SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSOAC
Mental Health Services
Oversight & Accountability Commission

INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

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 Board of Supervisors.
☐ Local Mental Health Board approval Approval Date: November 6, 2024
☐ Completed 30 day public comment period Comment Period: November 6, 2024
☐ BOS approval date Approval Date: _____ If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: December 10, 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: December 2024 or January 2025 ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo County
Date submitted: TBD
Project Title: Progressive Improvements for Valued Outpatient Treatment (PIVOT)
Total amount requested: $5,650,000 ($5M service delivery for 5 years, $200K BHRS administration, $450K evaluation)
Duration of project: 5 years

PIVOT is a multi-county system redesign Innovation (INN) project, initially developed by Orange County, that supports counties in preparing for behavioral health transformation and the transition to the Behavioral Health Services Act (BHSA). Given that counties face similar system-level challenges, the project promotes cross-county learning and capacity building as counties redesign their behavioral health systems.

San Mateo County BHRS is opting into one of the five components of the PIVOT concept. The Orange County plan, which offers full background on the need and design of the project, is attached. Approval of the project in San Mateo County is contingent upon Mental Health Oversight and Accountability Commission (MHSOAC) approval of the Orange County project.

Proposed PIVOT Component(s) to Implement in San Mateo County:
☐ Full-Service Partnership Reboot
☐ Integrated Complex Care Management for Older Adults
✓ **Developing Capacity for Specialty MH Plan Services with Diverse Communities**
☐ Innovating Countywide Workforce Initiatives
☐ Innovative Approaches to Delivery of Care

LOCAL NEED

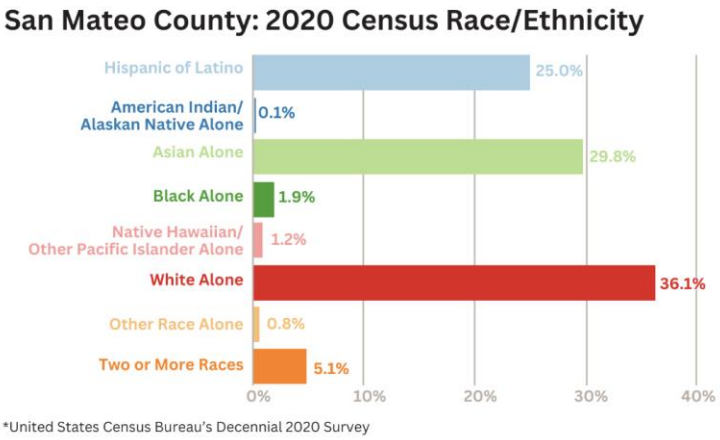
In San Mateo County, as in other counties, mental health services are split into services for individuals with *mild to moderate* behavioral health conditions and specialty mental health services (SMHS) for individuals living with *serious mental illness* (SMI) or *substance use disorders* (SUD). In San Mateo County, community-based mental health providers typically provide MHSA-funded early intervention and peer support services. Additionally, community-based organizations (CBOs) are often the best equipped to provide culturally informed strategies in diverse communities–or what the California Reducing Disparities Project (CRDP) calls *community-defined evidence practices* (CDEPs)—alternatives or complements to standard evidence-based practices that "offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve." As counties transition to BHSA and prioritize billable services, it will be critical to develop the community

infrastructure and network of providers eligible to bill Medi-Cal for both specialty mental health, peer supports, and early intervention services.

County Demographics

San Mateo County is a diverse county in terms of race/ethnicity, country of origin, and language. As such, there is a great need to ensure that culturally informed CDEPs are integrated in the behavioral health system as the statewide behavioral health reform moves forward.

Race/ethnicity. San Mateo County has a total estimated population of 754,250. In 2020, 36.1% of residents identified as White (non-Hispanic), followed by 29.8% of individuals who identified as Asian, and 25.0% who identified as Hispanic/Latinx. Black/African American individuals made up 1.9% of the population, Native Hawaiian/Pacific Islander individuals made up 1.2%, and American Indian/Alaskan Native made up 0.1% of the population. Individuals who identified as two or more races made up 5.1% of the population, and individuals who identified as another race made up 0.8%.[1]



Country of origin. An estimated 35.9% of San Mateo County residents were born outside of the United States.[2] The regions of birth included Mexico and Central America, South America, Europe/Canada/Oceana, and Asia (60%, 6%, 5%, 29% respectively).[3] In 2019, according to the Migration Policy Institute, San Mateo County had 55,000 undocumented residents.[4]

Languages spoken. Nearly half (45.2%) of San Mateo County residents speak a language other than English at home. The most common foreign languages spoken in San Mateo County are Spanish (17.2%), Chinese which includes Cantonese and Mandarin (9.3%) and Tagalog (6.2%).[5]

[1] San Mateo County, County Executive's Office, using 2020 United States Census. https://www.smcgov.org/ceo/san-mateo-county-demographics-0

[2] San Mateo County, County Executive's Office, using American Community Survey, 2018-2022, 5-Year Estimates.

[3] San Mateo County 2020-2021 Cultural Competence Plan. https://www.smchealth.org/sites/main/files/file-attachments/final_smc_bhrs_ode_cultural_competency_plan_20_21_0.pdf?1642194682

[4] San Mateo County 2020-2021 Cultural Competence Plan.

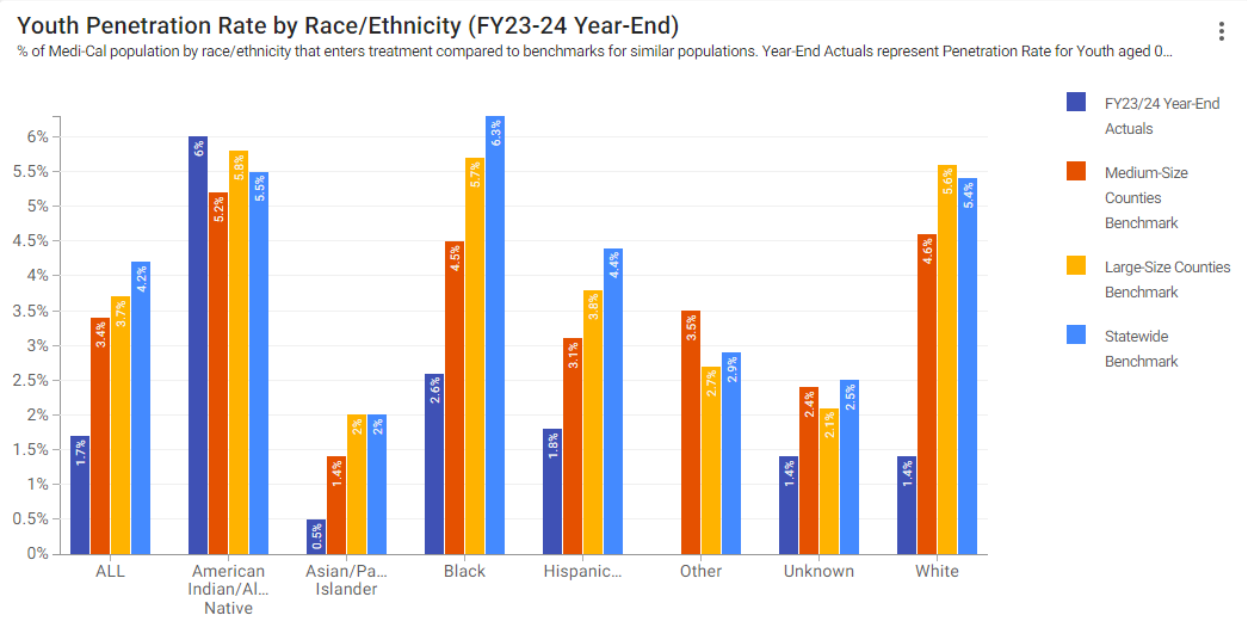
[5] Source: San Mateo County, County Executive's Office, using American Community Survey, 2018-2022, 5-Year Estimates

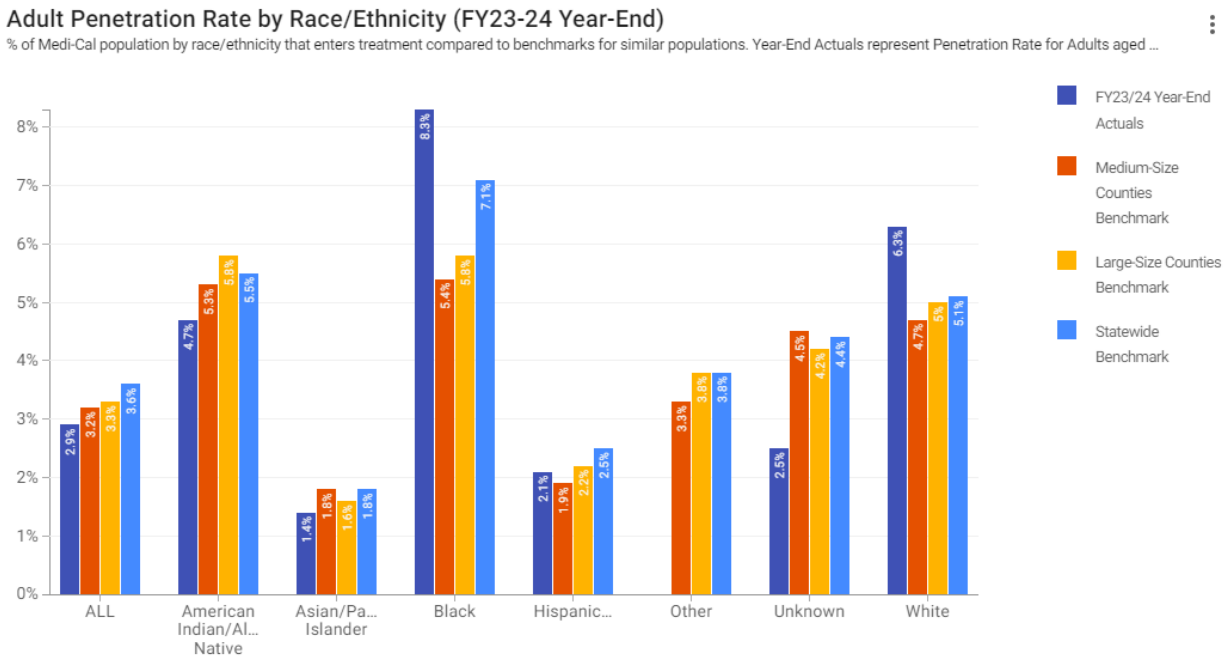
Underrepresented Groups in the Behavioral Health System

Penetration rates for specialty mental health and substance use services represent the percent of Medi-Cal eligible individuals who are served by the county behavioral health system. Looking at penetration rates for mental health and substance use services by race/ethnicity helps to identify communities that are underrepresented in the BHRS system of care.

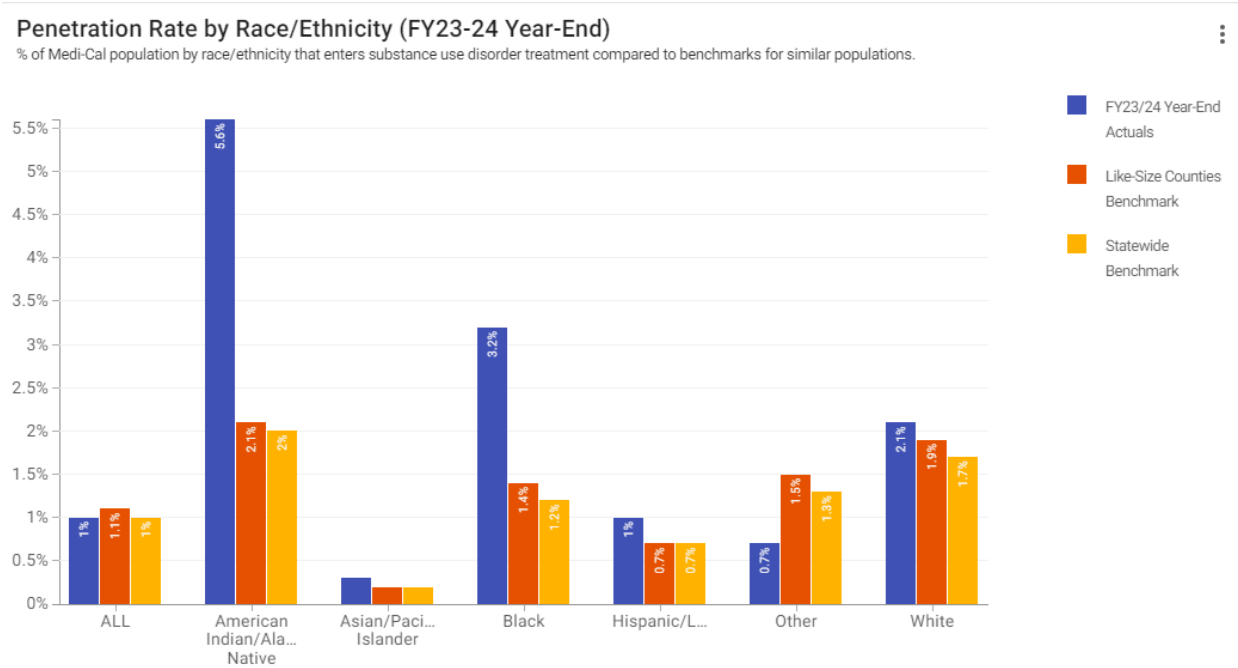
Mental health penetration rates for youth in San Mateo County are low across all race/ethnicity categories. For adults, overall rates are lower compared to similar-size counties and the state and more specifically underrepresentation of American Indian/Alaskan Native and Asian/Pacific Islander.

FY 23/24 Year-end penetration rates of youth and adults for mental health treatment by race/ethnicity category.





FY 23/24 Year-end penetration rates for substance use disorder treatment by race/ethnicity



Gaps in Medi-Cal Billing

In San Mateo County, larger and established community-based providers are certified to bill for Medi-Cal reimbursement for their culturally informed early intervention mild-to-moderate and SMHS (e.g., StarVista's San Mateo County Pride Center). Yet, there are challenges for smaller CBOs that do not have

the infrastructure or capacity needed to become a SMHS provider and/or certified bill Medi-Cal for eligible peer support and early intervention services.

In San Mateo County, there are at least 15 MHSA-funded peer support and early intervention providers that could potentially bill to Medi-Cal if support were available to help them be certified and train them in billing procedures. These programs range from $75,000 to $650,000.

The PIVOT project creates an opportunity to sustain effective and culturally informed early intervention and peer support services funded by San Mateo County MHSA (e.g., The Cariño Project, Farmworker Equity Express, Kapwa Kultural Center, Recovery Connection, California Clubhouse, Helping Our Peers Emerge: From Hospitalization to Healthy Community Integration; Joven Noble, Mindfulness-Based Substance Abuse Treatment, INSPIRE Brief Intervention, Promotores Model - Outreach Collaboratives, Music Therapy for Asian Americans, etc.) and enhance the volume and quality of culturally informed SMHS by assisting CBOs to become SMHS providers, certify to bill Medi-Cal, and help them identify components of successful CDEPs that can be billable. This project will determine steps to help CBOs that are interested become SMHS providers and/or certified to bill for their early intervention CDEPs and peer support services. It will test the model of billing that health care providers use and identify components of CDEPs for which counties could leverage Medi-Cal billing.

