their personal journey toward recovery. "Team" does not presuppose that all team members are supervised by the same person. Creative modes of coordination and accountability are encouraged, such as sub-contracting with other peer-run programs as the need arises.

B. Program Element Set Two: Outreach
Team members conduct outreach and engagement activities to a broad range of entities to ensure multiple points of entry for uninsured persons, including but not limited to:
    1. County Jails
    2. Emergency Departments
    3. Faith-based communities
    4. Family groups

5. Parent groups
6. Peer-run programs
7. Self-help groups
8. Urgent Care Centers

C. Program Element Set Three: Capacities

Both strategies will include the following program elements (capacities):

1. Ability to sustain trusting reciprocal relationships with peers;
2. Capacity to link to and secure desired services within time constraints;
3. Willingness to advocate for peers, including advocating to obtain free services and/or appropriate assessments for individuals seeking professional services;
4. Experience in ways to enhance health, including but not limited to preparing nutritious food, participating in appropriate exercise;
5. Demonstrated knowledge of and linkage to self-help services;
6. Openness to spiritual beliefs and practices;
7. Experience with supervising peers.

D. Differences: There are two key differences between PRISM and the Peer-Run Crisis House strategies.

1. PRISM:
    a. Will include the capacity to assist peers in finding housing, including collaborative housing if preferred; and the ability to provide volunteer opportunities and support peers in finding jobs in the community.
    b. Will dedicate a specific amount of funding to serve peers being released from jails in Los Angeles County.
2. Alternative Peer-Run Crisis House Intends to provide a safe and healing environment for people to move through their psychiatric distress in a relatively brief time (up to 15 days) and then engage in further services, if so desired, which might include referral to the PRISM team.

VII. Barriers to Implementation

A. Finding and training peer staff quickly enough is one barrier to successful implementation. However, this barrier can be overcome by establishing a good connection with programs that offer trainings for peer so that they inform their graduates about these strategies and the kinds of jobs available.

B. Overcoming resistance on the part of some people to referring consumers to consumer-run programs. In part, this can be resolved through effective communication, coordination, organizational agreements, and County support on the front end of implementation. In addition, service providers will probably feel

the pressure of referring the uninsured to available services, as needs continue to rise.

VIII. Principles, Values, Standards

A. Peer specialists in a peer-run model will be responsible for designing and administering programs and securing services.
B. Safety concerns will be addressed in both training and supervision of the peer specialists who work in this model.
C. The peer-run model is consumer-driven and focused on developing trusting relationships with peers that support and enhance recovery.
D. The systems-level transformation will be the successful integration of mental health, health and substance abuse interventions within the context of a peer-run model that is both creative and cost-effective.

IX. Outcomes

A. Peer Wellness Individual Outcomes:
    1. Subjective measurements of increase in self-esteem and reduction of internalized stigma;
    2. Objective measurements of ways in which peers are now able to live in the community in a productive and healthy manner: housing, work or meaningful activity of their choice, reduction of incidents of incarceration or hospitalization.

B. System-Level Outcomes
    1. Ability to integrate mental health, physical health, and substance abuse service via peer-run strategies.
    2. Availability of a peer-run alternative crisis with the public mental health system.
    3. A collaborative structure that enables the coordination of multiple forms of peer supports.
    4. Measurement of the number of uninsured adults in both strategies who qualified for and are receiving benefits;
    5. Measurement of the degree to which uninsured adults in both strategies are accessing mental health, physical health, and/or substance abuse services in a cost-effective manner;
    6. Evaluation of the perception of peer-run programs in the public mental health system in Los Angeles County before and after the implementation of the Innovative Peer-Run Model.
    7. Leverage of non-DMH resources from peer-based networks such as donated professional services, food, meeting space, etc.

X. Projected costs

The attached budget describes the cost for the Integrated Peer-Run Model.

1. PRISM will serve 300 uninsured people per year at a cost of $1,460,000—or a total cost of $2,920,000 for two years.
2. The Alternative Peer-Run Crisis House will serve 216 uninsured people per year at a cost of $975,000 per year—or a total cost of $1,950,000 for two years.

