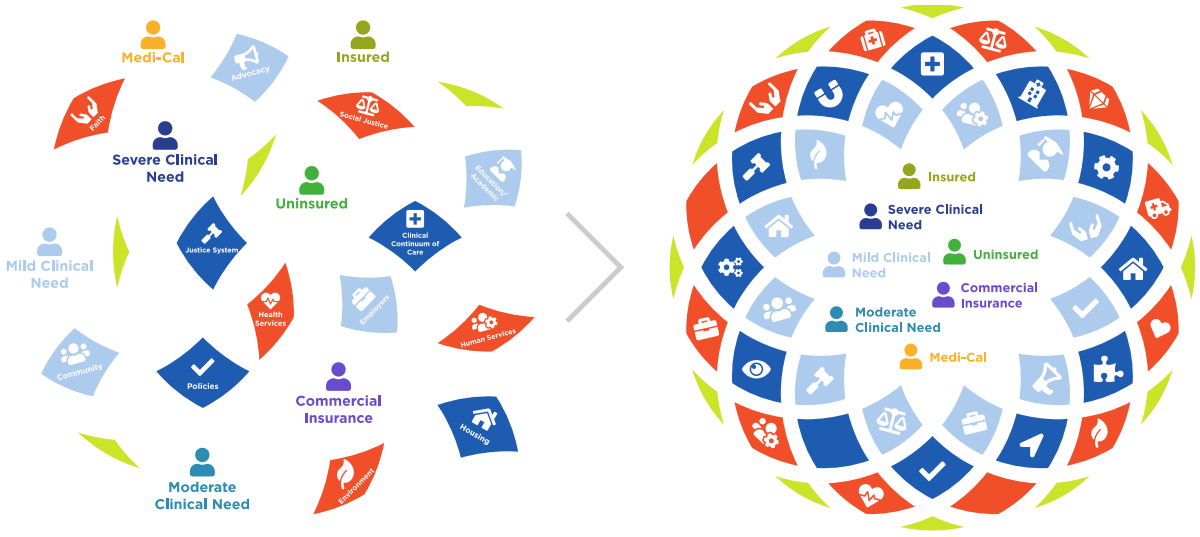
Behavioral Health System Transformation Innovation Project

ANNUAL REPORT



October 15, 2019 – September 30, 2020

ORANGE COUNTY | BEHAVIORAL HEALTH SERVICES

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Executive Summary

In May 2019, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the Behavioral Health System Transformation Innovation Project. The goal of this project is to create an integrated public and private behavioral health system that is responsive, coordinated and accessible to all Orange County residents, regardless of their insurance status, insurance type and/or level of clinical need. To achieve this end goal, transformational activities were categorized into two parallel yet interrelated areas: 1) aligning legal, fiscal and regulatory requirements (i.e., performance and value-based contracting) and 2) aligning local organizations in a unified navigation system (i.e., Digital Resource Navigator; DRN).

Following MHSOAC approval, the project launched on October 15, 2019. The Orange County Health Care Agency (OC HCA) contracted with a local non-profit organization, Mind OC, to begin the planning around performance and value-based contracting. In December 2019, OC HCA entered into a Participation Agreement with the California Mental Health Services Authority (CalMHSA) to act as the fiscal intermediary and contract on behalf of Orange County for the development of the DRN and overall evaluation of the BHST project. In March 2020, CalMHSA executed a contract with the University of California, Los Angeles (UCLA) to begin the planning and development of the DRN. CalMHSA is also in the process of executing an evaluation planning contract on behalf of OC HCA to begin the formative evaluation of the BHST project.

The first year of this project experienced delays as a result of the COVID-19 pandemic. In March 2020, the OC HCA issued a stay-at-home order and placed restrictions on large public gatherings, which significantly impacted the ability to host community engagement activities as planned. Despite the challenges and delays posed by the pandemic, Mind OC and UCLA identified alternative strategies to engage stakeholders and continue project activities.

This report reflects project activities from October 15, 2019 through September 30, 2020. The content was prepared by Mind OC and UCLA to reflect the progress, lessons learned and next steps in their respective component of the BHST project. The primary focus in the first year of this project involved extensive research to understand Orange County's readiness for transformational change and identify the necessary conditions to create this change. Information was gathered in the form of literature reviews, key informant interviews and numerous stakeholder meetings.

Project activities related to performance and value-based contracting included engagement with the Department of Health Care Services (DHCS) by OC HCA and Mind OC leadership, as well as participation in payment reform and California Advancing and Innovating Medi-Cal (CalAIM) behavioral health workgroups. At the local level, community engagement meetings were hosted to introduce the concept of performance and value-based contracting. Progress was also made in creating the conditions for success and proof of concept in Orange County's first Wellness Campus, a facility developed through a public-private partnership and designed to provide co-located behavioral health services. Preparations for the opening of this facility prompted intensive planning work around reimbursement and rate setting.

Significant progress was also achieved in the development of the DRN. A series of workgroups were facilitated with consumers, family members and providers to understand the current needs, barriers and challenges in navigating the behavioral health system within Orange County. The feedback gathered from these groups informed the scope of the navigation tool, identified features and functionality and contributed to the development of a project website.

As the BHST project enters its second year, Orange County looks forward to continuing community engagement meetings to identify community driven metrics, building and piloting the DRN in Spring 2021 and implementing the formative evaluation. Starting in January 2021, Mind OC will initiate an environmental scan and mapping project to identify and document non-county contracted mental health and substance use services available to Orange County residents. The information gathered will serve both the performance and value-based contracting and DRN components of the BHST project. For performance and value-based contracting, the information will be used to better understand the scope and supply of services available in Orange County, as well as the current commercial sector payment and reimbursement requirements. For the DRN, the information will be used to populate the digital resource navigator with private sector mental health and substance use services.

Project Background

Primary Problem

Orange County consumers, family members, and providers have identified several barriers to accessing needed behavioral health services, such as: public and private sectors operate in silos; insurance networks do not support person-centered access and service delivery, behavioral health system is too challenging to navigate; and available care is not delivered optimally.

One of the most significant underlying barriers to addressing these challenges involves the fragmented public and private behavioral health systems. As a result, people too often don't get the right care at the right time and face obstacles to knowing where to turn for care – such as identifying what is available to them – and figuring out how to pay for services that fall outside of their existing health plan, if they have one.

Project Description

The BHST project introduces a new practice or approach to the overall mental health system by seeking to identify the ways in which public and private funds can be braided to serve all Orange County residents, regardless of their insurance type or level of clinical need. The goal of this project is to create system level change that improves the quality of and access to services, which will require interagency and community collaboration, as well as extensive development and capacity building activities.

The BHST project proposes to work with State and local agencies, public and private health plans, and philanthropic and non-profit organizations to create a coordinated system that focuses on community defined values and performance metrics. To address system navigation barriers, Orange County proposes to partner with local agencies and organizations to consolidate and integrate their disparate directories into a single source. To the extent the above activities are successful, this project will:

- Develop and execute initial procurement and contracts designed to braid funds and include community-defined values and performance-based metrics (in addition to regulatory requirements);
- Provide technical assistance for local providers, as needed, to prepare them for new contracting and performance standards; and
- Deploy the digital resource directory and social determinants survey. Deployment will begin with a small-scale pilot and gradually expand in scope through later phases until it is available to all Orange County residents.

Formative Evaluation

Due to its focus on identifying methods to change processes and integrate policies across the public and private sectors, this project will utilize a formative evaluation. One of the key goals of a formative evaluation is to identify influences – both potential and real – on the progress and/or effectiveness of a project's implementation. Information is collected at all phases of execution and is used as part of a continuous feedback loop to improve the ultimate likelihood of successful project implementation.

Timeline

The MHSOAC approved the BHST Innovation Project on May 23, 2020 for a total of three years. The timeline below reflects key project activities, milestones and target dates throughout the duration of this project. The BHST proposal was anticipated to begin in July 2019 (the third quarter of the 2019 calendar

year); however, due to delays in the county procurement process, the project launched in October 2019. Project timeframes were updated in the proposal timeline below to reflect the actual start date.

This report covers the time period of October 15, 2020 through September 30, 2020, and focuses on updates to key project activities highlighted below. It is important to note that project activities during this period were heavily affected by the COVID-19 public health emergency. Significant time has been dedicated to adapting to this new reality.

Project Activities	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022	Jul-Sep 2022
Aligning Legal, Fiscal and Regulatory Requirements to Improve Quality and Access to Services												
Identify available funding streams and all applicable State and Federal rules/regulations	X	X	X	X	X	X						
Explore strategies to braid funds across the public, private and philanthropic/non-profit sectors							X	X	X	X		
Explore the feasibility of a universal reimbursement rate/structure	X	X	X	X	X	X						
Host local planning to help identify community values and preferred performance standards	X			X				X				X
Operationalize identified values and performance standards into measurable outcomes							X	X	X	X	X	X
Develop methods to incentivize service delivery						X	X	X	X	X		
Streamline reporting processes						X	X	X	X	X		
Meetings with DHCS legal, fiscal, and regulatory teams	X	X	X	X	X	X	X	X	X	X	X	X
Progress updates to MHSOAC				X				X				X
Develop and execute initial procurement and contracts									X	X	X	X
Provide technical assistance for local providers, as needed							X	X	X	X	X	X
Aligning Local Organizations to Improve Service Navigation												
Identify stakeholders to include in local planning meetings	X											
Outline the scope of directory		X	X	X	X							
Identify the phases of roll out and the specific service types to be included in each phase								X				
Outline directory features, including real-time provider updates and consumer reviews			X	X	X							
Create social determinants survey, developed in collaboration with stakeholders				X	X	X						
Progress updates to MHSOAC				X				X				X
Build digital resource directory					X	X	X	X				
Beta test and revise and the social determinants survey							X	X				
Deploy the digital resource directory and social determinants survey.									X	X	X	X

Performance and Value-Based Contracting

Prepared by Mind OC

This annual report begins with a project summary and brief updates on milestone achievement and associated progress and lessons learned. Specific Commissioner questions are then addressed, followed by next steps for the project, and a listing of the documents attached as appendices. After these sections, an overview is presented with detailed discussion of project activities.

This component of the BHST project involves the development of Performance / Value-Based contracts. The OC HCA has contracted with Mind OC to work collaboratively and with community stakeholders (e.g., consumers, family members, providers, etc.) to plan for strategies for value-based contracting and associated funding sources. The goal of shifting toward value-based contracting is to improve quality of and access to culturally responsive and inclusive behavioral health (mental health and substance use) services for all Orange County residents, regardless of insurance type.

Overall Project Activities

- Engage wide participation of stakeholders, community partners, providers and county staff to participate in planning activities and discussions
- Explore feasibility of braiding public, private and philanthropic/non-profit funds to create a universal reimbursement rate/structure
- Identify and operationalize community values and preferred, measurable performance standards
- Develop contracts incentivizing community defined and performance-based and regulatory standards
- Streamline reporting processes to comply with multiple sets of regulations and new performance outcome standards
- Prepare local providers for new performance standards and contracting through technical assistance
- Leverage existing partnerships and collaborations, in recognition that many activities are already underway in the community
- Share learning made available through templates, contracts, Request for Proposals, white papers and presentations
- Report out to stakeholders on learnings from State meetings and related initiatives that are relevant to the BHST work

Communication and Coordination

- **Community Planning:** Ongoing meetings with consumers & family members to identify community values and preferred performance standards
- **System Assessment & Capacity Building for Clinical & Financial Design:** Ongoing meetings with OC HCA Behavioral Health (BH), CalOptima, local private insurance plans, and related organizations (providers, etc.) to identify potential system-level metrics that could drive quality improvement and explore potential rate structures, braiding strategies, provider requirements, and incentives, as well as legal, fiscal and regulatory requirements.

Milestone Achievement and Associated Progress and Lessons Learned

Identify available funding streams and all applicable State and Federal rules/regulations	**Progress**
	• Mind OC contracted to lead this portion
	• Literature review
	• Community engagement activities
	• Structured key informant interviews (23+) with standard protocol & report (HCA Director, Health Plan Director, CA BH County Leaders, Washington & Oregon BH leaders, and local key Providers & organizations)
	• Analyses of funding sources & allocations of directly operated & contracted BH programs
	
	Lessons Learned
	• Consistently identified Central Barriers or complications
	  ○ Speciality Mental Health (SMH) carve out & associated divide of Mild and Severe and Persistent Mental Illness (SPMI) services
	  ○ Cost based – Service units reimbursement without option for 'bonus' exceeding actual costs incurred
	  ○ MHSA funding complications
	  ○ Overly complex/Overly simplistic BH measurements & no standard level of care system
	• Areas of Opportunity
	  ○ Single County Organized Health System (COHS) plan managing all Med-Cal services
	  ○ Collaborative potential of strong & aligned Leadership – OC HCA Behavioral Health Services (BHS), CalOptima, & Board of Supervisors
	  ○ Relative simplicity of the Orange County health care delivery system
	  ○ Lessons & Opportunities informed by related transformation efforts in California and Orange County

Explore the feasibility of a universal reimbursement rate/structure	**Progress**
	• Activities closely linked with identification of available funding streams & applicable regulations, as above
	• Creating the conditions for success and proof of concept in first Wellness Campus (i.e., North Camps)
	• Began intensive planning work for reimbursement & rate setting at North Campus
	• Meetings and community stakeholder driven work aligned with community movement and associated planning for a curated list of screening protocols, standardized intake form & protocol across care systems, and a universal data sharing agreement
	
	Lessons Learned
	• Overarching need for BH and physical health integration
	• System Transformation comes down to relationships, collaboration, & culture change
	  ○ All health care is local
	  ○ Personalities matter, but so does structure
	  ○ BH needs to be at the broader decision-making table

	○ Need for organizational and structural clarity
Host local planning to help identify community values and preferred performance standards	**Progress** • Hosted 10, single-occurrence community and stakeholder events to introduce the BHST project & concept of value-based payment models • Hosting 4 recurring community and stakeholder events to continue discussions around BHST and value-based payment • Customer Relationship Management implementation to support success of project goals **Lessons Learned** • Community focus is on access, • Audience matters – relating to the audience in terms they understand, i.e., defining terminology and concepts as needed • Great work is happening is Silos • Community desire in replicating what works and fixing what does not • Both Community and Providers agree on less forms and more time for care and payment for care that matters to community • Need to define "quality" that translatable for all audiences
Meetings with DHCS legal, fiscal, and regulatory teams	**Progress** • Continued engagement with DHCS by OC HCA and Mind OC leadership • Leadership Participation in Payment Reform and CalAIM BH workgroups • Monthly Policy updates with The Steinberg Institute **Lessons Learned** • Implementation of CalAIM has shifted to 2022 • Progress in other counties and states provide learning opportunities
Progress updates to MHSOAC	**Progress** • Submitting project report to MHSOAC

Return for Implementation Dollars

Orange County will continue to explore returning to the MHSOAC for approval of additional innovation funding to support implementation activities.

Update on Conversation with DHCS Regarding Medi-Cal / Billing Reform

Orange County is continuing to engage with DHCS regarding reforms for Medi-Cal and related billing and reimbursement through CalAIM planning activities and other channels. A summary of the current status of these issues as related to CalAIM is included below. Appendix I, Attachment D contains a summary of the Behavioral Health System Transformation: Part 1 Alignment with CalAIM.

Interim Update on Results of Consultation

A broad range of external consultants has been engaged to support the complexity and urgency of this project. Both professional and local community consultation is being considered.

