

## The TRIESTE\* Project:

**\*True Recovery Innovation Embraces Systems That Empower**

An Innovation Proposal to  
The Mental Health Services  
Oversight and Accountability Commission (MHSOAC)

Submitted by  
The Los Angeles County  
Department of Mental Health (LACDMH)

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## PREFACE

In November 2017, a group of 13 Los Angeles County officials and leaders visited Trieste, Italy to observe and study its World Health Organization (WHO)-recognized system of mental healthcare. The delegation (which refers to itself as the “Tribe”) was comprised of various stakeholders in our mental health system, most of whom find themselves at the nexus of mental health, homelessness and law enforcement policy and practice. In their professional roles, most of them are exposed – often on a daily basis – to heartbreaking stories of suffering experienced by people with severe and persistent mental illnesses who are also homeless, incarcerated, or simply living lives of quiet desperation in board and care facilities.

It is against this backdrop – and with the hope of finding alternatives that would better serve the most vulnerable and marginalized among us - that the Tribe travelled to Trieste to attend an international conference, “The Right and Opportunity to Have a Whole Life.” The conference was sponsored by the Trieste *Dipartimento di Salute Mentale*, whose leadership also planned site visits apart from the conference to introduce the L.A. delegation to the Trieste culture and practice.

What the members of the Tribe discovered both surprised and delighted them. There is little if any homelessness in Trieste and involuntary psychiatric hospitalizations have been virtually eliminated. They had the opportunity to meet and learn from their counterparts in the Italian provider community: clinicians, social workers, law enforcement, judiciary and peers. The Tribe was particularly impressed by the system’s ability to address the needs of the whole person – not just their illness – as well as the availability of and accessibility to off-hours and crisis services and the reduction of the need for inpatient psychiatric services.

Since their return, the Tribe has met regularly to consider ways to bring the principles and practices of Trieste to Los Angeles County. This proposal is the result of their ongoing discussions and reflects their hopes to improve mental health care for the most vulnerable citizens of Los Angeles County.

## EXECUTIVE SUMMARY

The concept of recovery has become the dominant paradigm for the provision of mental health services. Nearly everybody with mental health challenges, even those with the most severe impairments, is considered capable of “a life in the community not defined by their mental illness.” The Mental Health Services Act – the defining document for the provision of mental health services in California – requires an approach that goes beyond treating the symptoms of the illness and instead focuses on ensuring that people with mental illnesses have appropriate housing, social connection and belonging and purpose in their lives.

And yet, for all the acceptance and promotion of the recovery model, the actual on-the-ground results appear to be mixed at best. The increasing numbers of homeless people with a mental illness and the system’s relative inability to help people to achieve true community inclusion both suggest that there is something missing in the way that the recovery vision is being implemented.

It is our premise that the single greatest reason for our system’s failure to deliver on the promise of the recovery model is to be found in the way that we finance mental health care in the United States. At its core, the U.S. mental healthcare system is driven by two closely related factors:

- (1) compliance with the Medicaid-based fee-for-service payment system and its copious associated regulatory processes that are intended to ensure accountability, and
- (2) an over-emphasis on the treatment and mitigation of the symptoms of the illness rather than on the well-being of people served and their re-integration into the community at large.

In essence, our current payment and funding systems – presumably out of their concern for “fiscal accountability” – constrain and restrict our best intentions to actually meet the needs of the people we serve. If the recovery model is to ever actually fulfill its promise, we must create new and innovative payment, accountability and documentation systems that free us from the bureaucratic constraints that prevent us from providing the services that people actually want and need.

This MHSA Innovation Project proposes to implement five related innovations to create a pilot project that will demonstrate how both individual and system outcomes and consumer satisfaction in our mental health system can be dramatically improved without increasing the cost of services.

These five innovations are:

- A. A Recovery-Informed Reimbursement System
- B. Recovery-Informed Documentation and Process-Monitoring
- C. Recovery-Informed Performance Measurement
- D. Shifting to the Provision of “Well-Being-Focused” Services
- E. Technology that supports payment, documentation and accountability reforms

While for narrative reasons we will address each of these innovations in turn, it is important to note that we believe that these innovations are closely-related and all are necessary components of a true recovery-informed systems approach.

### Background

In late 2017, a group of thirteen Los Angeles County officials and leaders took on the task of examining the reasons for the suboptimal performance of the mental health system in the Los Angeles County. In November of that year, the group (hereafter referred to as “the Tribe”) visited Trieste, Italy, to attend an international conference, “The Right and Opportunity to Have a Whole Life” and study the local mental healthcare system which is recognized as an exemplary system by the World Health Organization and celebrated by experts in the field. Among the many key observations made during their visit: 1) there are essentially no homeless people with a mental illness in Trieste; 2) the jails are not overcrowded with inmates with a mental illness, and; 3) involuntary psychiatric care has been virtually eliminated.

Though there are surely a multitude of factors accounting for these observations that contrast so dramatically with L.A. County, it is our contention that the most significant reasons for the differences in outcomes are 1) the ways the two systems are financed and 2) the enormous difference in their bureaucratic, regulatory and reporting requirements. The staff in Trieste are blissfully unaware of and unconcerned with how the services they provide are paid for. Staff are able to do “whatever it takes” because they are not concerned that an audit will determine that the service they provided did not meet the criteria for “medical necessity.” And staff do not spend anywhere near the 25% of their time documenting the services they provide that is typical in Los Angeles.

### **INNOVATION A: A Recovery-Informed Reimbursement System**

Unlike the capitated system of Trieste, our public mental health reimbursement system is characterized by a fee-for-service reimbursement model that requires staff to bill by the minute (or hour or day, depending on the service). This reimbursement model diverts staff attention away from the care they are providing and the needs of the members they are serving to whether they are meeting their “billing goals.”

Furthermore, the fee-for-service reimbursement model creates a perverse incentive to provide more services (greater volume) than may be actually necessary for the member because the provider gets paid more as the amount of service increases. Because of the individual staff person's need to provide billable hours, it becomes tempting to provide additional services even though they may not be needed or desired by the member.

We believe that a reimbursement system that provides funding based on the outcomes of services (paying for value) rather than for the quantity of services provided (paying for volume) is best suited to provide the financial and accountability underpinnings for a true recovery-oriented system of mental health services. Therefore, we intend to implement a multi-tiered case rate system in which funding is based on the level of need of the persons served and is completely uncoupled from the amount of service provided. This approach will encourage and empower our caregivers to attend more flexibly to the successful personal recovery and community integration goals of those with serious mental health problems instead of forced compliance with relentless regulatory processes.

#### **INNOVATION B: Recovery-Informed Documentation and Process Monitoring**

The pilot project will implement a process-monitoring and documentation system that encourages staff to relate to their members as whole people rather than just to their illness. To promote the provision of well-being-focused rather than illness-focused services, we propose to completely eliminate the current Medicaid service classification system and replace it with a monitoring system that addresses all aspects of the member's quality of life as well as describing what the staff person actually did in his/her interaction with the member. All services will be designed to help members achieve the following goals:

- (1) A safe and healthy home in the community (HOME & HEALTH),
- (2) Acquiring and maintaining familial, social and intimate relationships (LOVE AND BELONGING), and
- (3) Acquiring and maintaining meaningful roles in the larger community (PURPOSE).

Implementation of this system will ensure that staff are addressing the needs of the whole person – not just the illness – as well as having the effect of significantly reducing documentation time and increasing time for the actual provision of care.

#### **INNOVATION C: A Recovery-Informed Performance Measurement System**

Our current system is characterized by a focus on monitoring (and paying for) services based on the quantity of the services provided regardless of their effectiveness. The

pilot will shift away from this type of process monitoring by fully implement the existing Key Event Tracking System (KETS) currently used by the State of California to track outcomes for Full Service Partnership (FSP) programs. These indicators will enable us to judge the pilot's effectiveness in increasing independent living and employment and reducing rates of incarceration and hospitalization in the population served.

In addition, we propose to implement a two-component system that measures our pilot's effectiveness in helping our members to develop the skills and the supports that they need to live in the larger community. The components of this system are the Milestones of Recovery Scale (MORS) and the Determinants of Care. The MORS defines recovery beyond symptom reduction, client compliance and service utilization. It sees meaningful roles and relationships as the driving forces behind achieving recovery and leading to a fuller life. The Determinants of Care help staff to understand which specific life domains the member is able to self-coordinate and the domains for which s/he needs either natural or professional support. Over time, it is expected that the member will learn to self-coordinate more aspects of his/her life.

The pilot will be able to evaluate its effectiveness in helping our members to become more self-coordinating, which in turn is expected to help the member to live more successfully in the larger community.

#### **INNOVATION D: The Proposed Service Array: Shifting the Balance from “Illness-focused” Services to “Well-being-focused” Services**

The most foundational service offered in the pilot will be to act as the member's health home in which both the mental and physical healthcare needs of the member can be addressed. Members will be assigned to a health home that reflects and is congruent with their level of need and their ability to self-coordinate their care. Wellness and Peer-Run Centers, Outpatient Clinics and FSPs could all serve as the health home for the member, with each of these levels of care providing the appropriate (i.e., needed) amount of assistance for the member to achieve the maximum level of independence in the community.

It is our belief that implementing innovations A, B, and C will create the financial and regulatory environment in which true, recovery-oriented, well-being focused services are most likely to thrive and achieve their intended effect. But to increase the likelihood of the success of this endeavor even further, the pilot intends to employ a trauma-informed, culturally competent approach that reverses the usual emphasis between clinical and psychosocial services by making the psychosocial services “primary” and the clinical services “ancillary.” For example, a wide variety of supported employment and supported education services will be available as well as an emphasis on leisure

and recreational opportunities. But in all services offered, staff will be aware of the significant roles that trauma and racial, ethnic and gender disparities play in the lives of the people we serve.

While we of course recognize that many of the members we serve require very high levels of traditional clinical services and supports (e.g., therapy, medication support), we also believe that we must constantly remind ourselves of and focus on the whole life the member is trying to lead in spite of having a severe and persistent mental illness. It will be the extensiveness and robustness of these psychosocial, non-illness centered services that will to a large degree determine our success in this endeavor.

The pilot will also implement new levels of crisis and emergent services including Peer Respite, Crisis Residential, and Urgent Care that currently do not exist in the proposed pilot region.

### **INNOVATION E: Technology that supports documentation, accountability and payment reforms**

The Reimbursement/Documentation/Accountability system proposed in Innovations A – C will require a significant investment in technology to realize its potential to reduce the documentation burden on staff and improve the effectiveness of care. We envision a HIPAA-compliant electronic health record that is accessible through a smart phone application. Staff will record not only their interactions with individual members but ALL the activities in their work.

Data will be entered into the EHR database either wirelessly or when staff return to the facility and dock their phone with the system.

It is expected that this voice-enabled system will reduce keyboard data entry by as much as 90% and thereby reduce the data entry time for staff by several orders of magnitude. It also has the benefit of being much more accurate and reliable in that it requires staff to enter their documentation on an ongoing, real-time basis.

### **SUMMARY**

For at least 30 years, the recovery model has held out the promise of a system that will achieve true community inclusion for people who are marginalized by their experience with severe and persistent mental illnesses. That promise remains unfulfilled. It is our belief that the primary reason it remains unfulfilled is that our bureaucratic and regulatory systems have not kept pace with or supported our improved approaches to service. This innovation proposal offers a roadmap as to how to create a “recovery-oriented bureaucracy” – which we do not believe to be an oxymoron! To the contrary, we believe that the innovations described here will improve our effectiveness (better

outcomes) and will increase both staff morale and member satisfaction with the experience of care.

We believe that ultimately this project has the potential to transform the mental health system in the United States. We respectfully request that the Oversight and Accountability Commission fund this proposal.

## **BUDGET**

This proposal to the Mental Health Services Oversight and Accountability Commission (MHSOAC) aims to obtain approval for the resources we need to administer and study a pilot system over a five-year period. In the first year of the project (July 1, 2019 – June 30, 2020), \$11,850,000 is budgeted to reflect upfront, one-time infrastructure investment for purchasing and renting facilities as well as designing, implementing and supporting electronic health record technology. The first year of the project will be used to engage community stakeholders, secure all necessary regulatory waivers, establish evaluation contracts and protocols, and site new services.

New services will actually begin on July 1, 2020 and the pilot will run through June 30, 2024. The baseline annual budget will be \$26,225,000 per year which reflects the current cost of all adults served in the geographic region over the 2017-18 fiscal year (approximately \$18,000,000) plus the funds needed to add a number of new services plus the cost of the evaluation of the pilot.

**Thus, total funding requested for the entire five-year innovation project totals \$116,750,000 (\$11,850,000 + (\$26,225,000 \* 4 years)).**

Within three years of launching the pilot, we anticipate that we will begin to see not only improved outcomes and customer satisfaction among the members we serve, but will also see improved morale among service providers. It is our hope and expectation that within five years we will achieve sufficient proof of concept to feel confident expanding the model across our county's mental health system. Ultimately, we are hopeful that the model will be so successful that we will be able to convince not only the state of California but also the federal government that the Medicaid financing and accountability system should be changed to reflect what we demonstrate through this project in Los Angeles County.

## **Proposed Timeline for Implementation – First 20 Months**

### November, 2018

- Initial draft of concept paper completed

### December, 2018

- Determination of the geographic boundaries of the pilot

### March, 2019

- “Final” draft of concept paper completed
- Determination of the precise population to be served and initiation of economic analysis of current county expenditures for the population
- Expanded stakeholder process to vet concept paper begins
- Submission of concept paper to MHSOAC

### April, 2019

- Initial presentation to members of the MHSOAC

### May, 2019

- Submission of full proposal for five-year innovation grant to the MHSOAC with expectation that grant will be awarded to begin effective July 1, 2019 through June 30, 2024.
- Initial discussions/negotiations with potential independent evaluators to determine scope and cost of the evaluation
- Initial discussions/negotiations with potential EHR vendors to determine scope and cost of the new EHR.
- MHSOAC officially awards Innovation Grant (MH Month!)

### July 1, 2019 – June 30, 2020

- Securing all necessary regulatory waivers
- Expanded stakeholder process to determine scope and implementation of services
- Selection of independent evaluator and implementation of evaluation protocols
- Selection of EHR vendor and implementation of system
- Initial training of staff on all data collection and accountability systems

### July 1, 2020

- Doors open and services begin under the pilot project.

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*Community care cannot really be effective if it aims simply at efficiency in the management of target populations, defined by their illness and/or related deviant behaviors (Basaglia, 1987). It must strive to preserve the idea of the person as a whole, while combating social exclusion and new forms of institutionalization. (Mezzina, 2014)*

The Trieste Community Mental Health System (adapted primarily from Mezzina, 2014)

By many accounts, since the early 1970s the community mental health system in Trieste, Italy has served as an inspiration and a model to European states and cities seeking to improve their systems of care for people with mental illnesses. Under the direction of Dr. Franco Basaglia, in 1973 Trieste became a World Health Organization (WHO) pilot center for deinstitutionalization and community mental health care. In 1987, the Trieste Department of Mental Health was declared a WHO Collaborating Center.

In 1980, the San Giovanni Hospital, then with a daily census of up to 1200 patients, became the first long-term psychiatric hospital in Europe to close and the staff and resources were reassigned to a much more community-based system of care. While phasing it out, a complete alternative network of community services was set up and today consists of the following services and programs:

- four Community Mental Health Centers (CMHCs), each responsible for a catchment area of 50,000 to 65,000 inhabitants, all open 24 hours a day, with four to eight beds each.
- one General Hospital Psychiatric Unit (GHPU) with six beds, mainly used for emergencies at night, with very short stays of usually less than 24 hours.
- the Habilitation and Residential Service, which has its own staff and cooperates with nongovernmental organizations (NGOs) in managing approximately 45 beds in group homes and supported housing facilities at different levels of supervision up to 24 hours a day, as well as two day-care centers.

Another extremely important feature of the Trieste model is the use of accredited social cooperatives to provide training and meaningful roles for its service recipients. Work activities include agriculture, building, cleaning, tailoring, hotel operation, restaurant, and home catering businesses. All workers, except trainees, are voting members of the cooperative businesses.

The leaders of the mental health system in Trieste, however, would argue that it is the philosophy of care that is much more important than any specific services or programs that their system offers to their service recipients. Those principles and values include the following (adapted from Trimbos, 2012):

1. A holistic approach: in mental healthcare, the individual, and not the disorder, is emphasized. There are no patients or clients, but users, '*utenti*'. Social exclusion is seen as a result of the medical model with its particular language, hierarchical relations and structure. The 'relational world view' is expressed by the following:
  - a. An individual's needs are assessed on the basis of his personal story/history, which also addresses his social relations, from family to neighborhood.
  - b. In order to meet the needs of a user, personal relations between care workers and users are considered central.
  - c. Services are evaluated in terms of personal routes to recovery and empowerment. To back up this idea, the community service center is open 24-7.
2. An ecological approach: the emphasis is on the social context, the network and the social groups to which an individual belongs. Care is offered by the community, is outreaching, proactive and accessible, and aims at social inclusion. Care workers enter into relationships with the individual and his family, with housing services etc. The community center offers prevention, as well as basic and specialist treatment for all users in the region for which it is responsible; because of its 'territorial responsibility' for users, the community center cannot transfer patients with complex problems to other centers.
3. A legal approach: there is an emphasis on the civil rights of individuals with psychiatric problems, both in a legal and a social perspective. To create a community which guarantees inclusion and the possibility that everyone can exercise their social rights, a support network is essential. Deinstitutionalization means having individual control over one's own route to recovery.

