Los Angeles County Department of Mental Health
and
Kedren Community Health Center INC.

CHILDREN'S COMMUNITY CARE VILLAGE

CALIFORNIA MHSA INNOVATION PROJECT APPLICATION 2023

To providing a one-stop holistic and integrated health, mental health and housing services centered around the child and family in one location, to improve mental health outcomes for children.

The LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT ADMINISTRATION

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☐ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to the Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
X Local Mental Health Board Approval Date: February 20, 2023
X Completed 30-day public comment period Comment Period: January 20, 2023 through February 20, 2023
☐ BOS approval date Approval Date: If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: January 23, 2024. *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: November 16, 2023 ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***

County name:	**Los Angeles County**
Date submitted:	**November 16, 2023**
Project Title:	**Children's Community Care Village (CCCV)**
Total amount requested:	**$100,594,450**
Duration of project:	**5 Years**

TABLE OF CONTENTS

Section 1:

INNOVATION REGULATORY REQUIREMENT CATEGORIES

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria.
The proposed project:

- ☒ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.
- ☒ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population.
- ☒ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system.
- ☒ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite.

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☒ Increases access to mental health services to underserved groups.
- ☒ Increases the quality of mental health services, including measured outcomes.
- ☒ Promotes interagency and community collaboration related to mental health services or support or outcomes.
- ☒ Increase access to mental health services, including but not limited to services provided through permanent supportive housing.

PRIMARY PURPOSE

The purpose of this Innovative Project is to create a new mental health continuum of care for children that includes interim family housing in a single location to assess if this unique children's care village model will:

1. Increase options and coordination to appropriate levels of mental health care for children and youth in Los Angeles County's Service Area 6 (SA 6) and surrounding communities, resulting in better outcomes.

2. Promote community and interagency collaboration by focusing on the overall wellbeing of the family unit, as opposed to a specific condition.

3. Decrease emergency department usage and inpatient hospitalization for these children and youth.

4. Increase stabilization for families in crisis, thereby stemming the pipeline into the foster care system.

5. Decrease housing insecurities faced by families experiencing homelessness or at risk of becoming homeless.

6. Increase access and improved follow up to care by eliminating barriers to transportation.

Section 2:

PROJECT OVERVIEW

PRIMARY PROBLEM

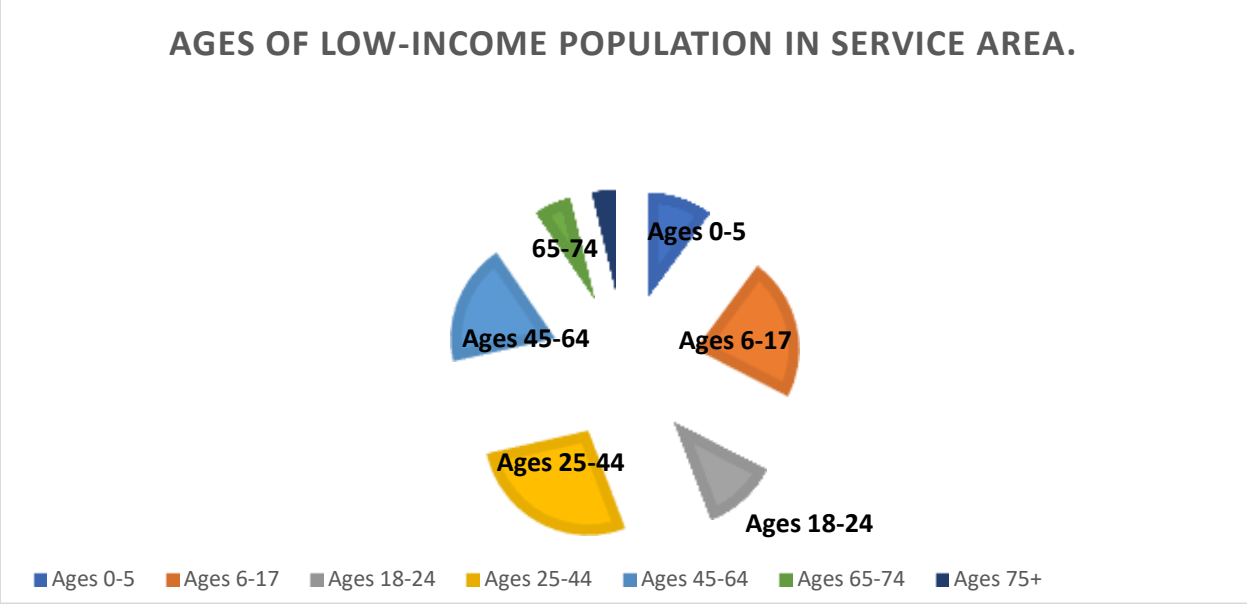
According to the US Census Bureau's 2020 Count, there are nearly one million children 5 to 12 years of age who reside in Los Angeles County. Prior to the COVID-19 pandemic, mental health disorders were the major causes of morbidity and poor health outcomes for children, resulting in issues with overall healthy development. In 2021, the Office of the Surgeon General released a report entitled Advisory on Protecting Youth Mental Health. It provided details about the mental health crises children and youth were facing prior to the pandemic and listed factors that exacerbated their conditions during and post-pandemic. These include inadequate access to health care and social services, and increased household stressors of income loss, and housing stability.

Service Area 6 (SA 6) is one of Los Angeles County's eight Service Areas (SA). It covers over 51 square miles and includes 25 neighborhoods within the city of Los Angeles and three unincorporated districts. It is home to an estimated 1,056,870 residents. At 88 percent, SA 6 is ranked highest of all SAs in Los Angeles County on the Centers for Disease Control and Prevention/Agency for Toxic Substance and Disease Registry (CDC/ATSDR) Social Vulnerability Index (SVI), which tracks 16 social factors that helps government officials meet the needs of vulnerable populations. These factors include socioeconomic status, housing insecurities and lack of transportation resources.

Socioeconomic Status

South Los Angeles, a culturally rich and diverse area, is an area with one of the largest concentrations of poverty in the United States at a rate that is more than twice the state and national averages. More than one-half (52.7%) of residents in SA 6 live at or below

Figure 1



Source: U.S. Census Bureau, 2020 American Community Survey 5-Year Estimates, Table B08101.

200% Federal Poverty Guideline (FPG), and experience both housing and transportation insecurities which result in significant barriers to accessing mental health and health care. According to survey data from a 2017 report issued by LA County Department of Public Health, 41.6% of adults did not finish high school in SA 6, which is the highest percentage across all County Service Areas. Only 8.6% have a four-year or graduate college degree. Among SA 6 households 33.6% experience poverty, nearly double that of LA County and most of the other service areas. Additionally, more than half of the SA 6 households have children. Figure 1 shows the breakdown of poverty in SA 6 by age group.

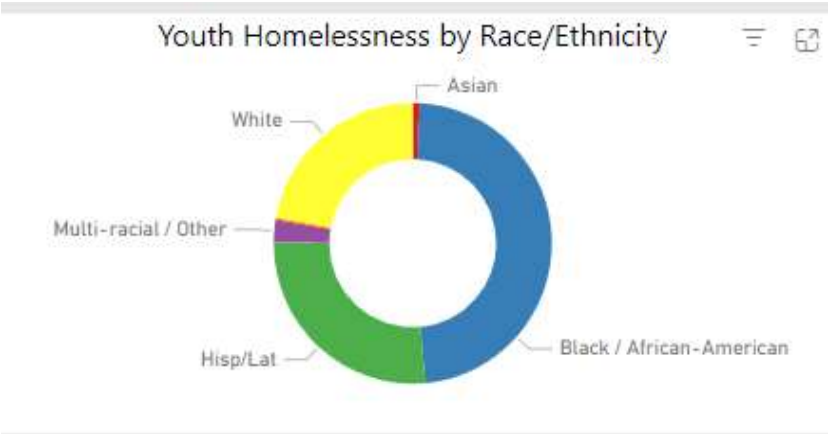
These examples of socio-economic disparity and poverty contribute to the poor mental health of parents and children throughout the SA.

Housing Insecurities/Homelessness

Housing challenges have resulted in increased homelessness across the service area. Reliable, consistent counts for this population are challenging because homeless counts are independent for each county and each year. Timing as well as strategies for finding, counting, and surveying people found living on streets and in parks and shelters vary across counties.

Homeless count methods vary slightly from year to year, although the increasing volume of homelessness according to the annual counts and the increasing visibility of homelessness throughout the area is testimony to this worsening situation.

Figure 2



The Los Angeles Homeless Services Authority (LAHSA) reports that in SA 6 there were 14,598 individuals experiencing homelessness according to the January 2022 point in time count, including 26 unaccompanied minors and 364 transitional head of household 24 years of age or younger. Figure 2, above, shows youth homelessness by race and ethnicity. Black/African Americans and Hispanic/Latinos represent the majority. LAHSA's 2022 homeless count for SA 6 identified nearly 546 children and eight youth experiencing homelessness and with mental illness. For these youth and their families, navigating mental health service providers and programs, meeting eligibility requirements for treatment or placement, and having their care needs addressed across multiple programs, specialists, and locations is a barrier to care. These figures include 307 females, 235 males and four (4) who identify as transgender.