Next Steps

A. Identify available funding streams and all applicable State and Federal rules/regulations
   - Work will continue in alignment with other project activities.
   - Key activities will be developing a series of white papers, tool kits, and play books to inform and guide overall next steps

B. Explore strategies to braid funds across the public, private and philanthropic/non-profit sectors
   - White papers, tool kits, and play books mentioned above will also cover these topics
   - Establishing proof of concept for measurement, data collection and sharing, and exploring value-based payment options for services. Orange County's Be Well North Campus, currently under construction, and slated to begin delivering services in January 2021 offers a significant opportunity for this work.
   - Engaging private/commercial plan(s) to contract for/cover services provided at North Campus
   - Advancing discussions and thinking among key Orange County leaders about system models to support the goals of integration and value-based payments discussed above

C. Explore the feasibility of a universal reimbursement rate/structure
   - As above

D. Host local planning to help identify community values and preferred performance standards
   - Orange County will further deepen work in this area, working with community partners to ensure consumers, peers, and family members are engaged and informed around BHST activities and goals

E. Operationalize identified values and performance standards into measurable outcomes
   - As above

F. Develop methods to incentivize service delivery
   - As above

G. Streamline reporting processes
   - As above

H. Meetings with DHCS legal, fiscal, and regulatory teams
   - Orange County and Mind OC will arrange meetings with DHCS to discuss the strategies under discussion and ensure ongoing alignment with CalAIM
   - Orange County will also continue to align with other counties who are seeking to be at the "vanguard" of CalAIM and other system transformation efforts

I. Progress updates to MHSOAC
   - Orange County welcomes the opportunity to share updates to the MHSOAC

J. Develop and execute initial procurement and contracts
   - As above

K. Provide technical assistance for local providers, as needed
   - A robust work plan is under development, beginning with a provider assessment to determine readiness and specific technical assistance needs
   - Technical assistance will be focused on capacity building for county staff and functions as well as contracted providers

Documents Attached as Appendices

I. Orange County Behavioral Health System Transformation and Value Based Payments: Findings from Key Informant Interviews
    a. Attachment A: Interview Participants
    b. Attachment B: Key Informant Interview Questions
    c. Attachment C: Highlights of Related Programs and Activities
    d. Attachment D: Behavioral Health System Transformation: Part 1 Alignment with CalAIM
    e. Attachment E: MHSA Innovation Background
II. Alignment of BHST and Be Well OC
III. BHST Overview and Answers to Common Questions
IV. Be Well Orange County Coalition Meeting (March 19, 2020) Meeting Summary and Survey Results
V. Behavioral Health System Transformation: Summary Findings from NAMI Groups
VI. Steinberg Institute Agenda and Discussion Items

Overview

BHST was approved by the MHSOAC in May 2019, for a three-year term. The innovation project officially launched on October 15, 2019 when the Orange County Board of Supervisors began an agreement with Mind OC. The OC HCA has contracted with Mind OC to work collaboratively and with community stakeholders to plan for strategies for value-based contracting. Mind OC is a 501(c)3 non-profit organization created to facilitate Be Well OC, a movement driven by a coalition of over one hundred public/private/faith based/academic institutions united to build a system of mental health and substance use care for all residents of Orange County regardless of payor source.[1]See Appendix II for additional information on the alignment of BHST and the Be Well movement.

Role of Mind OC

Upon execution of the agreement with OC HCA, in October 2019 Mind OC established and staffed a project office of highly qualified staff and subcontractors. Core staff assigned to the project include:

Title	FTE	Description of Role
Director of Operations	1.0	Planning the building of proof of concept of BHST
Director of System of Care	1.0	Planning the communications and data sharing mechanism of BHST as well as planning and executing the community engagement strategy.
Director of QI and Network Development	1.0	Providing overall project management and related activities of BHST
Assistant Project Manager	0.5	Providing project management support
Senior Executive Assistant	0.75	Providing support for projects, including scheduling and other logistics and materials preparation

With Mind OC, Orange County is working with consumers, peers, family members and other community members, along with State and local agencies, public and private health plans, and philanthropic and non-profit organizations to create a coordinated system of care that bridges the public and private sectors to improve quality of and access to services. Mind OC's activities, on behalf of Orange County and in service to this innovation project, include:

Identify available funding streams and all applicable State and Federal rules/regulations

Progress

As part of the initial work toward System Assessment & Capacity Building for Clinical & Financial Design, a series of key informant interviews were conducted with subject matter experts around California and nationally. Interviews explored how related systems across California and the country are approaching transformation efforts and how those experiences can inform the work in Orange County. Mind OC and OC HCA developed a list of subject matter experts, and a series of 23+ structured key informant interviews was arranged, using a standard interview protocol. See Appendix 1, Attachment B.

Interviews explored how related systems across California and the country are approaching transformation efforts and how those experiences can inform work in Orange County. Interviews included the OC HCA Behavioral Health Director and Former HCA Director, now Interim CEO at CalOptima, as well

[1] See https://bewelloc.org/ for additional information on Be Well OC.

as discussions with California health and behavioral health leaders across six counties and one large statewide foundation, and leaders in Washington and Oregon. In addition, interviews have begun with local key Provider Organizations and Providers to establish baseline knowledge of the those currently operating in Orange County.

Full detail about these interviews may be found in the interim draft report, "Orange County Behavioral Health System Transformation and Value Based Payments: Findings from Key Informant Interviews" included in Appendix I.

This interim draft report of summary findings captures the key information shared during these interviews. It is important to note that this draft report is very much a component of the beginning of the work of BHST, and the information provided here is intended to support and guide upcoming activities and additional avenues of enquiry.

Work toward identifying available funding streams and applicable State and Federal rules/regulations was also closely linked to planning work for California Advancing and Innovating Medi-Cal (CalAIM). CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of the population by implementing broad delivery system, program and payment reform across the Medi-Cal program. Orange County was a very active participant in the planning for CalAIM.

In addition to these activities, Orange County is working with Mind OC to analyze the funding sources and allocations across directly operated and contracted behavioral health programs and services.

Lessons Learned

Early lessons learned related to available funding streams and State and Federal rules/regulations highlight the need to broaden the scope of inquiry to address the need for specialty behavioral health to be clinically, administratively, and financially structured to support physical health just as primary care and other physical health services need to be structured to support behavioral health. Several factors were consistently identified as central barriers or complications:

The specialty behavioral health carve out managed by the counties and the mild-to-moderate behavioral health/physical health benefit administered by (generally) Medi-Cal health plans

Cost based reimbursement centered on units of services delivered, and the current inability to pay any sort of "bonus" that exceeds actual costs incurred

MHSA funding is unique to California, adding an additional complicating factor, especially in light of how deeply intertwined these funds have become with Medi-Cal services

Measurement efforts regarding behavioral health service outcomes tend to be overly complex (e.g., DLA-20) or overly simplistic (e.g., follow-up after emergency department visit or hospitalization for mental illness) and there is no standard level of care measure that is used consistently in California

These barriers and complications are not new, and have been continually revealed to be inextricably linked to efforts to identify available funding streams and State and Federal rules/regulations.

Several areas of opportunity for Orange County's BHST work also emerged through the course of this work:

CalOptima, created by the Orange County Board of Supervisors in 1993 as a County Organized Health System (COHS), manages Medi-Cal services for the entire county, and only for Orange County. Compared to many other areas in California with more complex health plan arrangements (e.g., the COHS spans multiple counties and associated Boards of Supervisors, the county is served by multiple Medi-Cal managed care plans, etc.), moving toward a more aligned, payer agnostic system of care can be a more focused partnership between the County and Cal-Optima

The collaborative potential of strong and aligned leadership at Orange County's Health Care Agency, Behavioral Health Services and CalOptima was regularly noted, as was the strong potential embodied in the Be Well movement and a supportive Board of Supervisors

Key informant interviews highlighted the **relative simplicity** of the Orange County health care delivery system, in comparison to other counties, regions, and states, with Orange County services being largely limited to behavioral health, with exceedingly limited directly provided physical health care services (as opposed to having a county operated Federally Qualified Health Center or hospital)

Related transformation efforts offer many lessons and opportunities from the activities that have already been undertaken in California and Orange County, to say nothing of across the nation, and the coming transformation envisioned in CalAIM. Several of these past initiatives, such as Whole Person Care, Drug Medi-Cal Organized Delivery System, and Health Homes are summarized in Appendix I, Attachment C

Explore the feasibility of a universal reimbursement rate/structure

Progress

Exploration of feasibility and approaches for reimbursement rates and structures was also included in the work to identify available funding streams and applicable regulations. Much of the information on progress and lessons learned is included in Section B, above. Based on the information gathered from key informant interviews and other activities, in July 2020 Orange County began intensive planning work regarding the reimbursement and rate setting opportunities at the first of the Wellness Hubs (i.e., North Campus) envisioned in Be Well Result 5. This work will continue and intensify in the coming period.

Lessons Learned

Early lessons learned related to feasibility and approaches for reimbursement rates and structures also align with many of the lessons regarding funding streams and regulations. Again, a central lesson was the reiteration of an overarching need for **integration** so that specialty behavioral health services are clinically, administratively, and financially structured to support behavioral and physical health just as primary care and other physical health services need to be structured to support physical and behavioral health. Research and experience are demonstrating that system transformation ultimately comes down to **relationships, collaboration, and culture change:**

- **All health care is local:** County relationship with managed care organizations must be considered, such as levels of openness and trust between these entities, as does communication among all health care stakeholders including the private side
- **Personalities matter, but so does structure:** Transformation can be driven by key change agents but will require structured organizational relationships for sustainability
- **Behavioral health needs to be at the table** with the state and regulators, with knowledge of the issues, ideas for thinking them through, and commitment to engagement.
- **Focus on clarity,** by addressing organizational and structural changes, creating more nimble alignment, and better role clarity and accountability across the system, establishing a clear understanding of who is doing what and aiming for better efficiency

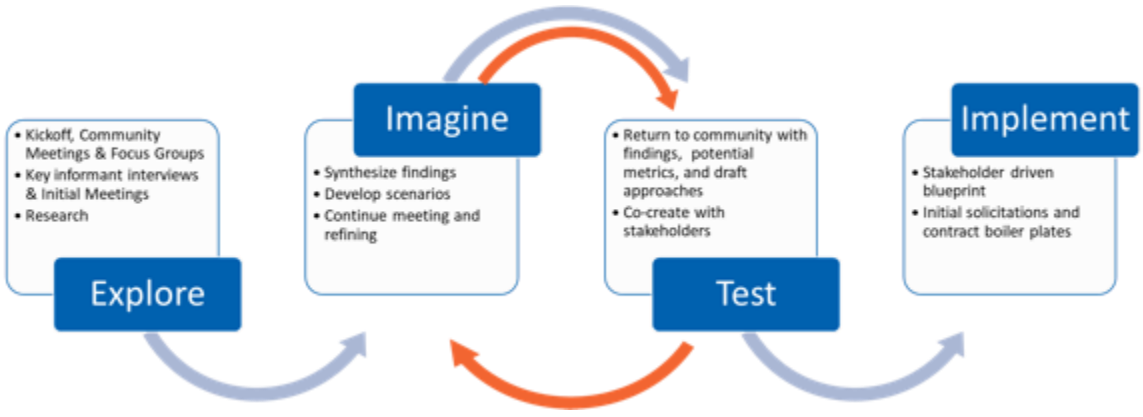
Host local planning to help identify community values and preferred performance standards

A Learning Community model was chosen for implementation of the community and stakeholder engagement process, using a modified human centered design approach. This model allows for a continuous feedback loop for gathering information and reflecting how discussions influence strategies, programs, services, and policy. Additional engagement would include key informant interviews and focus groups with identified partners, champions, and ambassadors. The goal of the engagement model was to provide a forum for discussion and feedback on building assets and resources that can help meet the needs of Orange County residents.

Original plans were to conduct in-person sessions for all meetings to allow for community participation, synthesize the information, and conduct follow up sessions to share back what was heard. Two in-person sessions VBP Kick-Off meetings, February 2020) were held before the project required a shift from in-person to virtual meetings due to the public health pandemic.

One of the fundamental elements of this project is the role of Orange County residents and the provider community. To begin to develop a Value-Based Provider Contract to work by, stakeholders must first understand what the current system and definition of “value” is and then work with that knowledge to define expectation for “value”.

The graphic below depicts the vital role of community engagement in the imagining and testing phases, with continual feedback and refinement to ensure that what is ultimately implemented supports community values and preferred performance standards.



Progress

BHST VBP Kickoff meetings

On February 5, 2020, two in-person stakeholder events were assembled, the first meeting at 10 to 11:30 a.m. in Mission Viejo, and the second meeting at 6 to 7:30 p.m. in Garden Grove. A general introduction of the concept of Value Based Payment (VBP) models and the BHST Innovation project, overall goals, and core concepts of Performance/Value Based payments and contracting was provided to the community. Tabletop discussions were used to further engage the community, allow for discussion and socialization of the concepts presented. A secondary function of these sessions was to ascertain the level of understanding of VBP by the community. The events were well attended by providers, community members, and stakeholders, with an evening session held in hope of attracting broader attendance by community members after their workday, with boxed lunches served to those in attendance. In addition to the presentation and general feedback received during the events, a follow- up survey was sent to all attendees of each event. The plan was to host additional in-person events but was halted due to the public health pandemic. See Appendix III, BHST Overview and Answers to Common Questions.

Be Well OC Coalition Meeting, March

On March 19, 2020, the Be Well Orange County movement convened its quarterly coalition meeting. The meeting was held from 1:30 to 2:30 p.m. via Zoom. 295 participants connected to the web and participants attended from 13 phone numbers.

The meeting focused on an introduction to the BHST Innovation Project from Dr. Jeff Nagel, Dr. Clayton Chau, and Dr. Karen Linkins. After the meeting, participants were asked to complete a short survey to provide feedback that will inform the next phases of this project. Participants were also asked to contribute to a survey to help identify areas in which to develop performance outcomes and measures. Feedback gathered through this survey will be shared at other community and stockholder input sessions over the next several months to help advance the goals of the BHST Innovation Project. See Appendix IV Be Well Orange County Coalition Meeting (March 19, 2020) Meeting Summary and Survey Results.

NAMI Sessions

In June - July 2020, we began engagement sessions with consumer and family members via zoom meetings held by NAMI OC. NAMI OC, National Alliance for Mental Illness Orange County, began holding online focus groups as a way to continue to help support and connect the consumer and family member community in the midst of COVID-19. There were six online evening sessions where we connected with 100 Orange County residents. The sessions provided exceptional opportunity to hear from the service utilizer community frequenting the SPMI services, including dual diagnosis, outpatient, inpatient, partial hospitalization, intensive outpatient and residential services. See Appendix V Summary Findings from NAMI Groups.

Peer Led Learning community

Engagement sessions with a small group of Peers began in June 2020. The conversations are part of ongoing efforts to establish and support more meaningful connections and inclusion of the Peer community in behavioral health work in Orange County. Planning for engagement activities that target broader inclusion of the Peer community for stakeholder feedback and learnings has been ongoing. Upcoming Peer engagement activities led by Peers, to include the general community in focus groups will begin in fall 2020.

Be Well OC Result Area #3

Recurring monthly meetings have been established since October 2019, including over 55 stakeholders and organizations with an interest in "Closing Treatment Gaps and Improving Access to Care". Three priority activities that this group has identified to work on during 2020 are focused on identifying screening tools and protocols, creating a standardized intake form and protocol, and creating and piloting a universal data-sharing agreement. Once the activities were shared by this group, the clear alignment with BHST work emerged as an opportunity to test each of the concepts in combination with a subset of providers or organizations that can carry out the work and potential for demonstrating proof of concept.

YoPros

Young Professionals group is a group of young adults interested in the future of Orange County's behavioral health and healthcare system. The YOPROS have established a recurring monthly meeting on the third Wednesday of each month from 12 to 1 pm, to identify key priorities they would like to address in Orange County, providing a voice and support system for behavioral health for the youth and young professionals community. Presentations on the work of BHST and the concept of VBP was presented to this group on July 14, "An Enhanced Introduction to BHST" and September 16, "BHST and VBP" during their monthly virtual meetings. After the meeting, they were sent a copy of the Community Survey to complete.

Be Well OC Campus Family/Stakeholder focus groups

A small focus group was established for the Be Well North Campus, meeting on March 2 in person and September 9 over zoom. Recurring meetings have been set for a monthly discussion, the agenda focused on creating an environment at North Campus that best supports healing and recovery for those seeking care at the Campus. Along with the physical environment, experience of care, services to be provided, and setting the conditions to embrace a shift in provider contracting that elicits a value-based payment approach are topics for ongoing discussion.

Customer Relationship Management (CRM) System

Mind OC identified a need to invest in a Customer Relationship Management (CRM) system to support BHST efforts to "track all deliverables including but not limited to number of community engagements, meeting topics, outreach contacts to specific agencies or organizations, number of individuals participating in events, and participant demographics." Mind OC contracted with a highly qualified subcontractor to support this effort. The subcontractor's work included consultation, requirements gathering, discovery and demonstration, migration, customization, training and support. The success of the project depends on establishing, strengthening, growing, and monitoring stakeholder relationships and opportunities for additional engagement.