### Payment Reform and the importance of how we pay for services

Having observed and studied the mental health system in Trieste, it is our conclusion that the most significant differences between the mental health system in Trieste and ours in Los Angeles are: 1) the ways the two systems are financed and 2) the enormous difference in their bureaucratic, regulatory and reporting requirements. The staff in Trieste are blissfully unaware of and unconcerned with how the services they provided were paid for. Contrast this with our Medicaid system in which staff must be constantly aware of the financial ramifications of the services they are providing and whether they

meet the criteria of “medical necessity.” These requirements make it extremely difficult for staff to provide the kind of whole person care that typifies the system in Trieste.

We have concluded that the most critical innovation needed to improve our L.A. County mental health system is the adoption of a financing system that relieves the direct service staff person of any focus on the financing of the service and thereby frees up and encourages the staff to address the “whole person.” This will require movement away from the current fee-for-service model and adoption of a tiered case rating system, the details of which will be explained in Innovations A below.

Related to and nearly as important as the financing system is the need to create a recovery-informed monitoring system that focuses on the whole person (Innovation B) and a performance measurement system that moves us toward a focus on outcomes (Innovation C). This does not mean completely abandoning the monitoring process, but it requires us to streamline our monitoring processes and redesign how we use that information to improve services and inform staff about their performance.

### **INNOVATION A: A Recovery-Informed Reimbursement System**

As mentioned above, one of the most striking differences between the mental health system in Trieste and the L.A. County public mental health system is the manner in which services are reimbursed. Trieste is characterized by a capitated system in which every resident of the city is covered by a single mental health system and the mental health center receives a set amount per resident per year (Currently \$88 US). For these funds, the system is expected to provide for all the needed mental health services for the entire population of a defined region, including crisis and inpatient services.

Unlike the capitated system of Trieste, our public mental health reimbursement system is characterized by a fee-for-service reimbursement model that requires staff to bill by the minute (or hour or day, depending on the service). This reimbursement model diverts staff attention away from the care they are providing and the needs of the members they are serving and shifts it to whether they are meeting their “billing goals.” Furthermore, the fee-for-service reimbursement model creates a perverse incentive to provide more services (greater volume) than may be actually necessary for the member because the provider gets paid more as the amount of service increases. Because of the individual staff person’s need to provide billable hours, it becomes tempting to provide additional services even though they may not be needed or desired by the member.

For all these reasons, it is clear that our current bill-by-the-minute fee-for-service reimbursement model needs to be scrapped. But with what should it be replaced? Because of the public-private distinction mentioned earlier, having a single capitation rate that applies to the entire population within a given geographic region is impossible

because the majority of people living in any given region is covered by the private – not the public – system. In addition, because it is the people with the most severe and persistent mental health needs who have been “carved out” of the general population and placed in the public mental health system, the per capita costs of serving them will be much higher than the costs of serving the general population.

We believe that a reimbursement system that provides funding based on the outcomes of services (paying for value) rather than for the quantity of services provided (paying for volume) is best suited to provide the financial and accountability underpinnings for a true Trieste-like recovery-oriented system of mental health services. Therefore we suggest the implementation of a multi-tiered case rate system in which funding is based on the level of need of the persons served and is completely uncoupled from the amount of service provided.

As it happens, a real-world experiment in this model was undertaken right here in Los Angeles County and it is to that example that we now turn.

#### Back to the Future: The Village Integrated Service Agency Case Study

On July 1, 1990, Mental Health America of Los Angeles (MHALA – then known as the Mental Health Association in Los Angeles County) opened its Village Integrated Service Agency in Long Beach, California. The Village ISA, as it was then known, was modeled on a combination of the Assertive Community Treatment model and the Fountain House Clubhouse model. Many articles and papers have been written about the Village, its philosophy and practices, and its success in treating its members.

What is less well-known about the Village ISA is that it was implemented as a true random-assignment clinical trial to test whether the services offered were actually more effective than the “usual and customary” services being provided in the same local community. People who were recruited for the study were told that they had a 50% chance of being assigned to “a new model of mental health care” or to the existing mental health clinic. 120 individuals were randomly assigned to the Village and 120 individuals were assigned to the comparison group. The recruitment and randomization were done under the supervision of an independent research firm that was also engaged to conduct the follow up evaluation on effectiveness and efficiency of the Village vs. the comparison group.

After a three-year evaluation, the independent evaluator issued a report on the project, the main results of which appear in Table 1. In summary, the results of the Village ISA were significantly better than those of the comparison group in a number of domains, including reduced hospitalization and institutional care, more satisfaction with services and less burden on family members. On the expense side, the report estimated that the Village expended \$300,000 less on hospitalization than was expended on the members

of the comparison group. The Village psychiatrists had admission and discharge privileges at a local hospital and paid very close attention to when a member needed to be hospitalized and when they could be discharged. We believe that this was one of the primary reasons that Village members' hospital stays were significantly shorter than those of members in the comparison group.

## INDEPENDENT EVALUATOR'S FINDINGS:

### MAJOR HIGHLIGHTS

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- Village members had significantly fewer hospital days than the comparison members. Village members also had significantly lower costs for inpatient care.
- At the Village, 72.6% of members tried paid employment over a three-year period, compared to 14.6% of the comparison group.
- The percentage of Village members living in group and institutional settings declined from 15.8% at baseline to 10.8% after three years. Among the comparison members, the percentage remained fairly constant from 23.7% at baseline to 23.2% after 3 years.
- Village members reported more solitary leisure activities and more activities with others during the week before the interview than did comparison members. Village members reported significantly more support at each of the three annual interviews.
- Families of Village members reported significantly less burden and less stress from burden than did family members of the comparison group. Families of Village members also were much more positive about the member's hopes for the future than families of the comparison group.
- Members at the Village were significantly more satisfied with mental health services than members in the comparison group.

In Chandler, D., Meisel, J., Hu, T., McGowen, M., & Madison, K. Client Outcomes in a Three-Year Controlled Study of an Integrated Service Agency Model. *Psychiatric Services*, December, 1996, 47, No. 12, pp. 1337-1343.

#### Table 1

What was also unusual about the Village ISA was the mechanism of its funding. MHA was paid \$15,000 per member per year (a single-tier case rate) and for those funds was expected to provide all mental health services for its 120 members including inpatient hospitalization. In other words, MHA was at full-risk for the cost of the services to the members and was therefore incentivized to keep high-cost, inpatient services as low as possible. Because California provided general funds for the project and no Medicaid was involved, there was no minute-by-minute billing requirement and the only

documentation required of the staff was a monthly summary of the member’s progress. Responsibility for tracking the outcomes of the Village and comparison group members was given to the independent evaluator, who conducted interviews regularly both with the members as well as their families.

**SERVICE EXPENDITURE PATTERNS: VILLAGE vs. COMPARISON GROUP**

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<u>Type of Service</u>	<u>Village Percent of Total</u>	<u>Comparison Percent of Total</u>
Case Management	40.6	10.1
Day Treatment	0.2	1.0
Medications	11.2	10.2
Residential	0.3	2.1
Socialization	11.6	1.2
Outpatient Therapy	4.7	23.2
Vocational	25.1	1.3
Acute Hospital	5.1	27.9
Long Term Care	1.3	23.1

The three largest areas of expenditure for the Village members were in case management, employment services and socialization services. The three greatest areas of expenditure for the control group were acute hospitalization, outpatient therapy, and long-term care.

In Lewin-VHI, Inc., with Meisel, J., & Chandler, D. The Integrated Service Agency Model: A Summary Report to the California Department of Mental Health, June, 1995.

Table 2

Another striking result is that Village members were nearly **five times more likely to engage in employment activity** than members of the comparison group. We will return to this finding when we address Innovation D.

While the specific recovery practices in which the Village staff engaged are undoubtedly part of the reason for these positive outcomes, it is also extremely informative to observe the differences between how funds were expended on Village members vs. how they were expended on members of the comparison group (See Table 2).

What is most striking in these results is that the Village ISA spent approximately four times the percentage of its budget on case management as did the staff providing

services to the comparison group. Similarly, the Village ISA spent approximately 10 times as much of its budget on socialization as did the staff serving members of the comparison group. And finally, as a percentage of its budget, Village ISA staff spent nearly 20 times as much on vocational services as the staff serving the members of the comparison group.

We suggest that a very large part of the reason for the marked difference in service expenditure patterns between the Village and the comparison group is that the staff of the Village were completely unencumbered by the fee-for-service reimbursement model that had to be followed by the staff serving members of the comparison group. Much like the staff in Trieste, the Village ISA staff were effectively insulated from those kinds of considerations which freed them to be able to offer whatever services the member needed and/or requested.

### Implementing a Multi-Tier Case Rate System

The case study of the Village ISA demonstrates that the case rate model of reimbursement is much superior to our current fee-for-service model and is likely to create an environment in which a Trieste-like system can thrive. However, if we are to adopt such a reimbursement model, it is necessary that the system be multi-tiered rather than the single-tier system that characterized the Village. When the Village ISA opened its doors in 1990, the belief that people could truly recover from severe and persistent mental illness had not yet taken hold. As a result, no thought was given to the idea that, as people get better, they require less care and the costs of supporting them over time should decrease. To the contrary, it was rather disparagingly assumed that “once a high utilizer, always a high utilizer.”

Over the last several decades, a lot of evidence has accumulated that this assumption is untrue. Many people who were significantly impaired and whose costs of care were extremely high have been able to live productive lives in the community at large with correspondingly extremely low costs for their care. Our reimbursement system needs to take this reality into account. It is a multi-tier case rate system that both reflects this dynamism in the individual’s costs of care over time while simultaneously providing the optimal environment in which staff can provide flexible and creative whole person care.

We are proposing that a specific geographic region be “carved out” to serve as a demonstration for a Trieste-like system of care that employs a multi-tier case rate reimbursement system. The population to be served would be every inhabitant of the defined region who is currently eligible for Los Angeles County funded services (generally, the Medicaid specialty mental health population). The proposed system would be revenue and expense-neutral; that is, it would reflect the total current funding for the region currently used by the defined population. But it would establish four to

five case rates that reflect average expenditures for people at different levels of need/impairment and therefore require different levels of care.

Some of the foundational work for establishing a multi-tier case rate system has already been done in Los Angeles. In 2014, a number of agencies in the Association for Community Human Services Agencies (ACHSA) established the Full Service Partnership (FSP) Integration Pilot. This pilot was initiated under the assumption that our healthcare systems would ultimately move toward a pay-for-performance system and the intention was to be “ahead of the curve” when that change finally took place. These agencies agreed to employ the Milestones of Recovery Scale (MORS) and the Determinants of Care (see Innovation C on pages 25 - 29 for a detailed explanation of these measures) as a means of assigning their members to a specific level of care. They further agreed to then track the movement of their members through the various levels of care with the ultimate goal of determining our ability to improve the lives of people served while simultaneously lowering the costs of their care.

LEVEL OF CARE	RULE PARAMETERS
5 Residential / inpatient services for people who are gravely disabled or are currently a danger to self or others	If MORS score is a 1 <u>then</u> LEVEL OF CARE is a 5
4 High Intensity Community Based OP	If MORS score is a 2 or 3, <u>then</u> LEVEL OF CARE is a 4 and/or If sum of determinants equals 5 or more, <u>then</u> LEVEL OF CARE is a 4 and/or If sum of determinants equals a 3 or 4 and one of those determinants is required weekly care coordination, <u>then</u> LEVEL OF CARE is a 4
3 Moderate Intensity Community Based OP	If sum of determinants equals a 3 or 4 and required weekly care coordination <u>IS NOT</u> one of those determinants, <u>then</u> LEVEL OF CARE is a 3 and/or If sum of determinants is 2 or less and MORS score is 4 or 5, <u>then</u> LEVEL OF CARE is a 3 and/or If sum of determinants is 2 or less and MORS score is 6 or 7 and the client has been stable at the current MORS score for less than 6 months, <u>then</u> LEVEL OF CARE is a 3
2 Wellness Services	To be determined: All other clients not meeting above rules will be assigned to LEVEL OF CARE 1 OR 2.
1 Recovery Maintenance	To be determined: All other clients not meeting above rules will be assigned to LEVEL OF CARE 1 OR 2.

Table 3

Table 3 above is a hypothetical algorithm that demonstrates how various combinations of the individual’s MORS score and the sum of his/her determinants could be used to assign him/her to a particular level of care.

This system of determining levels of care is based on the following assumptions:

- The single greatest indicator of the overall cost of services is the amount of time staff must spend with clients.
- The less “self-coordinating” a client is, the more time staff will need to spend with them. Therefore, the practical goal of services is to help clients to become more “self-coordinating” over time.
- “Self-coordination” must be operationally defined by specific, actionable behavioral domains that staff can assist clients to learn and accomplish on their own.
- Levels of care can be objectively determined and will reflect the level of clients’ ability to self-coordinate.

This algorithm is provided for demonstration purposes only. The actual criteria for assigning members to a specific level of care would need to consider both clinical and economic factors and take the specific population in the intended demonstration area into account. But this example demonstrates how such a system could rationally allocate resources to members and provide reimbursement for services based on their level of need while allowing us to track our ability to move them to lower levels of care over time.

The system also has the benefit of getting “double duty” out of our performance indicators. In Innovation C we will describe how the MORS and the Determinants of Care will be used as outcome indicators. there are no additional measures needed to track level of care, again minimizing the documentation impact on staff.

### **INNOVATION B: Recovery-Informed Documentation and Process Monitoring**

Clinical providers, both County directly-operated and contracted providers, expend enormous resources ensuring that their staff enter all their billing data into the system to ensure that they are reimbursed for the services they provide. It is estimated that up to 25% of the direct service staff person’s time is spent on billing and documentation. And of course the more time that staff spend documenting services the less time they have to actually provide services to their members.

But in addition to the burden of simply entering the amount of time expended in serving the member, direct service staff are expected to demonstrate that the service they provided meets the burden of “medical necessity;” that is, they must narratively justify that the service provided was medically necessary to address the member’s needs. Failing to do so will result in the possible withholding of payment for the service.

It would be difficult to overstate the soul-killing effect this system has on the morale of staff in our mental health system. It is our contention that this system of reimbursement/documentation makes the adoption of Trieste-like recovery-oriented service system extremely difficult if not completely impossible. First, the very term “medical necessity” tends to focus on the member’s illness rather than on the member’s larger quality of life needs and goals. In their concern over providing a service that may not be reimbursed, staff will tend to gravitate toward a more illness-based intervention because it is perceived as “safer” from a reimbursement standpoint.

It should be pointed out that nobody is suggesting that there should be no accountability standards for staff. But process monitoring is important not for the traditional reason of ensuring reimbursement, but to allow systems to learn what is working and what isn’t. We should strive for documentation standards and evaluation systems that will support and incentivize good recovery-oriented practices on the part of our direct service staff. We believe that the characteristics of such a process monitoring system would include the following:

- Process indicators that are meaningful and understandable for all stakeholders in the system: members, direct service staff, supervisors and middle-level management, executive leadership, elected officials and funders, and the public at large.
- Process indicators that trace and are consistent with and specific enough to reflect the individual member’s “recovery journey” and provide direction to staff as to whether interventions are working.
- Process indicators that reflect the needs and goals of the whole person.
- A system that requires no more than 5% of the individual staff person’s time to be spent on documentation and evaluation.

What part of the member’s whole life (what domain) did you and the member work on? (Component 1)

To accomplish this, we propose to completely eliminate the current Medicaid classification system and replace it with a two-component process-monitoring system that addresses all aspects of the member’s quality of life as well as describing what the staff person actually did in his/her interaction with the member. At every contact with a member, the direct service staff will record which quality of life domain was the primary focus of the interaction (Component 1). The quality of life domains include the following:

1. Residential (HOME & HEALTH)
2. Employment (PURPOSE)
3. Education (PURPOSE)

4. Financial (HOME & HEALTH)
5. Independence (HOME & HEALTH, PURPOSE)
6. Physical Health (HOME & HEALTH)
7. Substance Use / Abuse (HOME & HEALTH)
8. Legal (HOME & HEALTH)
9. Family / Intimate / Social relationships (LOVE & BELONGING)
10. Mental Health (HOME & HEALTH)
11. Leisure / Recreation (PURPOSE, LOVE & BELONGING)
12. Spirituality/Identity (PURPOSE, LOVE & BELONGING)
13. Other

These twelve categories capture virtually all aspects of an individual’s quality of life. (The ubiquitous “Other” is included as a placeholder for some domain that we may have neglected to consider). Note that each of these quality of life domains is tied to one or more of the three primary goals of the pilot. At every interaction between staff and member, staff would be expected to record the quality of life domain that was the focus of the service provided.