LEARNING OBJECTIVES

The table below lists the learning objectives designed for the Orange County project along with additional learning objectives for San Mateo County.

PIVOT Learning Objectives (Orange County)	Additional Local Learning Objectives
1. What are the minimum requirements for a CBO to become a Medi-Cal/DMC-ODS provider? 2. What type and level of technical assistance is needed to support CBOs? 3. In what ways does a hub and spoke model effectively support capacity building? 4. Does embedding culturally based approaches for specialty mental health care improve penetration rates and client outcomes? 5. Which CDEPs are most effective? 6. How can CDEPs be utilized to generate revenue?	1. To what extent and how does the process of billing Medi-Cal change CBOs' service delivery practices (e.g., structure of services, time spent on administration)? 2. What adjustments do CBOs need to make to their practices in order to incorporate Medi-Cal billing into their practice?

LOCAL COMMUNITY PLANNING PROCESS

PIVOT is pending approval from the MHSOAC and is scheduled for review on October 24, 2024 MHSOAC meeting. In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three-Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. San Mateo County's current MHSA Three-Year Plan strategies all embed three core components: *1) embed peer and family supports into all behavioral health services; 2) Implement culturally responsive approaches to address existing inequities; and 3) increase community awareness and education about behavioral health topics, resources and services.*

Implementing PIVOT component – to develop the community infrastructure and network of providers eligible to bill Medi-Cal for both specialty mental health, peer supports, and early intervention services – not only supports core BHSA priorities but also addresses San Mateo County local priorities. Appendix 1 describes the Three-Year Plan CPP process and Appendix 2 includes the MHSA Strategy Recommendations for San Mateo County.

<u>INN Idea Selection Process</u>

- ✓ With the availability of funding for new INN projects to be approved in the current fiscal year, BHRS sought to identify potential INN projects from its 2022 idea submission round that would meet current needs and align with the priorities of the BHSA.
- ✓ BHRS staff reviewed the 14 ideas that had been pre-screened in 2022 against the Innovation requirements. In order to prioritize INN projects that could be sustained under the BHSA, staff screened the 14 ideas to identify projects that included treatment/recovery and/or early intervention services. Most project ideas were in the area of prevention; five ideas included components of early intervention, treatment, and/or recovery.
- ✓ BHRS conducted an internal feasibility review of the five projects, and determined to move forward with two of the INN proposals based on BHRS capacity and priorities for the BHSA transition. In addition, BHRS decided to move forward with two multi-county collaborative INN projects.
- ✓ On September 5, 2024, the MHSA Steering Committee met to review the two community-derived INN ideas, and the two multi-county collaborative projects, and provide comment and considerations for the projects through breakout room discussions and online comment forms.
- ✓ *[This section to be updated after closing of the public comment process] The Behavioral Health Commission voted to open the 30-day public comment period on October 2, 2024 and reviewed comments during the public hearing and closing of the public comment period on November 6, 2024. [Substantive comments received are summarized in Appendix 3/No other substantive comments were received]. All comments and letters of support are included in Appendix 3.*

ALIGNMENT WITH BHSA

The PIVOT project supports the county's transition to BHSA by identifying system-level changes that will expand culturally-informed billable services and a well trained and supported behavioral health

workforce. These changes will create a sustainable foundation for the delivery of high-quality services for the most vulnerable and at-risk individuals.

BHSA Transition Questions	Response
How does the proposal align with the BHSA reform?	The project focuses on expanding accessible, culturally informed billable services for the "most ill and vulnerable" population and to be able to intervene in the "early signs of mental illness or substance use".
Does it provide housing interventions for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness?	No
Does it support early intervention programs or approaches in order to prevent mental illnesses and substance abuse disorders from becoming severe and disabling?	Yes, the project focuses on developing internal BHRS infrastructure to be able to support community-based mental health providers who typically provide early intervention services, to develop their capacity to provide billable specialty mental health services and early intervention services.
Does it support Full-Service Partnership efforts and services for individuals living with serious mental illness?	No
How will the County continue the project, or components of the project, after its completion without the ability to utilize certain components of MHSA funding for sustainability?	The project is self-sustaining as BHRS will develop the infrastructure to support community-based network of providers. Ongoing staffing needs will leverage the additional BHSA 2% administration allocation available to counties to implement BHSA priorities.
How does the project assist the county's transition to the behavioral health reform?	BHSA expands and increases the types of support available to the most vulnerable and at-risk individuals, which includes peer support services and early intervention strategies. The project develops the infrastructure necessary to provide these services in a culturally informed manner.

SUSTAINABILITY

The project is self-sustaining as BHRS will develop the infrastructure to support community-based network of providers. Ongoing staffing needs will leverage the additional BHSA 2% administration allocation available to counties to implement BHSA priorities.

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The total Innovation funding request for 5 years is **$5,650,000**, which will be allocated as follows:

Service Contract + Infrastructure: $5,000,000	**Evaluation: $450,000**	**BHRS Administration: $200,000**
· $500,000 for FY 24/25 · $1,000,000 for FY 25/26 · $1,000,000 for FY 26/27 · $1,000,000 for FY 27/28 · $1,000,000 for FY 28/29 · $500,000 for FY 29/30	· $60,000 for FY 24/25 · $85,000 for FY 25/26 · $85,000 for FY 26/27 · $85,000 for FY 27/28 · $85,000 for FY 28/29 · $50,000 for FY 29/30	· $30,000 for FY 24/25 · $40,000 for FY 25/26 · $40,000 for FY 26/27 · $40,000 for FY 27/28 · $40,000 for FY 28/29 · $10,000 for FY 29/30

Direct Costs will total $1,500,000 over a five-year term and includes all contractor expenses related to delivering the program services (salaries and benefits, training costs, program supplies, rent/utilities, mileage, translation services, subcontracts, etc.). Direct costs will also include provider infrastructure incentives to support capacity building for MediCal billing of up to 15 BHRS contracted providers.

Indirect Costs will total $650,000

- $450,000 for an independent evaluation contract to develop all annual reports and the final report due by December 31, 2030. The evaluation contract includes developing the evaluation plan, supporting data collection throughout the five years of implementation, data analysis and preparing the annual and final reports required.
- $200,000 is for BHRS county business, procurement processes, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project.

Federal Financial Participation (FFP) there is no initial anticipated FFP. Opportunities for developing Medi-Cal billing capacity for BHSA early intervention providers will be pursued.

Other Funding: The County will go through a local bidding process to identify the contractor for direct services; the bidding process will inquire about any in-kind or other revenue sources that can be leveraged.

	BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
	EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**FY 29/30**	**TOTAL**
1.	Salaries							
2.	Direct Costs							
3.	Indirect Costs	$30,000	$40,000	$40,000	$40,000	$40,000	$10,000	**$200,000**
4.	**Total Personnel Costs**	**$30,000**	**$40,000**	**$40,000**	**$40,000**	**$40,000**	**$10,000**	**$ 200,000**
	OPERATING COSTS*							
5.	Direct Costs							
6.	Indirect Costs							
7.	**Total Operating Costs**							**$**
	NON-RECURRING COSTS (equipment, technology)							
8.								
9.								
10.	**Total non-recurring cost**							**$**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)							
11.	Direct Costs	$500,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$500,000	**$5,000,000**
12.	Indirect Costs	$60,000	$85,000	$85,000	$85,000	$85,000	$50,000	**$450,000**
13.	**Total Consultant Costs**	$560,000	$1,085,000	$1,085,000	$1,085,000	$1,085,000	$550,000	**$5,450,000**
	OTHER EXPENDITURES (please explain in budget narrative)							
14.								
15.								
16.	**Total Other Expenditure**							**$**
	BUDGET TOTALS							
	Personnel (total of line 1)							**$**
	Direct Costs (add lines 2, 5, and 11 from above)	$500,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$500,000	**$5,000,000**
	Indirect Costs (add lines 3, 6, and 12 from above)	$90,000	$125,000	$125,000	$125,000	$125,000	$60,000	**$650,000**
	Non-recurring costs (total of line 10)							**$**
	Other Expenditures (total of line 16)							**$**
	TOTAL INNOVATION BUDGET	$590,000	$1,125,000	$1,125,000	$1,125,000	$1,125,000	$560,000	**$5,650,000**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

	BUDGET CONTEXT – EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
	ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for administration</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**FY 29/30**	**TOTAL**
1.	Innovative MHSA Funds	$530,000	$1,040,000	$1,040,000	$1,040,000	$1,040,000	$510,000	**$5,200,000**
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding							
6.	**Total Proposed Administration**	$530,000	$1,040,000	$1,040,000	$1,040,000	$1,040,000	$510,000	**$5,200,000**
	EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**FY 29/30**	**TOTAL**
1.	Innovative MHSA Funds	$60,000	$85,000	$85,000	$85,000	$85,000	$50,000	**$450,000**
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding							
6.	**Total Proposed Evaluation**	$60,000	$85,000	$85,000	$85,000	$85,000	$50,000	**$450,000**
	TOTALS:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**FY 29/30**	**TOTAL**
1.	Innovative MHSA Funds*	$590,000	$1,125,000	$1,125,000	$1,125,000	$1,125,000	$560,000	**$5,650,000**
2.	Federal Financial Participation							**$**
3.	1991 Realignment							**$**
4.	Behavioral Health Subaccount							**$**
5.	Other funding**							**$**
6.	**Total Proposed Expenditures**	$590,000	$1,125,000	$1,125,000	$1,125,000	$1,125,000	$560,000	**$5,650,000**
	*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting** **** If "other funding" is included, please explain within budget narrative.**							

Appendix 1. MHSA Three-Year Plan, 2020-2023
Community Program Planning (CPP) Process

The MHSA Three-Year Program and Expenditure Plan is developed in collaboration with clients and families, community members, staff, community agencies and stakeholders. In November 2022, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan commenced and engaged over 400 diverse clients, family members, staff and community agencies and leaders representing geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors across various means of providing input (surveys, input sessions, public comments). Planning was led by the MHSA Manager, Behavioral Health Commission MHSA Co-Chairpersons, an MHSA Three-Year Plan Workgroup and the MHSA Steering Committee. A draft CPP process was provided to the Behavioral Health Commission (BHC) and the MHSA Steering Committee in December 2022. Stakeholders provided input and comments on the process and what additional stakeholder groups should be engaged.

CPP FRAMEWORK

MHSA THREE-YEAR PLAN WORKGROUP

Between November and January 2023, a workgroup was convened made up of diverse stakeholders including clients, family members, community members and contracted service providers. The workgroup met monthly with the goal of co-designing an MHSA 3- Year Plan Community Program Planning (CPP) process that is equitable, inclusive and honors and centers the voices of marginalized communities. The objectives of each meeting included the following:

- Review and advise on data needed to support a comprehensive needs assessment
- Advise on the community input process and community engagement best practices, to ensure it is inclusive of all vulnerable communities
- Support opportunities for all San Mateo County community members to provide input

The MHSA Three-Year Plan Workgroup guided and informed the process each step of the way:

1. Needs Assessment
    - Informed Data Collection resources
    - Advised on the Community Survey structure
2. Strategy Development
    - Informed Community Input Sessions strategy
    - Advised on the creation of a Facilitator Training for stakeholders to support input sessions
    - Facilitated Community Input sessions
3. MHSA Three-Year Plan Development
    - Reviewed the Recommended Strategies for accuracy

COMMUNITY PROGRAM PLANNING PROCESS

1. Needs Assessment – this phase of the CPP process included the following two steps:
    - ✓ Data Review: Over 30 local plans, assessments, evaluation reports, and data were reviewed to identify prominent mental health and substance use needs reported across service sectors and the community. All of the concerns identified in the needs assessment review were categorized into the following 8 areas of need.
        i. **Access to Services** - this category captures the needs of diverse cultures and identities (race/ethnicity, LGBTQIA+, veteran status, age) related to accessing mental health and substance use services, including knowledge and education and culturally responsive approaches to engaging communities.
        ii. **Behavioral Health Workforce** - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient workforce to address the needs and the diversity of the community. This includes supporting individuals with lived experience as clients and/or family members of clients of mental health and substance use services to join the workforce and support all services and programming.

iii. **Crisis Continuum** - this category captures needs related to mental health and substance use crisis response, as well as appropriate community-based supports and stabilization during and after a crisis.

iv. **Housing Continuum** - this category captures the housing needs for individuals living with mental health challenges ranging from assisted living facilities to having access to permanent supportive housing, to early assessment of risk of homelessness and culturally responsive approaches and support with locating and maintaining housing.

v. **Substance Use Challenges** - this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

vi. **Quality of Client Care** - this category captures the needs of clients that are in treatment for mental health and/or substance use challenges to have timely access to care when needed, are successfully connected to services after an emergency and receive culturally responsive approaches to their treatment.

vii. **Youth Needs** - this category is age-based and captures mental health and substance use challenges for school to transition-age youth ages 6-25, it includes recent data for adolescent suicides, juvenile justice involvement, school-based and on-campus supports.

viii. **Adult/Older Adult Needs** - this category is age-based and captures mental health and substance use challenges for adults and older adults, it includes recent data related to increasing complexity of needs, general poor mental health outcomes, and suicide prevention needs.

✓ Community Survey: The identified needs from the review of local plans and data were included in an online survey that was distributed broadly to individuals living or working in San Mateo County. The survey asked respondents to share any additional concerns related to mental health and/or substance. Additionally, the survey requested that respondents rank the 8 areas of need in order of importance.

There were 129 survey respondents to the survey, the Needs Assessment summary of results were presented to the MHSA Steering Committee on February 2, 2023, to launch the Strategy Development phase.

2. Strategy Development – this phase of the CPP process included the following two steps:

✓ Community Input: 31 community input sessions and key interviews with diverse groups and vulnerable populations (immigrant families, veterans and transition-age youth) were conducted. Based on advice from the MHSA Three-Year Plan Workgroup, groups were asked to select 1 of the 8 areas of need to brainstorm strategies in the areas of prevention, direct service and workforce supports.* Participants were asked what possible solutions (services, programs, infrastructure, etc.) would they recommend to address the need they selected. See Appendix 2. for the full list of Strategy Recommendations.