What is a Customer Relationship Management system? A Customer Relationship Management (CRM) system is a cloud-based technology software to effectively manage and document stakeholder data and interactions in a systematic way. CRMs, such as Salesforce, have long been a must-have in the commercial and private sector in order to manage customer information and identify sales opportunities; however, successful organizations and projects within the public and nonprofit sectors have begun using these systems to track, monitor, and document programs.

Why a CRM for BHST? CRM capabilities are extremely beneficial for projects such as BHST, particularly when engaging with large numbers of stakeholders across an array of sectors and communities. From maintaining strong relationships with constituents, to segmenting stakeholders by topical and interest

areas, tracking engagement activities, and streamlining required data collection processes, CRMs manage data effectively and efficiently.

Lessons Learned

What was reinforced as a learning from this first phase of community engagement is that audience matters. We knew at the onset of community engagement the need to define value-based payment models, realizing that the level of understanding varied by attendee. Hosting the kick-off sessions allowed the team to find a baseline to help guide our next steps. Understanding who the audience was and to what degree they understand VBP, and defining quality services for reimbursement purposes, will need to be approached at the consumer/family/community level, at the provider and provider organization level, and at the Health Plan and Hospital systems level.

At the same time, we had to shift approach resulting from the health pandemic. In doing so, we were able continue smaller engagement sessions, meeting community where they were at, I.e. online and telephone support groups or gatherings, and ask for invitations to conduct more intimate focus groups that allowed for meaningful engagement and broader feedback. As we move through the community engagement process, we are learning that the consumer/family/community member would like to have an experience in behavioral health care that models the same service level they would receive for medical care. As we begin to engage with more providers, we are learning that they are invested in the patient experience and want to understand how to continue to meet their health plan and regulatory demands, while still providing exceptional quality experience to their patients. Recognizing this is only the first report to the MHSOAC, and we have additional exploration work with the community, both provider and consumer level, we look forward to bringing more tangible evidence and get closer to developing metrics that meet the community and county needs. In addition, we are happy to provide a presentation of our initial findings (and this report) to the MHSOAC at your request.

Meetings with DHCS legal, fiscal, and regulatory teams

Progress

Mind OC leadership has actively participated in monthly meetings and engaged in specific work groups with DHCS prior to and over the course of this project. Dr. Clayton Chau, MD, representing Mind OC, Orange County, California, and now Health Care Agency, Orange County, attended the following Regulatory, Research Focused and CalAIM Behavioral Health Workgroups from October 2019 through February 2020, at which time meetings in person ceased due to the pandemic.

- DHCS Regulatory meeting 10/31/19
- DHCS Leadership meeting 12/13/19
- CalAIM Behavioral Health Workgroups 1/23/20, 1/31/20, and 2/5/20

In addition to these meetings, we have begun monthly policy calls with The Steinberg Institute, beginning July 2020. The meeting attendees include members from Mind OC, Health Care Agency, and The Steinberg Institute. The focus of our agenda covers State budget priorities, regulatory updates, changes, and any foreseeable obstacles that could impact this project, along with continued monitoring on the status of CalAIM. See Appendix VI Steinberg Institute Agenda and Discussion Items.

Lessons Learned

With the advent of COVID-19 and the pause of CalAIM, as well as Dr. Chau's transition from Mind OC to OC HCA, these meetings have been largely on hold. Orange County intends to resume these in the coming period.

Progress updates to MHSOAC

Orange County is pleased to submit this first project report to the MHSOAC and is eager to share additional updates.

Interim Update on Results of Consultation

A broad range of consultants has been engaged to support the complexity and urgency of this project. Both professional and local community consultation is being considered.

Project Strategy, Clinical, Peer & Finance: Consultants with subject matter expertise have been engaged to address key policy, strategy, clinical, peer and finance issues that underlie the project.

Local Community Consultation: The budget for local community consultation includes specific costs for activities associated with engaging local stakeholders, including consumers, family members, peers, and providers. Due to the value of their lived experience and their unique perspectives of the behavioral health system, consumers, family members and peers will be hired to assist with facilitating workgroups. The key element of this budget is to engage target populations and stakeholders who have not previously engaged in community planning meetings. Costs include: community planning meetings; development of meeting materials and promotion; communications/content design; translation services; and travel expenses.

System Navigation

Prepared by UCLA

The Digital Resource Navigator (DRN) is part of a larger BHST Innovation Project tasked to establish a countywide, coordinated ecosystem of optimal behavioral and mental health care, support and services. The Project Team is working with the community in Orange County to create a digital navigation tool where individuals can find and utilize mental health and related social services they need across public and private settings. Other social services--such as education and housing--will be included too. For individuals unsure of their needs, an optional social determinant of health screener will help guide them to appropriate services.

Identify Stakeholders to Include in Local Planning Meetings

Progress

Participatory engagement is a cornerstone of the DRN. It ensures that project activities reflect participatory program planning principles --transparency, respect, power sharing, co-leadership, and two-way knowledge exchange -- and reflects the priorities and needs of diverse agencies, providers, administrators, families, and patients and consumer stakeholders. Various activities were designed to engage stakeholders in participating and providing input to inform the features and functionality DRN. This section summarizes participation thus far and plans to connect with more stakeholders.

The Project Team has successfully connected with 119 individuals, 25 of whom are consumers or family members. Thirty-six are providers or administrators who are actively involved in the project, and the rest of our stakeholder group are those who have helped connect us to consumer and provider groups in their network and continue to stay involved in the DRN's development.

Thus far, members of the following organizations are actively involved in the development of the DRN:

1. Boat People SOS
2. CalOptima
3. The Cambodian Family
4. City of Irvine Police Department
5. Coalition of OC Community Health Centers
6. Council on Aging Southern California
7. Family Support Network of OC
8. First 5
9. Human Options
10. Mental Health America
11. Mental Health Association of OC
12. MindOC
13. Minnie Street Family Resource Center
14. NAMI OC
15. OCHCA Veteran Health Services
16. OC Crisis Assessment Team
17. OC Links
18. OC Outreach & Engagement
19. OC Social Services Agency

20. OMID Multicultural Institute of Development
21. Pathways of Hope OC
22. Roman Catholic Diocese of OC
23. St. Joseph Hospital
24. St. Norbert Church
25. Viet C.A.R.E.
26. Wellness Center South
27. Wellness Center West

The Project Team conducted a series of 12 workgroups with stakeholders between June 26, 2020 and October 26, 2020. The workgroups are a venue for residents of Orange County to come together to have a conversation on topics (e.g. resource navigation, social determinants of health, data privacy) that inform the development of the DRN. Each workgroup session was designed to garner input from (1) program administrators and providers, (2) consumers and family members, or (3) a mix of both. Each session was 90 minutes in length and conducted via Zoom. An example slide deck for a consumer-based workgroup and a subsequent analysis is presented in Appendix VII.

For stakeholders who were unable to attend the workgroups, project staff conducted one-on-one interviews (30-45 minutes in length) over the phone or Zoom that covered topics mentioned above. A total of 16 individuals participated in 27 interviews. The key learnings from workgroups and presented in the section below:

Workgroup	Summary	Participant Count
Provider Session 1 ➔ Project Overview and Icebreaker ➔ Conversation: How to get the help needed? ➔ Next Steps and Summary	Team introduced the project, and participants shared what would be their 'win' for the resource navigator, such as cultural competence, usability, and empowering clients to identify their own needs. Participants shared that clients have a hard time getting the help they need due to stigma, lack of awareness about resources, cultural and other barriers.	Provider/Professional: 8 Consumer/Family: 1 OC MHSA INN: 3 Project Team: 6 Total: 18
Provider Session 2 ➔ Icebreaker ➔ Conversation: Who are the Helpers? ➔ Reflection ➔ Closing	As an icebreaker, participants shared how they contributed to the OC community. After, participants identified the key qualities they look for in a helper: humility, transparency, empathy, compassion, availability, and cultural competency. These qualities were more highly emphasized than being knowledgeable about resources. Individuals in need want more than just a referral, they wanted someone who would listen to their story and support them through the entire navigation.	Provider/Professional: 12 Consumer/Family: 1 OC MHSA INN: 2 Project Team: 6 Total: 21

Provider Session 3 ➔ Icebreaker ➔ Conversation: Social Determinants of Health (SDoH) ➔ Summary & Planning	Participants discussed the importance of understanding the Social Determinants of Health (SDoH) in their work to provide whole-person care, including mental and behavioral health services. The SDoH are inextricably connected to whether a consumer can access services or even acknowledge that they have a need. Determinants like health literacy, structural environment, and need for basic resources must be considered. This finding reflects a need to include a SDoH screener in the DRN.	Provider/Professional: 6 Consumer/Family: 3 OC MHSA INN: 1 Project Team: 6 Total: 16
Provider Session 4 ➔ Icebreaker: Key Exercise ➔ Conversation: Data Privacy and Security ➔ Summary and Planning	Participants discussed best practices for developing trust and clarity in data policies: accessible and culturally competent language; explanations of what the data will be used for, by who, and who will have access; and providing some sense of control over the data being collected. There was a preference for asking for consent contextually as needed versus a large front-loaded consenting process that all users must go through.	Provider/Professional:5 Consumer/Family: 0 OC MHSA INN: 2 Project Team: 5 Total: 12
Provider Session 5 ➔ Activity: Show your resource list ➔ Conversation: Resource Lists ➔ Summary and Planning	Participants were asked to show and tell their resource lists or guides on Zoom and describe what they include, how they organize and update their list, and whether they share their list. Participants then described their challenges with connecting appropriate resources to their clients, and the group discussed features in the DRN that would improve resource organizing, navigating, and sharing.	Provider/Professional: 8 Consumer/Family: 1 OC MHSA INN: 2 Project Team: 7 Total: 18
Provider Session 6 ➔ Conversation: Eligibility Applications ➔ Summary and Planning	Participants shared how they and their clients complete the eligibility application process, such as by phone, online, or mail-in. This process was described as intimidating and complicated for consumers, and as a barrier to seeking services. Providers offered ideas to improve this process in the DRN and listed major applications that the DRN should include.	Provider/Professional: 6 Consumer/Family: 1 OC MHSA INN: 2 Project Team: 8 Total: 24
Provider Session 7 ➔ Conversation:	Participants consisted of navigators, outreach specialists, mental health professionals, and administrators from OC Links and OC	Provider/Professional: 12 Consumer/Family: 0

Referral & Coordination ➔ Summary and Planning	Behavioral Health Services Outreach and Engagement. Participants shared their intake, resource, navigation, referral, and follow-up processes. The group discussed how the DRN could make these steps easier for referrers.	OC MHSA INN: 1 Project Team: 8 Total: 21
Provider Session 8 ➔ Introduction to User Interface & Experience (UX/UI) ➔ Activity: UX/UI Homepage Testing ➔ Summary and Planning	As this was the first UX/UI workgroup, the Lead Designer for Chorus presented an introduction to UX and UI so participants would have a basic understanding of the workgroup's activity. Participants were given desktop and mobile versions of two OC Navigator resource navigation pages and asked to complete the same 3 tasks in each option. Participants shared what they liked about each option and what they would want to add or change to better help them and their clients find resources. Participants gave feedback on the layout, content, and language of the site.	Provider/Professional: 5 Consumer/Family: 1 OC MHSA INN: 2 Project Team: 8 Total: 16
Consumer Session 1 ➔ Project Overview ➔ Conversation:Who are your helpers? How do you or your helper connect to resources? ➔ Summary and Planning	This session is a repeat of Session 2, which was conducted with providers. Like providers, consumers and family members expounded the importance of personal connections with their helpers. Helpers were those who truly cared about them, could relate to them, and conveyed authenticity and hope. Participants discussed how they found help online or on government websites. They spoke in-depth about website interfaces they found intimidating, confusing, and off-putting, and also described features they liked in other sites.	Provider/Professional: 0 Consumer/Family: 14 OC MHSA INN: 1 Project Team: 8 Total: 23
Provider Session 9 ➔ Conversation: UX/UI Homepage Test Updates and Feedback ➔ Summary and Planning	The Project Team reviewed updates from the last UX/UI test to the homepage. Participants provided feedback and ideas to improve the interface of the Homepage , such as scrolling functions, descriptions of options in the DRN, and colors.	Provider/Professional: 6 Consumer/Family: 0 OC MHSA INN: 2 Project Team: 7 Total: 15
Consumer Session 2 ➔ Project Overview ➔ Conversation: What is your journey to	This session was similar to Consumer Session 1 and was conducted with a different set of consumers. Participants shared their unique needs and that of their families. They	Provider/Professional: 0 Consumer/Peers: 5 OC MHSA INN: 2 Project Team: 7

find help? How can a website help you? ➔ Summary and Planning	explained how they work with personal and formal networks to meet those needs. Participants brainstormed helpful website features with the Chorus/UCLA team.	Total: 14
Consumer Session 3 ➔ Conversation: UX/UI Homepage Test Updates and Feedback ➔ Summary and Planning	Participants were shown different versions of certain features, after which they voted on the options they preferred and shared how they thought they could be improved. Participants provided ideas on how to frame the needs assessment. The group was very willing to share the strengths and limitations of their communities when it came to accessing technology.	Provider/Professional: 0 Consumer/Family: 6 OC MHSA INN: 1 Project Team: 7 Total: 14
Consumer/Provider Session 10 ➔ Conversation: Resource Lists & Annotation ➔ Summary and Planning	Participants discussed whether they would like to have curated resource lists and how they would share lists with others. Participants described the sort of notes they would include for each resource, such as follow up information and their personal opinions about the resource.	Provider/Professional: 3 Consumer/Family: 5 OC MHSA INN: 1 Project Team: 7 Total: 16

Timeline

The DRN is on track for stakeholder engagement activities. Engagement activities began on June 26th, 2020. It is intended to be iterative and ongoing for the entire project period. New workgroup topics and stakeholder interviews are in development for existing participants. Additional sessions that cover prior topics will be made available to new participants, with an emphasis on engaging more consumer feedback.

Lessons Learned and Next Steps

The project has adapted its engagement strategy during the COVID-19 pandemic by utilizing the strategy described above to engage with a smaller group of stakeholders through video and telephone conversations. The DRN project has successfully engaged numerous consumers and families in the second round of engagement and plans to reach more in the next project period.

- Continue outreach to broaden stakeholder network
- Expand outreach to include additional representation from LGBTIQ, veterans, and other stakeholders
- Identify flexible times to schedule additional engagement activities on weekends and after work hours for those that cannot attend during the workday
- Explore in-person opportunities for engagement with stakeholders if possible

Outline the Scope of the Directory

Progress

The scope of the DRN, similar to the features and functionality, is informed through stakeholder engagement. The key learnings from the engagement activities and how it defines the outline of the DRN is detailed below. Other project activities (i.e. Advisory Group and Website Development) that broadly influence the outline are also summarized.

Stakeholders Inform the Scope of the DRN

Key learnings from the workgroups and stakeholder interviews and how they inform the scope of the DRN are presented in the table below. Please note that this represents one point in an iterative development process that will continue to evolve with ongoing exploration and refinement with stakeholders.