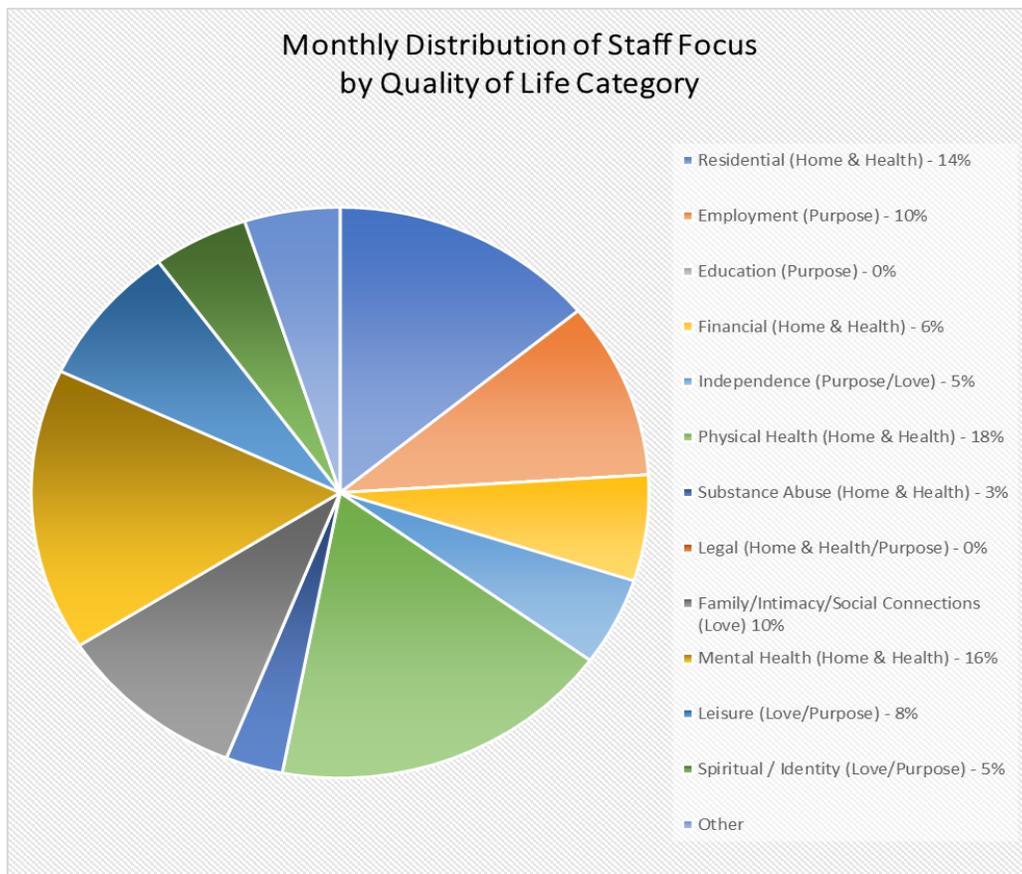


Figure 1

Figure 1 above provides an imaginary illustration of how a staff person might distribute his time over his overall caseload. Compared to other staff, he might spend significantly more time tending to the physical health needs of members because that is a specialized area of his scope of practice compared to other service staff.

Recording this simple piece of information has enormous ramifications for the improvement of services. It reminds the staff person at every interaction that they are working with a whole person who has goals and needs not just defined by their illness.

It also allows supervisors, programs and systems to monitor the amounts and percentages of time that direct service staff spend attending to various aspects of their members' lives.

But more importantly, imagine how these data for individual staff members could be "rolled up" and aggregated to demonstrate the extent to which not just individual staff, but how programs, agencies and larger systems are addressing the overall quality of life of the members they serve! This is information that is currently unavailable and, lacking that information, there is absolutely no way to know if our staff are making progress in our efforts to address the "whole person" and helping them to find "places to live, people to love and purpose every day." But having this information will enable us to transform into a "whole person-oriented" system.

#### But what did you DO with the person? (Component 2)

As was mentioned earlier, our current Medicaid-based documentation system does require staff to classify the services they provide. However, that classification system has relatively little utility because the categories are designed primarily to determine how much will be reimbursed for each service rather than providing information regarding what the staff person actually did with the member. To be fair, the system does expect the staff person to provide a narrative of what was actually provided during the service and how it addresses "medical necessity." But the fact that it is narrative and not standardized means that there is no way to aggregate the data or extract any general learning for the program, agency or system at large.

As an alternative, we intend to adopt a standardized list of services that are intended to reflect the "typical" experience of members at different points on their recovery journey. These recovery-based service categories include:

1. Welcoming / engagement
2. Crisis interventions / Responding to basic safety needs and community expulsion threats
3. Assessments and planning
4. Building and maintaining the safety net / "protective factors"
5. Motivating / Engaging in growth-oriented activities

6. Promoting mental wellness and treating mental illnesses and substance abuse disorders to reduce barriers
7. Promoting physical wellness and treating physical illnesses
8. Providing and building support
9. Rehabilitation / Skill building
10. Building personal growth and responsibility
11. Community integration
12. Community development
13. Promoting self-reliance, separation from services, and graduation

A description of each service category is provided in Appendix 1.

### Example: Nurse

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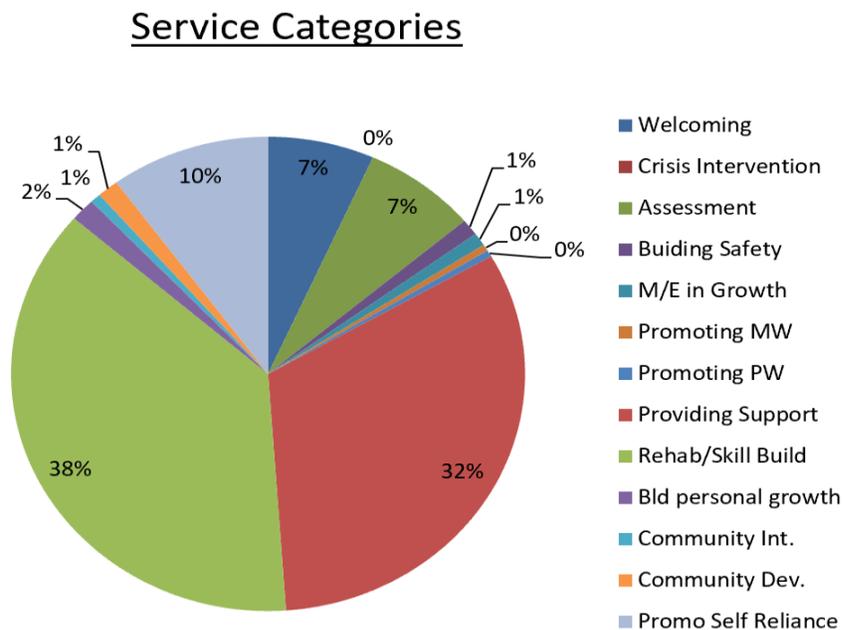


Figure 2

Figure 2 offers a hypothetical example of the distribution of services for one staff person.

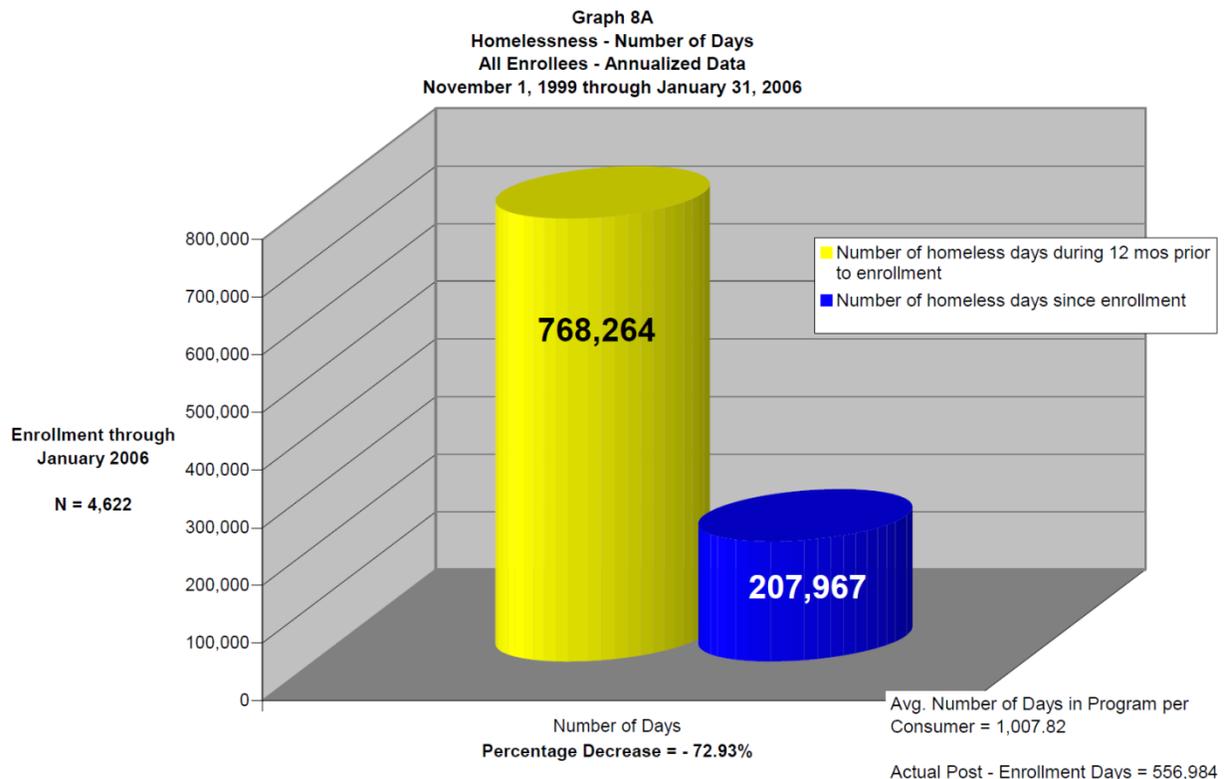
All staff would need to be trained on this system to ensure sufficient understanding of the service categories and reliability across staff. But along with the Quality of Life monitoring (Component 1), this classification system would ensure a whole person recovery-oriented focus and provide invaluable information at the individual as well as

the aggregate levels. It provides a tool to supervisors to help their staff to examine what might not be working in their interactions with any particular member and a framework for understanding the member's recovery journey.

### INNOVATION C: A Recovery-Informed Performance Measurement System

As important as it is to incentivize and monitor service interactions that are whole person- and recovery-oriented, it is actually even more important that we have a means to determine if all those services are having the intended effect; that is, are we actually helping the people we serve to recover?

In 2005 the State of California implemented an outcome tracking system for all of its Full Service Partnership (FSP) programs serving the highest need members with severe and persistent mental illnesses. This system, called the Key Events Tracking System (KETS), monitors and records changes in certain domains in the member's life. For example, at entry into an FSP, the member's current residential status is recorded (e.g., homeless through living independently) as well as his/her residential status for the entire year leading up to program entry. Whenever the member changes residential status, it is recorded, allowing the system to determine how effective it is in, for example,



reducing homeless. An example of how these data are reported is shown in Figure 3.

Figure 3

The graph shows that, for the 4,622 members enrolled statewide in the AB 2034 program through January 2006, the number of days homeless that they experienced after being enrolled in the program dropped nearly 73% compared to what they experienced prior to enrollment.

Similarly, Figure 4 compares the pre-enrollment hospital days for all the members who had at least 72 months in the program with their post-enrollment hospital days on a year-by-year basis. The data clearly show that the programs were successful in every year in reducing hospitalizations from baseline and that the overall trend improved year over year.

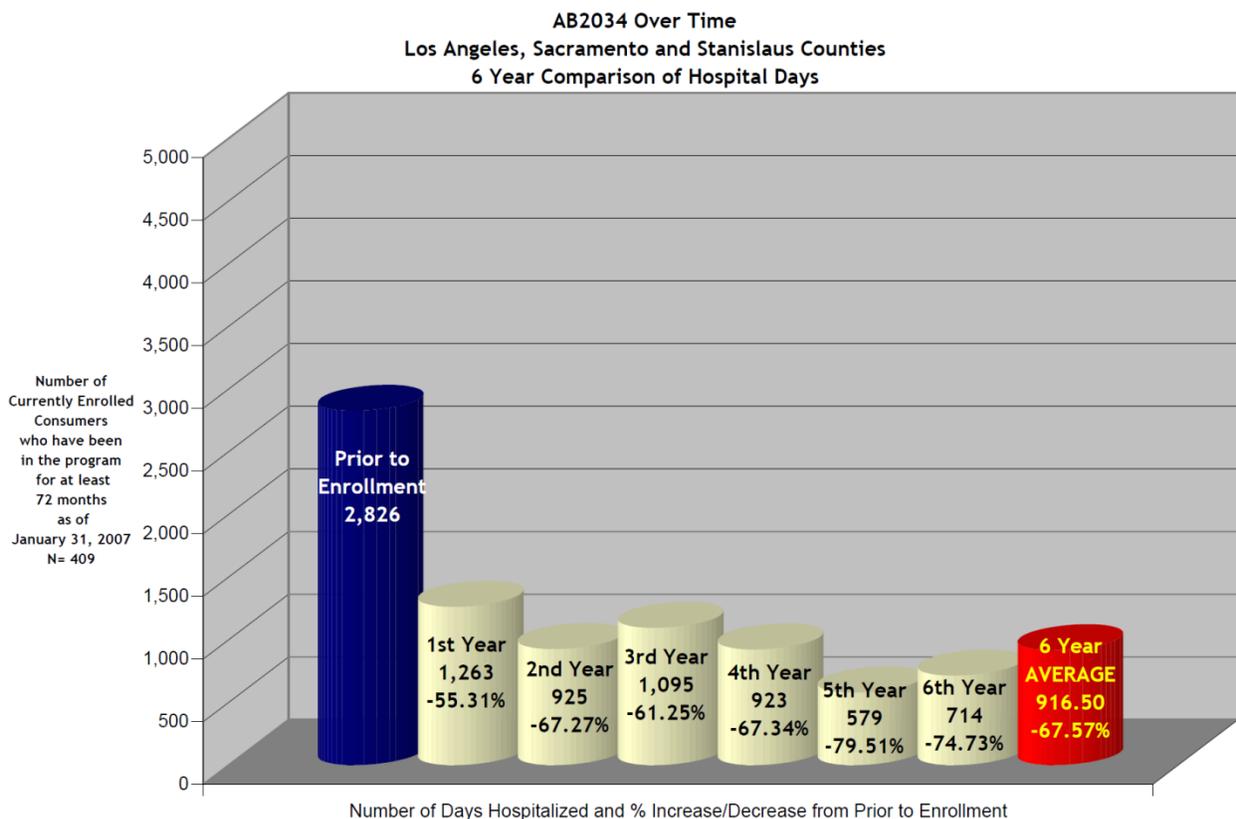


Figure 4

The domains measured by the Key Event Tracking System are extremely relevant to the pilot's goals. For example, tracking the residential, incarceration, and hospitalization statuses of our members will enable us to evaluate our ability to help them maintain HOME & HEALTH. Similarly, tracking their status in regard to employment and educational will provide valuable information regarding our ability to achieve and maintain PURPOSE in their lives. We also intend to make some technological changes

(See Technology Section) to make the system more responsive to staff and easier for staff to use.

However, while the large epidemiological indicators of homelessness, hospitalization and incarceration rates address the “risk” components of our members’ lives, with the exception of employment and education rates they do little to inform us about our effectiveness in addressing the “meaning and belonging” parts of our members’ lives. They are especially unhelpful in showing whether our services are effective in helping members to develop social connection and community belonging. Additionally, they provide no information or direction at the individual staff-member interaction level regarding whether the member is acquiring the skills and supports that will enable them to achieve “a place to live, something to do, and a person to love.”

To remedy this lack, we propose to implement a two-component system of “micro indicators” that are designed to measure our system’s effectiveness in helping our members to develop the skills and the supports that they need to live in the larger community. Similar to the process monitoring indicators of Innovation #1, the characteristics of the outcome tracking system should include the following:

- Outcome indicators that are meaningful and understandable for all stakeholders in the system: members, direct service staff, supervisors and middle-level management, executive leadership, elected officials and funders, and the public at large.
- Outcome indicators that are sensitive to and responsive to the actions taken by staff in their interactions with members.
- Outcome indicators that trace and are consistent with and specific enough to reflect the individual member’s “recovery journey” and provide direction to staff as to whether interventions are working.
- Outcome indicators that reflect the needs and goals of the whole person.
- A system that requires no more than 5% of the individual staff person’s time to be spent on documentation and evaluation.