XI. Implementation Timeline

Timeframe	Activities
Jan 2010	Estimated Plan Approval from CA Dept of Mental Health
Feb - Apr 2010	Competitive Bidding Process
May - July 2010	Contract Negotiations, Board Approval and Awarding of Contracts
Aug – Oct 2010	Start up and Staffing of Peer-Run Models Training of culturally diverse staff in resources, including multiple self-help peer-run resources, team building, reporting methods and safety issues with input from mental health professionals and consultants to this model
Nov 1, 2010	1st Quarterly Formative Evaluation and Reporting Presentation of training materials and report on methods for addressing any barriers to developing links to integrating health, mental health and substance abuse services
Nov 2010 - Jan 2011	Outreach and Engagement Provision of training and consultation on jail linkages as well as community engagement with ongoing feedback to PRISM and the crisis houses on outcomes
Feb 1, 2011	2nd Quarterly Formative Evaluation and Reporting Report on outcome measures Summary of challenges and successes with regard to creative use of peer specialists (people in recovery, family members, parent partners) in integrating health, mental health and substance abuse services in a culturally competent manner
Feb - May 2011	Integrated Peer-Run Services Provided Adjustments to strategies as needed with ongoing training and consultation on scope of peer support and cultural competency with ongoing feedback to PRISM and the crisis houses on outcomes
June 1, 2011	3rd Quarterly Formative Evaluation and Reporting Report on outcome measures and use of peer specialists as team members, including any supervisory or administrative issues that have been addressed and resolved in addressing crises and integrating health, mental health and substance abuse services
June 2011 - Aug 2012	Integrated Peer-Run Services Provided Adjustment to strategies as needed with ongoing training and

	consultation on scope of peer support and cultural competency as well as ongoing feedback to PRISM and the crisis houses on outcomes
Sept - Dec 2012	Summative Evaluation/Final Report Report on Outcome measures Summary of challenges and successes with regard to staffing, supervision and administration peer-run crisis houses as an alternative to hospitalization and PRISM as a client-driven peer-run approach to the integration of health, mental health and substance abuse services Share results and learnings with various local, state and national audiences.

Los Angeles County Mental Health Commission

MHSA Oversight and Accountability

550 South Vermont Avenue, 12th Floor
Los Angeles, California 90020
TEL: (213) 738-4772 ~ FAX (213) 738-2120
Email: mentalhealthcommission@dmh.lacounty.gov
Website: http://dmh.lacounty.info/mhc

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November 19, 2009

Marvin J. Southard, DSW
Director, Department of Mental Health
550 S. Vermont Ave., 12th Floor
Los Angeles, CA 90012

Dear Dr. Southard:

MENTAL HEALTH SERVICES ACT
MANDATED PUBLIC HEARING – INNOVATIONS PLAN (MODELS)
LOS ANGELES COUNTY MENTAL HEALTH COMMISSION

On Thursday, November 19, 2009, the Los Angeles County Mental Health Commission hosted a mandated public hearing. The purpose of the public hearing was to inform the public of the current status of the Innovations Plan (INN). It was also an opportunity for open questions and comments, and to seek action and support consistent with a favorable approval for the plan. Four comprehensive and innovative models were presented and very well received by both the public and the Commission.

The Innovation's plan focuses on identifying new practices for the primary goal of learning and increasing the array of creative and effective approaches that can be applied to mental health services for specified populations. Given that the primary focus of INN funding is improving practice through learning, INN funded projects will enable the Department of Mental Health to increase the quality of services and improve outcomes for consumers, promote community collaboration, integrate health, mental health and substance abuse services while healing system fragmentation which is a major impediment to service quality and good outcomes.

The hearing was attended by over 250 constituents, including clients, family members and local political activists. Spanish and Korean translators were available to ensure that constituents could actively participate in the hearing, as well as American Sign Language services.

After hearing the public comments and final recommendations for the plan, the Mental Health Commission unanimously passed a motion that approved the process for the INN plan.