Figure 3

2022 SHELTERED YOUTH SA 6[1]

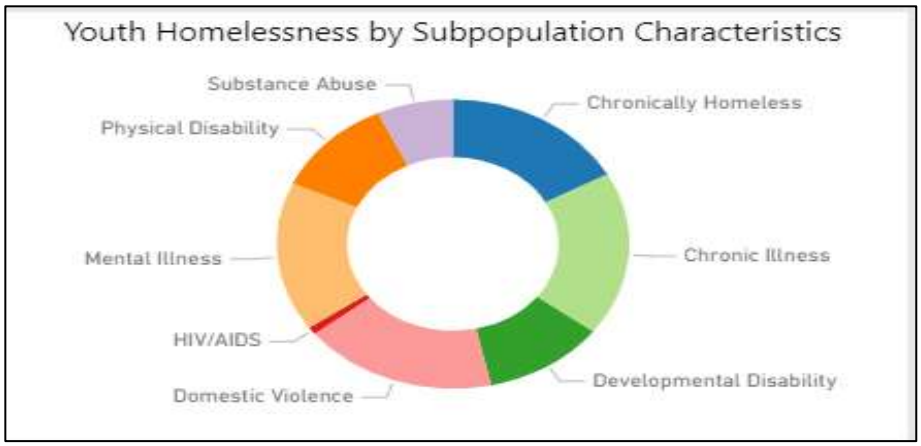
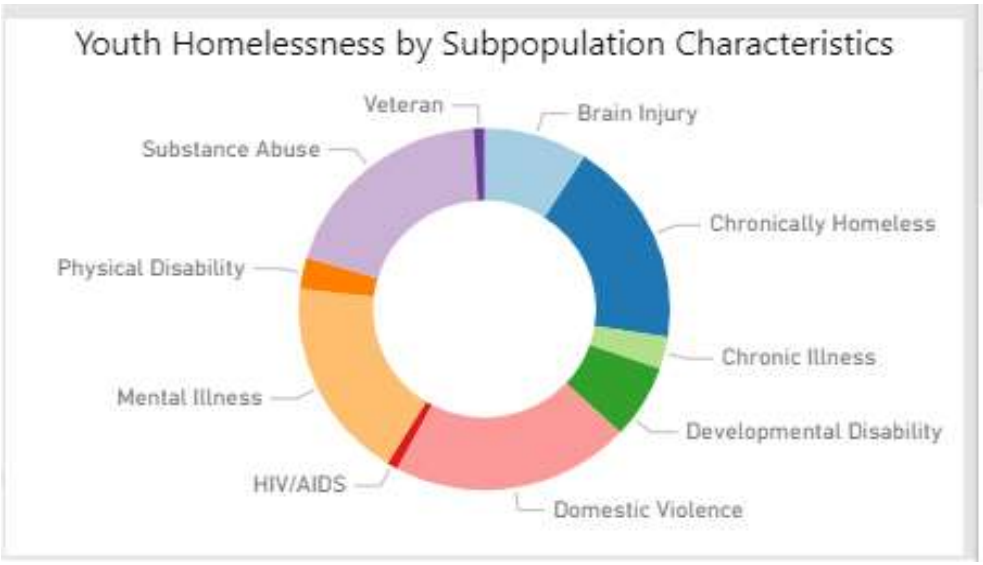


Figure 4

2022 UNSHELTERED YOUTH SA 6[2]



To further illustrate the extent of the problem faced by homeless youth, LAHSA collected subpopulation characteristics in 2022 for these youth, identifying cases of substance abuse (66), mental illness (98), chronic illness (72) or HIV/Aids (5), brain injury (19),

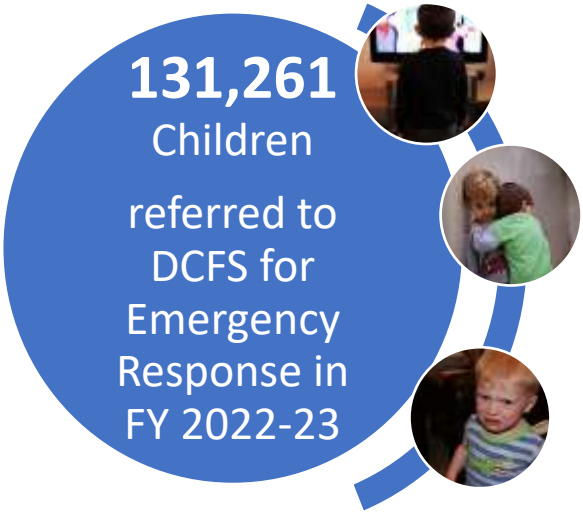
[1] https://www.lahsa.org/data?id=35-youth-count-by-service-planning-area-spa-

[2] https://www.lahsa.org/data?id=35-youth-count-by-service-planning-area-spa-

developmental disabilities (54), victims of domestic violence (108), veterans (2) and chronic homelessness (100).

Furthermore, when the data is separated by sheltered and unsheltered as illustrated in Figures 3 and 4, the differences illustrate the service needs and gaps affecting this population, and especially pertaining to substance use and chronic illnesses.

Children in Households:
Children reside and are cared for in a variety of household structures, with various related family members. According to data calculated from the 2020 California Health Interview Survey, only 54.8% reside in a household with an independent married couple/domestic partnership with at least one parent. More than 20% live with a single parent, 14.4% with grandparent(s), and 7.4% with some other relative and 60,955 (1.6%) children in the service area do not live with their families, living instead with non-relatives, in foster care, group homes or are homeless. Significantly, 45.2% have a living situation that has been linked to a higher probability of having experienced adverse childhood experiences (ACEs).



44,569 (34%) children were Victims of Neglect

26,184 or 1 in 5 children were at risk due to a sibling having been abused

14,132children, (55.1%) were 9 or younger

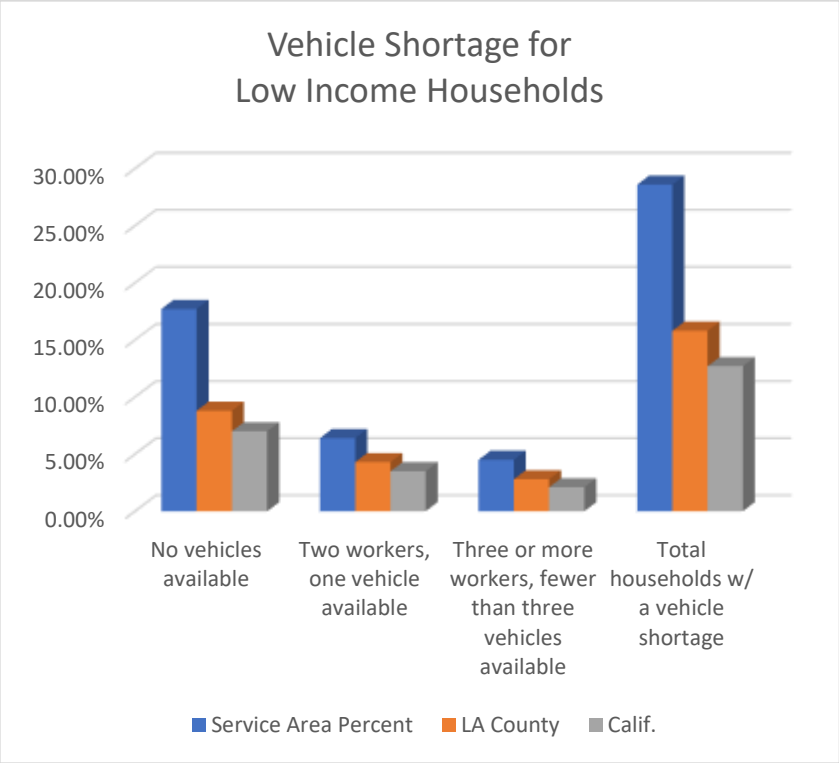
January 2023- LA County DCFS Monthly Fact Sheet

According to the LA County Department of Children and Family Services' (DCFS) Fact Sheet, across LA County, 131,261 children were referred for emergency response with one-third (34%) alleged to be victims of general neglect from July of 2022 through June of 2023. One in five (19.9%) were considered at-risk with a sibling having been abused. Sadly, 16.3% had allegations of physical abuse and 17.1%, emotional abuse. Of the children requiring DCFS involvement, more than one-half were nine years of age and younger - birth to two, 18.2%; three to four, 12.2%; and five to nine, 24.7%. For this

period, 60.5% of children were Hispanic, 23.9% Black, and 10.6% White. During this period, 14,269 children were in out of home placement[3].

Transportation Barriers in SA 6

Figure 5



For the residents in SA 6, transportation barriers present a significant challenge to accessing care and services. Notably, according to the American Community Survey[4] five-year average, 17.7% of households have no vehicle, and more than one-quarter (28.6%) have a vehicle shortage, where there are fewer vehicles than employed persons in the household. Families are thus challenged in traveling for employment as well as medical appointments. This is also true for family members who do not work and are without private transportation to get to medical appointments or to take children to appointments. As shown in the graph, the percentage of service area residents who report having no vehicle and those with a vehicle shortage, as well as the percentage of residents countywide, statewide, and nationwide without vehicles or with vehicle shortages. As demonstrated in Figure 5, vehicle shortage is significantly higher in SA 6 than elsewhere in LA County or California as a whole.

While public transportation is available in SA 6, there are challenges in terms of wait times, and bus and/or train stops that are not near residents' homes. This is further

[3] Data and Monthly Fact Sheets | Los Angeles County Department of Children and Family Services (lacounty.gov)

[4] *Source: U.S. Census Bureau, 2020 American Community Survey 5-Year Estimates, Table B08122 and C17002. Some data extrapolated by Gary Bess Associates.*

complicated by having to navigate these challenges[5] with small children or individuals with physical disabilities (per client feedback). From some parts of SA 6, clients take three or more buses to get to services and it can require significant coordination on behalf of the client and their family/caregivers.

The data demonstrates that many residents in SA 6 lack appropriate access to mental health services and experience both housing and transportation insecurities. These factors pose significant barriers to accessing care. A strategy is needed to address these disparities in childhood so residents in SA 6 may achieve improved mental health outcomes as adolescents and adults. This Innovative Project proposes a new model that will allow for a continuum of mental health care for children ages 5 to 12 and on-site interim housing for families of clients in one location thereby allowing children to receive the appropriate level of care in the right setting at the right time without the barriers to housing and transportation that may contribute to missed appointments and/or the inability to seek care.

[5] *Source: U.S. Census Bureau, 2020 American Community Survey 5-Year Estimates, Table B08122 and C17002. Some data extrapolated by Gary Bess Associates.*

PROPOSED PROJECT

A. **Narrative**:

The First Community Care Village for Children & Families that Focuses on Mental Health Continuum of Care Including Housing.

The proposed project will provide a continuum of mental health services and resources that will address these issues and improve the health, wellbeing, and social value indices of the children and families in SA 6 by creating new mental health programs that do not currently exist in Los Angeles County and co-locating them with enhanced existing programs all in one location.

