



LOS ANGELES COUNTY
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Hollywood 2.0 Concept Note

The Department of Mental Health is seeking concepts from our Community Workgroups on innovative ideas to implement in the Hollywood 2.0 Pilot Project. Please note that timing and funding source will also guide which ideas the Department is able to move forward with.

Primary Purpose (check at least one):

Increase access to mental health services	☒
Increase quality of mental health services	☒
Promote interagency collaboration related to mental health services, supports, or outcomes	☒
Increase community and peer collaboration and input regarding mental health service delivery in the Hollywood area	☒

Project Approach (check at least one):

Introduces a new mental health practice or approach	☒
Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population, or community. (Include how they will engage with the other Hollywood 2.0 providers in the description)	☐
Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting	☐
Participating in a housing program designed to stabilize a person's living situation while also providing supportive services on site	☐

Working Title of Proposal	Recovery through enhanced care: a team-based psycho-social approach to community mental health care
Target Population (including age group, any clinical requirements (e.g., diagnoses, co morbidity, housing status, etc.))	☐ 0-5 Yrs ☐ 6-15 Yrs ☒ TAY 16-21 Yrs. ☒ TAY 22-25 Yrs ☒ Adults 26-59 Yrs ☐ Older Adults 60+
Need and/or Service Gap Addressed	The original TRIESTE Innovations Pilot sought to enhance the level of care and support provided to mental health clients by embracing a range of psycho-social supports, in a community setting, that



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	is more robust than traditional clinical supports provided in institutional settings. One innovation to be tested involved a “payment reform” model which uncoupled decisions about treatment from Medicaid reimbursement limitations and created a capitated budget from which to provide services. Not only would clients have access to more universal life support (e.g., payments for non-clinical supports such as housing-related expenditures, transportation, emergency expenses, tuition, etc.) , but the workers in the system would also be freed up from burdensome documentation and would have the discretion to accompany their clients in ways that were meaningful to their recovery journey. The Innovations Pilot also sought to expand the workforce to include peers and anticipated the creation and cultivation of service supports throughout the community that would support the whole-life needs of people served.
Two Sentence Description of Proposal	This proposal calls for a manageable, yet meaningful four-year pilot, inspired by the original innovation grounded in the TRIESTE proposal approved by the MHSOAC in May 2019. This pilot would apply the same flexibility associated with services offered that are uncoupled from the traditional Medicaid model and are available 24/7.
Estimated Annual Program Costs ** (see note below)	>1M ☐ 1-3M ☐ 3-5M ☒ <5M ☐
Community Partners	The following organizations in Hollywood would come alongside this pilot within a pilot. Hollywood 4WRD, Heart Forward, PATH, The Center, My Friend's Place, Kaiser, Hollywood Food Coalition, Pacific Clinics, John Wesley Health Center and others.
Implementation Issues/Challenges	• Workforce shortages • There must be a commitment to meaningful data collection (tedious, yet critical) • We must speak up that Cal AIM does not reduce documentation burdens as envisioned by the original pilot, though this may have been an expectation at the time the pilot was altered in 2021.



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Short-term Goals/Outcome	• Embrace creativity and discretion with respect to how team members (staff, peers and community members) come alongside clients due to flexibility of funding. • Begin a dialogue on the elements of systems change that are required to foment meaningful improvement in the delivery of mental health services. • Embrace and train around a recovery model. • Increase client engagement, decision making, socialization, articulating needs, meaningful activities and interests, satisfaction with service • Anticipate a 25 percent increase in productivity of team members because of less time spent on documentation.
Long-term Goals/Outcomes	There has not been a meaningful attempt to tackle payment reform since the pilots of the 1990s in California. Arguably, the results achieved from those studies helped to inform the creation of the Mental Health Services Act. Replicating the core features of this almost 30 years later could help to inform the need for additional flexibility that could/should be baked into CalAIM and also possibly help inform payment reform on a national basis. Long term, we expect the following would be revealed and we posit that these outcomes will be more favorable as compared to the study group associated with the Hollywood 2.0 pilot (as measured by the academic partner): • Enhanced vocational and educational outcomes • Reduced overall expenditures (on a per person/per year basis) • Higher consumer and family member satisfaction with mental health service system • Continued engagement with mental health service supports • Recovery and wellness as measured by agreed upon score systems (e.g., Milestones of Recovery – specifically Level 7 and 8) and other evaluation instruments, to be determined by academic partner



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	• Restoration and maintenance of connections to natural support systems – family, faith and community • Culture change within the traditional bureaucracy • Decrease in ER, hospitalization, incarceration, substance use, crisis/relapse • Increase in literacy, employment, physical health
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** Program costs

For this pilot within the pilot, the county would carve out approximately \$3 to 5M from the annual budget of \$26M (up to 20 percent). In this scenario, approximately \$20,000 per person (flexible funds) would be available to serve approximately 150 to 250 people (a representative sample, randomly selected). The pilot team (consider as a 24/7 “extended case management team”) assembled to work with this study group would have considerable discretion to support and provide services, but the funds would not include payment for housing or hospitalization. The case management team does not have to be staffed entirely by licensed professionals; peer workers are envisioned with several advantages, including contributing to an innovative practice in expanding and diversifying our workforce. Arguably, this team approach would also emulate some of the features of the “system concierge” envisioned in the original pilot because of their sustained connection to people assigned to the study group.

Because innovation is also desired in the manner in which data is collected and streamlined, the request envisions an additional set-aside to contract for a technical consultant to create the innovative data collection tool.

Some costs still need to be accounted for and could be discussed with the county and an academic partner as this program is designed. For example,

Freed from the requirement to provide Medicaid documentation, staff in the pilot will implement a much less burdensome documentation system that focuses on the outcomes of services rather than process documentation. This system, while expected to be much less burdensome than the current system, will still require additional technical quality assurance staff to ensure that the data being collected are reliable and valid. This is an additional cost that might be able to be part of the overall academic partner contract.

- The size of this study group could be minimized, but that decision should be made in consultation with the academic partner.

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- The pilot within the pilot could operate out of the proposed clubhouse (under a nonprofit provider), which would provide a community-based non-clinical setting for a team to operate. Another alternative would be for it to operate out of the proposed Safe Landing site, if that site, as implemented, is designed to connect people with appropriate services and support whether or not they qualify for Safe Landing interim housing.