Sincerely,

Jerry Lubin
Chair

JL:TGL:ch

ATTACHMENT J
Innovations Plan – Summary of Comments from Posted Public Comment Period and Public Hearing (October 20-November 19, 2009)
County of Los Angeles – Department of Mental Health

A Mental Health Commission Public Hearing was held on November 19, 2009 regarding the County of Los Angeles Department of Mental Health Innovations Plan. The Mental Health Commission Chair, Jerry Lubin, and Department of Mental Health Staff responsible for the Plan were introduced to the stakeholders. The facilitator, Rigo Rodriguez, informed the stakeholders of their purpose and role regarding the Public Hearing process. Mr. Rodriguez explained to the stakeholders that they will hear presentations on the Innovation Plan including a summary of the planning process, model descriptions, evaluation plans and budget estimates. Each table at the hearing participated by submitting verbal or written questions, comments, concerns, and suggestions regarding the Plan. All comments were audio recorded and a typed transcriber was additionally employed for accuracy. A comprehensive record of the questions, comments, and concerns was subsequently developed. The following is a summary and analysis of substantive questions, comments, and suggestions that include translations from our Korean and Spanish constituents:

Comments/Questions related to the Numbers Served and the Budget

Several questions were raised regarding the Innovations Plan's estimates of the numbers served and the estimated costs in the budget. Based on the comments received, LAC-DMH increased the estimates for numbers served to include those reached through the outreach, engagement, education, and screening efforts. LAC-DMH staff responded that in general the Innovations Plan attempted to use the broadest and most general outline for budgeted services to be provided in order to maintain a high level of flexibility for the proposals that will be submitted by agencies during the competitive bidding process. This flexibility will allow agencies the opportunity to submit proposals that are truly creative and innovative.

More specifically, the costs of the models were estimated based on a combination of data regarding per client cost for outpatient services, medication costs, and other data obtained from stakeholders and subject matter experts for each model. In general, the data from the stakeholders and subject matter experts we consulted revealed a wide range of cost estimates from $600/year for physical health and $1,500/year for mental health to $4,000 per year for outpatient mental health services and $3,600/year for medication. There are models in other states that reportedly can deliver integrated services for as low as $1,150/year per person. LAC-DMH emphasized that the numbers provided in the Plan are the best estimates with the data currently available. As this is a learning grant, one aspect we will learn is how much integration of these services will cost for specific populations and where we can realistically find cost savings and leveraging. During the competitive bidding process, LAC-DMH will welcome proposals that can serve more clients at less cost than what is estimated in this Plan.

Comments/Questions related to Evaluation

The public expressed concerns that the $1 million reserved for evaluation in the budget was too low, and others provided suggestions for how to document the learnings. LAC-DMH explained that imbedded within each model are funds for evaluation activities such as participation in data collection and reporting. What is learned from the Innovations Plan will be documented and shared through a wide variety of means and to broad audiences, and LAC-DMH will consider the suggestions during the development of the RFS and the evaluation plan.

Other comments included suggestions regarding what outcomes should be measured, indicators to use, and methods of collecting data. LAC-DMH will consider these suggestions during the development of the RFS.

Comments/Questions related to the Integration Models

Many comments and questions concerned specific program aspects of the models and their implementation. For example, there were questions about how oversight and accountability of medical services will work, how the mobile teams would cover the whole county, how American Indian healers would be credentialed, and how many peers would be employed and paid. LAC-DMH responded that many of these questions concern the implementation aspects of the plan and cannot be answered until the RFS's are written and receive responses. The concerns and questions raised will be revisited during the RFS development. Since virtually all of these services will be contracted out, those proposals that will be successful are those that integrate care the best, have the best outcomes measurements established, are the most culturally competent, and reach out to the most groups. LAC-DMH has heard the loud and clear request that whatever the implementation, the programs must decrease fragmentation, enhance community partnerships, identify the effective elements that transcend all models, be responsive to peer input, and be pragmatic, avoiding any past preconceptions or doctrines.

Another common theme in the questions concerned the role of faith-based organizations in the Plan. LAC-DMH responded that faith-based organizations are included in the document; they inadvertently were not included in the public hearing's PowerPoint presentation. Faith-based organizations are important components of the network of community-based resources, especially in the ISM models.

Other questions concerned how the services provided will be accountable to consumers and consumers' needs. LAC-DMH responded that as part of the evaluation of these models' ability to integrate services, LAC-DMH intends to survey stakeholder groups including consumers. These surveys will be used to measure success of both service integration and health and community outcomes. LAC-DMH also intends to provide

accountability for specific physical health measures such as cholesterol, weight, and blood sugar levels.

Another comment concerned how the models will serve the LGBTQ population. LAC-DMH responded that LGBTQ individuals are part of the target groups, and program proposals will be expected to address their needs. Other comments included encouragement for the Plan to consider partnerships and outreach to a wide variety of other service providers and departments such as police, probation, short-term housing services, and other advocates. LAC-DMH will consider all of these suggestions during the RFS process.