The two components of this system are the Milestones of Recovery Scale and the Determinants of Care.

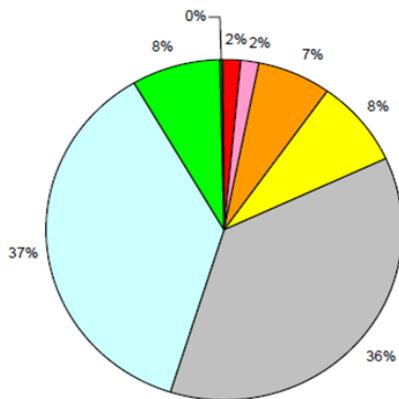
The Milestones of Recovery Scale (MORS) is a valid and reliable one-page, single score assessment that takes just two minutes to complete. It quantifies the stages of an individual’s recovery using milestones that range from extreme risk to advanced recovery and everywhere in between. The MORS is rooted in the principles of psychosocial rehabilitation and defines recovery beyond symptom reduction, client compliance and service utilization. It operates from a social psychological perspective which sees meaningful roles and relationships as the driving forces behind achieving recovery and leading to a fuller life. (See Appendix 2 for an example of the scale)

The MORS is the ideal instrument to enable us to evaluate our system’s effectiveness in helping members to achieve the goals of LOVE & BELONGING and PURPOSE. Indeed, the scale describes an individual as being in “early recovery” in the following manner:

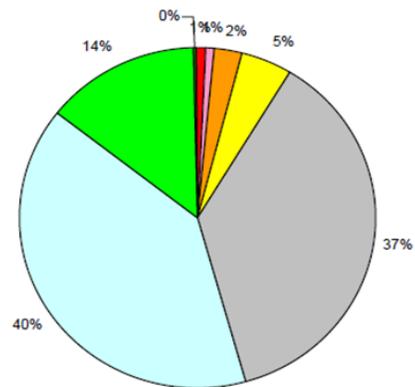
These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.

**Milestones of Recovery Scale  
Progress Chart - Milestones**

	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6	Score 7	Score 8	Total
August 2010	7	8	29	37	163	164	36	1	445
August 2011	4	4	11	21	167	182	65	1	455
Percentage Change	-43%	-50%	-62%	-43%	2%	11%	81%	0%	0%



August 2010



August 2011



Note that, while there is certainly a component of HOME & HEALTH included in this

## Figure 5

definition of recovery, it places at least as much emphasis on the importance of the presence of a social network (LOVE & BELONGING) and the presence of meaningful roles in the larger community (PURPOSE). At admission and every month thereafter, every member is given a rating by a staff person who knows the member well enough to make an accurate rating. For example, most members who are homeless would be rated Experiencing High Risk, Not Engaged (MORS-2) when the mental health system first encounters them. Over time, we would expect the ratings of individual members to go up as they proceed in their recovery journey. The goal is for every member to reach the milestone of Advanced Recovery and by collecting these data we are able to evaluate our system's effectiveness in accomplishing this.

Figure 5 above is an example of how the MORS data can be used to determine program effectiveness. It shows the aggregate MORS ratings for 455 members and how they shifted over a 1-year period. The data show consistent reductions in the number of members at the lower milestones (1-4), almost no change in the number of members rated at milestone 5, increases in the number of members rated at milestones 6 and 7, and no change at milestone 8. Having ongoing MORS ratings on every member in your caseload/agency/system gives you a multitude of ways to ask the question, "How are we doing?"

For example, how many people who are at High Risk/Unengaged (MORS-2) when we first meet them on the streets are we able to help get to Early Recovery (MORS-7)? On average, how long does that process take? Why was one program able to accomplish this in 18 months on average, when it takes another program 2 years? But most importantly, it allows us to answer the question of whether we are helping members to live a life of meaning in a supportive community of their choosing.

### The Determinants of Care

Compared to the general population, people with severe and persistent mental illnesses receive disproportionate amounts of healthcare because of their multiple co-morbid conditions and their relative inability to self-coordinate their care. It is clear that an individual's ability to "self-coordinate" is significantly related, if not critical, to his/her ability to achieve positive health outcomes. It is also clear that health outcomes will not improve unless we work with our members to improve their ability to self-coordinate or, failing that, to help them to acquire either natural supports or professional care coordination services.

As mentioned earlier, one of the underlying constructs of the MORS is the member's *general* level of skills and supports. The purpose of the Determinants of Care is to "unpack" this dimension and provide greater specificity as to which domains the

member is able to self-coordinate and the domains for which s/he needs either natural or professional support. The determinant domains are the “actionable behaviors” that staff help members to acquire so that they can live a fuller life in the community. Clinical staff have reported that they have found the determinants to be quite helpful in directing their care and interventions with their members.

The determinants are structured as a binary choice for the staff person to assess whether the member is self-coordinating or needs support in the following domains:

Does the client...

1. ...require staff support to manage his/her own financial resources?
2. ...require staff support to coordinate his/her own transportation needs?
3. ...require staff assistance with 2 or more Activities of Daily Living?
4. ...require at least once per week contact with staff to coordinate his/her care?
5. ...require staff support to manage his/her medication?
6. ...require staff to manage community relations and minimize disruptive behaviors?
7. ...show less than 6 months stability at his/her current level of recovery?
8. ...require CSS (Flex) funds to meet basic needs (housing and food)?

Every member is assessed monthly and receives a “Determinants Profile” based on whether the answer to each question is positive (i.e., the member needs staff support) or negative (the member does not need staff support). The greater number of positive determinants, the greater the member’s need for care and support. Over time, it is expected that the number of positive determinants will decrease as the member learns to self-coordinate various domains in his/her life. Programs, agencies and entire systems can evaluate their effectiveness in helping their members to become more self-coordinating, which in turn is expected to help the member to live more successfully in the larger community.

Figure 6 demonstrates how a program or agency can evaluate its ability to help its members become more self-coordinating. It shows the data over an 18-month period for the percentage of members who “require at least once per week contact with staff to coordinate his/her care.”

## Determinant Change Over Time: Weekly Care Coordination

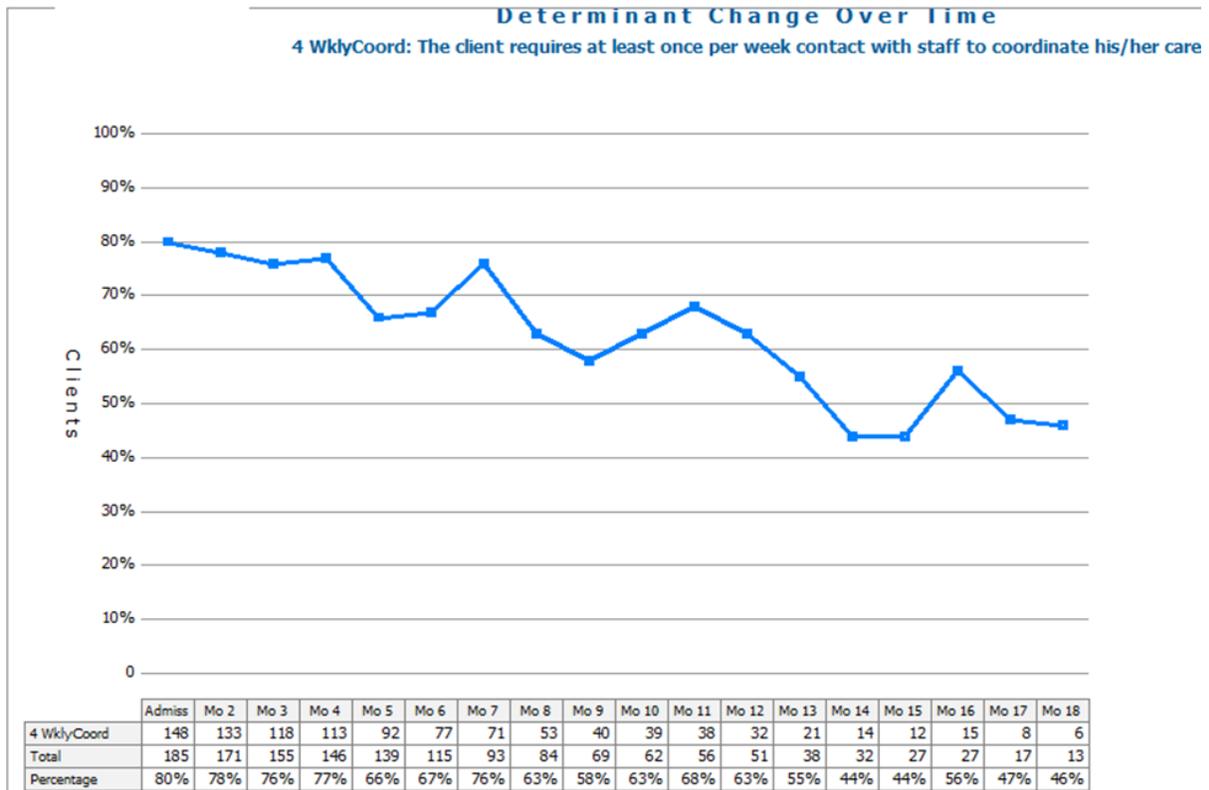


Figure 6

In this example, 80% of the members required this support from staff at admission to the program. Over time, the number of members requiring at least once-per-week contact gradually decreases until it is at 46% for those members who have been in the program for 18 months.

Essentially, the steeper the slope of the line from upper left to lower right, the more effective (faster) the program/agency/system is in helping its members to improve the particular determinant being considered. This kind of trend data is available for all the determinants and is invaluable for informing us regarding our ability to help our members become more self-coordinating. Combined with the MORS data, they provide all the data we need to determine if the people we serve are indeed recovering.

### Summary of the Recovery-Informed Tiered Case Rate / Process Tracking / Performance Measurement System

We believe that, taken together, Recovery-Informed Reimbursement (Innovation A), Recovery-Informed Documentation and Process Monitoring (Innovation B), and Recovery-Informed Performance Measurement (Innovation C) have the potential to revolutionize the delivery of mental health services in Los Angeles County and ultimately across the United States. The advantages of such a system include:

- Process and outcome indicators that are intuitive and understandable by all levels of stakeholders.
- Process and outcome indicators that incentivize staff to focus on the “whole person.”
- Process and outcome indicators that prioritize value over volume.
- Minimizing the amount of time staff spend documenting the care they provide and thus increasing the time available to actually provide care.
- Increasing staff morale by insulating them from the financing of services and allowing them instead to creatively and flexibly provide the care that members need.

These innovations are absolutely essential to create the reimbursement, administrative, and regulatory environment in which a recovery-based can exist and thrive in the U.S. With these innovations in place, it is likely that other resource and cultural changes could be considered and implemented. It is to those possibilities that we now turn.

#### **INNOVATION D: The Proposed Service Array: Shifting the Balance from “Illness-focused” Services to “Well-being-focused” Services**

The foregoing discussion focuses heavily on the pilot’s intended changes to the payment, documentation, and accountability systems currently in place (Innovations A, B, and C). We believe that without these “infrastructure” changes, real mental health system reform in the shape of improved outcomes and increased stakeholder satisfaction will be impossible to achieve. However, we also believe that these changes, while necessary, are insufficient in and of themselves. When we free our direct service staff from their current documentation burdens and give them the opportunity to embrace their most recovery-oriented inclinations, our system must still provide an array of services that will empower members to invest in their own recovery and achieve the goals of “somewhere to live, something to do, and someone to love.”

It should be pointed out up front that it is our belief that there is no new, “silver bullet” service that has been missing from the current service array which, if added, would suddenly result in improved outcomes. Rather, we believe that our system must shift its emphasis away from providing illness-focused services and move toward providing trauma-informed, culturally competent and wellbeing-focused services. We will examine this issue in much greater detail below.

It is also important to recognize that every mental health system is actually comprised of *two* parallel service continuums. First, there is the “normal,” ongoing system that participants access on a day-to-day basis for regular, non-urgent services. These services include transitional residential placements, traditional clinics offering ongoing therapy and service coordination, wellbeing centers, drop-in centers and clubhouses

offering recreational and social support, and psychosocial rehabilitation services such as supported employment and supported education. There is also the second continuum of care that consists of crisis or urgent care services. This continuum typically includes psychiatric mobile outreach and assessment, mental health urgent care centers, respite and crisis residential programs, emergency rooms and psychiatric hospitals. The second continuum could also be seen as including the services that are primarily characterized by the connection between mental health and law enforcement/criminal justice; namely, jail mental health and the mental health court system (see Figure 7 below).

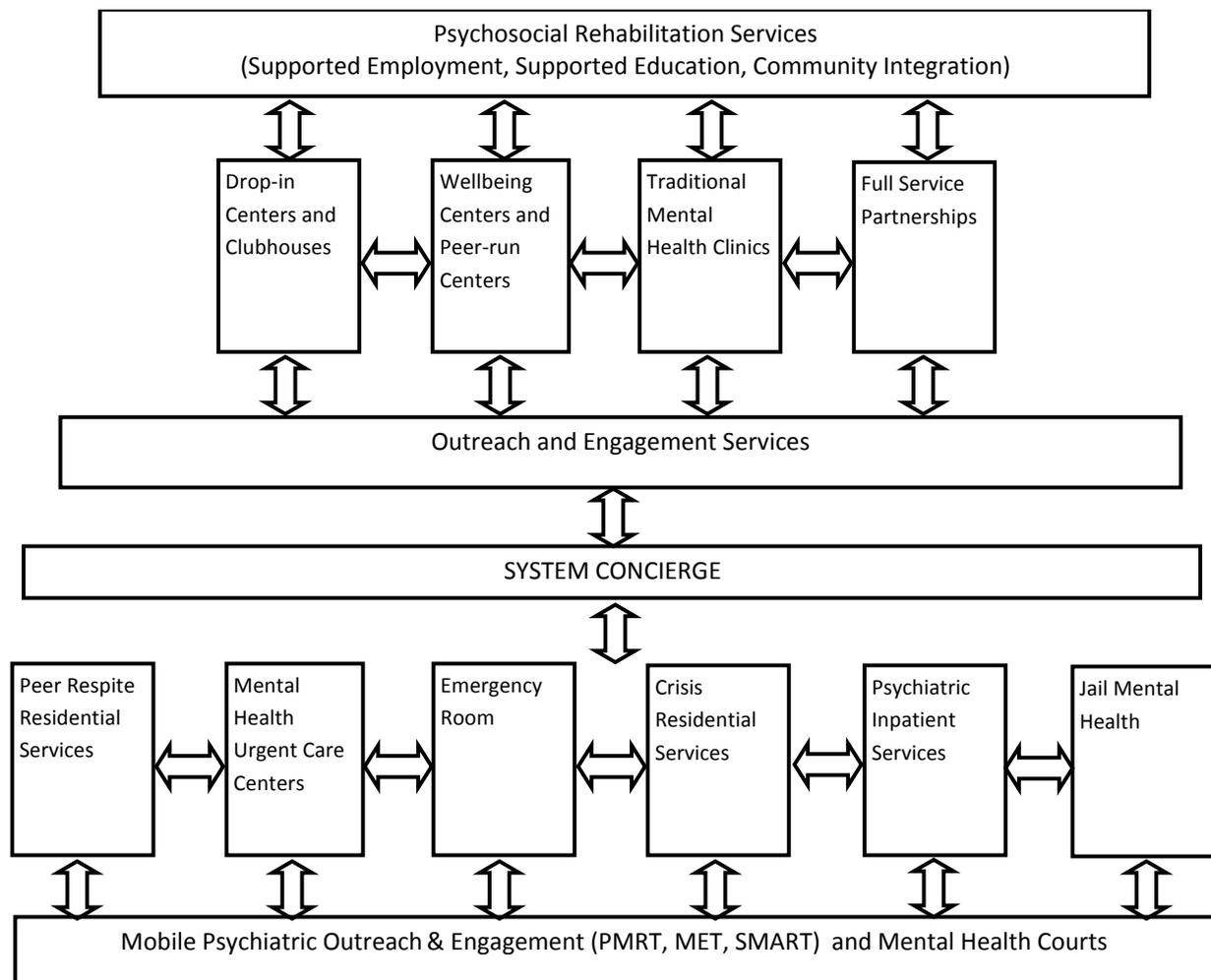


Figure 7

Figure 7 graphically represents the two service continuums as envisioned in the pilot. At the top of the diagram is the routine (non-urgent) service continuum, ranging from drop-in centers and clubhouses to Full Service Partnerships (FSPs). At the bottom of the diagram is the urgent care service continuum, ranging from peer respite residential services to mental health services in the jail. Both continuums are arranged with lower

intensity services on the left and higher intensity services on the right. Generally speaking, the per capita cost of services also increases fairly linearly as utilization moves from left to right.