The Los Angeles County Department of Mental Health (LACDMH) provides specialty mental health services for children through a network of directly operated and contracted community outpatient clinics across the County. LACDMH has identified a community-based non-profit organization, Kedren Health, Inc. (Kedren), a Community Mental Health Center, to partner with for this Innovations proposal because of its long and deep ties to the local community as well as their experience with the array of mental health services for children.

Kedren was incorporated in 1965 for the purpose of:

- operating a community mental health center with a child guidance clinic and day treatment center.
- operating a therapeutic nursery school for emotionally disturbed children.
- diagnosing and treating emotional disorders and to prevent mental illness through family counseling.
- conducting seminars for the education of the community.
- engaging in research with findings made available to the public; and
- training and certifying mental health personnel, including doctors, psychologists, cultural anthropologists, nurses and social workers.

Furthermore, Kedren is licensed as an Acute Psychiatric Hospital and Community Mental Health Center that operates in two locations in South Central Los Angeles. With Kedren's south location to provide children's services, and it is at this location, bordering the Watts community, that LACDMH and Kedren plan to locate its Innovative Project, known as the Children's Community Care Village (CCCV).

The CCCV will demonstrate the first of its kind, best practice "village" concept dedicated to children and families that will include the delivery of the new services listed below and include the existing children and youth services at Kedren (i.e., acute inpatient, FQHC

and outpatient programs). These services/programs will be integrated into new programs to ensure a full continuum of care is available to provide our clients with the right care at the right time and right place. New services include:

- Intensive Case Management with an assigned care coordinator for each family as part of a Continuity of Care and Treatment Team to coordinate care among the continuum and ensure child and family voice and access to the most appropriate level of care.
- A full spectrum of children and youth mental health outpatient services including outpatient care and Integrated Comprehensive and Intensive Care for children.
- A children and youth crisis residential treatment program (The first and only CRTP in LA County dedicated to children and youth).
- A children and youth crisis stabilization unit.
- On-site transitional housing for children and families in crisis to include units for parent-child interactive therapy.

These new services will integrate and augment with the existing services on the same campus and surrounding network of services that are not funded with MHSA which includes but is not limited to:

- An inpatient acute psychiatric hospital,
- Federally Qualified Healthcare Center (FQHC) for primary and specialty care,
- Inpatient and outpatient pharmacy,
- Social services linkages,
- Community integration and reintegration programs,
- Parental supports and treatment for mental health and substance use,
- Transitional housing for families experiencing homelessness, and
- Work and life skill development programs.

-+

Collectively, these services are designed to increase access to care, minimize disruption in the life of the child, youth, and family, and directly address some of the needs outlined in this proposal:

- Improve access to health and mental health resources.
- Address the needs of children, youth, and families with limited access to transportation.
- Reduce homelessness.
- Improved success in school.

- Reduce incidence of neglect and abuse by assuring timely access to care in times of crisis.

CCCV SERVICE CONTINUUM

Intensive Care Coordination (ICC)

The proposed ICC project will involve cross-agency collaboration to connect every service at Kedren with another, guided by family voice and choice and the needs of the child/youth to facilitate strength-based, individualized, culturally and linguistically relevant assessment. Crisis can disrupt the lives of children and youth as well as their families. The enhanced ICC services at the Community Care Village will follow the youth across levels of care to minimize disjointed care and disruption by ensuring the children and youth in outpatient settings can continue in their school of origin.

The teams providing these services will foster a collaborative relationship among the child or youth, their family, and involved child-serving systems. In addition, they will provide support and validation needed to gain trust to develop and maintain a constructive and collaborative relationship among the child or youth, their family, and involved child-serving systems.

The child or youth will be reassessed upon admission to another setting. The ICC coordinator will continue to follow the child or youth, allowing the team to build on the skills developed during their time within a higher level of care. The continuity provided by the ICC coordinator along with the discharge summary from the previous setting will assist the team to continue strategies that yielded positive results. The comforting strategies identified by the family and child will be the focal point of services provided. The teams providing these services will be skilled in adjusting their 1:1 or group interventions to the client's strengths and needs.

Each family at the Kedren CCCV will have an Intensive Care Coordinator (ICC) who will be part of the Child Family Team (CFT) and responsible for ensuring that:

- Components of plans from any of the system partners (including the mental health client plan, and plans from child welfare, special education, juvenile probation, etc.) are integrated and unified, to comprehensively address all identified goals and objectives.
- The activities of all parties involved with service to the child or youth and/or family are coordinated, to ensure that all team members work in cooperation with one another to support and promote successful and enduring change.

ICC services will be available from the first service provided on campus, during their time served in a Kedren program, to the time an individual is confirmed to be linked to a provider in their home community.

The ICC will also be responsible for:

- Ensuring that medically necessary services are accessed, coordinated, and delivered in a strengths-based, individualized, and culturally and linguistically relevant manner, and that services and supports are guided by family voice and choice and the needs of the child/youth.
- Ensuring that medically necessary mental health services included in the child's/youth's plan are effectively and comprehensively assessed, coordinated, delivered, transitioned, and/or reassessed, as necessary, in a way that is consistent with the full intent of the Integrated Care Plan. The ICC will coordinate and consult regularly with treating team members to ensure continuity of care particularly during transition.
- Facilitating a collaborative relationship among the child or youth, his/her family, and involved child-serving systems.
- Providing support and validation to gain trust to develop and maintain a constructive and collaborative relationship among the child or youth, his/her family, and involved child-serving systems.
- Supporting the parent/caregiver in meeting his/her child's or youth's needs.
- Ensuring services are provided that equip the parent/caregiver to meet the child's/youth's mental health treatment and care coordination needs, as described in the child's/ youth's plan.
- Ensuring access to non-traditional, and or community defined and culturally relevant treatment services.
- Helping to establish the CFT and provide ongoing support.
- Providing care planning and monitoring to ensure that the plan is aligned with, and coordinated across, the mental health and child/youth-serving systems, to allow the child/youth to be served in his/her community, in the least restrictive setting possible.

Engaging the child/youth and his/her family is foundational to building trust and mutually beneficial relationships between the family and the ICC. By eliminating barriers to transportation and access to care and providing a stable housing environment, Kedren's CCCV will provide a successful path for children and their families with the critical support of the ICC.

Transport for Children to their School

To minimize disruption during crisis, Kedren will provide comprehensive support and coordination for children, including educational services. The ICC will ensure

transportation and collaborate with local transportation services and schools to ensure that the child or youth have safe and reliable transportation to and from their school of origin. Kedren will provide transportation if no other options are available. The ICC will be responsible for:

- **Collaborating with the child or youth school of origin:** Work closely with the child's school of origin to understand their transportation policies and available options.
    - Advocate for the transportation needs of the child, collaborating with school's team to find suitable solutions.

- **Assess Individual Needs:**
    - Conduct assessments of the transportation needs of each child.
    - Identify children who require specialized transportation services due to disabilities or other unique circumstances.

- **Coordinate with Families:**
    - Work closely with the family to understand their transportation challenges and preferences.
    - Facilitate communication between families and transportation providers to ensure a smooth transportation experience.

- **Advocate for Transportation Assistance:**
    - Assist families in accessing transportation assistance programs or subsidies available in the community.
    - Provide advocacy services to help families navigate the application process for transportation assistance programs.

- **Emergency Transportation Plans:**
    - Develop emergency transportation plans in case a child cannot use their regular transportation method (e.g., due to illness or family emergency).
    - Establish protocols for handling transportation emergencies and communicate these plans to families and transportation providers.

- **Monitor and Address Issues:**
    - Regularly monitor the transportation arrangements to ensure they are reliable, safe, and meeting the needs of the children.
    - Address any transportation-related issues promptly, working closely with transportation providers and families to find solutions.

- **Provide Supportive Services:**
    - Offer supportive services to children during their transportation, such as assigning a staff member to accompany children who require additional assistance or supervision during transit.

By working collaboratively with schools, families, transportation providers, and community organizations, the ICC will ensure that the child has access to safe and reliable transportation to attend school regularly. Customized solutions and ongoing communication are key to successfully coordinating transportation services for these children.

Continuity of Care and Treatment Team

The treatment team will have multiple occupational therapists that will be working with the child or youth upon admission and throughout their treatment to minimize disruptions as the child transitions from different levels of care. It will also eliminate the duplication of services and instead promote coordination of services.

Occupational therapy is a skilled clinical service defined by integrated assessment and treatment of barriers to participation in daily life to promote wellbeing. Trained and licensed in the therapeutic management of functional needs associated with both physical and mental conditions, occupational therapists serve as a bridge between medical and behavioral health care with a central focus on enhancing quality of life through full inclusion and engagement in personally meaningful activities, routines, and life roles regardless of diagnosis or disability.

Occupational therapists are uniquely positioned to translate the promise of integrated care into practice through a whole-person approach that centers what matters most to the individual in each clinical encounter and facilitates collaborative care coordination.

Occupational therapists' fluency in the nuances of medical, mental health, developmental, educational, and vocational systems equip the interdisciplinary team to circumvent the fragmentation that further perpetuates health disparities in already underserved communities. When delivered in a mental health setting, occupational therapy specifically targets social, emotional, or behavioral factors and contributing environmental influences impairing an individual's ability to fully participate in these domains, including but not limited to:

- Basic activities of daily living.
- Instrumental activities of daily living such as communication device use, transportation use and money management.
- Work, play, sleep, physical activity, leisure activity, and safe sexual activity.
- Personal health management.
- Social participation including family, peers, and intimate partner relationships.
- Community participation including religious/spiritual routines, neighborhood inclusion, and community outings.

- Daily/weekly routines including balancing multiple life domains and transitions between tasks.

Occupational therapy services enable even the highest-need and most clinically complex clients, including those underserved by psychotherapy, medication support, and case management alone due to intensity of functional impairment, past/present stressors, neurological and/or co-occurring disability. Occupational therapy connects children and youth with their key support figures and accommodate their daily life environments to reduce sources of distress and develop core functional capacities for participation at home, school, and in the community in accordance with their personal mental health treatment goals.