Some questions were in regards to the level of acuity that would be served by this model. LAC-DMH responded that it envisions that appropriate outpatient services would be directed to both acute and chronic mental health conditions of varying severity at integrated clinic sites. The program selection process will favor those proposals that provide integrated services that best meet the need for learning and the needs of the population being served. Many individuals from this population have need for onsite specialty mental health services. However, onsite availability of additional non-specialty mental health services is by no means precluded.

Other questions concerned how the Integrated Peer-Run Model would assist individuals in addressing their physical health and substance abuse issues. LAC-DMH responded that the model is designed to provide linkage to the needed services provided by professionals, and funds are set-aside in the budget to purchase clinical services from fee-for-service and other qualified providers of physical health, mental health, and substance abuse services. The physical health and substance abuse services will not be provided by peers themselves. Rather, reciprocal, self-help peer services can motivate, reinforce, and encourage activities that improve mental health, physical health and recovery from substance abuse.

Additional questions asked why UREP communities were differentiated for services, and if Caucasians could receive services under these models. LAC-DMH responded that since UREP groups were one of the three focal populations identified by the Plan, each community-designed ISM is designed with a mix of services defined by each ethnic community that is currently difficult for the UREP group to access. These services are likely to be beneficial to these specific populations. Moreover, the goal of the ISM is to learn whether non-traditional resources from ethnic communities can complement formal clinical services to improve quality of care and better outcomes for UREP families. However, there is no specific individual racial requirement in order to receive such services.

Comments/Questions related to Operations

The public asked several questions related to the operations and implementation of the Plan. For example, one person wanted to know if previous services that were funded would be incorporated into the Innovations services. LAC-DMH responded that the Innovations funds will be used for this particular set of models, so they will not fund programs that are part of the other plans. Hopefully the state economy will improve, and more MHSA funding will be available for other services as well. Another question concerned the timing of implementation, to which LAC-DMH responded that the expectation was to implement these programs beginning August 2010.

Other questions were related to the RFS process itself. For example, do applicants have to limit themselves to applying for just one model or can they apply to more? LAC-DMH responded that the models must be tested separately from one another, but a single organization could apply for more than one grant, each possibly from a separate model. However, each approved program grant must be implemented separately as the purpose of the plan is to test the distinctive effectiveness of each model. Mixing the models within a given program would preclude the accomplishment of this purpose.

Another concern was raised regarding the complexity of integrating such large systems and the need to bring in outside experts to assist with program and transition planning. It was suggested that more time be allotted for start-up and planning so that appropriate attention can be paid to the mutual responsibilities of these previously independent systems and how linkages between them will actually work. LAC-DMH shared this concern and responded that the purpose of INN is to identify through careful evaluation those elements that should be adopted within larger systems. The results of INN will guide use in further system evolution through new program designs, and progress will be closely tracked and monitored.

One question raised was whether providers would be excluded from participating if they only integrated mental health and primary care services or if they did not employ peer staff. LAC-DMH responded that the successful programs must integrate mental health, physical health and substance abuse services. The employment of peer staff is strongly encouraged.

Lastly, other concerns were raised regarding attempts to follow particular doctrines or advocate for certain political views through this Plan (such as socialized medicine). LAC-DMH responded that the Innovations Plan design is pragmatic and is not based upon any past preconceptions or doctrines. The learning elements can be used in a variety of payor models and programs in the future.

Comments in Support of Innovations Plan

During the public comment period and the public hearing, LAC-DMH received many positive comments in support of the Innovations Plan. Of particular note were those from public participants of Native American, Asian Pacific Islander, and Consumer communities. For example, the Native American speakers frequently expressed their appreciation for the Community-Designed ISM that will explore how to incorporate Native American healers into the mental health system. Among other things, they said it would allow greater access to services that are congruent with their cultural and spiritual beliefs, and it could provide a replicable model for many other groups in addition to Native Americans. Several members of the Asian Pacific Islander community shared their enthusiasm for the Community-Designed ISM that will make wellness centers that are API-focused available to them. Many consumers also expressed support for LAC-DMH's plan to have peer-run programs as part of this Innovations Plan.