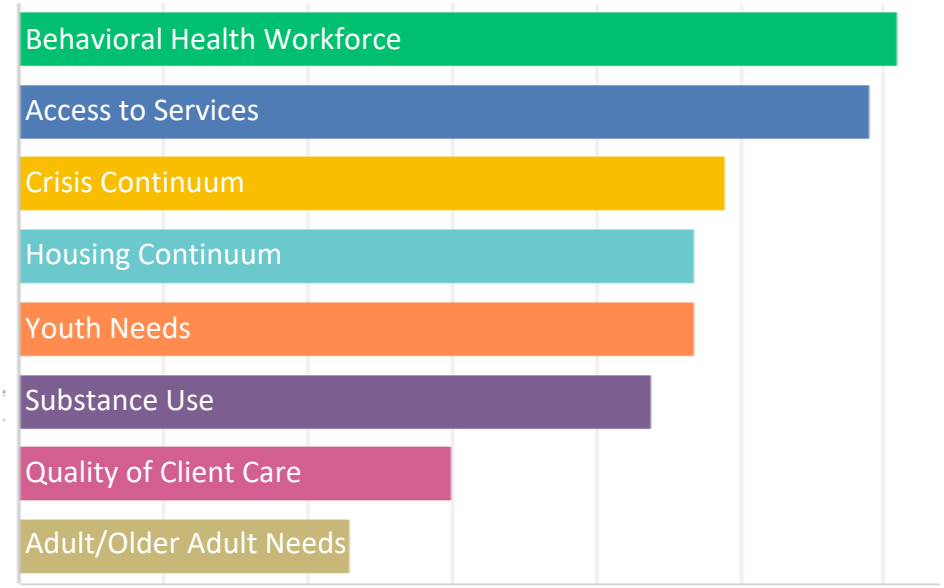
** As part of a simultaneous process to develop the MHSA 3-Year Workforce Education and Training (WET) Plan, 5 additional sessions were conducted to brainstorm around Behavioral Health Workforce strategies with the Diversity and Equity Council, Lived Experience and Education Workgroup, Alcohol and Other Drugs' Contracted Providers and BHRS Adult and Youth Leadership Teams.*

✓ Prioritization: To support the prioritization of strategies, participants were also asked: If you had to select one strategy to focus on over the next 3 years, which would you prioritize? Qualitative data analysis of all input received was conducted to identify the top strategy recommendations and key themes to present to the MHSA Steering Committee on May 4, 2023. Over 1,000 strategy ideas were shared via the Community Input sessions. This was narrowed down to 70 Strategy Recommendations across the 8 areas of need; strategies were included in this list if they were the top prioritized strategy by an input session group, they were repeated across input sessions, and for the areas of need that weren't selected as often by community groups (i.e., crisis continuum, substance use challenges, quality of client care and adult/older adult needs) all strategies that received a prioritization vote during in the input sessions were included.

Additionally, three key themes emerged from the input sessions overall, these strategies were brought up in virtually all input session: 1) Increase community awareness and education about behavioral health topics, resources and services; 2) Embed peer and family supports into all behavioral health services; 3) Implement culturally responsive approaches that are data-driven to address existing inequities. The idea is to incorporate these components into EVERY prioritized strategy moving forward.

The key themes and 70 Strategy Recommendations, Appendix 2., were presented to the MHSA Steering Committee on May 4th along with pre-recorded stakeholder video testimonials for each of the 8 areas of need and with an opportunity for additional public comments from meeting participants. Following the meeting the MHSA Steering Committee members were asked, via an online survey, to rank the 8 areas of need and help narrow down the scope of MHSA resources (both funding and planning) over the next three years. Given this prioritization, the areas of focus for the next three years will include Behavioral Health Workforce, Access to Services and addressing gaps in the Crisis Continuum. The MHSA Steering Committee was then asked in a follow-up survey to select their top Strategy Recommendations for each of the three prioritized areas of focus.

MHSA Steering Committee
Part 1 Survey Results – Areas of Need Prioritization:



3. MHSA Three-Year Plan – this phase of the CPP process includes the development of the plan, the 30-day public comment period and public hearing hosted by the Behavioral Health Commission (BHC) and the subsequent approval by the Board of Supervisors.

   - ✓ 30-Day Public Comment: The BHC voted to open a 30-day public comment period on June 7, 2023 and held a Public Hearing on July 5, 2023.
   - ✓ Board of Supervisor Approval: The BHC also voted to submit the MHSA Three-Year Plan to the Board of Supervisors for approval after the closing of the public comment period on July 7, 2023.

   This MHSA Three-Year Plan includes new funding allocations for the prioritized strategy recommendations, proposed funding allocations for other areas of need and strategy ideas that were identified; if there is an opportunity to leverage other efforts, initiatives, and/or external funding. The MHSA Three-Year Plan also builds on previous priorities. Funding and implementation for recommendations from the FY 20-21 Housing Taskforce and the Full Service Partnership (FSP) Workgroups will continue. See the Housing and FSP Workgroup priorities section.

   Additionally, The MHSA Three-Year Plan includes ongoing funding allocations for existing MHSA-funded programs. These programs are monitored, evaluated and adjusted as needed during the MHSA Three-Year Plan implementation years and recommendations are made annually about continuing, adjusting and/or ending a program. Changes to existing programs and services are included in subsequent Annual Updates, which involve stakeholder input, the MHSA Steering Committee and the BHC 30-day public comment period. Agencies selected to provide MHSA-funded services go through a formal Request for Proposal (RFP) process to ensure an open and competitive process to funding opportunities. The RFPs are posted on the BHRS RFP website, www.smchealth.org/rfps, which includes a subscription option to receive notifications.

MHSA THREE-YEAR PLAN STAKEHOLDER INPUT

Extensive outreach was conducted to promote the MHSA Three-Year Plan Workgroup participation opportunity, the Facilitator Training opportunity, the MHSA Steering Committee meetings, and the Community Input sessions. Flyers were made available in English, Spanish, and Chinese. Stipends to consumers/clients and their family members and language interpretation were offered at every meeting, childcare for families and refreshments were offered for in-person meetings.

Input included perspectives from clients and family members, communities across geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors. The sessions were conducted through 14 existing collaboratives/initiatives, 11 committees/workgroups, 3 geographically-focused collaboratives (Coastside, East Palo Alto and North County) and 3 stakeholder group key interviews of transition-age youth, immigrant families and veterans. The majority of the meetings were conducted online. Over 400 individuals participated across the various means of providing input (surveys, input sessions, public comments).

Input Session conducted

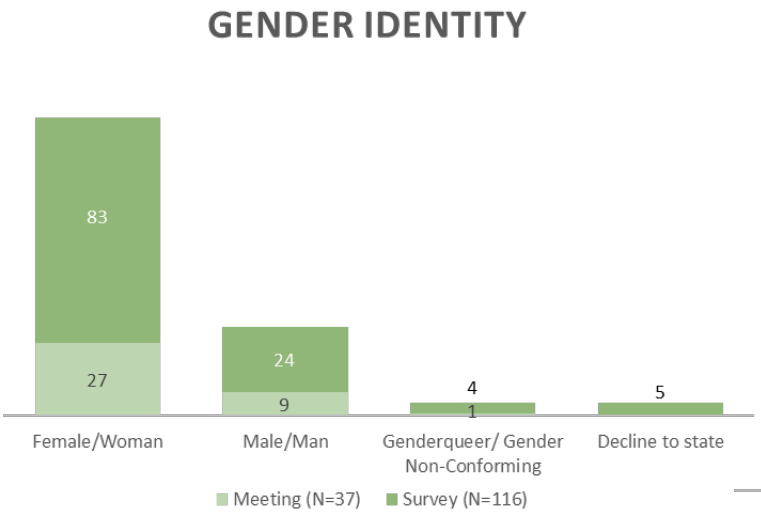
Date	Stakeholder Group	Input Session Topics
	MHSA Steering Committee	
2/2/23	4 Breakout Groups	Access to Services; Behavioral Health Workforce; Housing Continuum; Crisis Continuum
	Health Equity Initiatives	
2/3/23	Chinese Health Initiative	Access to Services
2/7/23	Pacific Islander Initiative	Youth Needs
2/8/23	Pride Initiative	Housing Continuum
2/14/23	African American Community Initiative	Quality of Client Care
2/14/23	Spirituality Initiative	Adult/Older Adult Needs
2/16/23	Native American and Indigenous Peoples Initiative	Quality of Client Care
2/16/23	Filipino Mental Health Initiative	Access to Services
2/28/23	Latino Collaborative	Access to Services
	Community Collaboratives	
2/10/23	North County Outreach Collaborative	Behavioral Health Workforce
2/16/23	East Palo Alto Behavioral Health Advisory	Behavioral Health Workforce
2/22/23	Coastside Collaborative	Access to Services
3/9/23	East Palo Alto Community Collaborative	Access to Services
	Peer Recovery Collaborative	
2/6/23	California Clubhouse/Heart & Soul	Housing Continuum
2/7/23	Voices of Recovery	Substance Use Challenges
	Behavioral Health Commission (BHC)	
2/1/23	BHC Older Adult Committee	Adult/Older Adult Needs

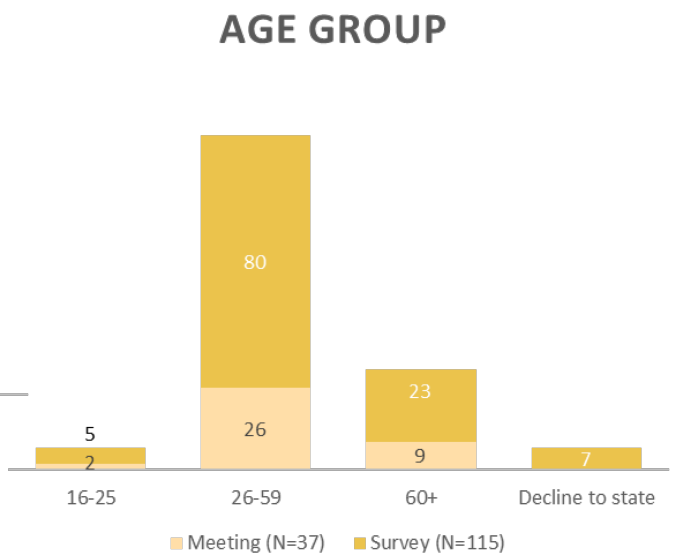
2/15/23	BHC Child and Youth Committee (3 Breakout Groups)	Youth Needs
2/15/23	BHC Adult Committee	Housing Continuum
2/21/23	BHC Alcohol and Other Drugs Committee	Substance Use Challenges
	Other Committees/Groups	
2/9/23	Housing Operations Committee	Housing Continuum
2/7/23	Lived Experience Education Workgroup	Housing Continuum
2/16/23	Contractors Association	Behavioral Health Workforce
2/20/23	Solutions for Supportive Housing	Housing Continuum
2/24/23	School Wellness Counselors	Youth Needs
2/14/23	BHRS Youth Leadership	Crisis Continuum
	Workforce Education & Training 3-Year Plan	
3/3/23	Diversity and Equity Council	Behavioral Health Workforce
3/2/23	Alcohol and Other Drug Providers	Behavioral Health Workforce
3/8/23	BHRS Adult Leadership	Behavioral Health Workforce
2/28/23	BHRS Youth Leadership	Behavioral Health Workforce
3/7/23	Lived Experience Education Workgroup	Behavioral Health Workforce
Key interviews conducted:		
Immigrant Families, Transition Age Youth, Veterans		Youth Needs; Access to Services

Demographics of participants

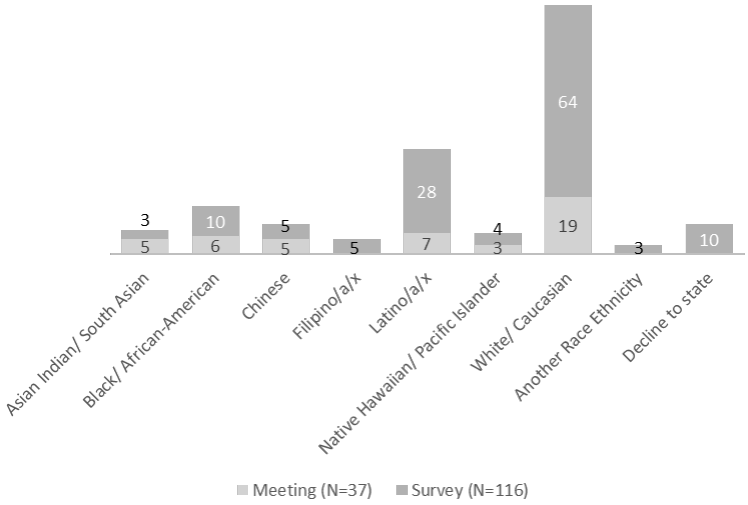
Demographic data was not collected from all 31 Community Input Sessions. 35 client and family members received stipends for participating in these sessions.

Demographics were collected for 129 survey respondents and 37 participants via a Zoom Poll feature during the two MHSA Steering Committee meetings focused on the MHSA Three-Year Plan Community Program Planning process.

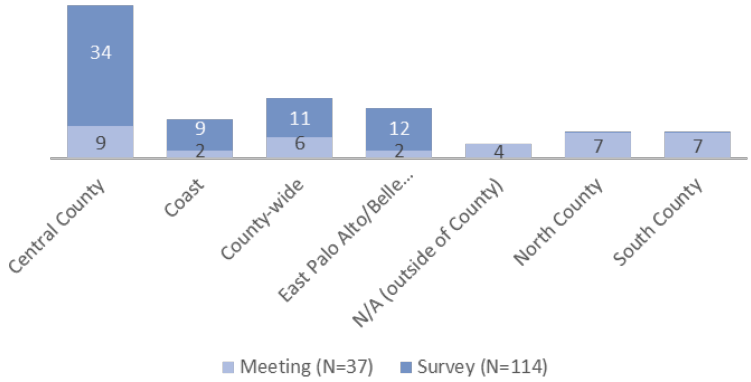




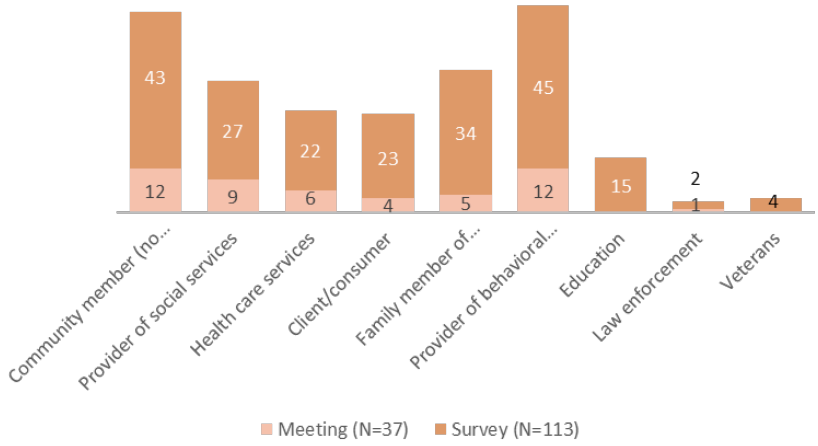
RACE/ETHNICITY



AREA OF COUNTY REPRESENTED



STAKEHOLDER GROUP



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Appendix 2. MHSA Three-Year Plan Strategy Recommendations

FY 23-24 to FY 25-26

30+ community input sessions and key interviews were conducted to brainstorm strategies to address San Mateo County behavioral health needs. The MHSA Steering Committee will be voting to prioritize across the Identified Needs and across the Strategy Recommendations. This prioritization will inform the allocation of resources over the next three-years. Across all community input sessions, three core themes emerged. These components will be incorporated into EVERY prioritized strategy:

1. **Increase community awareness** and education about behavioral health topics, resources and services
2. **Embed peer and family supports** into all behavioral health services
3. **Implement culturally responsive** approaches to address existing inequities that are data-driven

Direct Services & Supports / Prevention Early Intervention

Identified Needs	Strategy Recommendations
Access to Services	1. Coordinate behavioral health services for cultural and ethnic communities (centralize services, outreach and education for the Chinese community, hire bilingual/bicultural peer staff, etc.).
	2. Expand drop-in behavioral health services that includes access to wrap around services for youth.
	3. Provide school-based behavioral health services starting in elementary and middle school; include early diagnosis and assessment at high school grade level.
	4. Co-locate prevention services (support groups, programs, workshops, etc.) in community settings such as faith-based organizations, core-service agencies, community spaces, etc.
	5. Conduct racial equity analysis of BHRS policies and procedures to identify barriers to accessing care; include service utilization and staff capacity data.
	6. Expand services for older adults focused on addressing isolation, peer support, social engagement and intergenerational work.
	7. Expand the Health Ambassador Program to include diverse languages/cultures and subject expertise (substance use, justice involved, unhoused, human trafficking, etc.)
	8. Expand outreach partnerships to include increased mild-to-moderate services, faith-based organizations and veteran engagement.
	9. Promote volunteerism to increase social engagement and community cohesion.