Community Access & Support Network (CAN)

Kedren believes that community members are one of our strongest assets in destigmatizing mental health care which can help improve the overall mental health and wellbeing by positively encouraging those in need to seek treatment. As such, Kedren will work with LACDMH to recruit Community Ambassadors (Ambassadors) in the surrounding South Los Angeles communities to create a Community Access & Support Network (CAN). Ambassadors will include both family advocates and youth peer advocates.

The Ambassadors at Kedren will serve as problem-solvers and system navigators to help those who are seeking services to find appropriate resources. The will spend time in the community to raise awareness around mental health, availability of services, providing education and provide linkage to services. They will help nurture their communities, becoming an integral part of our health outreach efforts by empowering others, raising awareness, and supporting those in need to seek needed care. Onsite, the CAN ambassadors will provide peer support to both youth and families served at the CCCV.

Transitional Age Youth (TAY) Drop-In Center

Kedren's Transitional Age Youth (TAY) Drop-In Center will provide a safe space for young people ages 16-18 who are currently in or have been in the foster care system, victims of crime and those experiencing homelessness to access services such as linkages to employment services, education support, shelter/transitional housing, mental health, and extracurricular activities. The goal of the program will be to build the skills, self-esteem, and support system needed for TAY to transition into independent living in the community or to reunite with family.

In addition to access to showers, a laundry facility, resource library, computer stations, food and recreational space, services that the TAY Drop-In Center will include 1:1 and group counseling sessions, registration support for college, enrollment in vocational training, housing navigation support, and life-skills workshops that will foster good decision making for their futures.

Kedren will offer two new programs for children and youth at the CCCV that do not currently exist in Los Angeles County: a 16-bed crisis residential treatment program (CRTP) and a crisis stabilization unit (CSU). The ICC team will work with children, youth, and families served by the CRTP and CSU to manage transition of care within the campus or in their home community.

Crisis Residential Treatment Program (CRTP):
There are no CRTPs for children and youth in Los Angeles County at the current time. Kedren will build a new 16-bed CRTP at its CCCV.

CRTPs are designed to meet the needs of someone who is experiencing acute psychiatric impairment and moderate functional impairment but are not in need of inpatient care. The CRTP will provide short-term intensive and supportive services in a home like environment through an active social rehabilitation program. The average length of stay in adult programs is 10-14 days, not to exceed 30 days. The addition of the CRTP as an alternative to inpatient care will ensure minimal disruption in the life of the child or youth who can continue with their school of origin while working with their ICC coordinator and caregiver to transition to a lower level of care.

Having this service available in Los Angeles County will fill a void in the current system of care, allowing an appropriate treatment level between crisis stabilization and inpatient hospitalization. We firmly believe that by creating the first CRTP for children and youth in Los Angeles County we will see reduced costs, better quality of care, reduced delays in placement, placement in an appropriate level of care, and overall improved outcomes for children and youth.

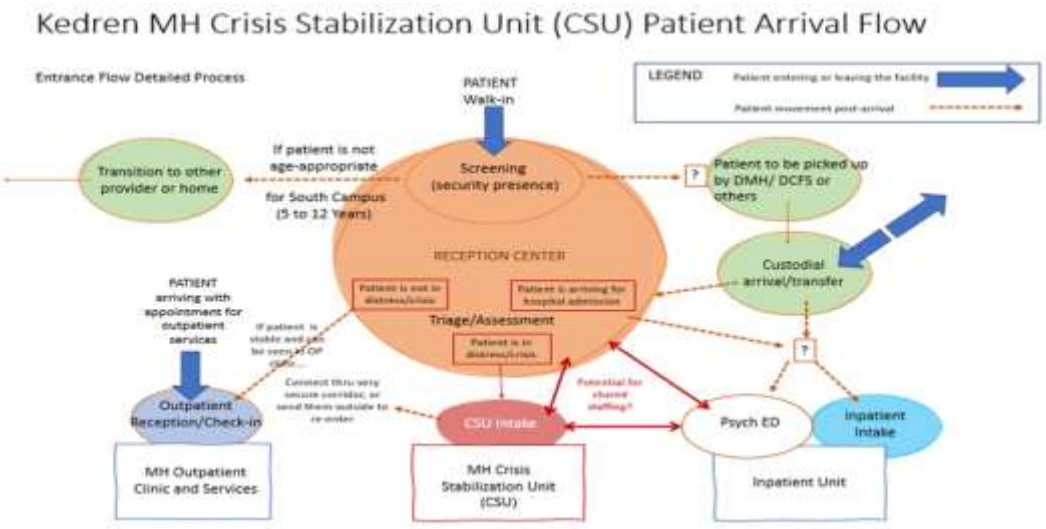
Crisis Stabilization Unit (CSU)
This community-based CSU will serve any child or youth who is experiencing a mental health crisis by providing stabilization and linkage services, providing another alternative to hospitalization or justice involvement. The focus will be on ensuring services culturally and linguistically appropriate, trauma focused, providing the least restrictive environment with the goal to return the child or youth back to their community setting.

Services include:

- 24/7 mental health assessment and crisis stabilization
- Therapeutic and mental health services
- Case management
- Family/caregiver support and education
- Referrals to community-based services for ongoing needs

The eight-bed CSU will provide a critical resource for stabilizing youth in psychiatric distress. It will divert emergency department usage and psychiatric hospitalizations and provide a resource for the outpatient center for children who present with a crisis. Figure 6 below details the patient flow to the CSU.

Figure 6



The *Integrated Comprehensive & Intensive Care for Children Program*:

Provides comprehensive, intensive, integrated, culturally and linguistically appropriate mental health and linkage services to children and young adults ages 0-21 and their families who have a serious emotional disturbance, are underserved, un-served, or inappropriately served. These clients may not have responded well to traditional outpatient mental health and/or rehabilitation services or those individuals who have incurred high costs related to acute psychiatric hospitalization or long-term care. They must satisfy one or more of the following criteria:

1. Lack a fixed, regular, and adequate nighttime residence.
2. Expulsion or suspension from school; chronic absenteeism (missing 10% of school days within a year).
3. History of suicidal and/or homicidal ideation; experiencing prodromal or first episode of psychosis psychiatric hospitalization in the last six months; experiencing first psychotic break.
4. Open DCFS case; experiencing two or more placements due to behavioral needs.
5. Transition to a less restrictive community setting.
6. Open Probation Department case.

7. With co-occurring disorders.
8. Experiencing severe mental health issues and not engaging in mental health services.

At the CCCV, children and their families will be provided with stable housing. Services needed for the child will be available onsite, and the ability to provide intervention and move a child between levels of care quickly should reduce psychiatric hospitalizations. In addition, the intensive treatment of the child will include collaboration and treatment of family members, as well as collaboration with oversight organizations.

Children and Youth Mental Health Outpatient Services:
The outpatient programs provide comprehensive, individualized child and family centered mental health and linkage services to children and adolescents ages 0-25 who reside in SA 6 and who present with SED or co-occurring substance abuse problems which contribute to maladaptive community functioning. Services are delivered by therapeutic teams trained to meet the unique cultural needs of the local community, embody unconditional care, flexibility, creativity, child and family centered services, school focused services, strength-based assessments, and interagency collaboration including by not limited to DMH, DCFS, Regional Center, Department of Probation, local schools, hospitals, social service agencies, etc.

The delivery of mental health services for children and youth is geared toward functional restoration through learning, development, family, and communal living. Mental health services assist clients in developing adaptive coping and social skills which foster recovery and resilience to augment functioning in the school, home, and community settings. ICC services will ensure coordination and continuity of care between the higher levels or care, outpatient care, alternative therapeutic or culturally relevant services, and other community-based services as identified by the child or youth and family.

Outpatient Children Program:
Provides comprehensive, integrated, linguistically and culturally appropriate mental health and linkage services to children ages 0 to 15 who have serious emotional and behavioral problems; are un-served, undeserved or inappropriately served; would not or are not able to access services in traditional settings due to stigma, preference, or multiple demands on families and systems that provide their care and meet at least one of the following criteria:

1. Are at risk of being removed from their home by DCFS.
2. Are at serious risk of school failure.
3. Are at risk of involvement in the juvenile system.
4. Have a co-occurring substance abuse or medical disorder.

5. Have experienced trauma.

In the proposed CCCV, children living onsite in the village would have readily available access to care. Adult family members who need care would have shuttle services available to Kedren's North Campus where adult services are located. Stigma associated with mental health care is eliminated because the CCCV is a place of healing where care is valued.

Transitional Family Housing:

Kedren will be working with a Cal Poly Pomona professor of architecture and his students, in collaboration with Beehive, our housing community partner, to develop 24 unique, cost-effective transitional housing units for families and single parent households. Also included in this housing model will be units for families who live out of the area who have a child in the inpatient or CRTP. Like the Ronald McDonald House, families can remain near the child in treatment and be part of the healing process.

Of the 24 residential units, four (4) units will be dedicated for parent-child interactive therapy (PCIT). These units will contain rooms like those in the residential units but will be used for PCIT and allow for coaching home interactions between the parent and child/children.

According to the CDC, "the mental health of parents and children is connected in multiple ways. Parents who have their own mental health challenges, such as coping with symptoms of depression or anxiety (fear or worry), may have more difficulty providing care for their child compared to parents who describe their mental health as good. Caring for children can create challenges for parents, particularly if they lack resources and support, which can have a negative effect on a parent's mental health. Parents and children may also experience shared risks, such as inherited vulnerabilities, living in unsafe environments, and facing discrimination or deprivation."

(CDC Children's Mental Health, 2023)

Providing housing within the family structure will offer an opportunity for families to receive immediate support and stabilization.

Providing housing within the family structure will offer an opportunity for families to receive immediate support and stabilization. This in turn will facilitate recovery, resilience and

increase opportunities for successful family and community engagement. The CCCV will facilitate access to needed services along the continuum for children and their families and offer access to enabling and supportive services that are designed to end the cycle of homelessness, retain family units, and reduce the effects of homelessness on mental illness treatment for children and their families.

This service is expected to reduce homelessness among participating families. It will also address mental health needs of children and youth while supporting the families, which we expect to result in reduced involvement of the Department of Children and Family Services, reduced out of home placement in foster care and/or juvenile justice settings, and increased performance in education.