Themes	Conversation	Key Learnings And Implication for Scope
Need	"If I'm an individual, what is something that will start the conversation of what it is I need?" "What I'm looking for is increased accessibility. When someone is in a crisis, that's the best time to get them into [the care system]."	There is a high level of need for culturally competent, local, and accessible resources in Orange County.
Trust	"Training and cultural competence is key. Having the ability to build rapport with who you're talking to. It's the first step to help anyone." "To be honest, have a sense of integrity, to be vulnerable so the person feels they're talking to someone who cares. [This] can be more important than the resource."	In addition to having the knowledge and training to link to appropriate resources, the helper should also be warm, honest, vulnerable, and empathetic to build trust. The DRN should work to incorporate these values into the user interface and user experience of the site.
Other Needs to Consider (Social Determinants of Health)	"What I may perceive as a major social determinant of health is not the same as someone else's perception." "The screening tools have to be mindful about how they guide answers. It's hard to do when we're using the computer when we're used to doing it in-person."	Participants identified loneliness, stigma, food insecurity, housing, health behaviors, health literacy, and transportation as common social determinants of health experienced by their clients. The SDoH screener should be easy to use and intentional about its measures.
Privacy and Security	"When I call and give my personal info to agencies/services I'm looking for online, how secure is this? Am I giving it to the right person? If I have some sort of knowledge beforehand that these are the questions I	Language around data privacy and trust should be understandable, culturally competent, and transparent about the data's use, access, and whether the user has control over their data.

	need to answer, this would take away feelings of anxiety and untrustworthiness" "A chat function is very important, and having it in multiple languages would be more amazing so people can feel comfortable if they don't know a word in language"	Seeking consent at numerous stages of the SDoH screener and resource navigation process would instill trust. The DRN should consider a chat function to help users understand their data privacy.
Resource Listing	"A challenge would be the ongoing maintenance of the resource list." "It's not just making a list but having a relationship with each of the programs is critical." "When there is a description of the program, we easily understand what types of services they provide and their eligibility requirements."	The DRN should provide thorough information about the resource, including eligibility information. The DRN needs to find an efficient way to organize and update all resources. The DRN should find a way to support human connections among referrers, agencies, consumers, and family members.
Accessibility	"Potential barriers are technology literacy or health literacy levels." "The application process for each of these programs is a nightmare. They're tedious, asking for a lot of information, and for someone who has visual or hearing impairment, it's not easy for them to go through the process." "If there is an opportunity within the scope of this project to consider a data sharing agreement, that may allow some ease of communication and potentially smooth the multi-agency connection."	The DRN should use friendly and understandable tone and diction to describe eligibility criteria. The DRN should include examples of applications from major programs so that users know the information they need ahead of time and provide a direct link to a case manager or the agency. Data sharing between agencies could expedite the referral and eligibility process.
Referrals	"It's basically knowledge on the streets and trial and error and knowing the system." "I think if we have it all digitized, it would save our backs. I know they get really heavy. I got my stuff from being in the field, but there's always stuff that changes and I have different information on my phone".	Each referrer has a unique knowledge base and modus operandi. A simple, organized, and updated tool would help them help their clients. Features of the DRN should make it easy for referrers to call agencies, locate nearest resources, and link to map applications.

		The DRN should include a feature to make notes about resources and programs to support follow-up, such as barriers to care or contact.
User Interface and User Experience	"Beautiful, great colors, soothing to look at. I'd enjoy using this site." "I like the option of having it in different languages. It should be obvious how it can be translated quickly." "Can we hover over the connect button and have 2 choices: call or email. They can choose and it would still connect them to the resource."	Participants liked the layout, colors, and easy-to-use interface of the OC Navigator site. Desired features include: a 'Connect' button to call and/or email the agency or case manager; a visible 'Emergency' button on each page; filters to help narrow resources; and translation to threshold languages.
Trust: where/who do people turn to for help?	"I gravitate more towards the formal professional [agencies] because it makes me feel more secure." "A lot of these government organizations, or these big agencies, just the look of the websites were very formal, they just look like they're meant for government employees. And they're not very appealing." "Exhibiting compassion and patience, and a level of humility. And it's really important to also exude a sense of hope"	Consumers and family members find helpers formally and informally. Some trust agencies and major programs because of the formality they lend, while others look for human connection in informal ways. Text-heavy sites with many drop-down menus are intimidating to navigate for consumers and family members.

Advisory Group

An advisory group--composed of key and strategic stakeholders--who contribute subject matter and community expertise provide additional voices to inform the scope. Thus far, three individuals--who provide the perspective of CalOptima, Mental Health America, and consumers/families respectively--have agreed to be members of the advisory group. More individuals will be identified and added when appropriate. Members regularly attend workgroups and communicate with project staff (e.g. phone conversation and email) as needed.

Moreover, the advisory group has been pivotal in facilitating other project efforts. This includes, but is not limited to, (1) outreach to individuals and groups to participate in engagement activities, (2) capturing resource directories currently in use by agencies and organizations, (3) identifying reimbursement and county reporting needs that can potentially be captured in the DRN, and (4) developing communication strategies to reach consumers.

Website Development

Another recurring theme from stakeholders is the need for a project website that will (1) allow Orange County residents to learn about the DRN project and keep up to date on progress, and (2) allow interested individuals to contact project staff to participate. Key learnings will also be disseminated--in keeping consistent with principles on transparency--in short write-ups on the website. The website is designed with stakeholder input in mind, and therefore reflects espoused values such as accessibility (e.g. streamline interface, inviting color/imagery, simple language). Finally, the project website can help inform a broader discussion on mental/behavioral health and help build capacity for the community (see Appendix VIII for draft pages of the DRN website).

Timeline

The project is on track to launch a pilot of the DRN in the community in Spring 2021. The DRN will continue to undergo six more iterative improvement cycles, where additional features and functionalities are developed, tested and refined based on stakeholder input and user feedback.

Lessons Learned and Next Steps

Stakeholders emphasize the importance of developing the DRN from the perspective of a whole-person. Much of the scope of the DRN is thus framed from this perspective--how best to support an individual on their journey to wellness and the role that the DRN can play in that journey. Key insights suggest trust and human relationship are core to this entire process. Other emerging themes that broadly define the outline are [1] accessibility (e.g. easy to use, approachable, cultural competence), [2] a questionnaire to ascertain an individual's needs and to help guide individuals to appropriate services and identify other needs, [3] how to keep resource listings updated, [4] mapping abilities and [5] referrals. The undercurrent to all of this is that project activities and the DRN must meet individuals where they are, and because Orange County is a diverse and dynamic community, meaningful engagement of all stakeholders--especially groups that have been historically underserved or unserved--is crucial.

- Explore how stakeholder input translates to actual features and functionality
- Consider how DRN can reflect what stakeholders believe are valuable (e.g. trust and accessibility)
- Continue work with advisory group; identify and recruit additional members as necessary
- Launch project website in November 2020 and disseminate key learnings

Outline Directory Features, Including Real-time Provider Updates and Consumer Reviews

Progress

This section summarizes how features and functionalities developed for the DRN--informed by stakeholder engagement--can begin to address the scope outlined in the prior section. The Project Team developed an initial draft build that explored some initial features (see Appendix IX for draft illustrations):

DRN Feature Outline

1. **Digital Resource Navigator Home Page**
    a. *Category listings and navigation*
    b. *General sitemap and entry to SDoH screener*
2. **SDoH Screener Survey Design and Questions**
    a. *Survey design and questions*

   b. *Survey functionality and progress visualization*

3. **Resource Listing Guide & Results**
   a. *Resource filtering by resource type*
   b. *Resource card view visualization and description*
4. **Resource Listing Detail Page**
   a. *Resource detail page for key resource information and self-referral*
5. **Additional Features / Functionality**
   a. *Responsive layout for mobile & desktop web*
   b. *Cross-browser compatibility of all major browsers*

Stakeholder feedback from workgroups on user interface and user experience (UI/UX) helped further refine existing functions and generate new functions. Finally, a complementary approach to developing features via "persona" is described.

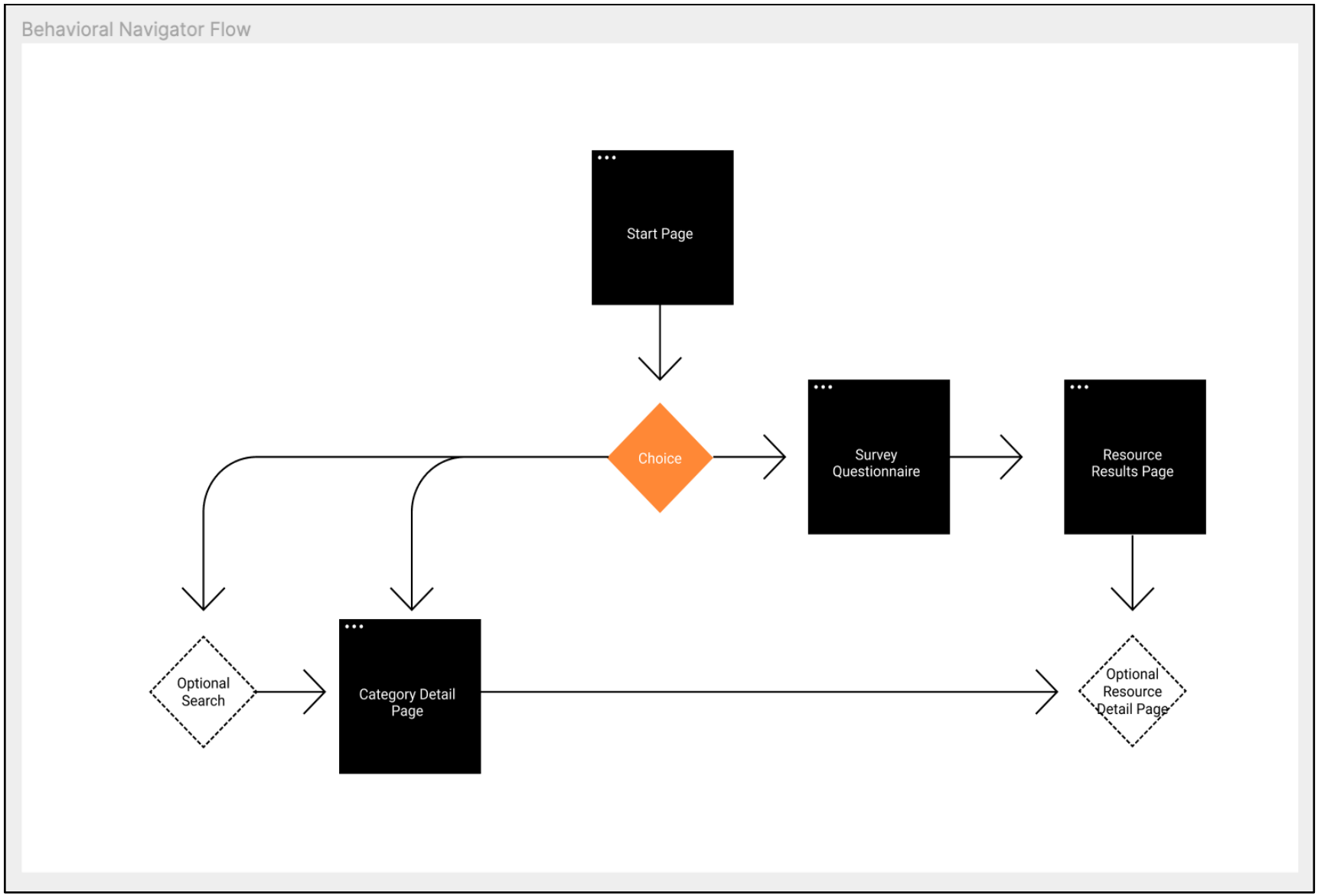
Preliminary Directory Features

Based on discussion from workgroups and stakeholders, aspects of the directory can be aimed at two broad categories of users: 1) individuals and families, and 2) staff and professionals.

Individual's Journey
Individual Dashboard a. Provide intake of social determinants of health (SDoH) screener b. Provide a search utility to match and filter resources based on SDoH. i. Resource attributes to be determined based on continued engagement with key stakeholders and community members. c. Provide an intake form to self-refer with a community organization. d. Provide a dashboard for users to view and manage their referrals.
Staff Journey
Staff Dashboard a. Provide intake of social determinants of health (SDoH) screener and other behavioral health screeners for adults (e.g. depression, anxiety, psychosis, alcohol/substance abuse). b. Provide a search utility to match and filter resources based on SDoH i. Resource attributes to be determined based on continued engagement with key stakeholders and community members c. Provide an intake form to refer a client with a community organization d. Provide a dashboard for peer navigators to view and manage their referrals and clients

Site Map--Individual Journey

This journey map outlines the general path users would follow to find resources using the DRN.



User Interface and User Experience (UI/UX) Update to DRN Features

Three workgroups sessions (Provider Session 8, 9, and Consumer 3) centered discussion on UI and UX. A sample of what stakeholders (providers, professionals, and consumers) said is bulleted below and its influence on the design is illustrated below. To the extent possible, multiple options for each feature are presented to garner feedback and provoke discussion through comparison and contrast.

Other features that have been discussed with stakeholders--such as the ability to provide real-time updates to resource listing and consumer reviews--are in development and will be presented in the near future.

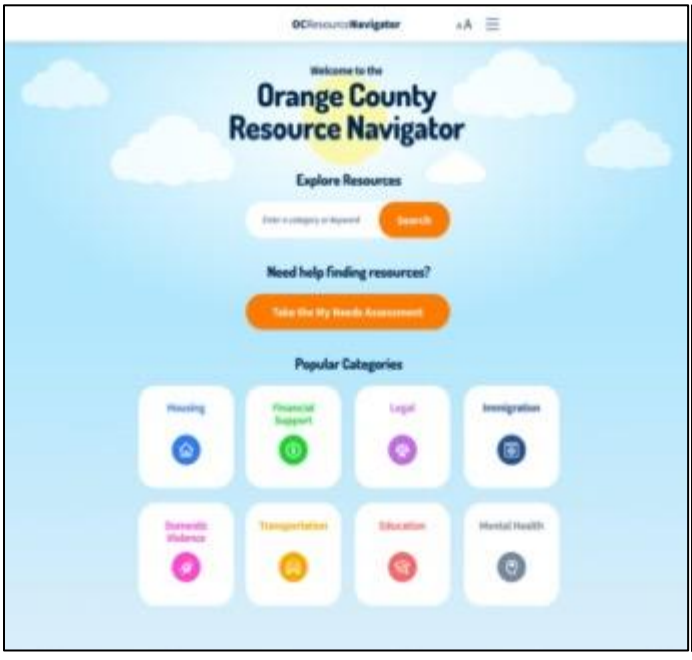
Stakeholder Input on Home Screen

- Home screen that is inviting and relaxing
- Simple user-friendly layout
- ADA compliance
- Ability to enlarge font
- Preference for intuitive icons over text heavy layout

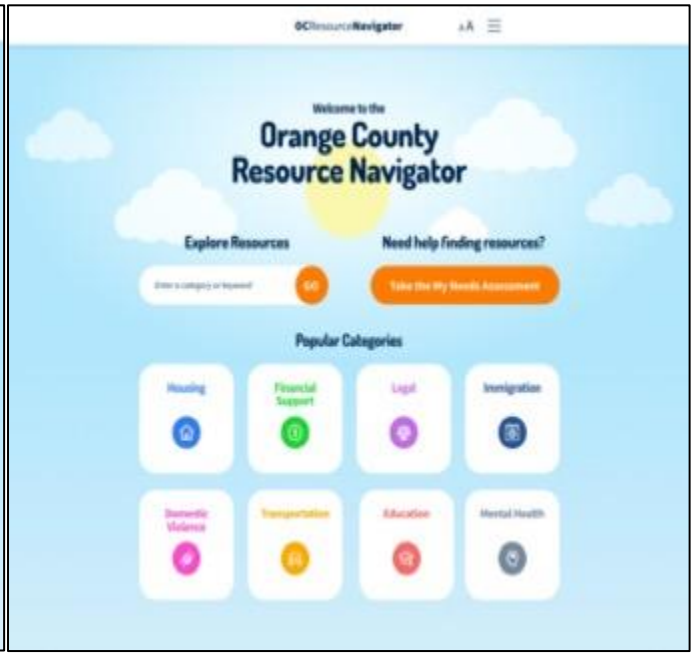
Two Iterative Updates to DRN Home Screen

Two new iterations of the DRN draft home screen were generated after the alpha build. Stakeholders preferred how elements were stacked in v1 compared to v2. Additional stakeholder input will drive the development of further iterations.