For obvious economic reasons, nearly all system reform efforts focus on improving access to and increasing utilization of the normal, non-urgent service continuum while at the same time reducing utilization of the urgent service continuum. The pilot is no exception to these goals, which we intend to address in two ways. First, the pilot will explore providing services not currently offered and will improve access to existing services in the non-urgent care continuum. This will decrease the likelihood that members will require urgent care services. In this endeavor, our fundamental assumption is that improvement in mental health status – and its attendant reduction of the need for urgent care – cannot occur “in a vacuum.” People will be much less likely to access the urgent care system when they have a life in the community that is not defined by their mental illness. It is for this reason that psychosocial rehabilitation and community integration services are placed at the top of the diagram with access points at all levels of care – it is these services that help people to “get a life.”

Obviously, we will never be able to totally eliminate all behavioral health crises. But one of our fundamental tasks will be to examine the ratio that currently exists between “illness-focused” and “recovery-focused” services with the aim of shifting the balance as much as possible toward growth and recovery-oriented care.

Secondly, within the urgent care continuum, we need to improve services at the outreach and engagement end of the spectrum. The mental health system in Trieste appears to have been able to accomplish this to a large degree and has virtually eliminated involuntary hospitalization. One of the major challenges of the pilot will be to improve and enhance the services at the (left) end of the urgent continuum before a crisis situation has progressed to the point where either involuntary hospitalization or incarceration become the only alternatives.

It will also be important to examine the connection points between the non-urgent and urgent service continuums. Interviews with various stakeholders suggest that a lack of communication and coordination between these two systems is at least partially responsible for much of the dissatisfaction with the current system expressed by both members served and other stakeholders. The pilot will introduce a new system-wide function, which we call the System Concierge, whose main goal is to reduce system fragmentation and improve communication and collaboration across system entities.

In summary, the diagram illustrates three important characteristics of the service array as envisioned in the pilot system. First, the diagram shows that non-illness centered, recovery-focused **psychosocial rehabilitation services** are envisioned as being primary and available regardless of the member’s current level of need. Secondly, **the**

**outreach and engagement function for both continuums of care is viewed as a system function** that may or may not be embedded within a particular level of care. (Currently FSPs are the only level of care that is required to provide this function as part of its services). Finally, we will propose the creation of a new pilot-wide function that we refer to as the **System Concierge**, whose role is to serve as the “glue” between the two continuums of service and ensure that participants do not fall through the cracks. Each of these three elements will be explained in detail below.

#### A Place to Call Home: The Central Role of the Health Home and Service Coordination

*Home is where, when you go there, they have to take you in.*  
- Robert Frost, “Death of the Hired Man”

Since the passage of the Affordable Care Act, the concept of the “health home” (or “healthcare home”) has become increasingly popular as a means for organizing the way healthcare is structured and delivered. Tom David (Health Affairs, February 2012) offers the following description of a health home:

... health home[s] ...offer a more expansive view of health promotion and improvement than more physician-centric medical home concepts. Such projects also acknowledge that medical care alone will be insufficient to ultimately achieve health equity for underserved populations. Patient and family engagement and self-management are seen as essential complements to clinical interventions. A health home prioritizes the voice of the patient and sees culturally sensitive prevention and primary care as the cornerstone for an integrated system of care. (David, 2012, p.1)

Within the pilot’s non-urgent, normal continuum of care, the most foundational service offered in the pilot will be to act as the member’s health home in which both the mental and physical healthcare needs of the member can be addressed. Members will be assigned to a health home that reflects and is congruent with their level of need and their ability to self-coordinate their care (see the description of the multi-tier case rate system on pages 18 – 20). Wellness and Peer-Run Centers, Outpatient Clinics and FSPs could all serve as the health home for the member, with each of these levels of care providing the appropriate (i.e., needed) amount of assistance for the member to achieve the maximum level of independence in the community.

Having the capacity to address the member’s physical healthcare needs is particularly important for the population of people with severe and persistent mental illnesses, who research has shown are likely to die from treatable chronic illnesses as much as 25 years earlier than the general population. There is also much anecdotal evidence to suggest that our population does not always feel welcome at standard community

health clinics and that those clinics may sometimes fail to serve them optimally. This does not necessarily mean that we must offer physical healthcare services directly, but at minimum it means acting as an advocate and a guide for members in their interactions with the physical healthcare system.

Among the population served by the public mental health system, we believe that there is a greater need for case management services than for therapy. While nobody is suggesting that therapy is not helpful for the public mental health population – especially in those cases where the member has experienced significant trauma – we believe that the current balance of those two service modes is not optimally matched to the needs of the population we are serving. As mentioned earlier (Table 2, page 15), one of the most significant differences between the distribution of services provided to members of the Village ISA and the members of the comparison group was the provision of case management vs. psychotherapy. The Village ISA had a ratio of case management to therapy of approximately 8:1 while the staff serving the comparison group members actually reversed that relationship with a therapy to case management ratio of approximately 2.3:1.

As a first step in the implementation, the pilot will examine the ratio of psychotherapy to case management services that currently exists in the pilot region with the aim of assessing whether that balance meets the need of the target population. The health home must ensure that the member has access to needed resources by acting as a broker on behalf of the member and by coordinating services and relationships with other systems and the community at large. But the health home must foster a deeper, more hands-on relationship that recognizes that members often need training in life skills and ongoing, permanent support in some areas of their life. The staff of the health home should see their roles as helping the member to develop the skills to become self-coordinating or, failing that, to help the member put in place the supports s/he needs to live as independently as possible in the community.

The following is a partial list of the life skills that the health home is responsible for helping a member to improve:

1. Managing medications
2. Managing money
3. Managing public transportation
4. Managing community relations (e.g., landlords, neighbors)
5. Managing activities of daily living (e.g., housekeeping, meal preparation, shopping)

Most people would agree that mastering these skills is strongly positively correlated with our ability to enjoy a decent quality of life, regardless of whether or not we have a mental illness. For this reason, one of the central functions of the health home must be

to provide members with the instruction, either individually or in groups, that will enable them to learn these skills to the extent of their choice and ability.

Members who have a higher level of need – such as those in an FSP – would be eligible to access any of the services at the lower, less intense levels. For example, an FSP or Wellbeing center member may avail themselves of services in a drop-in center or clubhouse. On the other hand, a member who has a job and is completely comfortable with and able to navigate physical healthcare services at her local community clinic may only want to receive mental healthcare services such as outpatient therapy at the Wellbeing center serving as her health home.

### Getting a Life: The Role of Psychosocial Rehabilitation Services in achieving LOVE & BELONGING and PURPOSE

While it is certainly important to help members lessen and/or eliminate their skill deficits, it must be pointed out that this is not done as an end in and of itself. Rather, the ultimate goal is provide opportunities for members to leverage their new skills in the service of “having a place to live, something to do, and someone to love.” While psychotherapy and medication support are often necessary components, we believe that they are insufficient by themselves to enable many of our members to make the leap to community employment or find new friendships and intimate relationships. They need services that are specifically designed to assist them in these endeavors.

To address these needs, the pilot system intends to offer access to a full range of psychosocial rehabilitation services such as supported employment and supported education. Participants across the continuum will be able to make use of these services regardless of their current level of care.

The support and involvement of the larger (i.e., non-mental health) community will be crucial in this endeavor. In Trieste, members of the general community are nearly always supportive of the mission and programs of the mental health system. They seem to take pride in the “model status” of the city’s mental health system and show little of the stigma and NIMBYism that seem so prevalent in the U.S.

The pilot intends forge a similar culture by leveraging existing relationships with the Hollywood business community to create a varied “menu” of employment opportunities such as short-term jobs in the community that connect members wanting temporary work with those in the community that seek day laborers. We will hire job developers and job coaches to help members both find and maintain longer term employment and career opportunities. Relationships will be developed with Los Angeles City College to assist members in exploring higher educational opportunities.

There is a great deal of evidence that social isolation and boredom have a significant detrimental impact on the population in general, let alone the population of people with

severe and persistent mental illnesses. To address this issue, the pilot will invest heavily in the enhancement of social and recreational opportunities for members. This will include the hiring of “community integration specialists” whose main role will be to serve as coaches to assist members in forging social support in the larger (non-disabled) community. Service hours will be expanded to include evenings and weekends to provide opportunities for community integration such as sporting events, picnics, yoga classes, etc.

The increased focus on social and recreational opportunities is an ideal opportunity to include the presence of peer supporters in the service mix. Tribe members reported that one of the social cooperatives in Trieste employed peers (along with non-peers) to act as service providers to peers with greater levels of impairment. This type of service, providing an opportunity for members to “give back” as they advance in their recovery, would seem to offer enormous opportunities for meaningful roles and will be given significant consideration for inclusion in the pilot.

In essence, the pilot intends to reverse the usual emphasis between clinical and psychosocial services by making the psychosocial services “primary” and the clinical services “ancillary.” While we of course recognize that many of the members we serve require very high levels of traditional clinical services and supports (e.g., therapy, medication support), we also believe that we must constantly remind ourselves of and focus on the whole life the member is trying to lead in spite of having a severe and persistent mental illness. It will be the extensiveness and robustness of these psychosocial, non-illness centered services that will to a large degree determine our success in this endeavor.

### Radical Welcoming: Re-envisioning Outreach and Engagement

It could be argued that the greatest challenge our current mental health system experiences is when we try to engage some of the most vulnerable and difficult to serve members of our community. Our response to individuals who refuse services has been to expand involuntary treatment outside of the hospital/inpatient setting in the form of Involuntary Outpatient Treatment (IOT). In contrast, the system in Trieste has virtually eliminated involuntary treatment. The book describing the Trieste system of care – entitled “Freedom First” (Muusse and van Rooijen, 2015) – makes the point that:

In Trieste, it is therefore a recurring, conscious decision not to lock up people: “open doors” at all time. To the...policy aim of reducing the hospital capacity and building a good support system in the community, a third mission emerges: reducing coercion in treatment, seclusion and long stay (closed doors). Shaping good ‘time-out’-facilities where people can be admitted in times of crisis, when outpatient counseling and (intensive) treatment (temporarily) is no longer sufficient, should be a focus point as well. (page 9)

Of course, there are significant differences between Los Angeles and Trieste that would make it difficult if not impossible to perfectly duplicate the Trieste model even if that were desirable. For example, there is no significant homelessness problem in Trieste and therefore their system rarely has to struggle with the difficult question of how to treat people with limited capacity who are living in dire straits on the streets. But it cannot be denied that in some way the mental health system in Trieste has made the services more inviting in a way that significantly reduces the need for involuntary treatment.

### Non-urgent Outreach and Engagement – Leveraging Low Demand Services

The first step in making our services more inviting is to expand the variety and accessibility of low-demand psychosocial rehabilitation services as described above. Drop-in centers and clubhouses are a proven means of increasing members' willingness to engage with the system and invest in their own recovery. Even more "advanced" services such as supported employment and supported education can serve as outreach and engagement tools by fashioning them around where the member is in the recovery process. For example, participation in temporary labor pools, sometimes referred to as "work for a day," can be used to provide homeless members with the opportunity to increase their income. Similarly, potential members could be invited to participate in social and recreational opportunities like a picnic or a sporting event. All of these situations provide opportunities for staff to build rapport with potential members even though they have previously refused services or have otherwise failed to establish their health home.

In essence, the pilot intends to re-envision outreach and engagement as a system function that extends across all levels of the non-urgent continuum of services rather than each level of service having its own outreach and engagement team. The Outreach and Engagement Team would be operated with staff from all levels of care who would work together to determine potential members' appropriate level of care. The team would be comprised of staff who could assess "target" (potential) members at all levels of need. Thus, the team would need a nurse to be able to assess the potential member's physical healthcare needs. Similarly, a Peer Advocate with extensive knowledge of social and recreational opportunities in the pilot region would make a valuable addition to the team by being able to connect potential members with referrals/connections to social and recreational opportunities that match the member's desires.

The team would be physically housed in the Clubhouse/Drop-In Center level of care. We envision the Drop-In Center serving as a low-demand "first introduction" setting for the potential member in which the staff could conduct their assessment over a cup of coffee and minimize fear and resistance on the part of the member. The team would

also explore the expansion of its service hours to include the evening hours (5 pm to 11 pm) as a way of offering more normalizing community integration activities.

### Urgent/Crisis Outreach and Engagement

As mentioned earlier, one of the common themes among members of the Tribe was how impressed they were with both the availability of mental health staff for “off-hours” crisis and urgent care situations and the lack of need for the involvement of law enforcement personnel in those same situations. In Los Angeles, as in most mental health systems in the U.S., after a certain hour crisis and emergency calls go through our 911 system and law enforcement personnel respond to the call. In the pilot system, we intend to implement a two-pronged effort to improve the system’s response to off-hours crisis and emergency calls:

1. expansion of the availability of mental health staff for true 24-7 response to mental health crises, and
2. expansion of and increased access to the lower intensity end of the urgent care continuum (peer respite services, mental health urgent care centers and crisis residential services) to reduce utilization of emergency rooms, hospitals and the jail.

In stakeholder discussions with both law enforcement and fire department personnel, a great deal of frustration was expressed by first responders regarding the lack of alternatives to emergency rooms and involuntary hospitalization. To address this need, the pilot system proposes to fund 10 Peer Respite beds (up to 2-week stay), 10 crisis residential beds (up to 2-week stay), and 10 Behavioral Health Urgent Care “slots” (up to 23-hour stay). These services will undoubtedly reduce emergency service and acute inpatient utilization and also reduce the burden on law enforcement and EMT personnel.

But in addition to these new service functions, the pilot also intends to test a level of service that we are calling “comfort care.” Our current crisis response system tends to take a binary approach: The member in crisis has the option of either being hospitalized or evaluated as not needing hospitalization and therefore receiving no care whatsoever. First responders report many situations in which they respond to calls where the member is in a “grey” area where their condition is serious but not posing an immediate psychiatric or medical danger. In these situations, the member often refuses treatment, preferring not to be taken to a hospital emergency room for evaluation. The pilot intends to expand its outreach and engagement team to include a “street medicine” component which would enable the team to receive a “hand-off” from the EMTs to address non-emergency medical conditions and transport the member to a much more welcoming setting like an after-hours clinic, drop-in center, or peer respite program.

While the usual “default response level” to crisis calls will include only mental health staff, law enforcement and mental health staff will need to establish a system in which

they can agree on the criteria for determining those situations in which law enforcement personnel are needed for safety reasons. Procedures will need to be established that allow mental health staff and law enforcement staff to communicate quickly and seamlessly when the need for collaboration arises.

#### Addressing System Fragmentation: The System Concierge

Every mental health system is a complex collection of various specialized services. This has become even more true over time as the philosophy of treatment for people with severe and persistent mental illnesses has evolved away from simply treating the illness and chosen instead to address the individual's entire life, including their housing, vocational, social, legal and even spiritual goals. This ever-increasing complexity often has the unintended consequence of requiring participants to learn to navigate multiple systems and their various cultures and requirements. While this can be a daunting experience for anybody, for people with severe and persistent illnesses – who are also negatively impacted by the social determinants of health – it can be so discouraging that they either never engage with the system or they quickly give up trying to access our services.

Systems generally address this issue in two ways. First, as mentioned earlier, the health home with its focus on service coordination is critical in helping members to navigate our complex systems of care as well as helping them to access community resources. Second, to the extent possible, agencies and organizations have attempted to create “one-stop-shops” in which a variety of services (e.g., mental health, employment, housing) are available to minimize the number of different bureaucracies that the member must navigate to meet their needs. With its focus on health homes, service coordination and psychosocial rehab services, the pilot system will employ both of these approaches to maximize the possibility of successful engagement. But the pilot also intends to introduce and test a new service function designed to serve not only as a bridge between the different levels of care, but more importantly as a bridge between the non-urgent and urgent continuums of service. We refer to this function as the System Concierge.

The System Concierge is envisioned as having two roles: advocacy and monitoring. In its advocacy role, the System Concierge will serve as an “ombudsman” for members and other stakeholders – particularly family members – who might believe that their loved one is receiving inadequate attention or care. The intention is to create an independent third party to serve as an “honest broker” between the member/member's family and the program that has been assigned as the member's health home. In those cases where the individual has not accepted services and/or has not been assigned to a health home, the System Concierge will work with the system's outreach and

engagement team to make members and their families aware of the service options available to them and help them explore what might be the best service fit for them.

In its monitoring role, the System Concierge will be responsible for tracking all transitions between the non-urgent and urgent continuums of care. This is particularly important when members move from high-intensity inpatient or jail settings back into the community. Unless the member is already enrolled in an FSP with its more intensive follow up after hospital discharge, they often fail to follow through on an initial referral or re-connect with an already established community-based program. The System Concierge will therefore need to have access to all hospital admission and discharge data as well as all jail mental health booking and release data to ensure that participants are not falling through the cracks. Using these data, the System Concierge will be responsible for following up with members recently discharged from the hospital or released from jail to ensure that they are engaged with the system.