Recruitment & Retention Strategies

Identified Need	Strategy Recommendations
Behavioral Health Workforce	1. Create a pipeline program focused on increasing Asian American and African American behavioral health staff, develop partnerships with local and neighboring academic and non-academic programs.
	2. Create more entry level positions and internships for students of diverse backgrounds; streamline hiring processes (e.g., onboarding and process to hire interns).
	3. Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities (e.g., partner with BIPOC-focused communities and student organizations and networks).
	4. Implement recruitment and retention financial incentives such as retention bonuses, signing bonuses, educational loan repayment for staff and contracted providers.
	5. Examine and adjust caseload size and balance, particularly for bilingual staff.
	6. Expand type, flexibility, and access to staff wellness and engagement opportunities (e.g., appreciation, healing activities, mentoring, behavioral health supports, networking events).
	7. Explore opportunities for alternative and flexible schedules and remote work.
	8. Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff (e.g., scholarships to pursue licensure/credentials, mentorship).
	9. Invest in support, retention and leadership development of peer and family support workers (training, fair compensation, career ladders, flexible hours, and mentorship).
	10. Address extra help and contracted positions, especially for those that interface with the community.
	11. Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties (e.g., salaries, cost of living, retirement plans, housing vouchers).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Crisis Continuum	1. Create stabilization unit(s) and dedicated teams.
	2. Expand step-down from hospitalization facilities, programs and teams (e.g., respite centers).
	3. Create a youth crisis residential in the County.
	4. Expand intensive outpatient services (extended Intensive Outpatient Programs for youth, day treatment programs, detox centers, etc.).
	5. Provide respite care and language-appropriate navigation supports for parents with children who experience a behavioral health crisis (5150, psychiatric emergency services, hospitalization, etc.).
	6. Expand non-armed 24/7 mobile mental health crisis response to serve the entire community.
	7. Expand drop-in centers for individuals that struggle with mental health and/or substance use.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Housing Continuum	1. Expand clinicians available to the Homeless Engagement Assessment Linkage team (a field-based outreach, engagement and intervention services).
	2. Expand supportive housing slots for individuals living with mental health and substance use challenges that do not require homelessness as an eligibility requirement.
	3. Provide housing maintenance and peer supports including case management, wrap around services, hoarding resources, and specialized services for older adults and other vulnerable communities.
	4. Develop a comprehensive housing database that includes real time waitlist times and availability.
	5. Incentivize board and cares (streamline the application process, reduce/subsidize licensing costs, etc.).
	6. Provide housing navigation and locator resources; include re-entry supports, bilingual peer supports, streamlined case management, simplified housing application and subsidized fees.
	7. Provide supports for section 8 housing including funding, vouchers, and training to landlords.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Substance Use Challenges	1. Create integrated services for complex needs including individuals with dual diagnosis or co-occurring mental health and substance use needs.
	2. Create longer-term sober living arrangements.
	3. Expand non-medication supports for individuals with addiction.
	4. Expand recovery-focused drop-in centers.
	5. Expand resources for reunification (support for parents, how to talk/interact with their children, etc.).
	6. Provide access to Narcan for clients and family members.
	7. Provide family-centered recovery supports that includes child care at every stage.
	8. Address intergenerational trauma in recovery and treatment.
	9. Expand early intervention resources for addiction.
	10. Provide education about substance use prevention starting in elementary school (how to say no, healthy boundaries, etc.).

Direct Services & Supports / Prevention Early Intervention

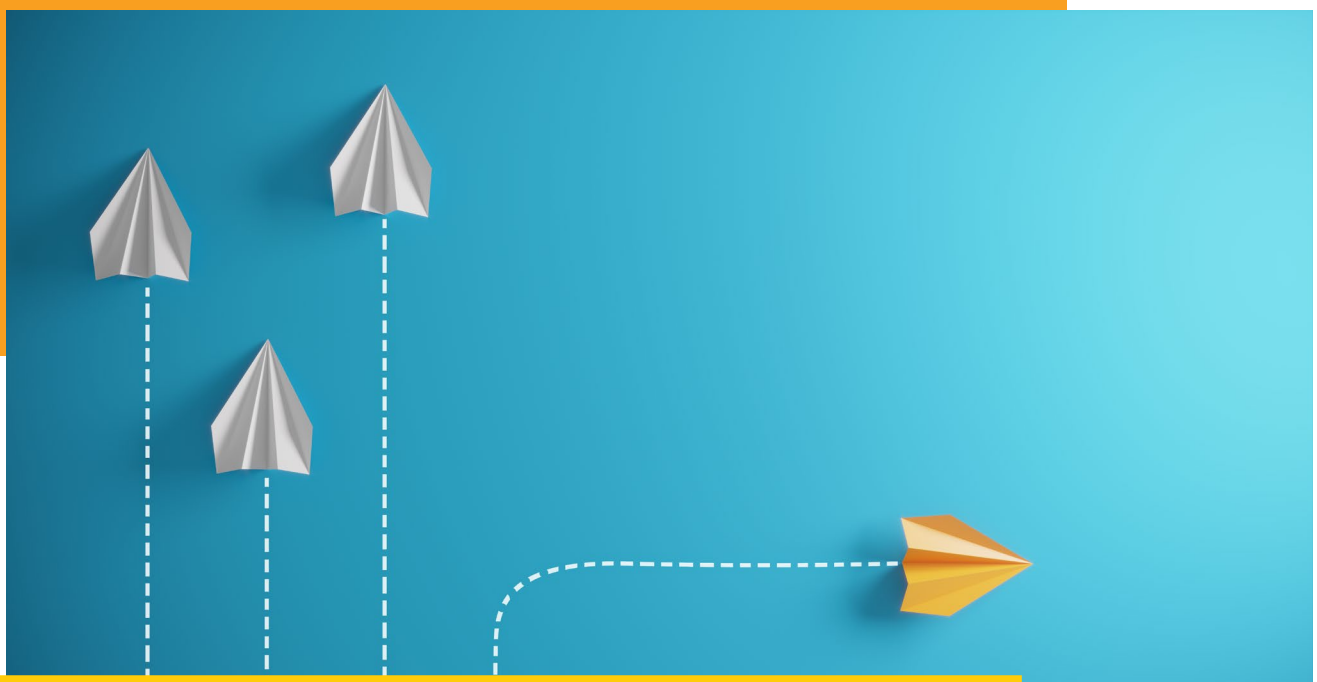
Identified Need	Strategy Recommendations
Quality of Client Care	1. Provide ongoing resource navigation and peer support in crisis situations.
	2. Create client centered services (meet people where they are, provide virtual/in-person, services in their language, flexible hours, etc.).
	3. Implement best practice sharing across BHRS clinics, including integrated services and identification of supports that can be offered across the county.
	4. Develop a streamlined BHRS intake process across the network of care.
	5. Develop partnerships for substance use referrals for clients with Access and Care for Everyone (ACE).
	6. Develop partnerships with indigenous community spaces and cultural healers.
	7. Address Adverse Childhood Experiences, Social Determinants of Health, and intergenerational trauma.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Adult/Older Adult Needs	1. Create internal processes to regularly review utilization and outcome data to inform responsive services for older adults.
	2. Create partnership between the County and Veterans Administration to increase supports for veterans (integration with primary care services, resources for women veterans on sexual assault, suicide prevention for veterans, etc).
	3. Expand capacity for neuropsychological evaluation and diagnosis.
	4. Expand in-home hoarding supports (linkages to services, case management, specialized therapy, decluttering, etc.)
	5. Expand services for individuals with complex needs; develop partnerships with organizations that can support complex client needs.
	6. Expand the OASIS team peer specialist' support for older adults, caregivers and family members.
	7. Develop an outreach and communication strategy on behavioral health and wellness in multiple languages; leverage existing networks (SMC Alert, neighborhood CERTs, etc.).
	8. Expand culturally relevant suicide prevention strategies.
	9. Expand prevention services to older adults prior to complications; develop partnerships with organizations that can provide these services.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Youth Needs	1. Address gaps in the crisis continuum for youth (increase 5150 beds, language capacity, expand non-law enforcement response, stabilization unit, crisis residential, etc.).
	2. Expand school-based behavioral health education and services starting in middle school that includes family therapy and peer support groups for parents, youth, and school staff.
	3. Expand school-based wellness centers.
	4. Expand afterschool-based programming.
	5. Expand availability of diverse wellness counselors and clinicians on all school campuses.
	6. Integrate wraparound services in schools, in partnership with community-based organizations.
	7. Provide Narcan in high schools (used to reverse opioid overdose).
	8. Expand Social Emotional Learning (SEL) curriculum in schools.
	9. Expand the Health Ambassador Program for both Youth and Adults; include case management and increased support for ambassador's families.



Program Improvements for Valued Outpatient Treatment (PIVOT)

MHSA INNOVATION Project

Orange County
2024

ochealth CARE AGENCY

TABLE OF CONTENTS

BACKGROUND

Proposition 1

In March 2024, California voters passed Proposition 1, resulting in significant changes to the Mental Health Services Act (MHSA). The proposition repurposes MHSA–changing the name to the Behavioral Health Services Act (BHSA), re-structuring the use of funding, and expanding on existing requirements.

One of the most significant changes under BHSA involves the funding components. The BHSA eliminates the MHSA components for Community Services and Supports (CSS; 76%), which also includes the ability to set aside funds for Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN); Prevention and Early Intervention (PEI; 19%); and Innovation (INN; 5%). Instead, BHSA requires 35% of funds to be directed toward Full-Service Partnership (FSP) programs to provide comprehensive care for individuals with the most complex needs; 35% for Behavioral Health Services and Supports (BHSS); and 30% toward Housing Interventions, including rental subsidies, operating subsidies, shared housing, family housing for eligible children and youth, and the non-federal share of certain transitional rent[7]. These changes result in a transition from five MHSA components to three, under BHSA (Figure 1).

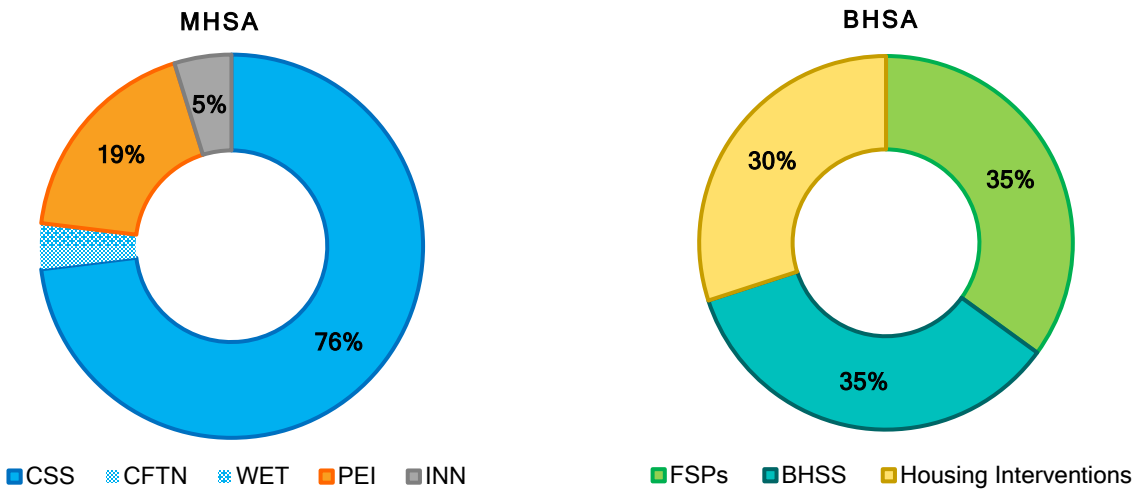


Figure 1. Restructuring of MHSA to BHSA funding components.

The Housing and BHSS component include additional funding requirements. Under the 30% Housing component, half of this amount (50%) is prioritized for housing interventions for the chronically homeless, and up to 25 percent may be used for capital development. Of the 35% of funds dedicated to BHSS, half of these component funds may be used toward behavioral health supports, such as outreach and engagement; workforce; education and training; capital facilities and technological needs; and innovative pilots and projects. The remaining 50% of BHSS funds must be used for Early Intervention programs to address the early signs of mental illness or substance use disorders, 51% of which must further be directed to children and youth ages 25 and younger (Figure 2).

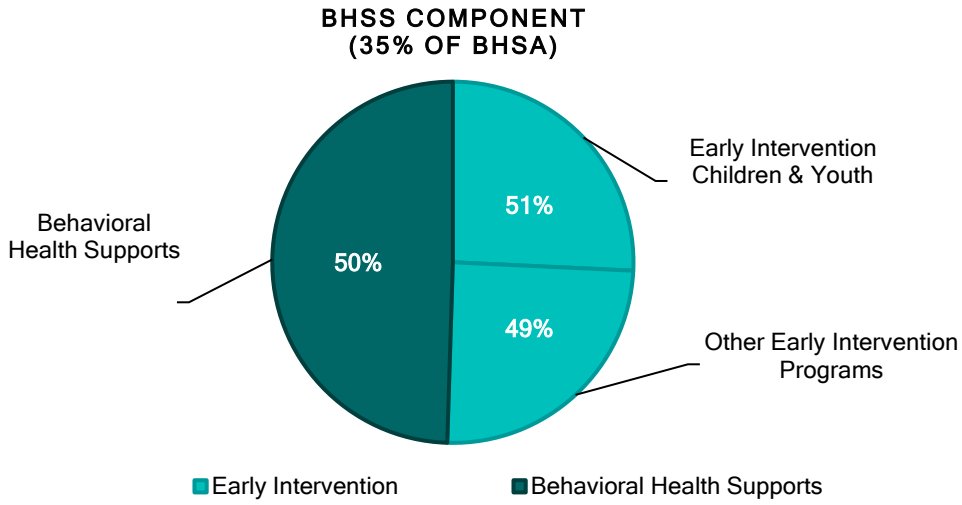


Figure 2. BHSS funding component details.

Between these funding requirements, counties have the flexibility to move up to seven percent from one category to another, for a maximum of 14% added into any one category. Finally, 10% of the total BHSA funds will be allocated to state administrative efforts to create new state-wide, state-led investments. These include population-based prevention (4%), workforce infrastructure (3%) and statewide oversight and monitoring (3%).

In addition to restructuring the funding components, the BHSA also expands the priority populations by including individuals with substance use disorders, and prioritizes individuals at risk of or experiencing homelessness, justice involvement, child welfare involvement, and/or institutionalization/conservatorship.