Option 1



Option 2



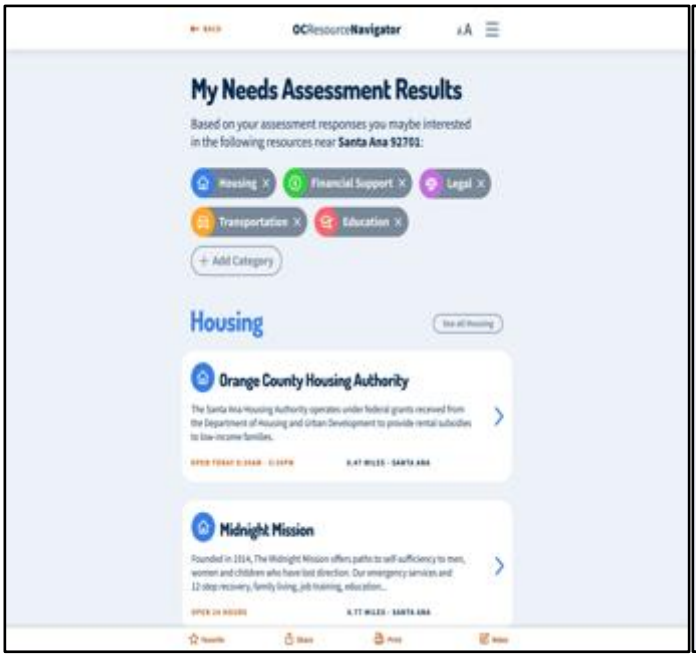
Stakeholder Input on Resource Listing

- Offer services on top of the page
- Use of color to highlight important areas and get users' attention
- 'Favorite' button to be on the top of the page instead of the bottom
- Highlight and emphasize information with different colors, such as who is served by an agency
- Hours of operation (e.g. listing hours and "open now")
- Ability to favorite resource and created curated lists of services
- Results can be shared via (1) email or text messaging or (2) print-friendly to share results to individuals without access to technology

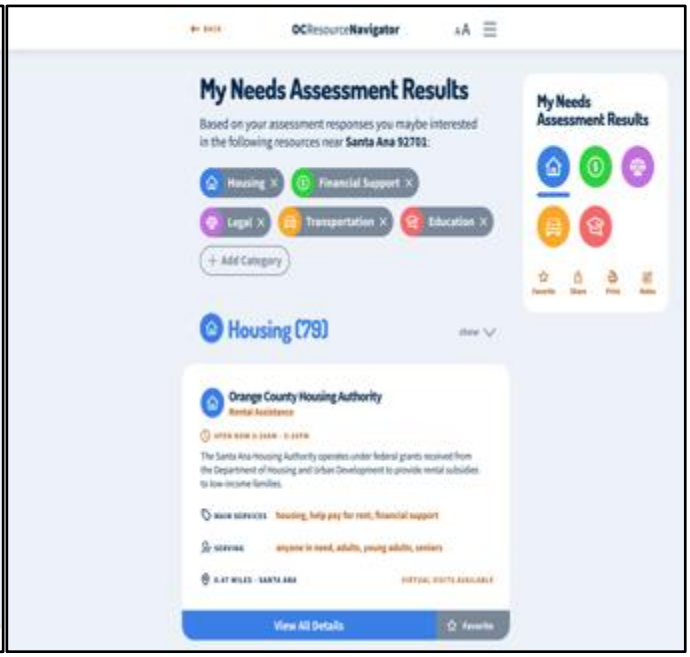
Two Iterations of the Resource List Page

Both iterations of the draft resource listing page have the same features and functionality. However, v1 is designed to be more streamlined to enable faster scrolling through resources at the expense of displaying more information.

Option 1



Option 2



Personas to Inform DRN Features

In addition to direct feedback from stakeholders, the DRN project is also using personas to develop features and functionality. A persona is a character created to represent a user type or specific segments (e.g. case worker or mom). Approaching development in this manner is complementary to our participatory engagement process and helps highlight functions that may be useful to multiple users. For example, if a case manager and mom wants to help a friend find a needed resource, how can a screener support both of them and also account for their difference in familiarity with behavioral and mental health? Three personas are presented below for reference.

Case Manager Persona

Individual Consumer Persona

Helper Persona

Timeline

The project is ahead of schedule in the development of DRN features. An initial draft build was submitted on August 1, 2020. Many of the core features and functionality have been updated since and numerous stakeholders have provided direct feedback. As mentioned in the timeline section above, the project is on track for a Spring 2021 pilot in the community.

Lessons Learned and Next Steps

By and large, many stakeholders had positive responses to the intuitive design elements, namely the ability to use the DRN without having to read a user manual. They expressed great enthusiasm that it is clear how conversations have informed design and features. Finally, developing multiple versions of a feature has generated engaging and dynamic discussions because when individuals explain their preference, it can help reframe the topic for others and contributes to capacity building.

- Continue to build out features and functionality
- Garner additional feedback on user interface and user experience

Create social determinants of health survey, developed in collaboration with stakeholders

Progress

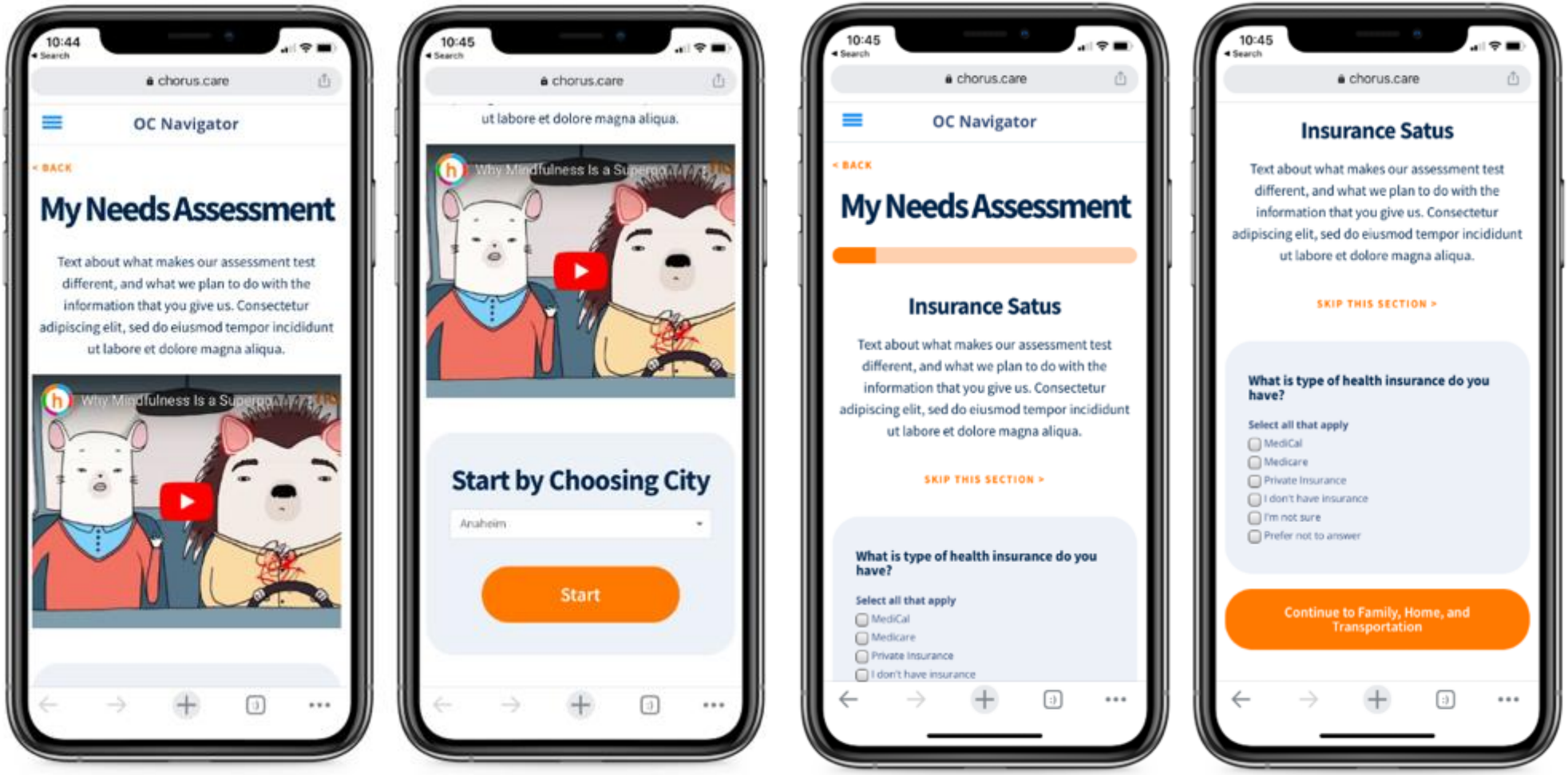
An optional DRN screener (composed of a SDoH and behavioral health screener) will filter and prioritized potential services based on an individual's reported needs. Additional behavioral health screeners will be included per stakeholder input. The development of the DRN screener is summarized below and a draft SDoH is included as Appendix X.

Social Determinants of Health Screener

Several measurement instruments were reviewed and in consultation with our methodological lead on measurements narrowed down to four commonly used questionnaires that displayed strong psychometric properties and have gone through validation efforts. Although there is good rationale to adopt either of the four, our findings from our stakeholder engagement--specifically Workgroup Session 3: SDoH--helped inform our selection as a base for the survey of PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risk, and Experience. Stakeholders emphasized the importance of (1) accessibility--which is paramount for individuals with low health literacy or limited English proficiency and (2) communication in terms of tone, word choices and how the conversation is framed. In light of this and given that PRAPARE was developed in a community setting with stakeholder input, it was selected as a starting point for further development.

Stakeholders provided input in Workgroup Session 8: UI/UX when the screener interface was presented. Per their recommendation, the screener is split across multiple pages by construct/domain, and a progress bar illustrates overall progress. Each page has an option to skip if users do not want to answer a question.

SDoH Screener Survey Draft Design and Questions



The DRN project also identified other domains that stakeholders reported as a priority or need (e.g. gender identity, physical health, safety). Project staff reviewed numerous options in each domain over several team meetings before making a selection. Furthermore, an additional bank of questions--which are optional--address other domains and constructs project staff and stakeholders view as important (e.g. concerns on parenting, immigration, and refugee status), and are still exploring how best to utilize them given the highly sensitive nature of some questions.

Timeline

The DRN project is on schedule for the development of the SDoH and behavioral health screener. It will be ready to launch with the DRN pilot in Spring 2021.

Lessons Learned and Next Steps

Overall, stakeholders believed a SDoH and behavioral health screener is beneficial to helping individuals identify needs and direction towards appropriate services. However, how it is implemented is paramount to success. To that end, they suggested we focus on (1) questions written for individuals with low literacy, (2) keeping the screener short in length to prevent response burden, and (3) the ability to skip questions that may be sensitive to users.

- Garner stakeholder input on current iteration of DRN screener
- Identify other measurement instruments and screeners that may be beneficial to include in the DRN as appropriate

Progress Updates to MHSOAC

This writeup represents our annual update to MHSOAC.

Build Digital Resource Navigator

Progress

The project is taking an iterative approach to inform design and build, which is consistent with the participatory approach we outlined above. An initial draft build was completed August 1, 2020 (see draft build in Appendix IX). An expanded build is planned for November 1, 2020. A brief summary of security and compliance, which is essential to the build, is detailed below.

Security and Compliance

The DRN project is working closely in collaboration with the OC HCA Information Technology (HCA IT) Security and Compliance team to ensure the UCLA Chorus platform used to develop the DRN meets the county and state information security requirements. Maintaining information security is of utmost importance, and as such this project has taken a comprehensive, active and in-depth approach to the review process, as well as the requests and guidance provided by the OC HCA IT Security Team. The Chorus platform is being vetted for the highest security standard set by OC HCA, which includes HIPAA compliance and ability to integrate with the County Electronic Health Record (EHR). The Project Team is on track to receive approved status from OC HCA IT Security Services before the end of Q42020.

Timeline

The project is ahead of schedule for the build of the DRN. A new iteration--reflecting the input an increasingly large network of stakeholders--will be submitted November 1, 2020.

Lessons Learned and Next Steps

The use of a participatory technology design process has resulted in a DRN that many stakeholders express great enthusiasm and excitement for.

- Continue to expand functionality to support individual/family journeys finding services
- Continue to update the design, look and feel and style of the site
- Add additional functionality including mapping, filtering and searching resources
- Continue build out of related DRN features.

Orange County Behavioral Health System Transformation and Value Based Payments: Findings from Key Informant Interviews

Prepared September 2020
By Mind OC

Contents

Introduction

Orange County's Behavioral Health System Transformation (BHST) Initiative was approved as an MHSA funded Innovation Project on May 23, 2019 for $18 million dollars over three years. BHST: Part 1[2] involves researching and developing performance/value-based contracts with providers to improve the quality of and access to culturally responsive and inclusive behavioral health (mental health and substance abuse) services for all Orange County residents, regardless of insurance type. This time-limited project runs from October 2019 through June 2022. The Health Care Agency (HCA) is partnering with Mind OC[3] to engage community stakeholders (e.g., consumers, family members, providers, etc.) to develop the value-based contracting plan and approach to ensure it aligns with and reflects the needs and values of the greater Orange County community.

To accomplish the goals of BHST-1, two streams interconnected activities are underway:

Community Planning: Ongoing meetings with consumers, family members, and providers to identify community values and desired performance standards and outcomes

System Assessment & Capacity Building for Clinical & Financial Design: Ongoing meetings with HCA Behavioral Health, CalOptima, commercial insurance plans, managed behavioral health organizations, health systems, and other related provider organizations to identify potential desired clinical model(s) and explore potential rate structures, braided funding strategies, provider requirements, and incentives, as well as legal, fiscal and regulatory requirements that support the clinical model(s)

As part of the initial work toward System Assessment & Capacity Building for Clinical & Financial Design, a series of key informant (KI) interviews were conducted with subject matter experts around California and nationally. Interviews explored how related systems across California and the country are approaching transformation efforts and how those experiences can inform the work in Orange County. For reference, the questions used to guide the interviews may be found in Attachment B.

This interim report summarizes findings from the key informant interviews conducted to date. It is important to note that this report presents findings from the initial phase of the BHST-1 work, and the information provided here is intended to support and guide upcoming activities and additional avenues of enquiry. The report is structured to parallel the interview questions, with findings summarized within the following sections

1. Key Factors for Behavioral Health System Transformation
2. Value Based Payment (and Measurement) Readiness
3. Related Initiatives
4. Technical Assistance Approach
5. Advice for Orange County
6. Other Considerations

[2] BHST: Part 2 is focused on the development of a Digital Resource Navigator. For additional information on that project, please visit: https://www.ochealthinfo.com/bhs/about/pi/mhsa.

[3] Mind OC is a 501(c)3 non-profit organization created to facilitate Be Well OC, a movement driven by a coalition of over one hundred public/private/faith based/academic institutions united to build a system of Mental Health and SUD Care for all residents of Orange County regardless of payor source.

Key Informant Interview Participants

The following details the types of individuals interviewed to date:

Geography	Participant Affiliation
Orange County	• Director, Health Care Agency Behavioral Health Services • CEO, CalOptima • Director of Behavioral Health Services, CalOptima
State of CA and other counties	• Health and Behavioral Health Leaders from Alameda, Fresno, San Bernardino, San Diego, San Mateo, Yolo • Medi-Cal Health Plans • California HealthCare Foundation • Major health/hospital system senior leader
Oregon and Washington	• Executive Director, King County Accountable Community of Health • CEO of Health Share of Oregon Coordinated Care Organization (integrating physical health, addictions and mental health, and dental care providers)

Summary Overview and Key Takeaways

Overall, KIs emphasized the need to structure behavioral health services clinically, administratively, and financially to support physical health just as primary care and other physical health services need to be structured to support behavioral health. Several factors were consistently identified as central barriers or complications:

The specialty behavioral health carve out managed by the counties and the mild-to-moderate behavioral health/physical health benefit administered by (generally) Medi-Cal health plans

Cost based reimbursement centered on units of services delivered, and the current inability to pay any sort of "bonus" that exceeds actual costs incurred

MHSA funding is unique to California, adding an additional complicating factor, especially in light of how deeply intertwined these funds have become with Medi-Cal services

Measurement efforts regarding behavioral health service outcomes tend to be overly complex (e.g., DLA-20) or overly simplistic (e.g., follow-up after emergency department visit or hospitalization for mental illness) and there is no standard level of care measure that is used consistently in CA

While these barriers and complications came up again and again, several areas of opportunity and advantage for Orange County emerged through the course of the interviews:

CalOptima, created by the Orange County Board of Supervisors in 1993 as a County Organized Health System (COHS), manages Medi-Cal services for the

entire county, and only for Orange County. Compared to many other areas in CA with more complex health plan arrangements (e.g., the COHS spans multiple counties and associated Boards of Supervisors, the county is served by multiple Medi-Cal managed care plans, etc.), moving toward a more aligned, payer agnostic system of care can be a more focused partnership between the County and Cal-Optima.