The system in Trieste is characterized by extremely open communication between staff and their clients' family members. The "default setting" on communication with family members in Trieste seems to be that it is okay unless the client specifically objects (i.e., opts out), whereas, the default setting in the U.S. is that communication cannot occur unless the client specifically allows it (i.e., opts in). Indeed, the Trieste staff seem mystified by our HIPAA regulations and couldn't imagine a system that was so limiting of their ability to communicate with the family of the person they were serving. Through the function of the System Concierge, the pilot intends to explore how our system can include family members more effectively and humanely in the service delivery process while still respecting the civil rights of the members being served.

### **INNOVATION E: Technology that supports documentation, accountability and payment reforms**

The Documentation/Accountability/Reimbursement system proposed in Innovations A – C will require a significant investment in technology to realize its potential to reduce the documentation burden on staff. We envision a HIPAA-compliant electronic health record that is accessible through a smart phone application. Staff will record not only their interactions with individual members but ALL the activities in their work.

For example, when the direct service staff leaves the facility to conduct an outreach visit to a homeless encampment, the staff will say "Begin drive to visit John Doe at homeless encampment." The application will then automatically record the amount of time that the staff spends on the road until the staff says, "Arrived at destination." When the staff actually begins the interaction with the member, s/he will simply say, "Talking with John Doe" and the system will record the amount of time spent with John Doe up until the time the staff says, "Concluding conversation with John Doe." The application will then report the amount of time spent in the interaction and will ask the staff to apportion the

time according to the quality of life domains discussed (Innovation A, component 1) and the type of service provided (Innovation A, component 2) during the interaction with the member.

Data will be entered into the EHR database either wirelessly or when staff return to the facility and dock their phone with the system.

It is expected that this voice-enabled system will reduce keyboard data entry by as much as 90% and thereby reduce the data entry time for staff by several orders of magnitude. It also has the benefit of being much more accurate and reliable in that it requires staff to enter their documentation on an ongoing, real-time basis.

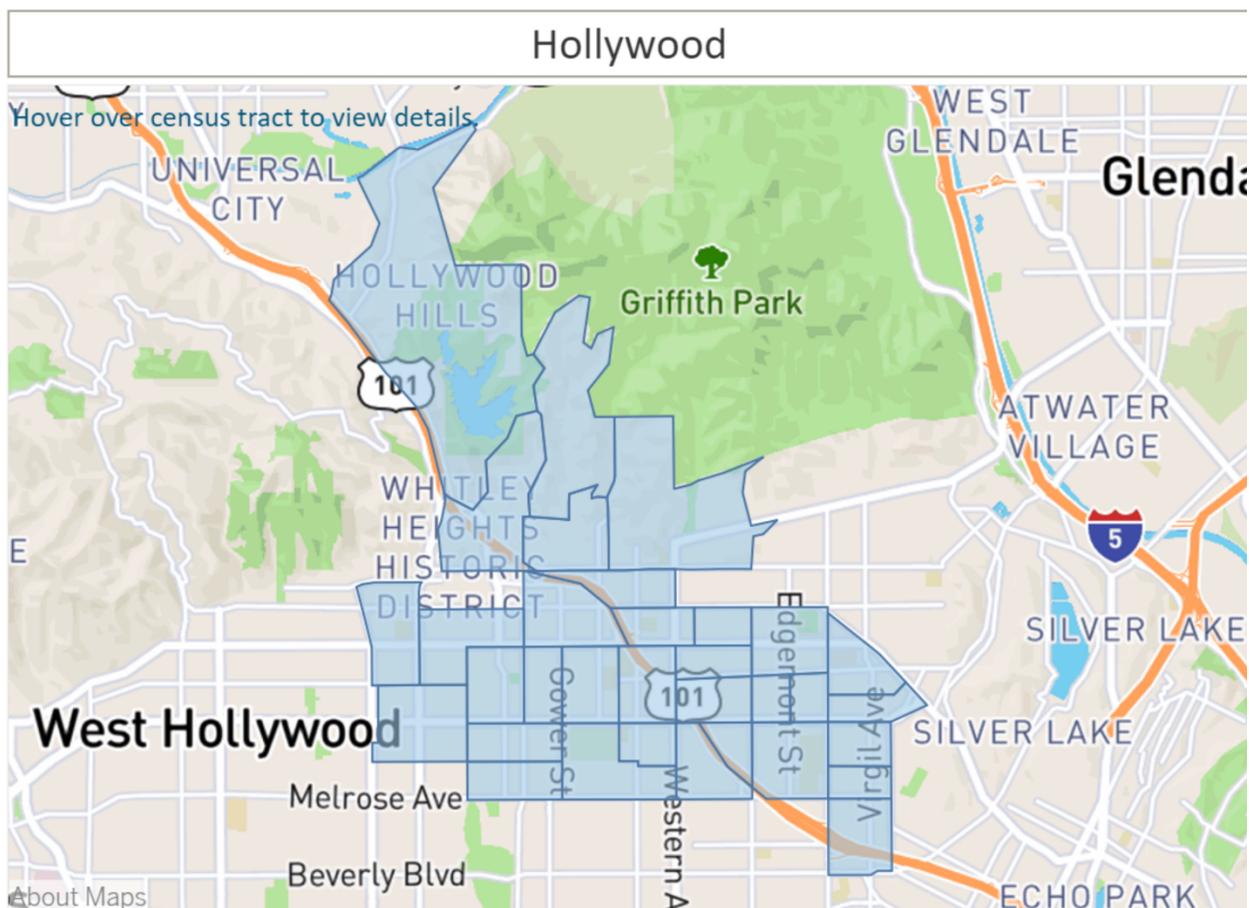
## **PROPOSED PILOT REGION AND POPULATION**

While our ultimate aim is to transform the entire Los Angeles County mental health system, this proposal will define a specific region and a specific population within that region to test the assumptions of the model and ultimately demonstrate proof of concept. To that end, the Hollywood area has been selected to serve as the geographic region for the pilot and the population will be defined as all individuals who meet the criteria for specialty mental health services. The population will include both individuals currently receiving mental health services as well as estimates of the homeless population who are not currently receiving mental health services but are likely to need mental health services and who are also already using other county and city services such as health and criminal justice at a greatly disproportionate rate.

### The Region

The “Hollywood region” will be defined (consistent with the Los Angeles Homeless Services Authority) as consisting of the following census tracts:

1893.00, 1894.00, 1895.00, 1896.00, 1897.01, 1901.00, 1903.01, 1905.10, 1905.20, 1908.01, 1908.02, 1909.01, 1909.02, 1911.10, 1911.20, 1912.03, 1912.04, 1913.01, 1913.02, 1914.10, 1914.20, 1915.00, 1916.10, 1916.20, 1917.10, 1917.20, 1918.10, 1918.20, 1919.01



The total population for these 28 census tracts is approximately 103,625 (2016 data). A map outlining these census tracts appears above.

### The Population

The service population will consist of (1) all individuals 18 years of age and older residing within the above-defined region who meet criteria for specialty mental health services, and (2) individuals 18 years of age and older who do not currently live within the above-defined region but have received mental health or substance use services from a County DMH directly-operated or contract provider between July 1, 2017 and June 30, 2018. As defined, this population will require estimates for the large numbers of homeless individuals living in the region who are likely to experience mental illnesses and/or substance use disorders.

## PROPOSED BUDGET and BUDGET NARRATIVE

### Introduction

L.A. County leadership realizes and acknowledges that The TRIESTE Project is an unusual innovation request. We are not proposing to implement an already defined new program or practice that will stand alone within the same old system. In essence, we are asking for innovation funding to temporarily replace the entire existing MHSA/Medicaid-based funding system within a specific geographic region to demonstrate how effectiveness and satisfaction can be improved when services are untethered from the current payment and documentation systems. These funds will allow us to engage the local community in a robust stakeholder process to determine what the community actually wants and needs and design a service system that will be more responsive to those needs.

However, because the system is not “pre-determined,” it is impossible to explicitly state the positions that will comprise the system and their full-time equivalencies. While there will certainly be social workers and psychiatrists, there is no way of knowing in advance how many there will be. Similarly, there are no job developer positions within the current pilot region, but if the system moves in the direction of providing supported employment services, then almost certainly these positions will come into existence. But it is impossible to estimate the FTEs until the stakeholder process takes place.

Because of this, our proposed budget makes some assumptions about allocations to certain categories. Our first assumption is that 65% of the budget of any mental health system will go to personnel costs, including both salaries and the employee benefit/tax burden package (e.g., health care benefits and employer’s tax burden). For the purposes of this budget, we have assumed that the benefit/tax burden package for employees is 40%. So, for example, a staff person earning \$50,000 per year would have a benefit/burden package of \$20,000 for a total compensation package of \$70,000. This is reflected under “direct costs” on line 2 of the attached budget.

Our second assumption is that our administrative overhead rate is 15% of the overall budget. This allocation appears in lines 3,6, and 12. We have allocated this cost in proportion to the expenditure to which the administrative overhead is attached. So, for example, 65% of the total administrative overhead for the system is allocated to personnel, because that is 65% of the overall budget.

While we believe that our allocations are well-grounded and reflect the realities of current mental health programs, should the TRIESTE project proposal be granted funding, we are also requesting that we be granted some flexibility in percentages we ultimately allocate to the different categories. Specifically, we would request a 10% variance (plus or minus) that would give us the authority to adjust allocations should the need arise. For example, if we discovered that our personnel costs were only 58% of our total budget, but our operating costs were higher by a comparable amount, we

<b>BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*</b>							
<b>EXPENDITURES</b>							
<b>PERSONNEL COSTS (salaries, wages, benefits)</b>		<b>FY 19/20</b>	<b>FY 20/21</b>	<b>FY 21/22</b>	<b>FY 22/23</b>	<b>FY 23/24</b>	<b>TOTAL</b>
1.	Salaries	535,700	10,260,000	10,260,000	10,260,000	10,260,000	41,575,700
2.	Direct Costs	214,300	4,105,000	4,105,000	4,105,000	4,105,000	16,634,300
3.	Indirect Costs	112,500	2,535,000	2,535,000	2,535,000	2,535,000	10,252,500
4.	Total Personnel Costs	862,500	16,900,000	16,900,000	16,900,000	16,900,000	68,462,500
<b>OPERATING COSTS</b>							
5.	Direct Costs	750,000	5,780,000	5,780,000	5,780,000	5,780,000	23,870,000
6.	Indirect Costs	112,500	1,020,000	1,020,000	1,020,000	1,020,000	4,192,500
7.	Total Operating Costs	862,500	6,800,000	6,800,000	6,800,000	6,800,000	28,062,500
<b>NON RECURRING COSTS (equipment, technology)</b>							
8.	Facilities/Tenant Improvements	4,000,000					4,000,000
9.	EHR/Comm System Integration	3,000,000					3,000,000
10.	Total Non-recurring costs	7,000,000					7,000,000
<b>CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)</b>							
11.	Direct Costs	2,500,000	2,000,000	2,000,000	2,000,000	2,000,000	10,500,000
12.	Indirect Costs	375,000	300,000	300,000	300,000	300,000	1,575,000
13.	Total Consultant Costs	2,875,000	2,300,000	2,300,000	2,300,000	2,300,000	12,075,000
<b>OTHER EXPENDITURES (please explain in budget narrative)</b>							
14.	Community Resource Dvlpmnt	250,000	225,000	225,000	225,000	225,000	1,150,000
15.							
16.	Total Other Expenditures	250,000	225,000	225,000	225,000	225,000	1,150,000
<b>BUDGET TOTALS</b>							
Personnel (line 1)		535,700	10,260,000	10,260,000	10,260,000	10,260,000	41,575,700
Direct Costs (add lines 2, 5 and 11 from above)		3,464,300	11,885,000	11,885,000	11,885,000	11,885,000	51,004,300
Indirect Costs (add lines 3, 6 and 12 from above)		600,000	3,855,000	3,855,000	3,855,000	3,855,000	16,020,000
Non-recurring costs (line 10)		7,000,000	0	0	0	0	7,000,000
Other Expenditures (line 16)		250,000	225,000	225,000	225,000	225,000	1,150,000
<b>TOTAL INNOVATION BUDGET</b>		<b>11,850,000</b>	<b>26,225,000</b>	<b>26,225,000</b>	<b>26,225,000</b>	<b>26,225,000</b>	<b>116,750,000</b>

Table 4

would request the ability to shift funds from one category to another as long as we did not exceed the overall budget amount.

Year One Budget (See Table 4 FY 19/20 above)

TOTAL: \$11,850,000

Because the first year of the pilot is essentially a planning year, it is necessary to provide a separate narrative for year 1 and another narrative for years two through five when the new system is in place and the services are being provided.

The year one budget focuses on “building the infrastructure” that will be needed to provide the facilities and equipment for staff to provide services under the new model. To that end, \$4,000,000 is allocated for the renovation and improvement of facilities intended to provide four new services not currently offered: a 16-bed transitional residence, a 10-bed peer respite service, a 10-bed crisis residential service, and a 10-slot urgent care center.

It is important to point out that these funds will not be used for the purchase or construction of new facilities; they will be used only for tenant improvements on existing properties that will allow the use of the properties for the intended programs.

Similarly, \$3,000,000 is allocated for the design and creation of 1) a new electronic health record (EHR) system that will support the new payment, documentation, and accountability systems, and 2) a communication system that allows the integration of police and fire first responder units with the mental health system to improve crisis response.

The first-year budget also includes \$2,500,000 for consultation in a wide variety of domains. With the shift from a more medical model to a more psychosocial model, we will be seeking consultation from experts in the following areas:

Overall Coordination/Project Oversight	200,000
Housing	150,000
Community Integration	100,000
Employment	100,000
Performance Measurement	50,000
Legal	200,000
Stakeholder Process Facilitation	200,000
Communication	100,000
Training	650,000
Evaluation	750,000

Table 5

As an example, in all likelihood we will need legal consultation regarding the seeking of waivers from the California Department of Health Care Services to allow us to receive innovation funds instead of Medicaid funds for services that we provide to Medicaid beneficiaries. We have also allocated \$200,000 for an outside facilitator to design and lead the overall stakeholder process.

We have allocated \$650,000 for the extensive training that we will offer during the first year of the project. Staff will receive training on the use of the new EHR and the new performance measures and how to employ and document them. We also intend to provide specific training in certain evidence-based psychosocial practices such as Individual Placement and Support (IPS) and other practices that will shift the culture toward a more well-being focused approach. We also intend to include trainings for the general community to reduce stigma and increase buy-in.

In year one we are allocating \$750,000 for the design and set up of the evaluation that will take place over the 5 years of the pilot project.

We are also allocating \$250,000 for community resource development that will allow us to incentivize faith organizations and businesses to offer opportunities that are welcoming and inviting to our members and staff and thereby build buy-in from the community.

Years Two through Five Budget Narrative (See Table 4 above FYs 20/21-23/24)

TOTAL: \$104,900,000 (\$26,225,000 per year for four years)

The budgets for years two through five reflect the relative completion of the stakeholder design process and movement toward the delivery of services. Therefore, the largest expenditure during this period is for staffing, which totals \$67,600,000 over the four-year period (\$16,900,00 per year). (As stated in the introduction, our assumption is the 65% of the budget will be allocated to personnel expenses.

The second largest expense during years two through five is for operating costs, which total \$27,200,000 (\$6,800,000 per year).

Consultant costs diminish significantly during years two through five, although we still anticipate a total cost of \$2,000,000 per year in this category. The major areas of consulting we anticipate are:

Overall Coordination/Project Oversight	200,000
Housing	150,000
Community Integration	75,000
Employment	75,000
Training	500,000
Evaluation	1,000,000

Table 6

Finally, as in year one we are allocating \$225,000 for community resource development that will allow us to continue to incentivize faith organizations and businesses to offer opportunities that are welcoming and inviting to our members and staff and thereby build buy-in from the community.

Table 7 below reflects the levels of funding that are allocated for administration (\$15.7m) and outside evaluation services (\$4.75m) over the life of the project.