Finally, BHSA significantly expands the reporting process, requiring the development of a comprehensive Integrated Plan that is inclusive of all behavioral health programs and funding streams.

BHSA will be effective January 1, 2025, and must be implemented by July 1, 2026.

Primary Problem

The BHSA will have several significant impacts to Orange County's behavioral health system of care. The expansion of priority populations to include individuals living with SUD will change the way in which the County conducts business and delivers services. In addition, the new categories eliminate prevention and innovation programs, and combines Early Intervention, CSS General System Development, workforce development, and CFTN into one bucket under BHSS. As a result, existing MHSA programs will need to be modified or eliminated to fit within the three BHSA funding components. In Orange County, these changes will result in a loss of $150 million in funding for currently funded programs that could only be funded under the behavioral health services and supports component. The County will need to identify strategies and solutions to support individuals who would no longer qualify for services under these new funding components.

Proposition 1 and the larger Behavioral Health Transformation initiative makes it clear that the state is envisioning an updated paradigm for public behavioral health services, especially those services provided through the specialty mental health plan (MHP). County specialty MHPs need to respond and reimagine their systems of care to meet the requirements. However, the existing system of care is not currently designed to easily integrate these changes. Furthermore, many of these changes will be effective January 1, 2025, and must be implemented by July 1, 2026, leaving Orange County with approximately 18 months to redesign its behavioral health system to meet the new requirements.

Response to Local Need

The BHSA will require a systemwide transformation of Orange County's behavioral health services. The MHSA INN component was designed to evaluate the impact of new or changed practices in mental health, with transformational change as its primary goal. Although the BHSA does not include a specific component for INN, current language included in Senate Bill 326 notes that approved INN projects can continue to be implemented past the July 1, 2026, start date. This opens the opportunity to utilize INN dollars to evaluate/identify successful strategies and administrative changes needed to prepare for the transition to BHSA and share lessons learned. The "re-imagining" of the overall system, along with the testing of new processes is proposed under the PIVOT INN project.

PROPOSED PROJECT

PIVOT Project Description

PIVOT is a comprehensive proposal with five components, each with its own activities and learning objectives. These components include:

1. Full-Service Partnership Reboot
2. Integrated Complex Care Management for Older Adults
3. Developing Capacity for Specialty MH Plan Services with Diverse Communities
4. Innovating Countywide Workforce Initiatives
5. Innovative Approaches to Delivery of Care

Each component was identified as a need through ongoing stakeholder feedback on Orange County's behavioral health system of care. In addition, each component aligns with and supports the county's transition to BHSA. The underlying goal connecting all components involves redesigning the system of care to prepare for BHSA.

Many counties across the state are facing similar challenges in their system of care. To support statewide learning, the PIVOT INN Project also proposes the opportunity for counties to participate in any of the components that align with their local planning efforts, system needs and INN funding availability. Collectively, this partnership can create a learning collaborative, as counties solve for similar problems in their local systems and navigate the transition to BHSA together.

PIVOT Components

Full-Service Partnership Reboot

The MHSA currently requires the majority of CSS funding be directed toward FSP Programs. Orange County currently funds FSP programs for all age groups that are implemented through a combination of contracted provider agencies and County clinics. FSP programs provide intensive outpatient services and case management for individuals living with serious behavioral health conditions. The FSP framework is based on a "no fail" philosophy and does "whatever it takes" to meet the needs of its members, and when appropriate their families, including providing supportive services. This framework builds

strong connections to community resources, and provides 24 hours per day, 7 days per week (24/7) field-based treatment and recovery services. The primary goal of FSP programs is to improve quality of life by implementing practices that consistently promote good outcomes for the member.

FSP programs will continue to remain a priority under BHSA, as the new legislation requires 35% of the total budget be directed toward FSP programs. Additional guidelines include[2]:

- Implementation of select evidence-based practices, including Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Individual Placement and Support (IPS) model of supported employment and high-fidelity wraparound.
- New established standards of care with levels based on an individual's acuity and criteria for step down into the least intensive level of care.
- Outpatient behavioral health services, either clinic or field-based, necessary for ongoing evaluation and stabilization of an enrolled individual.
- Ongoing engagement services necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and non-clinical services, including services to support maintaining housing.
- Integration of Substance Use Disorder (SUD) services.

Under these new guidelines, the County must examine its FSP programs and services to identify levels of care and determine the appropriate criteria for step down services. Administrative changes and modifications to program workflows and operations will be required to prepare FSP programs for this transition. The purpose of this PIVOT component is to prepare the County for the transition to BHSA by supporting activities within two main categories: 1) Technical and Data Infrastructure and 2) Administrative Processes. Component activities and objectives include:

- Technical and Data Infrastructure
    - Gather technical requirements for the new local data infrastructure needed for county and county-contractors to align with the new FSP standards while maintaining data collection and reporting standards.

    - Design, test, and implement applications that allow real-time access to view an FSP member's current level of care and functioning, with the goal of identifying when it's appropriate to transition to a different level of care.
    - Ensure data system follows all federal and state Information Technology security requirements.
    - Thorough cleaning of local data to prepare for the new path forward.
- Administrative Processes
    - Determine the FSP levels of care and identify criteria for step down to lower levels of care.
    - Determine administrative processes to ensure seamless transition between FSP levels, with minimal disruption to service delivery.
    - Identify process for tracking and reporting how members transition through levels of care.
    - For contracted programs, identify changes needed in the contract language to align with the different levels of care.
    - Strengthen ability to provide SUD or co-occurring services, with an emphasis on co-location of services and dual certification for Drug Medi-Cal Organized Delivery System (DMC-ODS) services.

Recent discussions around FSPs have focused on performance and value-based contracting. To prepare its system for a shift toward this social financing model, Orange County must first address the necessary prerequisites that inform value-based and performance contracting. Without the necessary data infrastructure in place to allow easy access to accurate data, the County runs the risk of drawing erroneous conclusions. Depending on Orange County's readiness and ability to adequately set up data infrastructure and administrative processes, additional component activities may include the following:

- Determine infrastructure needed to move forward in value-based contracting, which includes access and review of the data needed to determine metrics.
- Technical assistance and planning to identify individualized member values, operationalize data collection, and identify strategies to incentivize contracted providers.

- Identify how to set a contracting standard that can be monitored and reimbursed consistent with the state's standard.
- Explore and identify the process for fidelity monitoring.

With the upcoming changes in BHSA and the new requirements for FSP programs, counties must assess their systems' readiness to implement these changes. Orange County has recognized the need to address its data infrastructure and administrative processes to ensure a successful transition. This PIVOT component allows the county to address these primary needs.

Integrated Complex Care Management for Older Adults

Older adults are the fastest growing population in Orange County, and often face unique and multifaceted challenges that require specialized care and support. As individuals age, they may encounter a range of health concerns such as depression, anxiety, and neurocognitive disorders. Neurocognitive disorders—a term used interchangeably with dementia—is a general term that describes decreased mental function due to a medical disease.[12] It refers to a wide range of disorders that affect the brain, involving problems with thinking, reasoning, memory, and problem solving. The prevalence of neurocognitive disorders tends to increase significantly among older adults.

Research evidence and clinical observations suggest that many older adults living with dementia also experience concurrent mental health challenges. Mo et al. (2023) investigated the temporal relationship between psychiatric disorders and dementia diagnosis. Their study revealed a consistently heightened risk of psychiatric comorbidities in patients with dementia, beginning several years before diagnosis, peaking around the time of diagnosis, and persisting post-diagnosis. This finding underscores the necessity of integrating psychiatric interventions across the dementia care continuum. Asmer et al. (2018) explored the prevalence of major depressive disorder (MDD) among older adults with dementia and indicated a significant burden of depression within this population. Variations in MDD prevalence across dementia subtypes underscore the need for nuanced diagnostic and therapeutic strategies. Further investigations by Lai et al. (2018) and Choi et al. (2021) addressed the alarming rates of psychiatric disorders and suicide risk among different dementia subtypes. These studies emphasized the necessity of

tailored interventions and vigilant screening for suicide risk, especially following a dementia diagnosis. Schmutte et al. (2022) emphasized the heightened suicide risk in the year post-dementia diagnosis, especially among specific demographic and clinical subgroups. Early identification and support for individuals at risk are essential to mitigate adverse outcomes. Lastly, Stott et al. (2023) highlighted a potential protective effect of psychological interventions for anxiety disorders against future dementia incidence. Reliable improvement in anxiety symptoms following therapy was associated with reduced dementia risk, emphasizing the mitigation of certain risk factors through targeted interventions. Dementia risk is also reduced by aggressively treating depression with both medications and psychotherapy.

The co-occurrence of mental health conditions alongside neurocognitive disorders presents numerous challenges. The existing support systems often prove limited in terms of accessibility, adequacy, or availability. Long-term stable housing, treatment and services are often inaccessible, inadequate, or unavailable to older adults who are homeless or at risk of homelessness and living with dual mental health conditions and dementia.

This target population also presents a complex clinical landscape that demands a comprehensive approach to care. However, treatment is currently split between the managed care system and specialty mental health plan, with each responsible for specific portions of care. Each system utilizes different screening and assessment tools and views the treatment of the co-morbid condition through the lens of their system. Diagnostic hurdles emerge, as distinguishing between cognitive decline associated with neurocognitive disorders and symptoms of mental health disorders necessitates specialized training and careful assessment (Ording & Sørensen, 2013; Poblador-Plou et al., 2014). The diagnostic process is further complicated by the presence of overlapping symptoms, cognitive impairment, and potential stigma associated with psychiatric conditions. Consequently, delays in diagnosis and intervention may occur, hindering the timely provision of appropriate care and support (Fox et al., 2014).

Even after an individual is linked to services, the siloed system creates challenges in receiving quality care. Multiple medical problems and medications including over the

counter and herbal supplements make it difficult to treat individuals in a non-integrated setting. Addressing comorbid mental health conditions in the context of dementia requires a multifaceted approach. Cognitive impairment, communication difficulties, and potential medication interactions necessitate careful consideration when designing treatment plans (Subramaniam, 2019). Currently, Orange County's Behavioral Health Services division meets with local managed care providers to determine the best course of treatment for individual cases because an integrated system to effectively manage these cases does not currently exist. Outcomes to these cases tend to be highly individualized because of an inconsistent approach to cases, predicated by no clear funding stream or reporting structure, forcing providers to piece meal individualized treatment plans.

Alongside these clinical challenges, societal factors such as stigma and reluctance to seek help further compound the issue. Individuals and families may be hesitant to seek assistance due to fears of judgment or discrimination, leading to delays in accessing necessary support and treatment (Evans-Lacko et al., 2019). Ultimately, increasing awareness and understanding of comorbid mental health conditions in individuals with dementia among caregivers, healthcare professionals, and the public is critical. Educating communities about the complex relationship between dementia, mental health, and stigma can help reduce barriers to care and improve access to appropriate resources (Riley, Burgener, & Buckwalter, 2014). In addition, it is equally critical to highlight the value of a healthy lifestyle in curbing both psychiatric and neurocognitive disorders. as well as for positive general physical health.

Given the significant prevalence of dementia and the likely co-occurrence of mental health conditions among older adults, alongside the challenges within the existing system of care, there is a clear and pressing need for a targeted approach to support this vulnerable population. This PIVOT component seeks to address this critical gap by beginning to develop and plan a system of care for older adults living with both behavioral health and physical/neurocognitive conditions, which may include individuals who are homeless or at risk of homelessness.

Component objectives and activities will include but not be limited to the following:

- Multidisciplinary Approach: Identify and engage a team of experts who serve older adults across the continuum of care to inform the development of a holistic and comprehensive system of care for this target population.
- Outreach and Engagement: To create a process for identifying older adults considering the challenges and barriers reaching and engaging this unserved/underserved population.
- Training: To inform and educate providers on best practices in serving older adults living with co-occurring mental health conditions and neurocognitive disorders.
- Assessment: Engage experts in the field to create a different model for assessment that is recognized across the various systems.
- Complex Care Management/Navigation Plan: The multi-disciplinary team will collaborate on funding structures and care strategies to meet the comprehensive needs of older adults. This will involve a multidisciplinary complex care/navigation approach exploring blended funding and housing options.

As the population of older adults in Orange County continues to rapidly increase, a concerning trend emerges: a growing number of older adults face the dual challenges of managing neurocognitive disorders and mental health issues. The literature shows that addressing mental health concerns in individuals with or at risk of dementia is crucial for improving overall outcomes and quality of life in this vulnerable population. Addressing the mental health needs of older adults requires a holistic and interdisciplinary approach that considers the complexities of aging and mental health. This approach should involve collaboration among healthcare providers, social workers, caregivers, and community organizations to develop client-centered care plans that promote mental well-being, independence, and quality of life for older adults. This component recognizes the unique needs of older adults experiencing dual diagnoses and strives to create a system that fosters collaboration among stakeholders and promotes integrated care approaches. Through strategic partnerships and targeted interventions, this component seeks to create a more inclusive and supportive community environment, providing comprehensive care tailored to the unique needs of this vulnerable population.

Developing Capacity for Specialty MHP Services with Diverse Communities

Orange County is home to about 3.2 million people, making it the third most populous County in California, and the second most densely populated County in the state. It is also home to diverse populations, with six threshold languages other than English, including Arabic, Chinese, Farsi, Korean, Spanish, and Vietnamese. The image below shows County demographics at a glance:

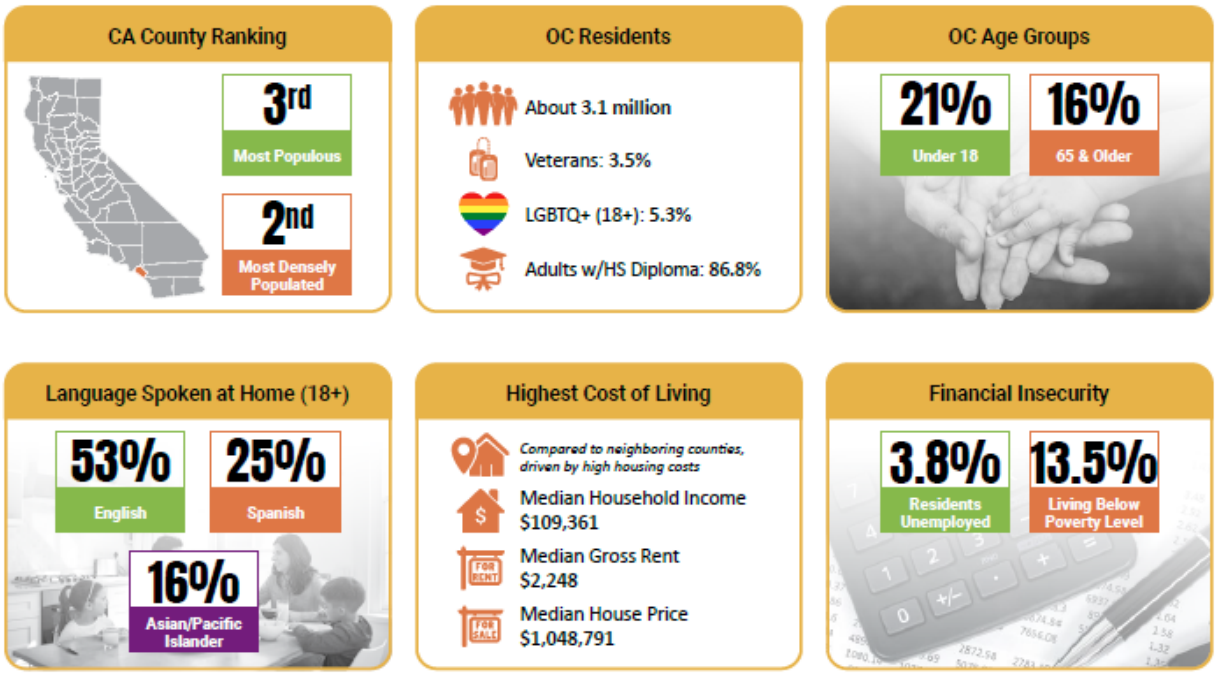


Figure 3. Orange County demographics as presented in the MHSA Annual Update for FY 2024–2025.