The collaborative potential of strong and aligned leadership at Orange County's Health Care Agency, Behavioral Health Services and CalOptima was regularly noted, as was the strong potential embodied in the Be Well movement and a supportive Board of Supervisors

KIs highlighted the **relative simplicity** of the Orange County health care delivery system, in comparison to other counties, regions, and states, with Orange County services being largely limited to behavioral health, with exceedingly limited directly provided physical health care services (as opposed to having a county operated FQHC or hospital)

Related transformation efforts offer many lessons and opportunities from the activities that have already been undertaken in California and Orange County, to say nothing of across the nation, and the coming transformation envisioned in CalAIM. Several of these past initiatives, such as Whole Person Care, Drug Medi-Cal Organized Delivery System, and Health Homes are summarized in Attachment C

Findings

1. Key Factors for Behavioral Health System Transformation

KIs were asked to discuss their overall experience and observations of behavioral health system transformation, including how they are approaching coming waivers (such as CalAIM) and potential significant changes to the carve out. As noted above, KIs emphasized an overarching need for **integration** so that specialty behavioral health services are clinically, administratively, and financially structured to support behavioral and physical health just as primary care and other physical health services need to be structured to support physical and behavioral health. KIs identified an array of **clinical** and **financial** design factors to consider, as well as several issues related to **measurement and data**. Recognizing that system transformation ultimately comes down to **relationships, collaboration, and culture change**, KIs also focused on the central role of these issues.

Behavioral Health Integration and Carve Out Factors

The Department of Health Care Services (DHCS) administers California's Medicaid (Medi-Cal) program. The Medi-Cal Specialty Mental Health Services (SMHS) program is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) of the Social Security Act. As the single state Medicaid agency, DHCS is responsible for

administering the Medi-Cal SMHS Waiver Program which provides SMHS to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). The MHPs are required to provide or arrange for the provision of SMHS to beneficiaries in their counties that meet medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals. See: https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx
KIs offered an array of observations on the carve out as well as the overall need for better integration of behavioral health services:

- **Barriers to care.** Bifurcation of payers and clinical services (the "carve out") was repeatedly identified as creating barriers to care coordination and other critical functions. As one KI said, "Much of what we do now is to work around these barriers."

- **Integration needed at many levels.** KIs called out various areas for addressing the need for integration to improve fragmentation and care coordination, including: 1) physical and behavioral health; 2) mild to moderate services and the specialty services administered by counties; and 3) county administered mental health and substance use services. Even within health plans, KIs noted siloing of functions such as behavioral health, case management, and utilization management and that better integration of these activities would support improved accountability, simplify reporting, and would likely reduce costs and improve outcomes.

- **Carving In could take various forms.** The most common concept for a carve in was the idea of transferring responsibility for the vast majority of current specialty behavioral health services from the counties to the health plans – such as what has occurred in Washington, Oregon, and many other states. Another option, under intense exploration in Los Angeles, would be to transfer responsibility for mild to moderate behavioral health services from the health plans to the county. Still another option would be to make the counties (or another entity functioning as a special needs plan) responsible for the whole health of individuals eligible for specialty behavioral health services.

- Readiness for change. County behavioral health leaders across California expressed deep commitment to transformation and improving client care. Other health leaders in California and other states also reiterated the importance of profound changes. A health plan leader highlighted that counties are key providers and partner extensively with other programs that effect their populations, with the result being that, "The more alignment the better the care."

- County staffing concerns. Since Medicaid expansion and parity, plans and counties have made progress toward better meeting the behavioral health needs of the people they serve. KIs expressed deep concern that these gains be maintained and not jeopardized through transformation. In Orange County in particular, concern for the County

workforce is paramount, given the 1,250 highly trained, specialized staff employed by Behavioral Health Services.

Clinical Design Factors

KIs identified three factors that are essential to address as part of the clinical design aspects of payment reform, including:

- **Clients first.** Understanding the client/patient experience and what they want to achieve is central to successful transformation.

> *Clients should not have to discern if they are mild to moderate to get better and should not have to go somewhere else to get treatment.*
> --Behavioral Health Leader

- **Look to Federally Qualified Health Centers (FQHCs).** KIs raised the opportunity and need to leverage and expand the established and successful integrated care continuum unique to FQHCs.

- **Penetration rates.** Some KIs noted that county behavioral health penetration rates for services remain too low, as is the case for mild to moderate services offered though health plans. Transformation efforts need to address this as a priority.

Financial Design Factors

KIs raised several considerations regarding factors associated with the financial design of payment reform, including:

- Limits of cost-based reimbursement. Today's cost-based reimbursement system limits or prevents meaningful influence over services and/or outcomes

- **Current, complex matrix of funding.** KIs noted that the current funding streams counties receive for behavioral health services presents significant challenges for transformation, especially as counties have increasingly leveraged MHSA funding as match for FFP. Various other layers further complicate matters including constitutional and judicial requirements, as well as state and federal legislative and administrative requirements.

- **Beware of unintended consequences.** KIs cautioned that while addressing costs is central to transformation, designing a financial model that supports needed clinical services must be carried out with an eye toward potential unintended consequences. Certain populations and services (e.g., unfunded, incarcerated) would remain under county responsibility in any scenario of the county and need special consideration.

Measurement and Data

An essential aspect of implementing payment reform with value-based contracting is having a robust data and measurement strategy. The following are key elements highlighted by KIs:

- **Meaningful level of care system.** KIs consistently flagged the need for a Level of Care System as a gap in the current system and a central component of successful transformation

- **Screening and assessments.** KIs emphasized the need to standardized, accurate, and up-to-date screening and assessment tools to reflect current practice. It was noted that current medical necessity criteria predate the ACA and do not consider health plan responsibility for mild to moderate services

Potential Measurement Framework (provided by KI)
Level 1: How much did we do (units of service, length of stay, etc.)?
Level 2: How well did we do it (access to care, timeliness, productivity)?
Level 3 (the gold standard): Is anyone better off and was the life of the human being improved?

- **Population metrics and outcomes.** The need for using broad, yet targeted and relevant population metrics is important, including incarceration, utilization of crisis services and other factors, was identified as an important issue to take up early in the planning process to focus expectations and facilitate goal setting.

- **Consistent measures across systems and care continuum.** KIs acknowledged that the complexity of the systems involved presents challenges for consistent measures across county operated and contracted providers, the mild to moderate service array, and the commercial side.

Relationships, Collaboration, and Culture Change

KIs identified several themes related to addressing the less concrete, relational and perceptual issues related to the culture changes needed for successful implementation, including:

- **All health care is local.** County relationships with Managed Care Organizations (MCOs) must be considered, such as levels of openness and trust between these entities, as does communication among all health care stakeholders, including those on the commercial side.

- **Personalities matter, but so does structure.** Transformation can be driven by key change agents, but will require structured organizational relationships and workflows for sustainability.

- **Behavioral health needs to be at the broader decision-making table.** As waiver efforts and regulatory changes are planned and develop at the state level and with regulators, leaders with knowledge of behavioral health issues, ideas for thinking them through, and commitment to engagement and integration need to be included.

- **Establish a clear understanding of who is doing what for role clarity and efficiency.** It is important to create a clear vision and approach by addressing organizational and structural changes, creating more nimble alignment, and better role clarity and accountability across the system.

2. Value Based Payment (and Measurement) Readiness

In the context of their considerations of behavioral health system transformation, KIs were asked specifically about readiness for the move toward different payment models. Again, KIs identified issues related to **clinical** and **financial** readiness, as well as several issues related to **measurement and data**, summarized below**.** While there was some discussion of past and present value-based payment activities for specialty behavioral services in California, the **limitations and complications** identified above featured prominently, including:

- The specialty behavioral health carve out sets up a situation where cost savings from improved behavioral health outcomes would accrue most heavily for the health plans

- Cost based reimbursement centered on units of services delivered, and the current inability to pay any sort of "bonus" that exceeds actual costs incurred

- California's unique availability of MHSA funding adds an additional complicating factor, especially in light of how deeply intertwined these funds have become with Medi-Cal services

- Measurement efforts regarding behavioral health service outcomes tend to be overly complex (such as the DLA-20), or overly simplistic (Follow-up after emergency department visit or hospitalization for mental illness) and there is no standard level of care system

Clinical and Financial Readiness

KIs provided recommendations regarding how to achieve clinical and financial readiness, including:

- **Using existing funds.** As part of assessing financial readiness, it is important to look at how to use existing funds and how to better braid those funds. The majority of County mental health and substance use disorder services are funded by tax revenue through sales tax and vehicle license fees that fund realignment. Shifting toward incentives is very exciting, but with underlying question of sustainability of services and adequacy of funding.

- **Cost based reimbursement is the known world.** Shifting to other reimbursement models requires careful consideration since they have not really been tested broadly.

> *I think VBP is the future but everyone is just dipping a toe into it at this point.*
> -- Health Plan Leader

- **State cost settlements must be addressed.** Payment reform must address state cost settlements with counties, including variability in costs and the backlog of cost settlements going back 8-10 years in arrears

- **Significant support and guidance for counties is needed.** Braiding the different funding streams to support an integrated model with value-based payments, such as per member/per month will require support and guidance for counties and other stakeholders (more on this below in the section on technical assistance approach)

- **Integrated agency designation.** Yolo County got designation from HHS at the state level as an integrated agency, allowing them to share funding from realignment across different parts of the agency, though still with very limited flexibility. This allows splitting staff across different state funding streams, such as public health nurses split between child welfare and public health

Data and Measurement Readiness

KIs identified a number of issues to consider regarding data and measurement readiness, including:

- **EHR complexity.** Counties and providers are using an array of EHRs, though some providers remain on paper. Limitations on reimbursing EHR implementation costs further exacerbate the challenges. EHRs are notoriously complex to administer for the functions they are designed for – whether for physical health, mental health, or substance use disorder services – few, if any programs are truly designed for integrated services.

> *Data is the biggest piece to be wrestled for transformation and value based payments*
> –Behavioral Health Leader
>
> *On the medical side, the metrics are very straight forward. Behavioral health metrics tend to be challenging and we need to make sure what we are measuring is appropriate and accurate.*
> – Health Plan Leader

- **42 CFR data issues.** Substance use services will need to be addressed, since timely access to this information will be essential for managing care and achieving outcomes and cost savings.

- **Limited measures at outset of full integration.** In Washington state, where plans are subject to quality withholds, the measures used during the initial phase of full integration were related to physical health, behavioral health penetration rates, and seven day follow-up for mental illness related hospitalizations.

- **Who gets the bonus?** Multiple KIs noted the complexity of establishing clients' assignment to a specific provider for services with current data systems across the payers involved, curtailing the ability to incentivize a provider for improved outcomes.

3. Related Initiatives

Many transformation efforts have already been undertaken in Orange County, parts or all of California, and across the nation. Of particular note is the State's CalAIM initiative. While currently on hold, this work is anticipated to begin in earnest in 2022. **KIs noted that Orange County has a tremendous opportunity through BHST to pave the way toward CalAIM.**

Detailed further in Attachment C, CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of the population by implementing broad delivery system, program, and payment reform across the Medi-Cal program. Like BHST, the major components of CalAIM build on various pilots and previous federal waivers with the goals of better quality of life for Medi-Cal members and long-term cost savings/avoidance.
KIs identified highlights from several other initiatives that informed their activities or offer guidance for the changes encompassed with changing payment models and contracting structures, including:

- **Dual Eligibles Coordinated Care Demonstration - Cal MediConnect.** California's Medi-Cal program and the Centers for Medicare & Medicaid Services (CMS) partnered to launch a financial alignment demonstration to promote coordinated health care delivery for Californians who are dually eligible for both Medicare and Medi-Cal. The demonstration – known as Cal MediConnect – aims to create a seamless service delivery experience for dual eligible beneficiaries, with the ultimate goals of improved care coordination, better health outcomes, and a more efficient delivery system. Cal MediConnect combines Medicare and Medi-Cal benefits into one health plan, with additional care coordination benefits.

- **Drug Medi-Cal Organized Delivery System.** The Drug Medi-Cal Organized Delivery System (DMC-ODS) will is intended to organize substance use disorder care and increase the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of standardized levels of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services.

- **Health Homes Program.** The Health Homes Program (HHP) is designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries. One

participant noted that HHP had supported integration of clinical and case management functions, though without financial integration.

- **Whole Person Care.** The Whole Person Care (WPC) regional pilots focus on the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. Pilots allow the use of various payment methods beyond traditional cost reimbursement and fee-for service, as well as payment for providers not otherwise covered by Medi-Cal, such as Community Health Workers.

In addition to references to specific programs, KIs offered a variety of overarching suggestions to guide Orange County's BHST project:

- **Look beyond California.** Other states hold lessons from their experiences addressing the carve-out, value-based purchasing, and other factors, though none have the complication of MHSA funding.

- **Measures matter.** KIs noted that seemingly formulaic efforts, such as moves to improve HEDIS scores, drove the alignment of incentive programs with strategic planning, and that, while the compliance may be a driving force, *"the bottom line is they that look at the measures to see how they interact with the lives of the members and their outcomes. There is a reason for the measures… Even if driven by compliance, if you keep clinical care at the fore there is still significant benefit."*

- **Schools are instructive:** Many counties, including Orange County, have leveraged MHSA funding to support school-based services, working collaboratively with school districts to blend and braid funding in ways that can inform other efforts beyond schools.

- **Primary care offers lessons:** Plans throughout California have been piloting value-based and outcome-centered provider contracting for primary care, and even for providers of mild to moderate level behavioral health services. In many cases these providers are also contracted with the County for specialty behavioral health services, offering opportunities to build on their experiences to support broader system transformation.

4. Technical Assistance Approach

County- and provider-level technical assistance for all aspects of behavioral health system transformation was identified as a critical need by **all** KIs. Clinical, financial, administrative, technical, and overall change management support were all highlighted. Because of the structure of the interviews and this report, much of what KIs saw as essential content for technical assistance is reflected above in sections "1. Key Factors for Behavioral Health System Transformation" and "2. Value Based Payment (and Measurement) Readiness." The feedback summarized below reflects KIs' comments on attributes and elements of TA that will meet the needs identified in other sections of this report.

> *Technical assistance feels like the hardest task – county leaders need their own navigator to help figure it all out at a system level!*
> -- Behavioral Health Leader
>
> *This is huge – one of the things I might suggest is for CBHA and CBHDA to come together to identify, as we know more, what is needed.*
> -- Behavioral Health Leader

In addition to the myriad county and provider TA needs identified, it is essential to note, as one health plan leader did, that ***"consumers and family members may define different areas of improvement from what payers want and what providers want."*** In other words, consumers and family members must be included in identifying TA needs and prioritization. The need to identify community defined values and metrics is an explicit component of the work of BHST, and TA will need to be designed to support a system that can deliver those values and metrics. Beyond the information gathered through the key informant interviews summarized in this document, a parallel yet linked process is underway to work with consumers, family members, peers, and community members to ensure their active participation in planning activities.

County Approach

Given the central role of county agencies in administering specialty behavior services in California, KIs focused on several elements of overall TA that will need to be provided for county staff and leadership. Much of this support would be best delivered on a statewide basis, but can also lend itself to helping counties, such as Orange County, who are working to get a jump start on needed transformation activities. Several KIs noted that a multi-county symposium or learning community approach could be helpful for vanguard counties as well as statewide efforts. Because of the intensity and complexity of the day to day work of county staff, KIs noted a need for TA to be delivered by experts who could be cognizant of those factors, while also deeply versed in the TA content and ways of accomplishing things differently.

The following elements were seen as essential for supporting individual, multi-county, and statewide TA toward transformation:

- **Participatory.** Administration of county behavioral health services goes beyond any one department. TA needs to include other county staff and leadership, particularly fiscal and contracting, but also electeds and their staff. One county, in conjunction with a move

> *Even one person can undermine in a very significant way.*
> -- Behavioral Health Leader

toward value-based payment, noted significant county staff resistance, and a perception that the needed changes presented insurmountable additional work. Over time, staff came to appreciate that what was needed was different work, and not just more work. Transformation efforts were noted to begin from an array of sources – the governor (as in Oregon), the legislature and state agencies (as in Washington), from different portions of county government (program, fiscal, contracting, Board of Supervisors), and from broad cross sector coalitions (such as Be Well in Orange County).

- **Contextual.** There was a consistent need identified for experts who could articulate what is being proposed and accomplished at the state level, in other counties, and in other states, as well as how to avoid pitfalls that impede transformation.