<b>BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)</b>							
<b>ADMINISTRATION:</b>							
<b>A.</b>	<b>Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY &amp; the following funding sources:</b>	<b>FY 19/20</b>	<b>FY 20/21</b>	<b>FY 21/22</b>	<b>FY 22/23</b>	<b>FY 23/24</b>	<b>TOTAL</b>
1.	Innovative MHSAs Funds	390,000	3,675,000	3,675,000	3,675,000	3,675,000	15,700,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
<b>6.</b>	<b>Total Proposed Administration</b>	<b>390,000</b>	<b>3,675,000</b>	<b>3,675,000</b>	<b>3,675,000</b>	<b>3,675,000</b>	<b>15,700,000</b>
<b>EVALUATION:</b>							
<b>B.</b>	<b>Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY &amp; the following funding sources:</b>	<b>FY 19/20</b>	<b>FY 20/21</b>	<b>FY 21/22</b>	<b>FY 22/23</b>	<b>FY 23/24</b>	<b>TOTAL</b>
1.	Innovative MHSAs Funds	750,000	1,000,000	1,000,000	1,000,000	1,000,000	4,750,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
<b>6.</b>	<b>Total Proposed Evaluation</b>	<b>750,000</b>	<b>1,000,000</b>	<b>1,000,000</b>	<b>1,000,000</b>	<b>1,000,000</b>	<b>4,750,000</b>
<b>TOTAL:</b>							
<b>C.</b>	<b>Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY &amp; the following funding sources:</b>	<b>FY 19/20</b>	<b>FY 20/21</b>	<b>FY 21/22</b>	<b>FY 22/23</b>	<b>FY 23/24</b>	<b>TOTAL</b>
1.	Innovative MHSAs Funds	11,850,000	26,225,000	26,225,000	26,225,000	26,225,000	116,750,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
<b>6.</b>	<b>Total Proposed Expenditures</b>	<b>11,850,000</b>	<b>26,225,000</b>	<b>26,225,000</b>	<b>26,225,000</b>	<b>26,225,000</b>	<b>116,750,000</b>

Table 7

## Budget Summary

The overall cost of this innovation proposal comes to \$116,750,000, of which \$4,750,000 is for the cost of the evaluation. Therefore, the five-year total cost of the system design and service package, excluding the evaluation, is \$112,000,000.

## **EVALUATION**

### Methods

A university-based evaluator will be engaged to independently assess and report on the outcomes of the project. Although it is impossible to conduct an evaluation with random assignment to treatment and comparison conditions, we will do the next best thing. We intend to compare the results and outcomes achieved with the target population in the defined pilot region with a demographically and fiscally similar comparison region and population within Los Angeles County. Using data provided by the CAO's office and the Department of Mental Health, one of the first tasks of the independent evaluator will be to define this comparison population and region. Once defined, we intend to survey and track the population in the comparison region using the same instruments and indicators that will be used with the pilot population (see below). Over the intended four-year duration of the pilot study, we will be able to observe and evaluate three broad questions:

- 1) Are the lives of the people served by the innovation pilot (members) significantly improved over time across the variety of measures and indicators,
- 2) Are the outcomes within the pilot population significantly better or worse than the outcomes in the comparison population, and
- 3) Are the costs of providing services to the pilot population greater or less than the cost of services provided to the comparison population?

### Intended Outcomes

The intended outcomes of the pilot fall into seven broad categories:

- 1) Improved Quality of Life
- 2) Reduction in Adverse Events
- 3) Improved Functional Status
- 4) Improved Member Satisfaction with Care
- 5) Improved Staff Job Satisfaction
- 6) Improved Family and Larger Community Satisfaction
- 7) Reductions in the Overall Cost of Care

The indicators for each of these outcome domains will be described below.

## Quality of Life Indicators

In keeping with the goals of helping our members to find PURPOSE and LOVE & BELONGING, quality of life indicators will be an important feature of the evaluation. As described in Innovation C, we intend to use the Key Event Tracking System (KETS) already in use in Los Angeles County and across the state. The two quality of life domains tracked by the KETS that are particularly relevant for our purposes are the Employment and Education domains, which allow us to evaluate our ability to help our members find PURPOSE in their lives. Upon entry into the program/study, all members are administered the KETS and their baseline employment and education statuses for the year prior to enrollment are recorded. While in services, any changes to their employment or education statuses are recorded in real time. These data will give us real-time access to the effectiveness of our services and will allow us to judge our effectiveness over time.

The Milestones of Recovery Scale (MORS) will be the major outcome measure used to evaluate our ability to help members find LOVE & BELONGING. While it is a broad measure of “recovery,” there is a very significant component of social connectedness and belonging within the MORS and we anticipate seeing improvements in MORS scores as social connectedness improves. However, we also intend to implement a self-report measure that will provide information from the member’s perspective on whether their needs for social connection, love and intimacy are being met. While there are many instruments that purport to measure this, we believe the determination of the specific instrument should be part of the stakeholder process that will occur in the year prior to the actual implementation of services.

Expected results: We anticipate an average 1.5 points-per-year increase in the MORS score across the pilot population vs. an average .75 points-per-year increase across the comparison population.

## Adverse Event Indicators

The three primary indicators of adverse events that the pilot will track are:

- 1) emergency room utilization rates,
- 2) hospitalization rates, and
- 3) incarceration rates.

As in the case of employment and education, upon entry into the program, a member’s prior year history of use of the emergency room, hospitals and jails and prison are recorded in the KETS. While in services, any use of the emergency room, hospitals or incarcerations in jail or prison are recorded in real time. These data will give us real-

time access to the effectiveness of our services and will allow us to judge our effectiveness over time in reducing these adverse events.

Expected results: We anticipate a 30% reduction in the rate of emergency room visits and hospitalization admissions and days across the pilot population vs. no change in the rates for people served in the comparison group. We also anticipate a 50% reduction in the rate of incarceration days for people served in the pilot vs. people served in the comparison group.

### Functional Status Indicators

The primary indicator for the outcome improved functional status will be the Determinants of Care (See Innovation C). The determinants are structured as a binary choice for the staff person to assess whether the member is self-coordinating or needs support in the following domains:

1. Managing medications
2. Managing money
3. Managing public transportation
4. Managing community relations (e.g., landlords, neighbors)
5. Managing activities of daily living (e.g., housekeeping, meal preparation, shopping)

The Determinants are assessed at baseline upon entry into the program and thereafter on a monthly basis. This will allow the pilot to determine its success in helping its members to become more self-coordinating over time.

Expected results: We anticipate a 10% increase per year in the number of members in the pilot who become self-coordinating in any one of the five functional domains vs. the number of members in the comparison group who become self-coordinating.

### Member Perception of and Satisfaction with Care Indicators

While there are many consumer and member satisfaction surveys available, we believe that it is essential that we seek stakeholder input to determine the actual instrument we will use. Fundamentally, at a minimum, the instrument selected/created should be able to capture the member's level of agreement with the following three statements:

- 1) I feel welcomed and respected by staff.
- 2) I am satisfied with my role in making decisions about my care.
- 3) I have the opportunity to involve family or other natural supports in my services.

The measure will be administered every 6 months after the member's admission to the program. To increase response rate, it will be available both in paper version as well as on-line.

Expected results: Members of the pilot population will be statistically significantly more satisfied than members of the comparison population.

#### Staff Job Satisfaction Indicators

As with member satisfaction with care surveys, there are many staff job satisfaction surveys available. As with members, we feel it is extremely important that we seek stakeholder (i.e., staff) input to determine the actual instrument we will use.

Fundamentally, the instrument selected/created should embody and reflect the level of staff endorsement of the following four characteristics:

- 1) Do our staff feel HOPEFUL and understand how our vision and mission resonate with their own personal values?
- 2) Do our staff ENGAGE WITH THE COMMUNITY in ways that support meaningful community roles for members and themselves?
- 3) Do our staff feel EMPOWERED to take responsibility and encourage risk-taking among their members?
- 4) Do our staff feel that they are part of the HEALING process and that they can use their own passions and valuable life experiences to the benefit of their members?

The measure will be administered to all staff on a yearly basis. The results will be used to provide feedback to management staff on an ongoing basis to identify when staff morale is low and provide insight as to how it might be improved.

Expected results: Staff in pilot will be statistically significantly more satisfied than staff serving members of the comparison population.

#### Family and Larger Community Satisfaction Indicators

To our knowledge, there are few if any standardized measures of family satisfaction with care. As with member and staff satisfaction, we believe that it is essential that we seek stakeholder input to determine the actual instrument we will use to measure family satisfaction with care. Fundamentally, at a minimum, the instrument selected/created should be able to capture the family member's level of agreement with the following three statements:

- 1) I feel welcomed and respected by the staff who are treating my loved one/family member.
- 2) I am satisfied and comfortable with my role in providing input and feedback to the staff member(s) providing care for my loved/on family member.

- 3) I have adequate opportunities to be involved in the provision of care and natural supports for my loved one/family member.

The measure will be available to self-identified family members of the pilot and comparison populations on an annual basis. The results will be used to provide feedback to both direct service and management staff on an ongoing basis to identify when family morale is low and provide insight as to how it might be improved.

Expected results: Family members of people being served in the pilot will be statistically significantly more satisfied than family members of the comparison population.

Similar to the measurement of family satisfaction, to our knowledge there are no measures of the larger community's general level of satisfaction with the mental health system. It is our belief that much of the NIMBY reaction of communities reflects a failure on our part to meaningfully engage with the concerns of the larger community and educate them about our goals and mission.

Therefore, we will engage the larger community of the pilot region in a robust stakeholder discussion about their needs and concerns in an effort to create a standardized survey that will allow us to evaluate our ability to address those concerns.

Expected results: Community members living in the pilot region will be statistically significantly more satisfied with their local mental health system than community members living in the comparison region.

#### Overall Cost of Care Indicators

The independent evaluator will have access to the cost data for all people served in both the pilot population and the comparison population. These data include not only the cost of outpatient mental health services, but also the cost of physical healthcare services, substance abuse prevention services, emergency room services, hospital services and jail and prison services. We anticipate that it will be a relatively straightforward process to compare the overall cost of services provided to the pilot population vs. the comparison population.

Expected results: If the pilot is successful in its goals, we should see significant reductions in the overall cost of services vs. the comparison population, even if we see slight increases in the costs of some services (such as psychosocial rehabilitation services, crisis residential services or urgent care).

#### Assessing Ongoing Sustainability

The County anticipates that the pilot will be wildly successful in improving effectiveness, improving satisfaction and reducing costs as described above. However, at a minimum,

the requirement for continuation of the pilot beyond the innovation period (4 years) only requires marginal improvement in outcomes at no increase in overall cost of services. The most difficult potential judgment for continuation beyond the innovation period will be if we are able to achieve significant improvement in outcomes with an attendant slight to moderate rise in the overall cost of services – a result that could occur if we are unable to lower the rate of adverse events such as hospitalization and incarceration. If that were to happen, a judgment would have to be made as to whether the level of improvement in the outcomes justifies the increased level of cost. Assuming positive outcomes from the pilot, the County will make the services an ongoing part of its annual request for MHSA CSS funds and anticipates drawing down matching FFP to serve as the main source of funding in the future.

## **Proposed Timeline for Implementation – First 20 Months**

### November, 2018

- Initial draft of concept paper completed

### December, 2018

- Determination of the geographic boundaries of the pilot

### March, 2019

- “Final” draft of concept paper completed
- Determination of the precise population to be served and initiation of economic analysis of current county expenditures for the population
- Expanded stakeholder process to vet concept paper begins
- Submission of concept paper to MHSOAC

### April, 2019

- Initial presentation to members of the MHSOAC

### May, 2019

- Submission of full proposal for five-year innovation grant to the MHSOAC with expectation that grant will be awarded to begin effective July 1, 2019 through June 30, 2024.
- Initial discussions/negotiations with potential independent evaluators to determine scope and cost of the evaluation
- Initial discussions/negotiations with potential EHR vendors to determine scope and cost of the new EHR.
- MHSOAC officially awards Innovation Grant (MH Month!)

### July 1, 2019 – June 30, 2020

- Securing all necessary regulatory waivers
- Expanded stakeholder process to determine scope and implementation of services
- Selection of independent evaluator and implementation of evaluation protocols
- Selection of EHR vendor and implementation of system
- Initial training of staff on all data collection and accountability systems

### July 1, 2020

- Doors open and services begin under the pilot project.

## Appendix 1

### Recovery-Oriented Service Categories

1. **Welcoming / engagement** – connecting the member with staff, program and peers, relationship building, demonstrating our “usefulness” to the member, engaging in collaborative goal setting, shared decision making, connecting with the member through self-disclosure
2. **Crisis interventions / Responding to basic safety needs and community expulsion threats** – accessing, collaborating with and/or diverting from hospitals and jails, advocating with the legal system to prevent incarceration, locating, placing in and/or paying for emergency shelter to prevent homelessness, safety interventions – medical, substance abuse harm reduction and prevention, responding to threats of dangerousness, suicidality, and impending harm (e.g., domestic violence)
3. **Assessments and planning** – assessing goals and needs, understanding their view of themselves, mental health status assessment, Quality of Life assessment, co-occurring conditions (e.g., medical, substance abuse, developmental disability), “eligibility” determinations (voc rehab, disabled students, SSI, bus passes), fitness determinations (legal competence, child custody and driver’s license)
4. **Building and maintaining the safety net / “protective factors”** - assisting in obtaining benefits and entitlements, connecting to poverty services (e.g., COA food bank, multi-service center), charity (e.g., bus tokens, food, clothes, toiletries), safe and secure housing, family connections, assisting in obtaining basic documentation (e.g., ID, birth certificate), connecting to basic social services (DPSS, SSA), connecting to cultural connections, (Native American services, UCC), connecting to spiritual strength and security (faith community)
5. **Motivating / Engaging in growth-oriented activities** – engaging in motivational interviewing, outreaching to isolated members, exposure to opportunities (e.g., plays, sports, dances, hobbies, job fairs, schools), exploration of possibilities for the future, career exploration, core gift activities, goal visualizing, peer bridging
6. **Promoting mental wellness and treating mental illnesses and substance abuse disorders to reduce barriers** – helping members to gain control over

their mental illness, helping members to identify and control their symptoms (e.g., WRAP), 12-step step work, medication services, providing psychotherapy, building emotional coping skills (e.g., CBT, coping with past traumas, anger management, relationship skills), building wellness skills (e.g., meditation, eating and sleeping routines, yoga), treatment of acute symptoms and relapses

7. **Promoting physical wellness and treating physical illnesses** – providing basic wound care, monitoring and treating chronic physical illnesses (e.g., diabetes, hypertension, chronic pain), medication management for physical illness medications, seizure response, physical illness education (e.g., diabetes, hepatitis), smoking cessation, promoting physical wellness (e.g., exercise and nutrition), pregnancy counseling, safe sex counseling
8. **Providing and building support** – connecting to resources (e.g., job development, educational) and community resources ( Faith-based Community Center, Gay and Lesbian Center, primary care provider, 12-step support groups, warm lines), connecting to social services (e.g., In Home Supportive Services, Family Preservation), participating together in community activities and opportunities (“giving moral support”), helping families to support members (e.g., family education, consultation, problem solving), providing help directly (e.g., “doing it for them,” adding structure to their lives, making decisions for them, “caretaking”)
9. **Rehabilitation / Skill building** – teaching, job coaching, supported models (employment, education, housing), in-vivo teaching, providing work experience, teaching self-help skills (e.g., budgeting, shopping, laundry, hygiene, medication management), helping the member to build and practice meaningful roles
10. **Building personal growth and responsibility** – helping members understand and move through normal stages of life (e.g., prolonged adolescence, first parenting, mid-life crisis, empty nest syndrome), building self- responsibility (learning cause and effect, not blaming others), building self- efficacy (building the ability to positively impact one’s life), empowering members
11. **Community integration** – developing and facilitating members’ connections beyond mental health and social services (taking a member to a Mommy and Me group, helping a member to join a bowling league, creating a calendar of low-cost community events), helping member to discover niches, roles, and opportunities in the community, promoting being a good neighbor and citizen, helping member

to invest in and give to community in positive ways, helping the member to learn to give to others

12. **Community development** – making the community a better place for people with mental illnesses, increasing tolerance and acceptance of mental illness, reducing segregation, reducing stigma, developing welcoming hearts in the community, building connections with other community social causes

13. **Promoting self-reliance, separation from services, and graduation** – building financial independence (getting off SSI and Section 8), obtaining private insurance, preparing for graduation, facilitating relationship changes with staff, finding and providing opportunities to give back to others still struggling, developing self-advocacy skills, developing friendship skills

# Appendix 2

## Milestones of Recovery Scale

CLIENT NAME:

MIS#:

PRINT DATE:

RATING PROCESS:  TEAM CONSENSUS  INDIVIDUAL RATER (NAME:

) RATING DATE:

### MILESTONES OF RECOVERY SCALE

Please circle the number that best describes the current (typical for the last month) milestone of recovery for the member listed above. If you have not had any contact (face-to-face or phone) with the member in the last month, please check here  and do not attempt to rate the member. Just return the form along with your completed assessments.

1. **“Extreme risk”** – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.
2. **“Experiencing high risk/not engaged with mental health provider(s)”** – These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.
3. **“Experiencing high risk/engaged with mental health provider(s)”** – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.
4. **“Not coping successfully/not engaged with mental health provider(s)”** – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.
5. **“Not coping successfully/engaged with mental health provider(s)”** – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.
6. **“Coping successfully/rehabilitating”** – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing “non-disabled” roles. They often need substantial support and guidance but they aren’t necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be “testing the employment or education waters,” but this group also includes individuals who have “retired.” That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.
7. **“Early Recovery”** – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.
8. **“Advanced Recovery”** – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbors.

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There is no ongoing per administration fee for the use of the Milestones of Recovery Scale. However, all scale users must receive training from a Licensed MORS Trainer PRIOR to use. If you are interested in using the MORS, please contact MHALA ([mors@mhala.org](mailto:mors@mhala.org)).