The County Behavioral Health Services operates as both the Specialty Mental Health Plan (MHP) and as a provider of specialty mental health plan services, coordinating and providing specialized behavioral health services for Medi-Cal members and uninsured individuals who meet the criteria for medically necessary care under the MHP. SUD services are delivered by both county-operated and contractor-operated providers in the DMC-ODS.

A review of Medi-Cal beneficiary demographics and penetration rates can help identify underserved and unserved populations. Penetration rate is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. In Orange County, the data revealed that

while the number of total eligible residents in the county increased in Calendar Year (CY) 2021, the number of beneficiaries served and overall penetration rates decreased from prior years (Table 1)[15].

Table 1. MHP Annual Beneficiaries Served

Year	Total Eligibles	Beneficiaries Served	Penetration Rate
CY 2021	954,392	23,310	2.44%
CY 2020	863,342	23,739	2.75%
CY 2019	852,008	25,321	2.97%

Overall, Orange County penetration rates were lower than those seen in comparable-sized MHPs and statewide across all age groups (Table 2) and all racial/ethnic groups (Table 3).

Table 2. Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	84,542	543	0.64%	1.29%	1.59%
Ages 6-17	216,756	9,648	4.45%	4.65%	5.20%
Ages 18-20	52,823	1,698	3.21%	3.66%	4.02%
Ages 21-64	490,980	10,922	2.22%	3.73%	4.07%
Ages 65+	109,293	499	0.46%	1.52%	1.77%
TOTAL	**954,392**	**23,310**	**2.44%**	**3.47%**	**3.85%**

Table 3. Penetration Rates (PR) of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	# MHP Served	# MHP Eligibles	MHP PR	Statewide PR
African-American	837	15,436	5.42%	6.83%
Asian/Pacific Islander	1,891	177,504	1.07%	1.90%
Hispanic/Latino	10,834	429,250	2.52%	3.29%
Native American	72	1,376	5.23%	5.58%
Other	4,363	180,793	2.41%	3.72%
White	5,313	150,035	3.54%	5.32%
Total	**23,310**	**954,394**	**2.44%**	**3.85%**

Based on the number of Medi-Cal eligible residents in CY 2021, and beneficiaries with an approved service, the following groups were identified as underrepresented:

- Asian or Pacific Islanders (API)

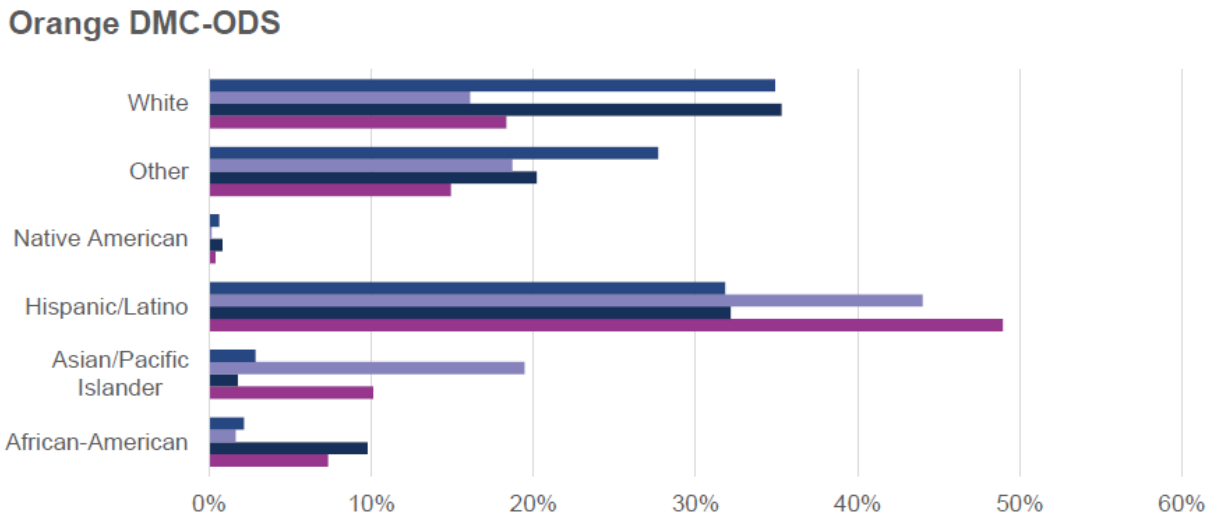
- Black or African Americans
- Youth 5 years of age and under
- Adults over the age of 60
- Native Americans
- Residents who spoke a language other than English

Among these groups, API beneficiaries were the most disproportionately underrepresented. The data available through the state is limited and does not further delineate nuances between the multitude of cultural differences between API, South Asia, Middle Eastern, North African (SAMENA), etc. populations. In addition, there is a lack of data concerning the delivery of behavioral health services for deaf and hard of hearing populations. However, there are existing non-Medi-Cal service providers that provide behavioral health services to these underserved populations.

One of the challenges in reaching these underserved groups may include limitations in the county workforce in providing culturally and linguistically appropriate services. Individuals are likely to seek support from Community-Based Organizations (CBOs) that serve their ethnic groups. CBOs are also more likely to integrate community-defined evidence practices (CDEPs) into their services that look beyond traditional empirical based models to emphasize behavioral health practices that a community considers healing. The MHSA Prevention and Early Intervention (PEI) component played a pivotal role in supporting the delivery of non- Medi-Cal based behavioral health services and supports through a CBO network. With the upcoming changes, CBOs will need to shift the types of services and supports being offered to these diverse populations.

Further, MHSA has not funded SUD services. SUD services are delivered by both county-operated and contractor-operated providers in the DMC-ODS. Across all payment sources, Orange County reported that approximately 32% of services were delivered by county-operated/staffed clinics and sites, and about 67% were delivered by contractor-operated/staffed clinics and sites[14]. Overall, Orange County reported that about 43% of services provided were claimed to Medi-Cal. A review of penetration rates for access to

SUD services through the DMC-ODS showed similar underrepresentation of racial/ethnic groups.



	African-American	Asian/Pacific Islander	Hispanic/Latino	Native American	Other	White
County % Served	2%	3%	32%	1%	28%	35%
County % Eligibles	2%	19%	44%	0%	19%	16%
State % Served	10%	2%	32%	1%	20%	35%
State % Eligibles	7%	10%	49%	0%	15%	18%

Figure 4. Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity CY 2021.

Hispanic/Latino and Asian/Pacific Islander DMC eligible residents were notably under-represented among those receiving SUD treatment. The under-representation of Asian/Pacific Islander DMC eligible residents among those receiving SUD treatment in Orange was substantially more pronounced than statewide.

To address challenges in reaching its diverse communities, Orange County needs to consider larger system changes to ensure the ongoing needs of the unserved and underserved populations living with serious behavioral health conditions and SUD are met. One potential solution is to build on the relationships between CBOs and the communities they serve by helping them develop their capacity for serving individuals living with serious mental health and/or substance use disorders. This PIVOT component seeks to identify the minimum capacity of a community-based organization to be able to become a specialty mental health plan/DMC-ODS contracted provider.

Component activities and objectives will include but not be limited to:

- Assessing what it takes for a CBO to become a Medi-Cal/Drug Medi-Cal provider.
- Identifying the type of technical assistance needed to support.
- Determining if embedding culturally based approaches for specialty mental health care improve penetration rates and outcomes.
- Identifying CDEPs that can generate revenue and be recognized by the state.
- Evaluating the use of a hub and spoke model to support capacity building.

The ability to determine the necessary steps for CBOs to become specialty mental health providers will have lasting benefits in the county's behavioral health system of care. It will improve access for Orange County's most unserved and underserved populations and help close the gap in penetration rates. It will also help identify CDEPs that can generate revenue for the County and CBOs serving these populations, creating a sustainable system of care. Lastly, this component will help build the capacity for CBOs to provide a broader range of services, strengthening their role in the system of care. This is especially critical as BHSA will have significant impacts on the funding of County's behavioral health programs. Many MHSA CSS programs leverage Medi-Cal in the delivery of services; however, these services will be impacted as the funding components transition from MHSA to BHSA, eliminating CSS as a component and folding its services under BHSS. Supporting CBOs in becoming specialty mental health providers will bridge the potential gaps in services as a result of changes in funding under BHSA.

Innovative Countywide Workforce Initiatives

Historically, California's public behavioral health system has experienced a shortage of behavioral health workers, changes in mental health occupational classifications, and underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs. WET is a program that provides training opportunities to the County's Behavioral Health Services (BHS) and contract agency staff, promotes the recruitment and hiring of a culturally diverse workforce, offers financial incentives, facilitates clinical

intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing the workforce shortage within Orange County through utilization of various strategies to recruit and retain qualified behavioral health employees. WET carries forth the vision of the MHSA to create a transformed, culturally competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

The Orange County WET component programs have experienced much success over the years, contributing to the development of a highly skilled workforce. However, some institutional barriers still exist, creating roadblocks for establishing integrated pathways to BHS employment. Orange County's vacancy rate showed that while there has been a slight improvement in the rate reported by the department, from approximately 18% in August 2023[5] to 13% currently, the County continues to face staff shortages in all positions, especially clinicians. Several factors contribute to these vacancies, including limited flexibility in work schedule; non-competitive and low pay; minimal pay differential for specialty skills (e.g., language competency); and slow hiring and human resources processes for potential candidates. These factors are extremely difficult to change within the existing County system, and many involve established processes that would take extensive resources and time to change.

A potential strategy to expand the workforce is through clinical internship programs. In the most recent MHSA 3-Year Plan, BHS identified the need to establish a centralized internship program that included paid internship positions; an employee 20/20 program that would enable an employee time to complete training and/or educational requirements for a degree or certification; and streamlining the path from internship to employment. Despite these efforts, barriers exist that limit the success of the existing program, including but not limited to:

- Competition amongst systems. For example, hospitals, education, criminal justice, and managed care plans all compete for the same qualified staff and interns.
- Limited ability to update minimum qualifications for entry level Behavioral Health Clinicians, including necessitating that applicants possess a Board of Behavioral Sciences (BBS) registration number prior to start date.

- Delays between graduation, hiring, and ability to start in BHS.
- Inability to establish the 20/20 program.

In addition, there is not an established coordinated, countywide behavioral health pipeline and pathway to support the development of the larger provider network. These challenges result in workforce shortages that impact an individual's access to care.

These challenges are not limited to the County, as the State continues to seek solutions to address this challenge with its recent behavioral health reform efforts. One of the tenets of BHSA is increasing access by building workforce infrastructure. BHSA will utilize 3% of its administrative funds on workforce investments to expand a culturally competent and well-trained behavioral health workforce to address behavioral health capacity shortages and expand access to services[7].

Similarly, Orange County is striving to build its workforce infrastructure and overcome a portion of these barriers by utilizing an approach that has been proven successful in non-mental health settings—apprenticeship programs. Apprenticeships combine paid on-the-job training with classroom instruction to prepare workers for highly skilled careers. Workers benefit from apprenticeships by receiving a skills-based education that prepares them for good-paying jobs. In addition, apprenticeship programs help employers recruit, build, and retain a highly skilled workforce.

This PIVOT component will take successful strategies from both internship and apprenticeship programs and utilize a third-party vendor as the "employer of record" to support payment of incentives for participating in the internship program. Because apprenticeships are longer than a typical internship, individuals participating in BHS internships will have the option to extend their paid learning opportunity beyond their educational requirement. A standard pay scale will be developed that incentives longevity and continues to provide incentives during the period between graduation and the receipt of a BBS registration number that is required to qualify for regular county positions.

Component activities and objectives include:

- Establish a multi-partner, countywide behavioral health workforce pipeline and pathway.
- Utilize third-party vendor to test alternative pathways to employment (e.g., apprenticeship program).
- Develop pathways that extend beyond traditional mental health clinician roles, including but not limited to substance use disorder counselors, all levels of peer specialists, community health workers, health and wellness coaches, and others.
- Provide option to extend paid learning beyond educational requirements.
- Develop a standard pay scale that incentivizes longevity.
- Provide incentives during period between graduation and receipt of a clinical registration number that is required to qualify for county clinical positions.

Through this PIVOT component, Orange County seeks to create a seamless pathway from paid internship to employment for diverse professionals and paraprofessionals.

Innovative Approaches for Delivery of Care

In the current system, primary care (physical health), SUD, and mental health systems operate according to each systems charting, billing, and regulatory requirements. Despite state movement toward a more integrated model, the simultaneous changes and initiatives have not allowed time for County systems to respond and think through the ways the systems need to be redesigned.

The current structure limits access to wholistic, integrated services forcing clients to navigate bifurcated systems to meet their healthcare needs. Even clinical space is often set up according to the system that primarily funds the clinic, limiting access to person-centered approaches to care.

In 2021, Orange County embarked on an effort to redesign its clinic spaces to be more culturally responsive and improve service delivery. This effort was based on feedback from community engagement meetings conducted in Fiscal Year (FY) 2020-2021, where participants shared that creating more welcoming spaces in clinic common areas would contribute to improved access to behavioral health services. County staff facilitated a series of focus groups with its Wellness Center participants to gather direct consumer feedback on creating a more culturally responsive, calming, inspirational, and a welcoming feel within the County outpatient clinic lobbies and clinic common areas. The original goal was to redesign 12 of the County's outpatient clinics, but due to challenges in cost, clinic relocations, lease terms, and county procurement processes, County staff were only able to redesign one clinic.

While the county is limited in its ability to physically change the external appearance of its clinics, this PIVOT component shifts the focus on changing the internal processes, such as reimagining the flow of clinic operations and providing a more integrated service experience for clients. This PIVOT component will utilize a User Experience model to collaborate with providers, consumers, and their family members to identify more culturally responsive, inclusive, and efficient delivery of care. The User Experience (UX) model or practice is typically utilized in the development of products, services or within the field of technology. It involves the process of understanding a user's expectations and satisfaction when interacting with a product or service to ensure that the products or services created reflect meaningful and relevant experiences to users. Orange County proposes to apply this UX model to improve its approaches to delivery of care.

Component activities and objectives could include:

- Redesign the flow of clinical operations, including specialized services for whole-person care approaches.
- Explore staffing patterns and credentialing that can support a broader range of healthcare services.
- Reimagine service delivery.
- Integrate services.
- Evaluate the impact of using a UX design on client outcomes.