All Kedren clients and family members in need of housing may work with our housing coordinator and team on placement or linkage to transitional housing, Section 8, permanent supportive housing, senior house, and market rate rentals.

A major component of successful service and recovery is stable housing, especially for those difficult and hard to reach clients. We anticipate that this will provide an opportunity for expanded service delivery to more than 238 families each year.

Program Development & Implementation

Identify which of the three project general requirements specified above [per CRR, Title 9, Sect. 3910(a)] the project will implement.

- *Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.*
- *Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system.*
- *Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population.*
- *Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite.*

The CCCV site will offer mental health services along the crisis treatment continuum and the mental health outpatient services continuum facilitating treatment collaboration. The CCCV will operate collaboratively across programs and services, helping children and families to become self-coordinating and successful in the community in which they live, reducing reoccurring incidents and the impact of those incidents, eventually increasing quality of life for the child and their family.

This is accomplished through establishment of new services such as the CRTP and on-site family housing and the re-imagining ICC services to partner with families, ensure voice and choice to support coordination across multiple levels of care and services. The addition of non-mental health supportive services such as school transportation meet mental health needs by minimizing disruption in the child or youths' life.

This innovation is the single point of service delivery site for all inpatient and outpatient services bringing holistic, cohesive care that addresses the whole child and family's needs. This will be a first fully integrated (not just co-located) model, and the only type of facility primarily focused on children.

With the CCCV, we are excited at the prospect of developing a new model of community-based practice that is replicable and uses many conventional approaches aligned and coordinated within one seamless system of care.

Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

The CCCV approach is in keeping with models of care that emphasize integration across disciplines and that are scalable to the level of care required. In critical medical care, when a child has a serious physical illness or injury, there are systems that afford holistic treatment for the child and family regardless of their ability to pay, providing interim housing, a dedicated team for intensive needs, therapies, outpatient care and enabling services; all in one location such as at cancer treatment centers. Intensive case managers facilitate resource enrollment, health care system navigation, supportive social services for parents, as well as access to the health care needed.

LACDMH thus proposes to introduce a comparable cohesive and comprehensive care model for a child's serious emotional and mental health needs. While medical hospitals across the country have replicable systems for physical health, we are not aware of a one-stop location where crisis intervention, crisis stabilization, intensive outpatient, follow up therapy, medical health offices, interim housing and other enabling services and supports for children and their family members is available.

Estimate the number of individuals expected to be served annually and how you arrived at this number.

The behavioral health clinical services at CCCV will serve all children with a focus on children ages 5 to 12. The "new" clinical services include 16 crisis residential treatment program (CRTP) beds, eight (8) crisis stabilization unit/urgent care center (CSU/UCC) beds, and an outpatient clinic to address the full continuum of mental health needs. Additionally, the housing modules will have space for up to 24 family units of various sizes. Additionally, these new services will be integrated with the 30-36 inpatient acute psychiatric beds and FQHC- primary care.

Table 1

SERVICE LINE	CAPACITY	Unduplicated Clients (Annual - Projections)	Service Encounters (Annual - Projections)
MHSA INN Funded Services:			
Crisis Residenttial (CRTP)	16 beds	417	5,40
Crisis Stabilization (CSU/UCC)	8 beds	2,920	2,920
Transitional Housing	24 units	238**	1,560
Integrated Care Coordination* (ICC)		2,111 - 2,695	36,591 - 46,700
Sub-Total		***5,686 - 6,270****	***41,071 - 51,180***
Non-MHSA INN Funded Services:			
Acute Psych Inpatient	30 beds	782	10,950
FQHC - Primary Healthcare		2,000	12,800
TOTAL		**8,468 - 9,052***	**64,821 - 74,930**

**NOTE: CRTP, CSU and/or Housing client will likely be an ICC client, since all programs are designed to be "integrated."*
*** Transitional Housing- 20 units traditional transitional housing + 4 units for PCIT*

As shown in Table 1 above, CCCV may serve up to 5,520 - 6,104 unique unduplicated clients with a service encounter projection of 43,255 - 53,364 visits annually. For the full campus, combining both new and existing programs for which services and capital costs are funded by other sources, the CCCV could serve up to 8,302 - 8,886 unduplicated clients with 67,005 - 77,114 service visits annually.

Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate.)

Eligible residents by race/ethnicity in main service area surrounding Kedren are reflected in Table 2.

Table 2

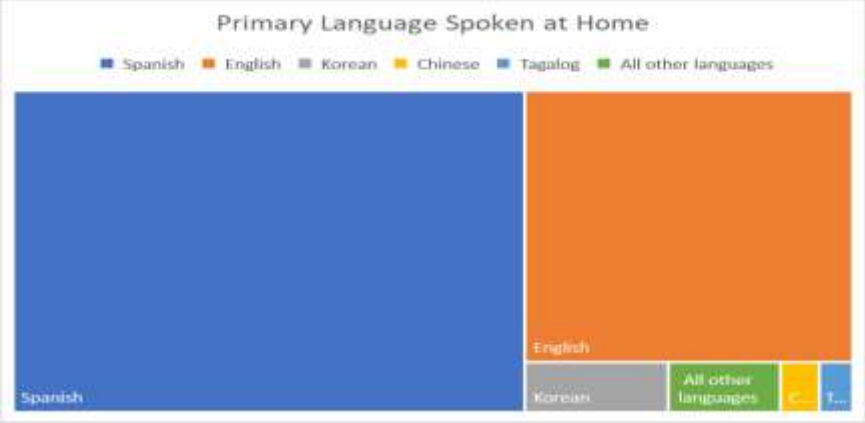
Race/Ethnicity[1]	Service Area Low-Inc. No.	Service Area Low-Inc. Pct.	LA County	Calif.	U.S.A.
Hispanic or Latino	391,495	68.4 %	48.3 %	39.1 %	18.2 %
Black or African American	121,798	21.3 %	8.1 %	5.7 %	12.6 %
Asian (South or East) or Asian Indian	29,767	5.2 %	14.8 %	14.8 %	5.6 %
Caucasian, Non-Hispanic (incl. North African and West/ Central Asian)	21,590	3.8 %	25.9 %	36.5 %	60.1 %
Other/ Multiple (non-Hispanic)	10,029	1.8 %	3.0 %	3.7 %	3.1 %
American Indian, Alaska Native, Native Hawaiian, or Pacific Islander	5,883	1.0 %	1.0 %	1.2 %	1.0 %
Total	572,209	100%	100. %	100 %	100%
Total non-Caucasian	550,619	96.2 %	75.2 %	64.5 %	40.6 %

Source: U.S. Census Bureau, 2020 American Community Survey 5-Year Estimates, Table B03002.

[1]Hispanic/Latino is separated only from Caucasian and Other. It is duplicated in all other race categories.

Understanding the racial and ethnic background of its service area residents allows LACDMH and Kedren to ensure that its client composition reflects the racial/ethnic make-up of the service area. It also allows human resources to hire qualified staff who are reflective of the cultural, racial, and linguistic characteristics of the client population. Clients and family members of diverse races, ethnicities, and cultures can face health disparities unique to them, which challenges us to identify interventions and treatments that are acceptable. Finally, it allows for targeted cultural competency training for staff to improve cultural sensitivity and understanding of cultural beliefs and experiences.

Figure 7



Source: U.S. Census Bureau, 2020 American Community Survey 5-Year Estimates, Table B03002.

[1]Hispanic/Latino is separated only from Caucasian and Other. It is duplicated in all other race categories.

Nearly two-thirds (67.1%) of service area residents speak a language other than English in their homes, compared with 56.8% in LA County, 43.9% in California, and 21% in the

United States. The predominant home language in the service area is Spanish, with 61.0% of service area residents speaking Spanish at home.

Language barriers are important to address as they can create obstacles that interfere with quality of life and health status. Among all residents who reported speaking a non-English language in their homes, close to one-third of them (36.2%) reported that they do not speak English "very well." This percentage represents more than 376,853 residents who report not feeling confident in their ability to speak English, and consequently, for whom language may be a barrier to healthcare.

To mitigate barriers to healthcare utilization, our partner, Kedren, employs bilingual, multi-cultural staff who regularly provide on-site translation services for clients with limited English proficiency, and has a contract with a language translation company that provides over-the-phone interpretation services.

LACDMH and Kedren embrace the diversity of the city, with multicultural, ethnic and gender diverse workplaces serving a population speaking a plethora of languages and diverse cultural backgrounds and of all genders, including LGBTQIA2-S, respecting the unique individuality of each person served by creating a treatment environment that is welcoming.

RESEARCH ON INNOVATION PROJECT

A. What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

In November 2017, a group of 13 LA County officials and leaders visited Trieste, Italy to observe and study its World Health Organization (WHO)-recognized system of mental healthcare. The lessons learned in the Village model are that even those with the most severe impairments are considered capable of "a life in the community not defined by their mental illness." This perspective is in keeping with the Mental Health Services Act, which requires an approach that goes beyond treating the symptoms of the illness and instead focuses on ensuring that people with mental illnesses, including children, have appropriate housing, social connection and belonging and purpose in their lives. While the Trieste model brings together various components of the community to meet the needs of the individual, this proposed model brings many of these services and family supports into one site.

Providers including the City of Hope Hospital, Children's Hospital of Los Angeles, Cedars-Sinai Medical Centers, Shriners Hospital and others, all offer supports to the family, not leaving the child or the family alone to navigate the complex health care system to meet the needs of a child. A child or parent out of the home for intensive treatment should have the ability to maintain that familial and social relationships.

While recognizing that many children will require high levels of traditional clinical services and supports (e.g., therapy, medication support), the CCCV model's focus is on the whole life of the child (and the family). It will be the extensiveness, comprehensiveness and robustness of these psychosocial, non-illness centered services such as the Continuity of Care and Treatment team ICC coordinators which serve to facilitate transition and minimize life disruptions that will ensure the success of this endeavor.

B. Describe the efforts made to investigate existing models or approaches close to what you are proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

We were unable to find extensive literature on a model similar to the CCCV. Some services, such as CRTPs do not exist for children.