## Appendix 3

### CURRENT SERVICE UTILIZATION AND FINANCIAL ANALYSIS METHODOLOGY

## Producing A Hollywood Baseline County Cost Estimate

The Trieste pilot proposal will draw on analysis conducted by the Clinical Informatics Division within Los Angeles County’s Department of Mental Health (CID/DMH) and the Research and Evaluation Services unit within the County’s Chief Executive Office (RES/CEO). The analysis will produce 12-month (FY 2017-18) estimates of DMH direct services expenditures, as well as similar direct services spending through four additional Los Angeles County agencies: The Departments of Health Services (DHS), Public Health (DPH), Probation and the Sheriff (LASD). Specifically, these estimates will encompass County service use patterns and frequencies observed for adults using DMH service facilities within Hollywood, California census tracts. These estimates, which are referred to in this discussion as *the Hollywood Estimate*, will establish a comparative reference point against which costs associated with the proposed Trieste pilot can be gauged.

The Direct Services Cost Components of the Countywide and Hollywood Estimates for FY 2017-18*	
Agency	Direct Services Costs
DHS	Outpatient, Emergency, Inpatient Treatment
DMH	Outpatient, Crisis Stabilization, Acute Inpatient, Residential Treatment
DPH	Outpatient, Detox, Maintenance and Residential Treatment through SAPC
LASD	Booking Fees, Jail Bed Days, and services provided through the Jail Ward+
Probation (Adult)	Probation Supervision for Adult Felons and AB 109ers**

\*In this context, *direct services costs* are simply the cost of services provided directly to individual clients and are not inclusive of administrative overhead or aggregated programmatic costs, estimated proportional distributions of which must be subjected to complex *pro rata* adjustments and assumptions, which are not necessary until they are compared against the pilot group and other populations.

+ The Sheriff’s records currently available for these estimates do not include medical and mental health services provided to inmates, except for hospital treatment episodes, which occur through the Jail Ward. Since 2015, medical encounters and episodes in the County’s jail system have been administered by DHS’s Correction Health division. Utilization data for Correctional Health may be available for analyses that are conducted after the preparation of initial cost estimates.

Showing FY 2017-18 Estimates from Multiple Points of View	
<b>Total Costs</b>	\$DHS + \$DMH + \$DPH + \$LASD + \$Probation
<b>By Agency</b>	\$DHS    \$DMH    \$DPH    \$LASD    Probation
<b>Per capita Overall</b>	Total Cost / De-duplicated Total Clients
<b>Per capita, by Agency</b>	\$DHS / DHS Patients \$DMH / DMH Patients \$SAPC/SAPC Patients \$LASD Jail + Booking /LASD Arrestees \$Adult Probation /Adult Probationers
<b>By Service Domain</b>	Health: \$DHS+\$DMH+\$DPH/SAPC Mental Health: \$DHS Psych + \$DMH Justice: \$LASD + \$Probation
<b>Per Capita, by Service Domain</b>	Health: \$DHS+\$DMH+\$DPH /Unique Patients

### Varied Cost Perspectives

The 12-month Cost Estimates will be shown from several perspectives: (A) *Combined* expenditures across the five agencies; (B) *by agency*; (C) *Per capita* across the five agencies; (D) *Per capita, by agency*; (E) *combined within service domains*; (F) *per capita* within service domains. Expenditures can also be shown by demographic characteristics and other person-level factors, e.g. homelessness, justice involvement, specialty mental health service use, high-cost service use, etc.<sup>1</sup>

<sup>1</sup> The initial analysis prepared by DMH and CEO will not parse the Hollywood Estimate by the portions that are revenue-driven and those that are Net County Cost (NCC), which are expenditures charged against the County’s General Fund.

Mental Health: \$DHS Psych + \$DMH /unique Pts  
 Justice: \$LASD + \$Probation / Unique Offenders

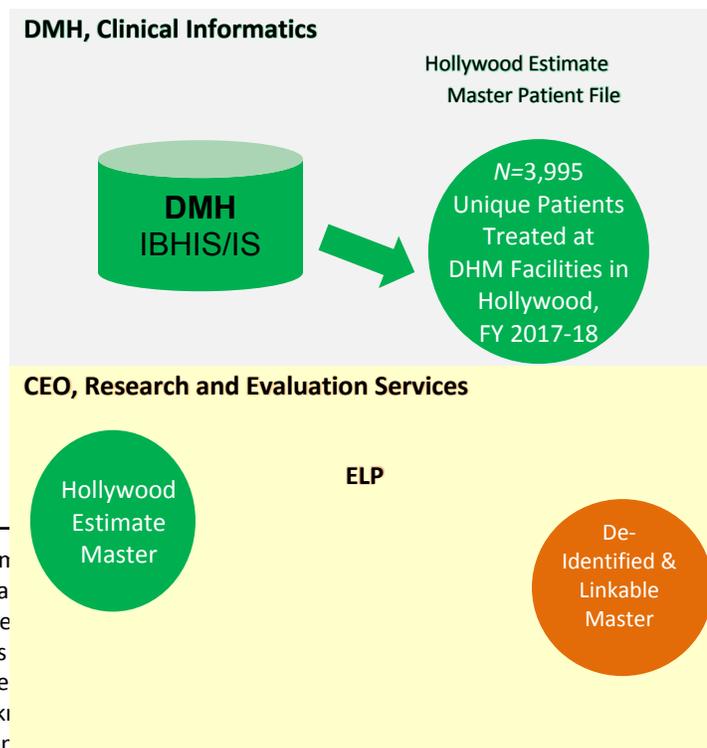
**Los Angeles County’s Integrated Data System**

Observed Service use patterns among patients and clients receiving services through four of the agencies included in the Hollywood Estimate - DHS, DPH/SAPC, LASD and Probation will come the CEO’s Enterprise Linkages Project (ELP), which is an Integrated Data System administered by RES since 2007.<sup>2</sup> ELP applies an algorithmic set of procedures to the data shared from agencies participating in the system’s master agreement, which at once anonymize the sensitive elements in the administrative records and assign the associated clients a unique client-level identifier. These anonymous person-level identifiers can be linked and de-duplicated across agencies and *within* the same agency, which enables persons to be tracked in their encounters with agencies across service disciplines.

Eight of the nine agencies sharing data with the CEO are County Departments, the five noted above along with the Departments of Children and Family Services (DCFS), Public Social Services (DPSS), and Workforce Development, Aging and Community Services (WDACS). Additionally, the CEO has access to the Homeless Management Information System (HMIS) for the Greater Los Angeles Continuum of Care (GLA CoC). The HMIS data is shared with the CEO through a separate Data Use Agreement (DUA) with the Los Angeles Homeless Services Authority (LAHSA), which permits these records to be processed using the same algorithmic application that anonymizes records from the other eight County departments participating in the ELP data sharing arrangement and, in doing so, enables the County and HMIS data to be linked at the client level. The anonymization of these records from various systems allows the linkages across service disciplines to remain in conformity with privacy and confidentiality protocols and statutes.

**DMH’s Master Cohort File**

DMH’s Clinical Informatics Division has assembled a master Cohort file of all adults with records of receiving treatment and services through Departmental facilities located within the geographic boundaries of Hollywood during 2017-18. The patient cohort was derived based on claims data extracted from DMH’s Integrated Behavioral Health System (IBHIS) and, to a lesser extent, its legacy IS system. The file



Within the County’s Health Services delivery system recoverable from the State. Within the justice domain The distinction is important insofar as, everything e maximizing net revenues is essentially the County’s will necessitate a deeper understanding of what the

<sup>2</sup> From 2007 to 2010, the pilot version of ELP was k ELP in November 2010. At present, ELP is transitor expected that the ‘modernized’ ELP will feature a significantly expanded array of data elements from all agencies participating in the ELP master agreement, of which DMH is one of the most critical.

contains basic Personally Identifiable Information (Name, DOB, SSN, Address, Basic Demographics, and the IBHS system identifier.

The cohort includes any DMH client who received at least 1 billable outpatient service at any of the designated service delivery programs within the Hollywood catchment area during fiscal year 2017-2018.



The following provider sites were identified for inclusion in defining the study cohort:

- LACDMH Directly Operated
  - o 1909 HOLLYWOOD MENTAL HEALTH CENTER
  - o 7739 HOLLYWOOD MHC WELLNESS CENTER
  - o 7771 HOLLYWOOD MHC FSP PROGRAM
  - o 7784 AMERICAN INDIAN COUNSELING CTR FSP
- LACDMH Contracted
  - o 7106 LA GAY/LESBIAN COMM SVC CENTER
  - o 7521 BHS HOLLYWOOD RECOVERY CENTER
  - o 7805 STEP UP HOLLYWOOD
  - o 7828 THE SABAN FREE CLINIC

A total of **3995<sup>3</sup>** distinct clients were identified for inclusion in the study population. The following distribution shows the included service programs through which cohort clients received FY1718 services. Within the cohort, 129 clients received services from more than one of the included service programs.

Service Program	Cohort Clients Seen
1909 HOLLYWOOD MENTAL HEALTH CENTER	3109
7739 HOLLYWOOD MHC WELLNESS CENTER	286
7771 HOLLYWOOD MHC FSP PROGRAM	141
7784 AMERICAN INDIAN COUNSELING CTR FSP	38
7106 LA GAY/LESBIAN COMM SVC CENTER	206
7521 BHS HOLLYWOOD RECOVERY CENTER	108
7805 STEP UP HOLLYWOOD	168

<sup>3</sup> For a number of reasons, including the need to draw data from both IBHIS and the IS and the erroneous creation of a new DMH Client ID by registration staff, a given “individual” may have received services that were submitted under 2 (or more) DMH Client ID’s. To adjust for this, a statistical matching algorithm was used to link such ID’s under a single common unique study ID. All analyses use this unique study ID to reconcile data associated to unique clients.

### **Mental Health Service Utilization and Cost Data**

LACDMH Outpatient and Crisis Stabilization service information was based on FY1718 claims data processed by LACDMH as of 1/14/2019 and drew from both the legacy IS (Integrated System) and IBHIS (the Integrated Behavioral Health Information System). LACDMH inpatient and other 24-Hour Residential utilization and cost data was derived, depending on the given facility, from IBHIS claims data, from IS episode data, or from IBHIS episode data. Because much of the inpatient and residential care is not reimbursed through claims transactions per se (i.e., rather are billed via invoice or are authorized by LACDMH then paid directly to the facility by the State) cost associated to episodic data was derived by determining the length of stay and multiplying by the daily rate for each facility<sup>4</sup>.

### **Other Health-Related Service Utilization and Cost Data**

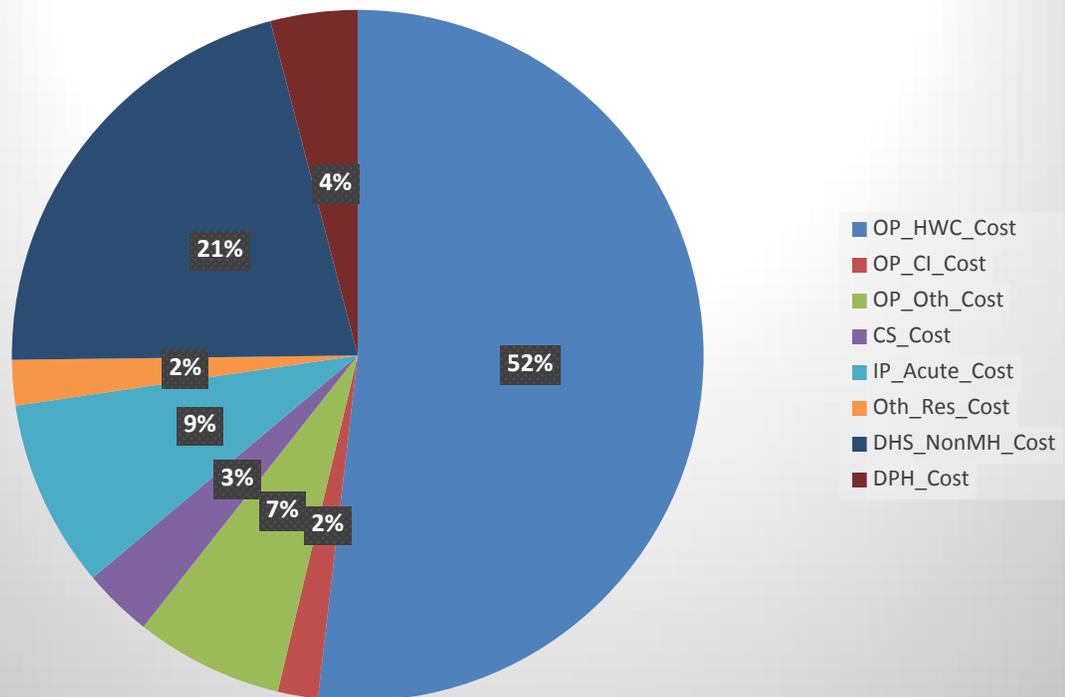
In addition, the Office of Clinical Informatics securely transferred a file identifying the cohort to the CEO/CIO Service Integration Branch so that it could be linked to FY1718 cost data from the Department of Health Services (DHS) and the Department of Public Health (DPH). Data from DHS excluded those costs associated to their Psychiatric Emergency Services (PES) and the psychiatric inpatient units to avoid double counting costs already captured in the DMH data.

### **Cost Categories**

<b>Category</b>	<b>Description</b>
<b><i>OP_HWC_Cost</i></b>	Outpatient services received through any of the "included" Hollywood programs
<b><i>OP_CI_Cost</i></b>	Outpatient Crisis Intervention services received through a non-included MH program (the majority of these were through DMH PMRT or LET programs)
<b><i>OP_Oth_Cost</i></b>	All other outpatient services received through a non-included MH program
<b><i>CS_Cost</i></b>	Crisis Stabilization through a Psychiatric ER or Psychiatric UCC
<b><i>IP_Acute_Cost</i></b>	Acute psychiatric Inpatient services
<b><i>Oth_Res_Cost</i></b>	All other residential MH services
<b><i>DHS_NonMH_Cost</i></b>	DHS service costs excluding DHS psychiatric services
<b><i>DPH_Cost</i></b>	DPH Substance Abuse Prevention and Control (SAPC) services

<sup>4</sup> When episodes overlapped the beginning or end of the study period an adjusted LOS was derived so as not to count costs outside of the study period. Similarly, a facility-type Average Length of Stay (ALOS) was used when it appeared that there was a spurious omission of an inpatient discharge date.

## Trieste/Hollywood Cohort FY1718 Cost by Category



Cohort Costs, by Service and, by Service Types and Categories						
Category	Number of Clients with Cost	Total FY1718 Cost	Minimum	Max	Mean among those with these services	Mean of cost across study cohort
<u>OP_HWC_Cost</u>	3995	\$14,127,571.11	\$2.47	\$120,893.73	\$3,536.31	\$3,536.31
<u>OP_CI_Cost</u>	214	\$547,456.16	\$133.76	\$29,218.08	\$2,558.21	\$137.04
<u>OP_Oth_Cost</u>	422	\$1,848,191.14	\$2.88	\$67,292.06	\$4,379.60	\$462.63
<u>CS_Cost</u>	493	\$885,252.41	\$120.00	\$25,776.68	\$1,795.64	\$221.59
<u>IP_Acute_Cost</u>	228	\$2,396,447.31	\$660.00	\$120,120.00	\$10,510.73	\$599.86
<u>Oth_Res_Cost</u>	33	\$578,208.79	\$354.01	\$98,441.82	\$17,521.48	\$144.73
<u>DHS_NonMH_Cost</u>	448	\$5,758,260.06	\$491.64	\$562,951.26	\$12,853.26	\$1,441.37
<u>DPH_Cost</u>	143	\$1,109,094.46	\$30.00	\$57,591.97	\$7,755.91	\$277.62
<b>TOTAL</b>	<b>3995</b>	<b>\$27,250,481.44</b>	<b>\$2.47</b>	<b>\$635,624.01</b>	<b>\$6,821.15</b>	<b>\$6,821.15</b>

### Establishment of a Comparative Baseline

The expenditures shown in the table above established the beginnings of a comparative baseline against which to gauge a Trieste pilot group both overall and by cost categories and service modalities. In the aggregate, the cohort's combined cost across the three agencies shown was \$27.3 Million, which averages to slightly more than \$6,821 per person. To a certain extent, artificial understatement of the costs is eliminated as a confounding factor since the cohort was selected based on encounters at DMH facilities,

which means the cohort does not include any individual who incurred no expenses, though the minimum cost of \$2.47 suggests there may be some merit in filtering out persons who incur costs falling below a specified threshold value.

Given the availability to DMH and RES of de-identified data in other service disciplines (justice, social services, child protection, workforce development, homeless services) additional cost components could be added to the comparative analysis, thereby offering a more exhaustive sense of the degree to which the pilot successfully offsets wasteful expenditures while promoting engagement with more cost efficient services and forms of treatment shown in evidence-based research to be associated with better outcomes.