Summary

PIVOT proposes to create and test service models where the delivery, care coordination, systemwide collaborations and payment for care is aligned to make a seamless and integrated experience for behavioral health clients, resulting in improved client outcomes. The project also intends to test innovative approaches to workforce recruitment and retention that have worked in other systems to strengthen the pathways to becoming a clinical service provider and incentivize retention of highly qualified staff.

This multi-component project will result in an overall system redesign while simultaneously addressing key areas of need in the current behavioral health system of care. Each component seeks to identify and develop successful behavioral health approaches that can be integrated across the system of care.

Request for Approval

With this comprehensive proposal, Orange County is requesting approval to utilize its INN funds to further develop the activities and evaluation plan and implement each PIVOT component.

In addition, because many counties face similar challenges in their system of care, Orange County is requesting the Commission's approval to make PIVOT a multi-county project, which would allow other counties the opportunity to join components that best align with their local needs and support their transition to BHSA. If approved, each

interested county would still undergo their local community planning process and provide a brief proposal of their county-specific plan, including their project budget (Appendix A).

EVALUATION

The PIVOT INN Project proposal identifies general learning objectives under each component. Each component will require its own evaluation plan and research team to track lessons learned. Upon approval of the PIVOT INN Project, Orange County, plans to contract with evaluators to support this effort.

If additional counties are approved to join, the overall objectives and evaluation plan will remain consistent among participating counties. However, because counties have their own unique needs and challenges, additional learning questions may be explored that add to and align with the common goal or mission of the PIVOT component(s). Research evaluators would work with all participating counties, gathering data and information to tell a cohesive story of successes and lessons learned.

Based on the activities and objectives of each PIVOT component, Orange County has drafted the following preliminary learning questions that will be further refined by research evaluators:

Full-Service Partnership Reboot

- How can the different FSP levels be operationalized to support timely and appropriate transitions in level of care?
- What administrative processes and program operations ensure that members experience seamless continuity of care during transitions between FSP levels?
- How can BHSA dollars be used to bill for SUD as a primary service?
- For contracted programs, what changes are needed in the contract language to incorporate the different levels of care?
- What are the standards for fidelity monitoring?
- What Quality Assurance and Quality Improvement practices need to be implemented to ensure fidelity?

Integrated Complex Care Management for Older Adults

- What are the most successful strategies for identifying this target population?
- What are the most effective assessments and interventions for this target population?
- What are the viable funding structures that can support this integrated model of care?
- What housing models would best support the needs of this target population?

Developing Capacity for Specialty MH Plan Services with Diverse Communities

- What are the minimum requirements for a CBO to become a Medi-Cal/DMC-ODS provider?
- What type and level of technical assistance is needed to support CBOs?
- In what ways does a hub and spoke model effectively support capacity building?
- Does embedding culturally based approaches for specialty mental health care improve penetration rates and client outcomes?
- Which CDEPs are most effective?
- How can CDEPs be utilized to generate revenue?

Innovative Countywide Workforce Initiatives

- Did the use of an alternative pathway, such as an apprenticeship program model, lead to increased employment engagement and/or retention?
- Which incentives contributed most to increased likelihood of employment engagement and retention?
- Does the development of a countywide initiative place the County in a better position to apply and qualify for grants to sustain/expand workforce initiatives?

Innovative approaches to delivery of care

- What clinic design or set-up elements are most impactful in supporting quality care and/or client engagement?
- Is there an optimal flow to the delivery of care?
- How does utilizing a user experience design impact client outcomes?

ALIGNMENT WITH INITIATIVES

For the purposes of this section, the PIVOT components will be referenced by their respective numbers:

1. Full-Service Partnership Reboot
2. Integrated Complex Care Management for Older Adults
3. Developing Capacity for Specialty MH Plan Services with Diverse Communities
4. Innovating Countywide Workforce Initiatives
5. Innovative Approaches to Delivery of Care

BHSA

The overarching goal of the PIVOT INN Project is to help Orange County, and other counties, prepare for the upcoming changes under the new legislation. As such, each PIVOT component aligns with the tenets of BHSA.

Full-Service Partnership Reboot

BHSA requires 35% of funds to be directed toward FSP programs. The new legislation also provides additional guidelines for FSP programs, including the establishment of levels of care. The FSP Reboot focuses on changing its administrative processes and building the data/technical infrastructure necessary to align with the new requirements under BHSA.

Innovative Countywide Workforce Initiatives

BHSA will utilize 3% of the total administrative funds to create a workforce infrastructure that seeks to expand a culturally competent and well-trained behavioral health workforce. Orange County is aligned with this effort, as this PIVOT component proposes to utilize an apprenticeship program approach to address its behavioral health workforce shortage and increase access to services.

The remaining PIVOT components each align with BHSA's emphasis on equitable care and reducing disparities. BHSA strives to create pathways to ensure equitable access to care by advancing equity and reducing disparities for individuals with behavioral health needs[4]. BHSA builds on many strategies to meet communities' needs for culturally

responsive services that improve health and reduce health disparities for all, including clearly advancing community-defined practices as a key strategy for reducing health disparities and increasing diverse community representation[4].

Developing Capacity for Specialty MH Plan Services with Diverse Communities

This component strives to ensure equitable access and reduce disparities by developing the capacity of CBOs that serve the County's diverse communities to become specialty mental heath providers. If successful, this will increase access to care for individuals who are otherwise unserved or underserved in the county system of care. This component also seeks to advance community-defined practices by identifying the most effective CDEPs and exploring opportunities to generate revenue for utilizing these approaches.

Integrated Complex Care Management for Older Adults

This component also strives to create pathways to ensure equitable access to housing and care to reduce disparities. It proposes the development of an integrated and comprehensive system of care that does not currently exist for older adults living with mental health conditions and neurocognitive disorders. If successful, the newly established system would provide older adults with access to a continuum of services that are currently operating in silos. This component also seeks to provide culturally responsive care as the treatment for this vulnerable population requires specialized training and individualized care plans.

Innovative Approaches to Delivery of Care

This component aligns with BHSA's goal of providing culturally responsive services. It seeks to change the current clinic space and approach to service to create a more seamless and efficient clinic experience for clients, and provide access to wholistic, integrated services.

MHSOAC Strategic Priorities

The PIVOT components also align with the following MHSOAC Strategic Priorities[11]:

	PIVOT COMPONENT				
MHSOAC STRATEGIC PRIORITIES	**1**	**2**	**3**	**4**	**5**
Goal 1: Champion Vision into Action					
1.1: Elevate the perspectives of diverse communities.		X	X		X
1.2: Assess and advocate for system improvements.	X	X	X	X	X
1.3: Connect federally and globally to learn and apply.	X	X	X	X	X
Goal 2: Catalyze Best Practice Networks					
2.1: Support organizational capacity building.	X	X	X	X	
2.2: Fortify professional development programs and resilient workforce strategies.			X	X	
2.3: Develop adequate and reliable funding models.	X	X	X	X	
2.4: Support system-level analysis to ensure the tailored care and universal access required to reduce disparities	X	X	X		
Goal 3: Inspire Innovation and Learning					
3.1: Curate an analytical-based narrative on the potential for innovation to improve behavioral health outcomes.	X	X	X	X	X
3.2: Establish an innovation fund to link and leverage public and private investments.	X	X	X		
3.3: Accelerate learning and adaptation in public policies and programs.	X	X	X	X	X
Goal 4: Relentlessly Drive Expectations					
4.1: Launch a public awareness strategy to reduce stigma, promote access to care, and communicate the potential for recovery.			X		
4.2: Develop a behavioral health index.					
4.3: Promote understanding of the progress that is being made and the advocacy that will result in further improvements.			X		

REGULATION REQUIREMENTS

Within this section, PIVOT components may be referenced by their respective numbers:

1. Full-Service Partnership Reboot
2. Integrated Complex Care Management for Older Adults
3. Developing Capacity for Specialty MH Plan Services with Diverse Communities
4. Innovating Countywide Workforce Initiatives
5. Innovative Approaches to Delivery of Care

General Requirement

According to the INN Regulations, an Innovation Project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solve persistent mental health challenges, including but not limited to, administrative, governance, and organizational practices, processes, or procedures; advocacy; education and training for services providers, including nontraditional mental health practitioners; outreach, capacity building, and community development; system development; public education efforts; research; services and interventions[12].

The PIVOT INN Project includes the following general requirements:

	PIVOT COMPONENT				
GENERAL REQUIREMENTS	1	2	3	4	5
Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention				X	X
Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population		X		X	
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			X		X
Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite		X			
Assesses a new or changed administrative, governance, and organizational practice, process, or procedure[2]	X	X	X		X

Primary Purpose

The PIVOT INN Project addresses the following primary purposes:

	PIVOT COMPONENT				
PRIMARY PURPOSE	1	2	3	4	5
Increases access to mental health services to underserved groups.	X	X	X	X	X
Increases the quality of mental health services, including measured outcomes.	X	X	X	X	X
Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes.		X	X	X	
Increases access to mental health services, including but not limited to, services provided through permanent supportive housing.	X	X	X	X	

Innovative Component

Although the overarching goal of the PIVOT INN Project focuses on preparing the county for the transition to BHSA, each component also has its own innovative aspect:

	PIVOT COMPONENT	INNOVATIVE COMPONENT
1	Full-Service Partnership Reboot	Establish new FSP levels of care and change existing data infrastructure.
2	Integrated Complex Care Management for Older Adults	Develop a new, comprehensive, and integrated system of care for older adults living with co-occurring mental health conditions and neurocognitive disorders.
3	Developing Capacity for Specialty MH Plan Services with Diverse Communities	Determine minimum necessary steps needed for community-based organizations to become specialist MH Plan providers.
4	Innovating Countywide Workforce Initiatives	Utilize an apprenticeship model and incentives to create a seamless pathway from education and training to employment for diverse professionals and paraprofessionals
5	Innovative Approaches to Delivery of Care	Re-imagine the clinic flow of operations to promote quality care and improve client outcomes.

Community Planning Process

To kick off the local community planning process (CPP), Orange County included PIVOT as part of its MHSA Annual Plan update for FY 2024-25. The Plan was posted on County's website for stakeholder review and comment from March 11, 2024, through April 15, 2024. During this time, the MHSA Office facilitated 12 community engagement meetings with local stakeholders to review updates to the MHSA Annual Plan, including a description of the PIVOT INN concept and each component. On April 24, 2024, the Behavioral Health Advisory Board (BHAB) held a Public Hearing, where a summary of the community planning process was provided and the BHAB affirmed the stakeholder process took place. Subsequently, on June 4, 2024, the Orange County Board of Supervisors approved the MHSA Annual Plan update for FY 2024-25, which included the County's plan to seek MHSOAC approval for the PIVOT INN Project.

Following the approval of the MHSA Annual Plan, INN Staff facilitated a follow up community planning meeting on May 16, 2024, where stakeholders participated in a World Café activity to provide feedback on several PIVOT components. This feedback was summarized into themes and reported to the stakeholders at the June 20, 2024, community planning meeting.

In addition to engaging local stakeholders, Orange County also shared the PIVOT concept with other counties, creating the opportunity for interested counties to join the project. Orange County met with other counties on July 7, 2024, at the CBHDA meeting to introduce the concept, and facilitated several follow up meetings with individual counties to further discuss the proposal concept and opportunity for partnership.

Cultural Competence and Stakeholder Involvement in Evaluation

Each PIVOT component activities will be informed by subject matter experts with experience and knowledge in that specific area of behavioral health. Each component will also be staffed with Peer Specialists to integrate the perspective of consumers and family members with lived experience in mental health and recovery.

To ensure each PIVOT component is inclusive of Orange County's diverse communities, this project will include translation services in the budget. These dedicated funds will enable the county to provide materials in its threshold languages and offer interpretation services during virtual and in-person meetings.

MHSA General Standards

The PIVOT INN Projects meets the MHSA General Standards through its various components. Each area is summarized and described in detail below.

	PIVOT COMPONENT				
MHSA GENERAL STANDARDS	1	2	3	4	5
Community Collaboration	X	X	X		
Cultural Competence	X	X	X	X	X
Client Driven	X		X		X
Family Driven					X
Wellness, Recovery, and Resilience Focused	X	X	X	X	X
Integrated Service Experience	X	X	X		

<u>Community Collaborations</u>

Full-Service Partnership Reboot: The process for determining the FSP levels of care and criteria will involve extensive collaboration and discussions with various stakeholders, including but not limited to county-contractors, Department of Health Care Services, and the MHSOAC to ensure alignment.

Integrated Complex Care Management for Older Adults: This component will require the development of a multi-disciplinary team who will work together to create a system of care for older adults living with co-occurring mental health conditions and neurocognitive disorders. It will also require collaboration between numerous community partners and organizations to develop a multidisciplinary complex care/navigation approach exploring blended funding and housing options.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: This component requires a collaboration and close partnership between the County and various CBOs interested in becoming specialty mental health providers.
Innovating Countywide Workforce Initiatives: This component will include partnerships with community agencies to establish employment pipelines and pathways. Through these collaborations the County has an opportunity to expand employment opportunities for professionals and paraprofessionals.

Cultural Competency

Full-Service Partnership Reboot: This component focuses on increasing access and providing treatment interventions that are tailored to the unique and comprehensive needs of program participants.

Integrated Complex Care Management for Older Adults: This component focuses on increasing access, reducing disparities, and providing treatment interventions that are tailored to the unique needs of this vulnerable population.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: Cultural competency is an essential element of this PIVOT component and directly covers key areas within this standard, including equal access to services; an understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups; and services that utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.

Innovating Countywide Workforce Initiatives: This component focuses on expanding the diverse behavioral health workforce to help increase clients' access to services, reduce disparities and provide more culturally and linguistically appropriate services.

Innovative Approaches to Delivery of Care: The purpose of this component is to deliver services in way that fosters cultural awareness, safety, and inclusion for all clients receiving services.

Client Driven

Full-Service Partnership Reboot: The process for determining the FSP levels of care and criteria will involve discussions with clients and family members receiving services to ensure the newly identified levels of care and criteria are appropriate and meet the needs of program participants.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: Clients and family members will play a critical role in supporting the identification of CDEPs that are most effective for their community.

Innovative Approaches to Delivery of Care: This component will rely directly on client feedback, utilizing a user experience model to determine the most successful approaches to delivery of care.

Innovating Countywide Workforce Initiatives: This component aims to expand the behavioral health workforce, potentially creating employment pathways for clients interested in providing peer support services or seeking Peer Specialist Certification. This would provide the County with an opportunity to create an integrated and diverse workforce that utilizes an individual's lived experience in mental health and recovery to support the clients and families they serve.

Family Driven

Full-Service Partnership Reboot: FSP programs provide services to family members to help support their own needs, as well as to enable them to assist their loved one's recovery. Family involvement in treatment and services can be critical to supporting and maintaining an individual's recovery and will remain a critical element of this component as clients move through the newly established levels of care.

Integrated Complex Care Management for Older Adults: Family members often play a key role as caregivers for their elderly loved ones. This component will be family driven as the perspectives of children, parents, spouses and loved ones will be considered when creating this comprehensive system of care for older adults.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: This component is family driven, as many culturally specific approaches include family members in their treatment plans and services.