According to the "Working Paper: California's Children & Youth Behavioral Health Ecosystem[6], researchers "found that systems that makeup California's ecosystem supporting the behavioral health of children, youth, and families – including our health care, early care, education, and social service systems – are disconnected from each other and from the young people, families and communities they serve." They also report that many who work in and with the systems intended to support youth and families, are understaffed, historically under-resourced, lack the tools and cultural competency needed to address the behavioral health needs of California's diverse communities, and "are rooted in long-standing systems of oppression." The result is that these systems are distrusted by children, youth, and families.

Furthermore, a fundamental flaw reported in the California Ecosystem report is that the current system is siloed. Integration, the foundation on which a new ecosystem must be built, is not present. The report states that an "integrated ecosystem can only be achieved through a collective effort that unifies young people, families, communities and the professionals that serve them, in shared goals, shared accountability, and shared support for the whole person, from birth through early adulthood (pg. 3)".

Family-focused service delivery in mental health services is a model that views the person with the mental illness in the context of their family relationships[7], which is what the CCCV aspires to do. Family focused practice that includes support for parent and child well-being, has been a promising selective prevention strategy and to enhance public mental health at the population level[8]. Thus, providing targeted intervention support for children

[6] https://www.cmhnetwork.org/wp-content/uploads/2023/03/Ecosystem-Working-Paper-_-ADA.pdf

[7] Foster K, Goodyear M, Grant A, Weimand B, Nicholson J. Family-focused practice with EASE: a practice framework for strengthening recovery when mental health consumers are parents. *Int J Ment Health Nurs.* (2019) 28:351–60. doi: 10.1111/inm.12535

[8] *Wahlbeck K. Public mental health: the time is ripe for translation of evidence into practice. World Psychiatry. (2015) 14:36–42. doi: 10.1002/wps.20178*

and their parents can break the cycle of intergenerational transmission of mental illness, when it is present, and especially improve outcomes for children of parents with a mental illness[9]. Furthermore, interventions targeting parental behavior or parent-child interactions have typically shown small but significant positive outcomes on sensitivity and responsiveness between parents and children[10].

LEARNING GOALS & OBJECTIVES

As described above, the model is evolving, building on recommendations from the literature and LACDMH's direct study. The learning questions for this proposal include the following:

- Does having an assigned Intensive Care Coordinator expedite access to appropriate levels of care and reduce the higher level acute psychiatric hospital inpatient admissions?

- Does access to non-traditional mental health services (e.g., creative wellbeing, neurofeedback, vocal modulation, drumming circles, peer to peer services, etc.) increase/improve engagement in SMHS and decrease length of time engaged in high intensity SMHS?

- Will having a scalable continuum of care in one location lead to better outcomes for children and their families, including
    - Support to safely continue to school of origin
    - Reduced psychiatric crisis
    - Increased access to care
    - Improved quality of care
    - Reduce time between step up/step down care levels

- Is the provision of housing for children and families who are currently experiencing crisis and/or homelessness an effective solution for stabilizing their lives and contributing to overall mental health outcomes including
    - Reduced child welfare involvement
    - Reduced out of home placement in foster or juvenile justice settings
    - Reduced days of homelessness among families
    - Improved education performance

[9] Wainberg ML, Helpman L, Duarte CS, Vermund SH, Mootz JJ, Gouveia L, et al. Curtailing the communicability of psychiatric disorders. Lancet Psychiatry. (2018) 5:940–4. doi: 10.1016/S2215-0366(18)30342-0

[10] *Thanhäuser M, Lemmer G, de Girolamo G, Christiansen H. Do preventive interventions for children of mentally ill parents work? Results of a systematic review and meta-analysis. Curr Opin Psychiatry. (2017) 30:283–99. doi: 10.1097/YCO.0000000000000342*
PubMed Abstract | CrossRef Full Text | Google Scholar

- If the CCCV is an effective model for children's mental health, what are next steps toward manualizing the model and moving toward establishing it as an evidence-based practice? How can this model be made scalable.

EVALUATION OR LEARNING PLAN

LACDMH intends to contract with an outside contractor with experience in evaluating mental health programs and outcomes. Based on the preceding questions to be answered and the goals and objectives described above, the following outcomes are anticipated:

- Improvement in Quality of Life for Participating Families – the problem addressed by the CCCV concept is disruption of a fragmented system of care by providing children and their families with an integrated residential program designed to overcome barriers that all too often interfere with improvement in personal health and wellness and family cohesion. A central theme is improvement in the child's functionality and the family system. The CCCV provider will implement a longitudinal quality of life assessment outcome tool to be completed by parents/guardians and older youth. While a tool has not been finalized, domains to be included in the assessment are:

    - mental and physical wellbeing.
    - relationships with family and friends.
    - social, community and civic opportunities.
    - personal development and fulfillment.

These domains can be found in the following assessment tools from which the selected assessments will likely come:

1. The Quality of Life Scale (Flanagan, 1978)[11]
2. McGill Quality of Life Questionnaire – Expanded (Cohen et al., 2019)[12]
3. Health-Related Quality of Life Questionnaire (CDC, 2000)[13]
4. World Health Organization Qualify of Life Instrument (WHO, 2012)[14]

[11] Flanagan, J. C. (1978). A research approach to improving our quality of life. American Psychologist, 33(2), 138-147.

[12] Cohen, S. R., Russell, L. B., Leis, A., Shahidi, J., Porterfield, P., Kuhl, D. R., … & Sawatzky, R. (2019). More comprehensively measuring quality of life in life-threatening illness: The McGill Quality of Life Questionnaire–Expanded. BMC Palliative Care, 18(92), 1-11.

[13] Centers for Disease Control and Prevention (CDC). (2000). Measuring healthy days: Population assessment of health-related quality of life. Retrieved from https://www.cdc.gov/hrqol/pdfs/mhd.pdf.

[14] World Health Organization (WHO). (2012). WHOQOL User Manual. Retrieved from https://www.who.int/toolkits/whoqol.

5. Global Quality of Life Scale (1996)[15].

The quality-of-life measure will be administered soon after enrollment and at intervals of three (3) months for as long as families are enrolled, and for three (3) months post discharge.

- Client Experience – Client experience encompasses the range of interactions that takes place within the behavioral healthcare system, including the care that they receive from clinical staff, care managers, and supportive services staff. As an integral component of quality care, client experience includes several aspects that clients value when they seek and receive care, such as getting timely appointments, easy access to services and information, and good communication with providers and other staff. Understanding patient experience is an important component for the CCCV model in that by looking at different aspects of client experience, we can assess the extent to which clients are receiving care that is respectful of and responsive to their individual and family needs, including cultural and linguistic preferences and values. We intend to build on the Consumer Assessment of Health Care Provider and Systems (CAHPS) tool, promoted by the Agency for Healthcare Research and Quality (AHRQ)[16], which provides well-tested questions that have benefited from a consistent methodology across a large sample of respondents to generate standardized and validated measures of client experience. Like the quality-of-life assessment, client experience will occur at enrollment as a retrospective assessment of previous experiences and at intervals of three (3) months during enrollment in the program and for three (3) months post discharge in that some services will continue.
- Provider and Staff Job Satisfaction – Just as client experience is a relevant line of inquiry, so too is the experience of providers and staff in that discontinuity in services is not just due to siloed systems, but also provider dissatisfaction and its impact on treatment. According to a study of social workers by Siebert (year), there is a burnout rate of 39% and a lifetime burnout rate of 75%[17]. This highlights the prevalence of burnout among social workers and allied professionals, and its potential impact on the CCCV program. We intend to use two (2) tools to assess satisfaction. The first is the Maslach Burnout Inventory (MBI), which is a psychological assessment comprising 22 symptom items that pertain to occupational burnout. The original form of the MBI was developed with the goal of assessing an individual's experience of burnout, and its measures three (3) dimensions: emotional exhaustion, depersonalization, and personal accomplishment (https://en.wikipedia.org/wiki/Maslach_Burnout_Inventory). The second tool pertains to employee and work satisfaction. We are considering a

[15] Hyland, M. E. (2003). A brief guide to the selection of quality of life instrument. Health and Quality of Life Outcomes, 1(24), 1-5.
[16] What Is Patient Experience? Content last reviewed August 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html
[17] Siebert, D.C., Siebert, C. F., & Taylor. (2007) Susceptibility to emotional contagion: Its measurement and importance to social work. McLaughlin, A

hybrid of two (2) tools. The first is the Brief Index of Affective Job Satisfaction (BIAJS), which is a four-item assessment that measures overall effective job satisfaction. The other is the Job Descriptive Index (JDI)[18], which measures satisfaction in five (5) areas:

- Pay
- Promotions and promotion opportunities
- Co-workers
- Supervision
- The work itself

We intend to compare the responses of CCCV staff with surveys completed by other staff of youth and family services agencies, and as a show of appreciation for participation, we will share the survey results with agency management.

- Process Assessment – A study of the CCCV's developmental process will be conducted to support replication of its success in other communities in California. A combination of content analysis of materials, key informant interviews with staff and service recipients, and focus group participants will be used to capture the CCCV's evolution as an integrated system of care and to identify critical success variables necessary for program and service development. Working from a logical model, which will include anticipated activities, outputs, and outcomes, and a PDSA (Plan, Do, Study, Act) cyclical approach, benchmark events will be documented, including the rationale for changes made to improve the program. From these observations in combination with the other outcomes proposed herein, a user-manual will be developed to guide programs that follow from the lessons learned by CCCV developers.

METRICS: In addition to the required demographic metrics, and the evaluative measures described above, we will capture additional quantitative data for the project that includes:

- Number treated in CRTP.
- Number of children discharged instead to Village with family.
- Number of families at risk of child removal
- Number of families who are at risk of being unhoused.
- Number of families reunified because of interim housing.
- Number of families who used transitional housing.
- Number of families who obtained permanent housing.
- Number of return admissions and time between admissions

[18] Smith, P.C., Kendall, L.M.,&Hulin, C.L. (1969) The measurement of satisfaction in work and retirement. Chicago: Rand McNally.

- Number of days to schedule an appointment when stepping up/down.
- Number of times more than 30 days for appointment availability
- Number of times a medication not refilled due to not having an appointment.
- Number of missed appointments
- Number of children who abandon care.
- Number of family members provided MH/SUD treatment.
- Number of family members engaged in Family Unit Treatment
- Number of wellness courses and participants
- Number of families using short-term housing to engage with treatment of child.