- **Results Focused.** Transformation will require aligning many clinical, financial, and administrative elements for common purpose. One county leader spoke of success in aligning measurement across an array of county functions, spanning behavioral health, public health, and social services, with a common results-based framework. This approach can also support needed trust building across and within state and county agencies and departments, particularly as resources are blended, braided, and deployed differently.

- **Inertia Aware.** State and county governments, agencies, and departments are, by design, bureaucratic. This allows for stable and reliable execution of their activities. However, when it comes to change efforts, such as a transformation of the behavioral health system, the very nature of these entities can pose a major obstacle. Additionally, the workforce within county behavioral health services was repeatedly noted as a potential challenge, requiring a central focus for TA. One KI noted that government institutions attract people who prefer standard procedures and limited changes. That said, virtually every transformation effort that was discussed was championed by dedicated county or government staff. Supporting these change agents was identified as a central attribute necessary for successful TA.

Provider Approach

At the provider level, the same needs for participatory, contextual, results focused, and inertia aware TA were identified by KIs. In addition to these attributes, KIs noted a need for an assessment of providers regarding their readiness for transformation activities and a move toward value based payments. The key elements identified by KIs for readiness assessment and TA generally aligned around clinical practices and outcomes based care, business practices and IT, and supporting organizational culture change and quality improvement.

- **Readiness assessment needed**: No KI was aware of a provider readiness assessment that had been conducted in California. There was a consistent sense that providers spanned all potential stages of readiness and interest/commitment for

transformation activities. For TA to be effective, it will need to support preparing the entire system for transformation, and thus a thorough readiness assessment was seen as vital. Provider willingness was often mentioned in conjunction, with a common theme that identifying provider buy in for a move toward outcomes based care was at least as important as establishing current technical readiness.

- **Clinical practices and outcomes based care**: As detailed above in section 1. Key Factors for Behavioral Health System Transformation, various elements of clinical integration were seen as central to transformation efforts, with significant TA needed to support advancement in this area. KIs noted a need to support providers with TA related to models of integration, population health management, and using standard levels of care at system, organizational, and individual clinician levels. Seemingly fundamental elements such as trauma informed care, motivational interviewing, peer provider services, and participatory documentation were also noted as provider TA needs. While many of these things were acknowledged to be perceived by providers as onerous, KIs noted that effective TA can bridge this barrier by tying the activities to their foundations in improving client care and outcomes, and expanding on prior efforts such as the ASAM levels incorporated into DMC-ODS.

- **Business practices and IT:** Recognizing that contractual requirements often drive clinical care as well as related business practices, KIs stressed the importance of supporting providers in building the robust systems required by a transformed system and related value based payments. The participatory TA elements discussed above were seen as even more vital at the provider level, where non-clinical staff will have central roles in ensuring that contract requirements and payment terms are fulfilled and documented. Recognizing that most behavioral health providers lack extensive cash reserves, fiscal TA was also seen as a common need to mitigate potential financial strain due to do payment timing from new payers.

- **Culture and quality improvement:** KIs noted that all of the activities discussed in conjunction with behavioral health system transformation will require extensive culture change and an overall move to quality improvement. The regulatory environment for behavioral health services has long fostered a focus on compliance, and in many ways a transformed system is intended to be comparatively freeing, with a renewed emphasis on client care and successful outcomes. With that shift, however, will be a marked change toward a culture of continuous quality improvement.

5. Advice for Orange County

Many KIs included advice throughout their interview, and that feedback is encompassed above. As time allowed and depending on the extent to which specific recommendations had been captured elsewhere, several KIs were

asked if they had any specific advice for Orange County's transformation effort.

Right direction	"I think you are moving in the right direction and you believe in data." BHST recognizes the importance of Specialty Mental Health services as well as supporting counties in learning to work collaboratively with plans.
Clarity is key	Success for BHST will require clarity and focus on the desired outcomes, expectations for each type of stakeholder, and what network of care is included.
Address private / commercial insurance and parity	"No one is really holding private side accountable for behavioral health parity – there are many clients whose parents are commercially insured, but still in county system"
Pilot!	"We always call things pilots and take a small population and then expand it, replicate it, and grow it." Smaller scale changes can reduce upfront investment and enhance opportunities to test for improvements
Constraints may offer opportunities	Health plans are going to continue to need encounter-level documentation and data, and leveraging existing billing mechanisms that use this information (like the CMS-1500) can help advance other elements of transformation.

6. Other Considerations

At the conclusion of each interview (time allowing!), KIs were asked about any other thoughts or considerations they thought should be considered. Given the scale encompassed by contemplating behavioral health system transformation, responses to this question spanned a wide array, summarized below:

Once in a lifetime moment	This is a rare chance for big system transformation to get better outcomes for the clients we care about – but, don't do it all at once (across state or local systems) because key participants simply can't handle the scale (such as health plans, large provider organizations, county leaders, etc.)
Transformation and integration have many layers:	• Financial integration has nothing to do with clinical integration, and operational integration at the direct service staff level is another factor to address • Approaches and designs will vary based on health plan(s) and county provided services, i.e., if a county directly provides physical health services or has integrated health and human services within one agency • Medicaid Managed Care is not THE answer, but it can help with some pieces, and having a single county ***"COHS is such a gift, it's crazy not to take advantage of it"***
MHSA successes can't be lost	MHSA offer so much, including the flexibility for peer support workers, outreach and engagement, and these are activities health

	plans are not well positioned for. "It would be a shame for this to get lost in the transition. When thinking of eliminating carve out or CalAim, I think of how my peer support workers have a lot of impact in clients' life – sometimes more than the psychiatrist."
Quadruple Aim	**The "quadruple aim"** offers a point of reference for the potential for improving quality, costs, health, and provider experience

Next Steps

As noted at the outset, this interim report of summary findings captures the key information shared during the initial phase of interviews. It is important to note that this report is very much a component of the beginning of the work of BHST-1, and the information provided here is intended to support and guide upcoming activities and additional avenues of enquiry. Key next steps for this work include:

- Ensuring consumers, peers, and family members are engaged and informed around BHST activities and goals
- Establishing proof of concept for measurement, data collection and sharing, and exploring value based payment options for services. Orange County's Be Well North Campus, currently under construction, and slated to begin delivering services in January 2021 offers a significant opportunity for this work.
- Engaging at least one private/commercial plan to contract for/cover services provided at North Campus
- Advancing discussions and thinking among key Orange County leaders about system models to support the goals of integration and value based payments discussed above
- Beginning technical assistance and capacity building activities for County and Providers
- Developing a series of white papers to inform and guide these next steps

Attachments

Attachment A: Interview Participants

- Alameda County
  - Rebecca Gebhardt, Finance Director of Health Care Agency (Interim)
  - Rickie Michelle Lopez, MBA, Assistant Finance Director, Alameda County Behavioral Health Care Services
- CalOptima
  - Richard Sanchez, CEO
- CalOptima Behavioral Health
  - Dr. Edwin Poon, Behavioral Health Director
- California Health Care Foundation
  - Catherine Teare, Associate Director, High-Value Care
- Fresno County Behavioral Health
  - Dawan Utecht, Director of Behavioral Health/Public Guardian
- Healthier Here, Washington
  - Susan McLaughlin, Executive Director
- Health Share, Oregon
  - James Schroeder, CEO
- Inland Empire Health Plan
  - Takashi Wada, Executive Director, Population Health
- Los Angeles County Department of Mental Health
  - Debbie Innes-Gomberg, Deputy Director, Los Angeles County Department of Mental Health, Quality, Outcomes and Training Division
- Orange County Health Care Agency, Behavioral Health Services
  - Jeff Nagel, Behavioral Health Director
- San Bernardino County Department of Behavioral Health
  - Dr. Veronica Kelley, Director
- Health Plan of San Mateo
  - Maya Altman, Chief Executive Officer
- Sutter Health
  - Larry Marx, M.D.. Director, Integrated Care. System Mental Health Services
- Yolo County Behavioral Health Services
  - Karen Larsen, Health & Human Services Agency Director

Attachment B: Key Informant Interview Questions

Orange County Behavioral Health Systems Transformation Project

The Orange County Health Care Agency received MHSA Innovation funding to support planning to move towards a public-private, performance/value-based payment system for behavioral health services.
Using the following set of questions, we would like to solicit your input and advice on key considerations for how we approach this effort.

Questions:

1. How is your county preparing for and approaching the behavioral health system transformation that will be required by waivers (such as Cal-Aim) and potential significant changes to the carve out?

2. What aspects of the move toward different payment models and contracting do you feel your county is or is not prepared for (e.g., pay for reporting, pay for performance, outcome measurement and reporting, level of need measurement, etc.)?

3. What previous initiatives have helped/are helping your county prepare for the changes encompassed with changing payment models/contracting structures? What external guidance or expertise is helping inform this work?

4. How and to what extent are you assessing county and provider readiness for the transition to value-based contracting, including data system capacity? What do you see as the priority issues to address related to integration at the clinical, financial, or administrative levels?

5. What technical assistance is needed for providers to prepare for and operate in a new payment structure?

6. What advice do you have for Orange County as it moves forward with this work?

7. Do you have any other thoughts or considerations we should know about?

Attachment C: Highlights of Related Programs and Activities

Medi-Cal

Medi-Cal is California's Medicaid program. This is a public health insurance program which provides needed health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low income people with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS. Medi-Cal is financed equally by the state and federal government. See: https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx

Medi-Cal Specialty Mental Health Services

The Department of Health Care Services (DHCS) administers California's Medicaid (Medi-Cal) program. The Medi-Cal Specialty Mental Health Services (SMHS) program is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) of the Social Security Act. As the single state Medicaid agency, DHCS is responsible for administering the Medi-Cal SMHS Waiver Program which provides SMHS to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). The MHPs are required to provide or arrange for the provision of SMHS to beneficiaries in their counties that meet medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals. See: https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx
Additional information can also be found in a Medi-Cal Explained Fact Sheet: Medi-Cal and Behavioral Health Services, available at: https://www.chcf.org/publication/medi-cal-behavioral-health-services/

Drug Medi-Cal Organized Delivery System

The Drug Medi-Cal Organized Delivery System (DMC-ODS) will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services. See: https://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx

The Mental Health Services Act (MHSA)

The Mental Health Services Act (MHSA) was passed by California voters in 2004 to transform and expand the mental health system. MHSA funds a variety of programs that provide services to people with mental illness or those at-risk of developing mental illness, to educate and train the mental health workforce, and to ensure that counties are equipped to serve those in need.
The BHST Project is an MHSA Innovation project. Innovation projects represent 5% of MHSA funds and are designed to evaluate new or changed practices. All Innovation projects must be approved by the MHSOAC. The projects are time-limited, with a focus on learning.

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program. The major components of CalAIM build upon the successful outcomes of various pilots (including but not limited to the Whole Person Care Pilots,

Health Homes, and the Coordinated Care Initiative) from the previous federal waivers and will result in a better quality of life for Medi-Cal members as well as long-term cost savings/avoidance.

CalAIM has three primary goals:

1. Identify and manage member risk and need through Whole Person Care approaches and addressing Social Determinants of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

See: https://www.dhcs.ca.gov/calaim

Medi-Cal 2020 Demonstration

California's Section 1115(a) Medicaid Waiver, entitled Medi-Cal 2020, was approved by the Centers for Medicare & Medicaid Services (CMS) on December 30, 2015, and is effective through December 31, 2020. The Medi-Cal 2020 Demonstration aims to transform and improve the quality of care, access, and efficiency of health care services for over 13 million Medi-Cal members.

Following the end of the waiver period, DHCS intended to implement California Advancing and Innovating Medi-Cal (CalAIM), a multi-year initiative to initiate overarching policy changes across all Medi-Cal delivery systems. As part of CalAIM, DHCS intended to transition all existing managed care authorities into one consolidated 1915(b) California managed care waiver, and propose an 1115 waiver with other program authorities. In 2019 and early 2020 DHCS conducted extensive stakeholder engagement for both CalAIM and the 1115 and 1915(b) waiver renewals. While the goals and objectives of CalAIM continue to be a high priority, DHCS announced the delay of CalAIM in May 2020, due to the impact of COVID-19. For more information about the CalAIM initiative and stakeholder engagement process, please visit the CalAIM webpage.

Because of the delay of CalAIM, DHCS will submit a 12-month extension request to CMS for the Medi-Cal 2020 waiver, to ensure continuation of important programs prior to their eventual transitions under CalAIM. DHCS will also submit a 12-month extension request to CMS for the state's 1915(b) specialty mental health waiver.

See: https://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx

Health Homes Program

The Health Homes Program (HHP) is designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries.

The HHP provides six core services:

- Comprehensive care management
- Care coordination (physical health, behavioral health, community-based LTSS)
- Health promotion
- Comprehensive transitional care

- Individual and family support
- Referral to community and social support services, including housing

See: https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Whole Person Care

The Whole Person Care (WPC) regional pilots focus on the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. See:
https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

Dual Eligibles Coordinated Care Demonstration - Cal MediConnect

California's Medi-Cal program and the Centers for Medicare & Medicaid Services (CMS) partnered to launch a financial alignment demonstration to promote coordinated health care delivery for Californians who are dually eligible for both Medicare and Medi-Cal. The demonstration – known as Cal MediConnect – aims to create a seamless service delivery experience for dual eligible beneficiaries, with the ultimate goals of improved care coordination, better health outcomes, and a more efficient delivery system. Cal MediConnect combines Medicare and Medi-Cal benefits into one health plan, with additional care coordination benefits.

Cal MediConnect is part of California's larger Coordinated Care Initiative (CCI). Building on many years of stakeholder discussions, the CCI was enacted in July 2012 through SB 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012). Further updates and clarifications to this initiative were enacted in June 2013 through SB 94 (Chapter 37, Statutes of 2013).

The Cal MediConnect program launched in 2014 and was ultimately implemented in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara. For more information, please visit CalDuals.org.

CCBHC

Washington Table

https://www.hca.wa.gov/assets/program/fimc.nationalreview.pdf

Attachment D: Behavioral Health System Transformation: Part 1 Alignment with CalAIM

Orange County's Behavioral Health System Transformation Innovation Project Part 1 (BHST-1) is focused on identifying the building blocks for a culturally responsive and inclusive system no matter who is paying. The overall vision for this effort is to create an integrated public and private behavioral health system that is responsive, coordinated and accessible to all OC residents; regardless of insurance type and/or clinical need. BHST-1 shares the three main goals of CalAIM, to:

1. Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

The immediate project of BHST-1 is to undertake the planning necessary to support development of a performance- / value-based contract in support of a coordinated system of care that bridges multiple sectors and improves quality of care and access to services. For this work, Mind OC and the Orange County Health Care Agency (HCA) are working collaboratively to engage the widest net of participation of county and county contracted staff, community partners, and consumers, family members, and other stakeholders, which we see as vital components to support building community and provider capacity for system transformation. Our activities will include:

- Exploring the feasibility of braiding public, private and philanthropic/non-profit funds to create a universal reimbursement rate/structure
- Identifying and operationalize community values and preferred, measurable performance standards
- Developing contracts incentivizing community defined and performance-based and regulatory standards
- Streamlining reporting processes to comply with multiple sets of regulations and new performance outcome standards
- Preparing local providers for new performance standards and contracting through technical assistance
- Leveraging existing partnerships and collaborations
- Sharing learning made available through templates, contracts, RFPs, white papers and presentations

In addition to the overarching alignment of goals, BHST-1 dovetails with many of the specific activities and goals for behavioral health within CalAIM:

- **Behavioral Health Payment Methodology:** BHST-1 is poised to build local capacity and readiness for the State's proposed reform of its behavioral health reimbursement and incentivizing quality objectives. In addition, Orange County will be examining other paths that could be alternatives or additions to the Intergovernmental Transfer (IGT) approach proposed by the State

- **Full Integration planning:** In many ways, Orange County offers a best- case scenario for looking at the potential and challenges of full integration in California. These same attributes are part of the drivers for BHST-1 and include:
    - A single COHS (CalOptima), for a single county
    - Strong working relationships and good alignment on goals among the leadership of the County's Behavioral Health Services, HCA, and CalOptima, including a shared commitment to the vision of BHST-1
    - An engaged Board of Supervisors
    - Active participation of major health systems and private plans
- **Integration of MH and SUD:** For the same reasons Orange County offers a promising scenario for looking at full integration, the County and the work related to BHST-1 will also offer a good test case for Clinical and Administrative integration and the potential for simplified DHCS oversight. With the County's progress with DMC ODS, and the leadership advantages referenced above, there is also a great opportunity for investigating ways to address the workforce integration issues.
- **Right Place, Right Care:** Medical Necessity Proposals (screening, assessment, prior authorization, medical necessity, and documentation): BHST-1 will by necessity be considering all of these issues as part of the stakeholder engagement, system assessment, and capacity-building

Attachment E: MHSA Innovation Background

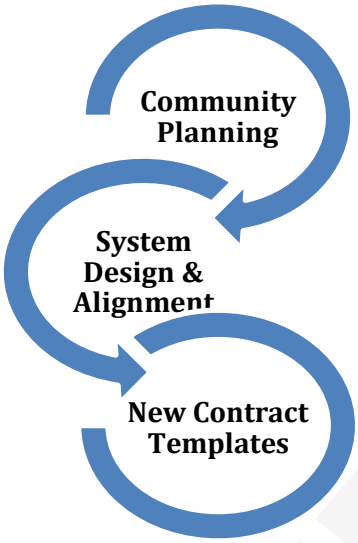
For several years, Orange County stakeholders have identified ongoing challenges in the current system: Cross Sector Fragmentation, Insurance Networks do not support person-centered access and service delivery, Inadequate knowledge of existing resources, services and benefits and how to navigate them, and Available care is not delivered optimally.