Innovative Approaches to Delivery of Care: This component will rely directly on client and family member feedback, utilizing a user experience model to determine the most successful approaches to delivery of care.

Wellness, Recovery and Resiliency Focused

Full-Service Partnership Reboot: This component focuses on determining and establishing levels of care for clients, which are recovery focused and tailored to their individual needs.

Integrated Complex Care Management for Older Adults: This component will require the development of a multi-disciplinary team who will work together to create a system of care for older adults living with co-occurring mental health conditions and neurocognitive disorders. The treatment for this target population is highly individualized and must be tailored to each person's unique wellness and recovery needs.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: This component ensures that services will reflect the cultural, ethnic, and racial diversity of mental health consumers, utilizing cultural practices to promote wellness and recovery.

Innovating Countywide Workforce Initiatives: This component focuses on expanding the behavioral health workforce, including the development of employment pathways for paraprofessionals. Expanding the Peer workforce promotes wellness, recovery and resilience for the individual and the clients and families they serve.

Innovative Approaches to Delivery of Care: The purpose of this component is to deliver services in way that fosters cultural awareness, safety, and inclusion for all clients receiving services. The goal is to create a space that promotes hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

Integrated Service Experience for Clients and Families

Full-Service Partnership Reboot: This component focuses on providing access to a range of comprehensive, wraparound services tailored to the unique and comprehensive needs of program participants.

Integrated Complex Care Management for Older Adults: This component focuses on establishing comprehensive and coordinated care for older adults that will require collaboration and integration of services between various systems of care. It will also explore blended funding and housing options to provide an integrated service experience for older adults and their families.

Developing Capacity for Specialty MH Plan Services with Diverse Communities: Through this component, the County and CBOs will partner to determine the necessary steps to becoming specialty mental health providers. CBOs that are eligible to become specialty mental health providers will have the ability to provide clients and family members with a range of integrated counseling services and community-defined cultural practices.

Innovating Countywide Workforce Initiatives: This component seeks to expand the behavioral health workforce, creating an employment pipeline for a diverse group of professionals and paraprofessionals. This would provide the County with an opportunity to create an integrated and diverse workforce that culturally and linguistically represents the clients and families they serve.

Timeline

This PIVOT INN proposal is a five-year project. Although there are five separate and distinct components, the project timeline will begin for all components once the first INN dollar is spent. If the MHSOAC approves the opportunity for interested counties to join this project, their five-year timeline will begin when their first INN dollar is spent.

Orange County plans to start this project immediately upon MHSOAC approval. Activities in the first year will focus on setting up the capacity and infrastructure to support each component. This includes:

- Identifying and contracting with project managers, subject matter experts and evaluators for each component.
- Engaging in ongoing community planning to further refine component activities.
- Determining staffing resources necessary to successfully execute activities.
- Drafting an evaluation plan.

This 12-month estimated timeline is based on the average length of time Orange County would need to complete its procurement process to contract with project managers and evaluators. In addition, if additional counties are approved to join this project, this adds further complexity to the contracting process, as each county must still comply with their own procurement processes and come to an agreement on a standard contract for shared project managers and evaluators supporting each component. This timeframe is also based on lessons learned from Orange County's participation in other multi-county INN collaborative projects, where the average length of time to set up the necessary administrative processes and develop a standard contract with vendors has taken up to 12 months.

The remaining time in this project (Years 2-5) will focus on the implementation of component activities outlined under the project description section of this proposal. During the last year of this project, discussions will focus on sustainability efforts identified under each component to ensure the appropriate termination of activities under MHSA INN funding and a seamless transition into BHSA. The figure below illustrates the five-year timeline.

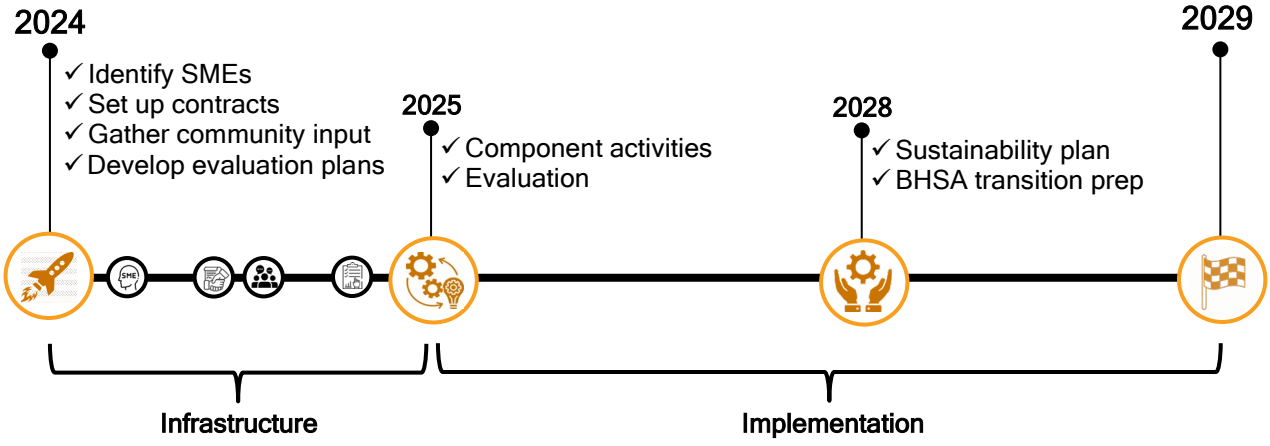


Figure 3. Five-year PIVOT INN Project timeline.

Contracting

The PIVOT INN Project will contract with various consultants and subject matter experts to support activities with each component. Orange County will follow its procurement process to identify qualified consultants, which may include releasing Request for Proposals, as appropriate.

Project Managers

Each PIVOT component will have its own project manager to direct tasks; monitor activities; coordinate meetings between the County, community members and stakeholders involved; and prepare regular status reports. If additional counties are approved to join this project, the project manager will also be tasked with coordinating between all counties; making sure activities remain consistent with the overall vision and goals of the PIVOT proposal; and creating reports that reflect a shared narrative and lessons learned across all participating counties.

Evaluators

Each PIVOT component will also have its own evaluator. The evaluator will be tasked with developing an evaluation plan; gathering information to track progress; providing recommendations to improve implementation efforts; and preparing reports that highlight successful approaches/strategies, barriers/challenges and lessons learned. These reports will be shared with the project manager to provide a comprehensive narrative of the component. If additional counties are approved to join, the evaluator will also be tasked with coordinating between all counties; making sure evaluation activities remain consistent with the overall objectives of PIVOT proposal and evaluation plan; and creating reports that reflect a shared narrative of successes, challenges and lessons learned across all participating counties.

Subject Matter Experts

Each PIVOT component will include various subject matter experts with extensive knowledge and experience in behavioral health services, peer and recovery services, and the specific target population and/or primary focus of the component. These subject

matter experts will inform component activities throughout the duration of the project, as appropriate.

Sustainability

While the PIVOT INN project and each of its components focus on local needs, it is also designed to help the county transition from MHSA funding requirements into the new requirements under BHSA. With this project, Orange County is seeking strategies to prepare its system and continue to make behavioral health services and supports available to unserved and underserved communities. Each component is designed with the intention of sustainability under BHSA.

Full-Service Partnership Reboot

The BHSA will allocate 35% of funds toward FSP programs. However, these funds are intended for service delivery rather than administrative support. The activities in this component are focused on determining the administrative changes and data infrastructure needed to successfully meet the new program requirements. Orange County is proposing to leverage its remaining MHSA INN dollars to help implement new changes into its FSP programs to support ongoing program operations and sustain service delivery under BHSA.

Integrated Complex Care Management for Older Adults

The collaboration between partners in this new system is essential to creating a funding structure that can support service delivery between the different disciplines. The INN funding will support the development of this system of care, and the funding structure created as a result of this collaboration will sustain the system and services beyond the PIVOT INN project.

Developing Capacity for Specialty MH Plan Services with Diverse Communities

The purpose of this component is to identify the minimum necessary requirements for CBOs to become Medi-Cal certified to provide specialty mental health plan services. Determining this process will allow other CBOs to assess their readiness and prepare

their systems. The ability to bill for Medi-Cal services will sustain this component beyond this INN project and bridge the gap in services for diverse communities.

Innovative Countywide Workforce Initiatives

At the end of this INN project component, the County will identify the most successful strategies for employee engagement and retention, and where possible, work with its Human Resource department to embed those approaches into its administrative policies. Furthermore, the development of a baseline infrastructure will enable the County to potentially apply for additional workforce development grants and opportunities with partners, resulting in sustain initiatives without relying solely on BHSA funding. Finally, the County will also explore the ability to maintain ongoing contracts with third party vendors through the BHSS component to sustain the successful approaches that are not possible within the county system.

Innovative Approaches to Delivery of Care

This component will integrate successful approaches into daily program operations, where possible.

Communication and Dissemination Plan

Orange County plans to share status updates about the PIVOT INN Project through:

- Presentations at local community planning meetings.
- Ongoing updates at BHAB meetings, with specific presentations upon request.
- Presentations at the California Behavioral Health Directors Association
- Annual project reports to the MHSOAC/BHSOAC.
- MHSA Annual Plan Update for FY 24-25.
- Future BHSA Integrated Plans.
- Orange County Health Care Agency Website
- Potential publication of research and evaluation results in peer-reviewed academic journals or presented at conferences to share our findings with the larger community.

BUDGET

Budget Narrative

Orange County is requesting approval to utilize $34,950,000 in MHSA INN funds to implement this five-year project. A detailed budget for each component will be developed through ongoing planning meetings that will further define component needs. A description of the expense categories and Full-Time Equivalent (FTE) positions are described below.

Consultant Contracts

- Project Managers for each PIVOT component (5 FTE) to ensure coordination and alignment of activities throughout the duration of this project.
    - The budget includes costs for travel, program supplies and equipment for each project manager to conduct activities and/or prepare reports.
- Subject Matter Experts (SMEs) for each PIVOT component (up to 25 FTE) to facilitate ongoing community planning discussions and inform component activities throughout the duration of this project.
    - The number of consultants and length of their contracts may vary depending on the needs of each component. As a result, the estimated budget accounts for annual contracts with up to 5 SMEs per component to allow flexibility, as needed.
- Evaluators for each PIVOT component (5 FTE) to support data tracking and consistency in reporting and lessons learned throughout the duration of this project.
    - The budget accounts for a principal investigator, research assistants, and supplies needed to conduct research activities and prepare reports.

Staffing Costs

- Staffing for each PIVOT component, which will include County staff time to monitor each component; internal County champions to support integration of component strategies or processes into the county system; and the ability to hire Peer Support Specialists (10 FTE), to include the peer perspective into each component.

Program Costs

- Program supplies to support PIVOT component activities, which may include but not be limited to the development and print of brochures, flyers, announcements and/or marketing materials; equipment such as phones, laptops or computers; costs for renting large meeting spaces or venues as needed and appropriate; and costs to provide incentives such as gift card, food, and transportation support for consumers and family members to participate in planning meetings.
- Translation support to ensure marketing materials, announcements, surveys and virtual and/or in-person meetings are available in Orange County's threshold languages (Arabic, Chinese, Farsi, Korean, Spanish, and Vietnamese)
- Travel for local and/or statewide activities related to each PIVOT component. Costs may include but not be limited to mileage, airfare, lodging, and food expenses.

Indirect Costs

- Orange County will apply a 5% indirect rate to support administrative activities, which was calculated based on the total program costs.

If additional counties are approved to join, each county will be responsible for funding their chosen PIVOT component and local activities. However, a portion of each county INN funds must go toward supporting a shared project manager and evaluator for their chosen component(s) to ensure coordination and aligned of component activities across participation counties, consistent evaluation, and shared learnings. A county's contribution to the project manager and evaluation will vary depending on their available INN funds.

Budget Grid

	Fiscal Year 2024-25	Fiscal Year 2025-26	Fiscal Year 2026-27	Fiscal Year 2027-28	Fiscal Year 2028-29	Total
Consultants						
Proj. Managers	$750,000	$750,000	$750,000	$750,000	$750,000	$3,750,000
SMEs	$3,750,000	$3,750,000	$3,750,000	$3,750,000	$3,750,000	$18,750,000
Evaluators	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
Staffing						
Staffing	$965,000	$965,000	$965,000	$965,000	$965,000	$4,825,000
Program						
Supplies	$275,000	$275,000	$275,000	$275,000	$275,000	$1,375,000
Translation	$100,000	$100,000	$100,000	$100,000	$100,000	$500,000
Travel	$125,000	$125,000	$125,000	$125,000	$125,000	$625,000
Indirect						
5% Admin.	$25,000	$25,000	$25,000	$25,000	$25,000	$125,000

Total Requested Budget: $34,950,000

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APPENDIX A. County INN Template

(Name) County

County Contact and Specific Dates:

- Primary County Contact:
- Date Proposal posted for 30-day Public Review:
- Date of Local MH Board hearing:
- Date of BOS approval or calendared date to appear before BOS:

PIVOT Components:

☐ Full-Service Partnership Reboot

☐ Integrated Complex Care Management for Older Adults

☐ Developing Capacity for Specialty MH Plan Services with Diverse Communities

☐ Innovating Countywide Workforce Initiatives

☐ Innovative Approaches to Delivery of Care

Local Need:

Additional Learning Objectives (if applicable):

Local Community Planning Process:

Alignment with BHSA:

Sustainability:

Budget Narrative:

- Total proposed budget
    - County Costs
    - Contractor Costs
- Budget by Fiscal Year and Specific Budget Category for County Specific Needs

APPENDIX B. Clinic Improvements

The images below reflect the vision of Orange County's stakeholders in creating a more culturally responsive and welcoming clinic space. After multiple rounds of community engagement, general themes emerged for a space that includes calming open-air landscapes, natural wonders, hope, peace, serenity, the use of animal, the use of multiple bright colors, a cultural reflection of the local community, and images that will last the test of time. With this feedback, the County consulted with a professional muralist to develop the murals.

A total of nine murals were created to reflect the visual concept of the natural wonders that are iconic to the clinic's surrounding area – coastal, wetlands, and mountainous landscapes, as well as their recognizable flora and fauna. The goal of this concept was to capture a sense of stillness, calm, peace, and serenity found in nature, that is recognizable and relatable to community stakeholders.

The images also incorporate symbols of hope, peace, and optimism - such as Lotus, Egret, and oranges - to give subtle recognition to the clinic's primarily Vietnamese demographic, while also considering the universal appeal of these symbols across cultures. For example, the Egret is a mythical creature in Vietnamese culture and a national bird of Vietnam. This figure was used in the wetlands mural inside the Adult and Older Adult outpatient clinic lobby.

In another example, the Lotus Flower is a profound symbol of resilience and enlightenment within the culture and daily life of the Vietnamese culture. This image was used in the mural located in the SUD outpatient clinic lobby.

The Children's lobby reflects the local parks and the orange trees that represent the County. To create an immersive experience, the different floors represent various natural and calming environments. The goal for these murals was to create a welcoming and calm space in the clinics and instill a sense of care for the quality of the client's experience.