Section 3:

ADDITIONAL INFORMATION FOR REGULATORY REQUIREMENTS

CONTRACTING

This project has been designated for implementation in SA 6, South Los Angeles, due to the demonstrated health, mental health, and social inequities in the community. LACDMH intends to partner with Kedren to provide comprehensive mental health services for children along the mental health continuum at the Children's Community Care Village. Kedren has longstanding ties to the SA 6. Kedren demonstrates an understanding of community needs because LACDMH has an existing contractual relationship with Kedren. In addition, to date Kedren has established additional funding sources for various project components, and the proposed site is located on property owned by Kedren, the selection of a contractor through an RFP process is not applicable.

MHSA GENERAL STANDARDS

A. Community Collaborations

The proposed initiative focuses on community and ways to introduce services and resources proactively and therapeutically across the county. LACDMH is committed to a recovery-based system of care.

This project has been in planning since 2021.The Board of Directors of Kedren and the community stakeholders in SA 6 have collaboratively engaged to vision, innovate and plan for the CCCV. The project was presented to Kedren and LACDMH stakeholders at a joint meeting on December 22, 2022, followed by an opportunity for public comment from January 20, 2023, through February 20, 2023.

B. Cultural Competency

LACDMH abides by the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as do our contracted agencies and partners. CLAS Standards advance health equity, improve quality, and help to eliminate health care disparities by offering an implementation blueprint.

Our partner, Keden, actively engages in efforts to ensure that linguistically matched services are available through the recruitment of bilingual staff members within service components. One of the challenges of working in Los Angeles is the diversity of languages spoken. While it is relatively easy to accommodate monolingual clients who speak Spanish, it is challenging to have translators available for less common languages. Other languages spoken by staff include Russian, Armenian, Vietnamese, Hmong, Cantonese, Mandarin, Japanese, Russian, Tagalog, Cambodian, and Laotian.

Additionally, Kedren offers a video relay system that provides sign language interpretation on demand. Providing culturally competent services includes understanding the unique

cultural needs of the community service. In addition to ensuring staff are reflective of the community service, the incorporation of ICC will allow children, youth, and families to voice their preferences in treatment, and alternative, culturally appropriate services will be considered as part of the treatment plan.

C. Client and Family Driven, Resiliency Focused

Every child and youth served at the CCCV will be offered ICC services, including ICC. The implementation of the Child and Family Team meetings will create space and structure needed for the child or youth and family to include who they identify as critical to care and care planning and to voice their concerns, needs, and preferences in treatment. Participants are encouraged to actively engage in their care and to express concern arising from problems with the care they received. Treatment plans and progress will be strength focused and reviewed at regular intervals and open communication between family members and care providers is encouraged.

D. Integrated Service Experience for Clients and Family

The application of a new model to facilitate service integration through the addition of the ICC services is a key innovation in this project. The goal is to improve the system by improving transitions across the system of care within and outside of the CCCV through a single coordinator who can tie the goals identified by the child and family in the CFT developed treatment plan with the services available at each level of care through coordination with the treatment teams. This reduces time spent re-establishing treatment goals and allows for the child or youth to build on their progress at each stage.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

The contracted evaluation will include metrics related to populations served, availability of culturally competent services and impact on identified disparities. Los Angeles County MHSA Stakeholders have prioritized the accessibility of culturally competent services and the reduction of disparities across LA County. An annual update on this project will be presented to countywide MHSA stakeholders during the planning process for feedback and recommendations.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Based on evaluation at project end, DMH will identify the appropriate funds to continue supporting services that are not self-sustaining if available. LACDMH and Kedren believe that the project is sustainable, and that care continuity will be provided through existing fees for services, the FQHC funding that Kedren receives, and contracts for service and/or referrals with the many partner organizations throughout Los Angeles County including LACDMH. If portions of the pilot are not sustainable or not successful, LACDMH will work to ensure continuity in care for all participants in the transition of the project.

COMMUNICATION AND DISSEMINATION PLAN

A. How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

All the input gathered will be incorporated into information disseminated to LACDMH, and through our collaborative partnerships with other community stakeholders. Further, ongoing input will be sought from clients, families and involved stakeholders as part of their organizational quality monitoring. As such Kedren has had and plans to continue community outreach regarding CCCV, services and community engagement. Further, because Kedren is a Federally Qualified Healthcare Center (FQHC), Kedren's Board of Directors is 51% consumers (as mandated by law) who live in the community/neighborhood. Participant and stakeholder input is explicitly imbedded into this program expansion.

LACDMH will share information about the evolving model with other jurisdictions interested in trying a comparable approach that builds on lesson learned. Updates will be shared in the LACDMH's Annual Update and Three-Year Plans. Regular updates will be provided to the local Mental Health Commission and stakeholders in regularly scheduled meetings. In addition, there is opportunity to participate through professional channels, such as conferences and association meetings, where findings will be shared, and technical assistance offered as the CCCV evolves.

B. KEYWORDS for search: Please list up to five keywords/phrases for this project that someone interested might use to find it in a search.

1. Intensive Care Coordination and Mental Health Continuum of Care
2. Children's Community Care Village and Mental Health Village
3. Crisis Residential Treatment Program for Children
4. One-Stop Shop
5. Integrated Services and Service Integration

TIMELINE

The total timeframe (duration) of the CCCV project is FIVE YEARS. Pre-construction has already begun using awarded funding noted earlier in the proposal, and full construction is expected to be completed by May 27, 2026. The augmentation of the service/operational dollars will commence in FY 2024-25, with full service/operational capacity (and full draw down) in FY 2026-27 for half of year three and the remaining two full years (providing enough data for evaluation and results analysis).

SERVICE DELIVERY/IMPLEMENTATION				CAP PROJECT: CONSTRUCTION
ICC	Transitional Housing	CRTP	UCC	
				2022: Planning & Pre-Dvlpmt.
				2023: Design Development
07.2024: START MHSA FUNDING	07.2024: START MHSA FUNDING	07.2024: START MHSA FUNDING	07.2024: START MHSA FUNDING	07.2024: START MHSA FUNDING
2024: Collect Base Line Data	2024: Collect Base Line Data	2024: Collect Base Line Data	2024: Collect Base Line Data	2024: Pre-Construction
2024: Integration Process Dvlpmt.	2024: Integration Process Dvlpmt.	2024: Integration Process Dvlpmt.	2024: Integration Process Dvlpmt.	
2024: Begin Hiring Staff				
2024: Begin Svcs + Data Collection				
2025: Continue Staffing Up				2025: Construction Begins
2025: 50% Svc Delivery (new + existing clients)				
2025: Begin Eval & Reporting				
2026: Full Staff Up	01.2026: Begin Hiring Staff	01.2026: Begin Hiring Staff	01.2026: Begin Hiring Staff	05.2026: Cert of Occupancy Issued
2026: Full Service Delivery (+Data)	06.2026: Full Svc Delivery (+Data)	06.2026: Full Svc Delivery (+Data)	06.2026: Full Svc Delivery (+Data)	
2026: Cont Eval & Reporting				
2027: Eval & Reporting (annual)	2027: Begin Eval & Reporting	2027: Begin Eval & Reporting	2027: Begin Eval & Reporting	
2028: Eval & Reporting (annual)	2028: Eval & Reporting (annual)	2028: Eval & Reporting (annual)	2028: Eval & Reporting (annual)	
2029: Final Eval. & Reporting	2029: Final Eval. & Reporting	2029: Final Eval. & Reporting	2029: Final Eval. & Reporting	
06.2029: END MHSA Funding	06.2029: END MHSA Funding	06.2029: END MHSA Funding	06.2029: END MHSA Funding	06.2029: END MHSA Funding

Section 4:
INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

INN PROJECT BUDGET & SOURCE OF EXPENDITURE

Budget Narrative

LACDMH total request for MHSA Innovations Funding of **$100,594,450**

The total request for operational costs for **five years** is $34,825,198 and $65,769,252 for capital costs.

The requested $34,825,198 MHSA INN for services will draw down an additional $62,567,519 in Medi-Cal match, for a **total service provision of $97,392,718**[18] over the course of five (5) years.

Key highlights of the main program components that are being funded:

Intensive Care Coordination (ICC):
The flagship and core for the CCCV, hiring for ICC will be aggressive and begin immediately upon acceptance of funds. We anticipate 50% staffing and service delivery capacity/capability of this new innovative program by the end of year one for all existing clients. By end of year two, Kedren will achieve full staffing and service delivery capacity/capability for existing and new clients. The end of year two (May 2026) will mark the completion of the campus and bring online CRTP, UCC and Transitional Housing services that will need to be integrated with each other and all existing programs.

The ICC Program will include approximately 68 FTE consisting of (but not limited to) psychiatrists, nurse practitioners, nurses, internists, social workers, case managers, program managers, pharmacists, dieticians, and support staff (such as but not limited to transportation specialists, outreach workers, peer advocates, clerks, etc.) working in specialized ICC teams depending on the client/family need.

Crisis Residential Treatment Program (CRTP):
The first and only CRTP for children in Los Angeles County will be in operation by the beginning of FY 2026.

In addition to ICC support, the 16 beds staffed by approximately 28 FTE consisting of a team of nurses (Charge Nurse, Nurse, LVN, CNAS/MHW) working in 12-hour shifts, along and clinicians; social workers, case workers, occupational therapists, psychologists, psychiatrists, nurse practitioners, internists, and support staff (dietician, food service workers, clerks, community liaison, etc.)

The average length of stay is anticipated to be 14 days.

[18] This amount only reflects the service dollar provided by the "new" services that are funded by MHSA INN. This does not include service dollars that will be provided for other services (existing) on the campus, such as inpatient acute psych, FQHC (primary care), etc.…

Urgent Care / Crisis Stabilization Center (UCC/CSU):
The UCC will be a 23-hour 59-minute emergency center that will be open to the public and fully operational beginning of FY 2026.

In addition to ICC support, the core staff will be a 10-12 chair unit staffed by approximately 29 FTE that consists of a team of nurses (Charge Nurse, Nurse, LVN, CNAS/MHW) working in 12 hour shifts, along with (but not limited to) social workers, case workers, occupational therapists, psychologists, psychiatrists, nurse practitioners, internists, and support staff including but not limited to an office manager, dietician, food service workers, clerks, and a community liaison.

Per state law, maximum stay cannot exceed 24 hours.

Transitional Housing:
The modular transitional housing complex will consist of 24 units capable of housing up to two (2) adults and two (2) children or one (1) adult and three (3) children, plus one (1) unit for the manager/residential advisor.

Two (2) programs will be run out of the facility with approximately 20 units dedicated to traditional transitional housing (with a focus on clients/families receiving services at Kedren) and four (4) units for Parent-Child Interactive Therapy (PCIT).

In addition to ICC support, the core staff for the programs will include nine (9) FTE consisting of full-time, on-site (live-in) resident advisor, social workers, case managers, occupational therapists, psychologists, psychiatrists, a nurse practitioner, pharmacists, and support staff including but not limited to the dietitian, food service workers, and community liaison.

The average length of stay is 8-9 months, with maximum stay not to exceed 18 months.

Special Note: Workforce Shortages
California and the nation have been experiencing massive, long-standing shortage of healthcare and social workers; a fact that is exponentially exacerbated in the mental health specialties. Kedren has already been working to address normal staff attrition. In anticipation of exponential new hires, we have accordingly reflected gradual onboarding of services and staff in the timeframe. With ample lead time for Kedren to ramp up to 100% service delivery capacity and capability to all our new and existing clients

Further, Kedren has already established partnership with Charles Drew University, and for several years Charles Drew doctors and nurses (primary and psychiatric) train at Kedren, as well as many other joint programs. Most recently in October of 2023, under the leadership of California State Assemblymember Mike Gipson, a new “joint nursing program” collaborative has been created between Kedren, Charles Drew and Cal State

Long Beach that will encourage new students into the field of nursing, practical application curriculum at Kedren/Drew, and most importantly Kedren/Drew will get priority in hiring in an effort to get graduates to work and stay in the local community.

Non-recurring costs - Capital Project

The MHSA INN request for Capital costs of $65,769,252 is requested to build state of the art, up to date facilities that will house a full spectrum of children and youth mental outpatient services, including a 23-hour urgent care crisis stabilization unit (UCC/CSU), an integrated "step-down" sub-acute crisis residential treatment program (CRTP), an outpatient pharmacy, and space for partner organizations and complementary services to engage with children and their families. All components of the CCCV are aligned with the MHSA INN directives, mission, and guidelines.

The MHSA INN capital project request covers only a portion of the building of the comprehensive integrated campus. The full project cost is over **$160,000,000** and includes a 30-36 bed inpatient acute psychiatric hospital, FQHC primary care, amongst other components **that have already or will be funded** by other public and private funding sources listed below:

- $57.4M - BHCIP (Behavioral Healthcare Infrastructure Program) Round 4
- $25M MHSA CFTN pending OAC approval of INN funds
- $2.5M - California State Legislature (2023)
- Land Grant - City of Los Angeles (in process)
- $1M - LA County Board of Supervisors, Supervisor Holly Mitchell (2022)
- $1M Various Foundations & Private Philanthropy (California Community Foundation, Weingart, Ahmanson, etc.)
- $10M FUTURE Private Capital Projects Fundraising Campaign (Foundations and Private Philanthropy)

The entire CCCV facility is approximately 134,764 gross square feet, with the MHSA INN funded portion approximately half 63,367 gross square feet. For the MHSA INN funded portion alone, it is far more cost effective for to build this facility than lease for the following reasons:

- No such facility exists: a 134,764 square foot campus, let alone 63,367 square foot space (that allows for hospital and clinical space) is not available nor existent in the South Los Angeles area.
- Even if space was available, the total cost to lease/rent such a facility would be minimum $55.1M over the same 5-year period;

- Annual lease of $3.4 million ($17.1 M for 5 years)
- $38M in one-time Tenant Improvement (*including but not limited to build-out, renovation, upgrades, CA OSHPD & city licensing, and other*) costs to get such a site program ready (avg TI of $600 sq/ft.)
- Additionally, Tenant Improvement will take 1-3 years depending on the level of renovations/upgrades needed and proper zoning and licensing.

- "Program sustainability" – in the "long run" post MHSA INN funding period, it would be far more cost effective to build/own now versus lease/rent, which ensures greater likelihood for continued program continuity and funding.

- Over a 30-year period of service, the expected rental/lease cost would be minimum $140M. If you build the facility today opposed to renting today, the cost saving would be $49.23M over the 30-year period. $49.23M that can be used to fund additional services.

We appreciate the consideration of the Mental Health Services Oversight and Accountability Commission for this much needed community service. This project represents real opportunity to address disparities in our SA 6, South Los Angeles region.

Budget by Fiscal Year & Specific Budget Category

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY								
EXPENDITURES: SERVICES	***FY 22/23***	***FY 23/24***	**YR 1: FY 24/25**	**YR 2: FY 25/26**	**YR 3: FY 26/27**	**YR 4: FY 27/28**	**YR 5: FY 28/29**	**TOTAL**
Personnel			$ 8,234,050	$ 8,645,752	$ 16,801,822	$ 17,255,724	$ 17,732,321	$ 68,669,669
Operating Costs			$ 1,131,027	$ 1,187,578	$ 3,223,969	$ 3,286,317	$ 3,351,782	$ 12,180,673
Evaluation			$ 250,000	$ 262,500	$ 515,625	$ 529,406	$ 543,877	$ 2,101,408
Community Based Organizations			$ 250,000	$ 262,500	$ 425,625	$ 439,406	$ 453,877	$ 1,831,408
Indirect Costs			$ 1,479,761	$ 1,553,750	$ 3,109,085	$ 3,190,657	$ 3,276,308	$ 12,609,561
Services Sub-Total			**$ 11,344,838**	**$ 11,912,080**	**$ 24,076,126**	**$ 24,701,510**	**$ 25,358,165**	**$ 97,392,719**
EXPENDITURES: CAPITAL PROJECTS	***FY 22/23***	***FY 23/24***	**YR 1: FY 24/25**	**YR 2: FY 25/26**	**YR 3: FY 26/27**	**YR 4: FY 27/28**	**YR 5: FY 28/29**	**TOTAL**
Non-recurring costs (Capital Projects: **MHSA INN Components***)			$ 14,728,252	$ 51,041,000				$ 65,769,252
Non-recurring costs (Capital Projects: Non-MHSA Components**)			$ 21,145,397	$ 47,832,985				$ 68,978,382
Non-recurring costs (Capital Projects: Pre-Planning)	*$ 500,000*	*$ 2,000,000*						
Capital Projects Sub-Total	***$ 500,000***	***$ 2,000,000***	**$ 35,873,649**	**$ 98,873,985**				**$ 137,247,634**
TOTAL INNOVATION BUDGET	***$ 500,000***	***$ 2,000,000***	**$ 47,218,487**	**$110,786,065**	**$ 24,076,126**	**$ 24,701,510**	**$ 25,358,165**	**$ 234,640,353**

* MHSA INN Components are referencing the capital projects costs for CRTP, CSU/UCC, Transitional Housing, and spaces for outpatient services/programs (offices, therapy rooms, activities room, etc...)
** Non-MHSA Components comprise of inpatient acute psych, FQHC (primary care) and other ancillary buildings.

Budget Context- Expenditures by Funding Source & Fiscal Year

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
FUNDING SOURCES: ADMINISTRATION + EVALUATION (Services)	***FY 22/23***	***FY 23/24***	**YR 1: FY 24/25**	**YR 2: FY 25/26**	**YR 3: FY 26/27**	**YR 4: FY 27/28**	**YR 5: FY 28/29**	**TOTAL**
Innovation Funds (Services)			$ 3,478,327	$ 3,652,244	$ 9,036,604	$ 9,228,347	$ 9,429,677	$ 34,825,199
Federal Financial Participation (Medi-Cal)			$ 7,866,511	$ 8,259,836	$ 15,039,522	$ 15,473,163	$ 15,928,487	$ 62,567,519
1991 Realignment								$ -
Behavoral Health Subaccount								$ -
Other Funding								$ -
Services Sub-Total	**$ -**	**$ -**	**$ 11,344,838**	**$ 11,912,080**	**$ 24,076,126**	**$ 24,701,510**	**$ 25,358,164**	**$ 97,392,718**
FUNDING SOURCES: CAPITAL PROJECT (Building Fund + One-Time)	***FY 22/23***	***FY 23/24***	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
Innovation Funds (Capital Projects)			$ 14,728,252	$ 51,041,000				$ 65,769,252
Federal Financial Participation (Medi-Cal)								$ -
1991 Realignment								$ -
Behavoral Health Subaccount								$ -
Other Funding: BHCIP Round 4	*$ 57,478,382*							$ 57,478,382
Other Funding: 2022 State Budget Grant		*$ 2,500,000*						$ 2,500,000
Other Funding: City of Los Angeles- Land Grant		*transfer*						$ -
Other Funding: LA County Board of Supervisor	*$ 500,000*							$ 500,000
Other Funding: MHSA CFTN (Pending OAC Approva of INNI)			$ 10,000,000	$ 15,000,000				$ 25,000,000
Other Funding: Foundations/Privat e Philantthropy	*$ 1,000,000*		$ 5,000,000	$ 5,000,000				$ 11,000,000
Capital Projects Sub-Total	***$ 58,978,382***	***$ 2,500,000***	**$ 29,728,252**	**$ 71,041,000**				**$ 162,247,634**
TOTAL PROPOSED EXPENDITURES	***$ 58,978,382***	***$ 2,500,000***	**$ 41,073,090**	**$ 82,953,080**	**$ 24,076,126**	**$ 24,701,510**	**$ 25,358,164**	**$ 259,640,352**

Highlighted in yellow are the amount requested from MHSA Innovations Funding. The total request is: **$100,594,450.**

Broken into: $34,825,198 for service/operational costs (over 5 years) plus $65,769,252 one-time for capital costs.