There is a lack of coordination across public and private behavioral health systems, which results in this cross- sector fragmentation. Because they operate in silos, it makes it difficult for people to figure out how to pay for out of network services. Access to needed services is based on insurance status and/or provider networks rather than cultural needs and preferences, leaving many individuals unserved and underserved. Navigating the public and private systems is complicated. Available resource directories either have outdated information or people often do not understand what services are available to them. Families and other county stakeholders want a system based on quality and recovery-oriented outcomes, not the current quantity-based measures such as numbers served or units of service.

To address these challenges, we want to create a system that can serve all Orange County residents, regardless of their insurance status, type, or level of clinical need. How can we braid public and private funds to create a system that serves all OC residents? If we want to create a value-based system based on the quality of services: What outcomes are important to consumers, their family members and our providers? How do we measure these outcomes? And just as important: How can we tie this into existing fiscal, legal and regulatory requirements? Once we establish how we want this value- based system to look, it will inevitably change the way we do business, so we then need to consider: How do we develop contracts that reflect these value-based outcomes? And finally, with a proposed plan for an integrated public and private behavioral health system: How can we help consumers and family members navigate it? All of these efforts will inform the development of new contract templates.

BHST Part 1: Addresses how we plan to create a value-based system that braids public and private funding, What performance and value-based contracting is, the work that is involved, i.e. Identifying the most important outcomes to measure and how they will be measured, identifying braiding strategies for public and provide funding and determining how this will align with legal, fiscal and regulatory requirements.

BHST Project Activities - Part 1 Performance-/Value-Based Contracting

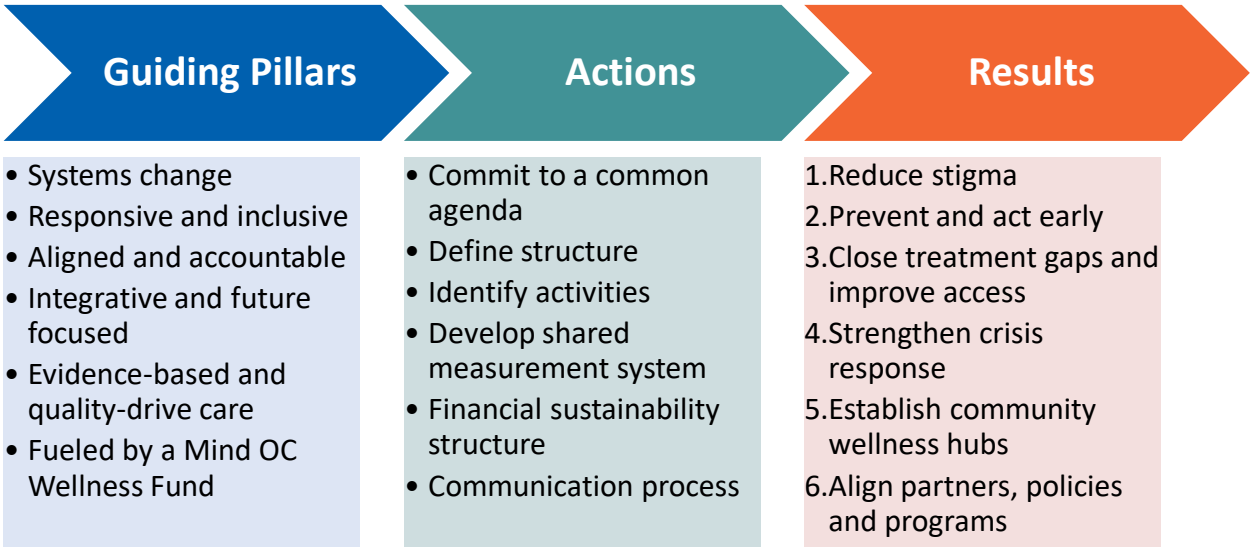


The result will be the development of contract templates that reflect performance/-value based outcomes, and a proposed plan to create an integrated public and private behavioral health system that serves all OC residents.

Alignment of BHST and Be Well OC

In parallel and alignment with BHST, Mind OC is facilitating Be Well Orange County as a community of action, leveraging collective power to transform mental health service delivery into a world class system of care. Be Well is establishing a communitywide ecosystem of optimal mental health care and supports for all residents of Orange County. This ecosystem will encompass high value physical health, mental health, and substance use services to address the range of needs from prevention, early intervention and crisis aversion, stabilization and acute care, and recovery. These services and supports will be available with consistency across Orange County when and where residents need them by engaging and leveraging the capacities of public and private sectors, including health plans, hospitals, clinics, schools and universities, faith organizations, and other community-based entities. This system will harness the power of the community and residents as responsible partners in achieving the Be Well OC vision.

Underpinning this work is the Be Well Blueprint, developed in collaboration with diverse stakeholders. The work is driven by guiding **pillars**, supporting organized **actions**, helping to achieve six critical **results**:



The broad array of sectors and stakeholders behind Be Well includes almost all major insurance payors with memberships in Orange County. This level of participation is vital for the sustainability of any model and system of care. Mind OC supports cross-sector, cross-organizational coordination and grants management and provides a clinical-community linkage function between providers, health systems, Cal Optima and others. Success starts with acceptance that the mental health sector alone cannot solve all of the challenges of this complex and pervasive health challenge. Be Well OC brings together a robust, community-based, cross-sector strategy – public-private, academic, faith, and others – to positively impact those challenges that diminish mental health and well-being. BHST is a separate and related effort to Be Well, with project activities that will synergistically support and advance planning that will help achieve each of the Results

identified in the Be Well Blueprint. BHST is particularly aligned with Results 3, 4, and 5. The first of the Wellness Hubs envisioned in Be Well Result 5 is taking shape, with the campus slated to begin providing services in January 2021. Orange County is using the opportunity of this campus to support proof of concept activities and further explore the feasibility of a universal reimbursement rate/structure related to the planning work of BHST, described below in Section C. Through ongoing planning of BHST, Orange County is creating a payer agnostic setting where high-level, inter-agency fiscal and administrative coordination occurs so that local providers can serve all Orange County residents regardless of their insurance status (i.e., insured, uninsured), insurance type (Medi-Cal, commercial, etc.), and/or level of clinical need (i.e., mild, moderate, severe). This includes working with consumers and other stakeholders along with the contracted providers to identify methods to change processes and integrate policies across the public and private sectors.

Figure 1. Depiction of the existing fragmented behavioral health system, operating independently.

Figure 2. Depiction of the future behavioral health system, operating interdependently.

Community stakeholders driving the work of Be Well Results 3 and 4, related to closing treatment gaps and improving access, and strengthening crisis response, respectively, have also seen alignment between their efforts and BHST. NAMI OC and CalOptima (the Medi-Cal health plan) serve as the backbone organizations for Result 3. These leaders and other participants in Result 3 have agreed to perform key functions related to BHST and are using 2020 to implement the following strategies, in support of BHST proof of concept work at the first Be Well Campus and other preconditions of success for the results of BHST:

- Create a curated list of screening protocols
- Identify & implement standardized intake form & protocol across care systems
- Create & pilot with a sub-set of organizations a universal data sharing agreement

Be Well Result Area 4 is focused on ensuring that all Orange County residents can access crisis support through a network of facilities, mobile teams and digital tools – also in alignment with the central goal of BHST. The Orange County Health Care Agency (OCHCA) and College Hospital Costa Mesa are serving as the backbone organizations for this result

area. Other key partners participating in this work are: Anaheim Union School District, Ambulance Providers, OC Sheriff, Cal Optima, State Council on Developmental Disabilities, Police Departments, NAMI, Didi Hirsch Mental Health Services, Kaiser Permanente, 211 OC, OC Department of Education, Beacon Health Options, HASC, CBOs, and FQHCs.

Appendix III – BHST Overview & Answers to Common Questions

BEHAVIORAL HEALTH SYSTEM TRANSFORMATION (BHST) INNOVATION PROJECT: PART 1
(October 15, 2019 – June 30, 2022)

Summary: This component of the Behavioral Health System Transformation Innovation involves the development of Performance / Value-Based Contracts. This time-limited project runs from October 2019 through June 2022. The Health Care Agency (HCA) has contracted with Mind OC to work collaboratively and with community stakeholders (e.g., consumers, family members, providers, etc.) to plan for strategies for value-based contracting and associated funding sources. The goal of shifting toward value-based contracting is to improve quality of and access to culturally responsive and inclusive behavioral health (mental health and substance abuse) services for all Orange County residents, regardless of insurance type.

Overall Project Activities

- Engage wide participation of stakeholders, community partners, providers and county staff to participate in planning activities and discussions
- Explore feasibility of braiding public, private and philanthropic/non-profit funds to create a universal reimbursement rate/structure
- Identify and operationalize community values and preferred, measurable performance standards
- Develop contracts incentivizing community defined and performance-based and regulatory standards
- Streamline reporting processes to comply with multiple sets of regulations and new performance outcome standards
- Prepare local providers for new performance standards and contracting through technical assistance
- Leverage existing partnerships and collaborations, in recognition that many activities are already underway in the community
- Share learning made available through templates, contracts, RFPs, white papers and presentations
- Report out to stakeholders on learnings from State meetings and related initiatives that are relevant to the BHST work

Communication and Coordination

Continuous feedback to and across the two following areas will be vital.

- **Community Planning:** Ongoing meetings with consumers & family members to identify community values and preferred performance standards
- **System Assessment & Capacity Building for Clinical & Financial Design:** Ongoing meetings with HCA Behavioral Health, CalOptima, local private insurance plans, and related organizations (providers, etc.) to identify potential system-level metrics that could drive quality improvement and explore potential rate structures, braiding strategies, provider requirements, and incentives, as well as legal, fiscal and regulatory requirements that support behavioral health system change

We recognize there are many questions related to a project of this nature. We will do our very best to address these. At the outset, however, we want to provide what we hope are some overall clarifications on the following page. We will continue to add to these as the project moves forward and will provide more detailed responses to questions not addressed here. This information is intended for stakeholders, community partners, providers and county staff.

Answers to Common Questions

What is this project? This component of the Behavioral Health System Transformation Innovation involves the development of Performance / Value-Based Contracts that move from payment for volume and costs toward payment for outcomes and value.

Who is responsible for the project? The Health Care Agency (HCA) has contracted with Mind OC to work collaboratively and with community stakeholders to plan for strategies for value-based contracting. Mind OC is a 501(c)3 non-profit organization created to facilitate Be Well OC, a movement driven by a coalition of over one hundred public/private/faith based/academic institutions united to build a system of Mental Health and SUD Care for all residents of Orange County regardless of payor source.

What is expected at the end of the project? Contract templates that include value-based payments and identify performance metrics and incentives related to behavioral health services.

How will this affect me? The goal is to make it easier to get and provide high quality behavioral health care services that are culturally responsive and inclusive, regardless of a client's insurance type.

Who is going to be involved in the project? Your participation in the process is vital, along with all stakeholders – and consumer, peer, and family member engagement is especially important.

How will you ensure diverse groups of stakeholders are involved in planning? Mind OC and HCA will make every effort to successfully engage the widest array of county and county contracted staff, community partners and stakeholders, but we must also rely on our community partners to support additional and deeper engagement. We need to all work together to ensure the diversity of participants, including factors such as ethnicity and race, culture, Veteran status, LGBTQ, limited-English speaking/monolingual communities and many others.

Are there incentives for individuals and family members to participate in the planning? Stipends, and other supports such as meals and transportation will be available as appropriate to support client, family, and community engagement.

What is the process for establishing provider contract metrics and incentives?

- The exact structure for measurement and incentives will be determined as part of the stakeholder engagement process, but, broadly speaking, it is anticipated that metrics and incentives will be geared toward supporting improvement and achievement of benchmarks, with a transparent plan for reevaluating over time.
- We expect metrics and associated incentives to address structural, process, outcome, client-reported, and other elements. Metrics and associated incentives will include health outcomes, health factors, clinical care, social determinants of health, care transitions, as well as client, family, and community experience.
- Any measures valued by the stakeholders will be considered.
- Once elements of the overall design, including metrics, are established, there will be an effort to align applicable compliance, funding, data sharing, and other requirements and programs.
- We will look to other efforts across California and the nation.

This project is meant to explore opportunities for improvement and transformation. Please keep in mind that there are significant challenges in all systems of care and this project is designed to be a step toward and ***part*** of the planning for solutions. Other efforts will still be needed and this project can be part of that solution.

Appendix IV – Be Well OC March 2020 Coalition Meeting Summary & Results

On March 19, 2020, the Be Well Orange County movement convened its quarterly coalition meeting. The meeting was held from 1:30 to 2:30 p.m. via Zoom. There were 295 participants connected to the web meeting and participants attended from 13 phone numbers.

The meeting followed the following agenda:

- Welcome and Be Well Updates (Dr. Richard Afable, Marshall Moncrief, Hieu Nguyen, and Dr. Karen Linkins)
- Introduction to Behavioral Health System Transformation Innovation Project: Part 1(Dr. Jeff Nagel, Dr. Clayton Chau, and Dr. Karen Linkins)
- Q&A Regarding BHST-1 (all participants)
- Upcoming Events & Announcements (Dr. Karen Linkins)
- Feedback on BHST via Survey (Dr. Karen Linkins)
- Next Steps, Closing and Thank you (Dr. Clayton Chau and Marshall Moncrief)

It is important to note that nearly 300 people dedicated valuable time as they balanced competing priorities in this unprecedented moment of global pandemic. In addition to several updates highlighting great work across the Be Well OC movement, the meeting focused on an introduction to the Behavioral Health System Transformation Innovation Project from Dr. Jeff Nagel, Dr. Clayton Chau, and Dr. Karen Linkins. After the meeting, participants were asked to complete a short survey to provide feedback that will inform the next phases of this project. A recording of the meeting is available here and the slides can be accessed here. Participants were also asked to contribute to an online survey sent to attendees following the meeting to help identify areas in which to develop performance outcomes and measures. Feedback gathered through this survey will be shared at other community and stakeholder input sessions over the next several months to help advance the goals of the Behavioral Health System Transformation Innovation Project: Part 1. Survey questions included the following:

1. What do you think are the top 5 areas that should be measured to know that you/your family members are getting high quality behavioral health care? [Pick up to 5]
2. What other areas should be measured to know if you/your family members are getting high quality behavioral health care?
3. What do you think are the top 5 areas that should be measured to know that Orange County's

behavioral health care system is delivering high quality care for the community? [Pick up to 5]

4. What other areas should be measured to know if Orange County's behavioral health care system is delivering high quality care for the community?
5. What questions and considerations do you have about this project (Behavioral Health System Transformation Innovation Project: Part 1)?

Survey results are summarized below.

Note on Limitations

It is important to note that this survey was designed to gather input from individuals who attended the March Be Well Coalition meeting and survey participation was voluntary. The 51 respondents comprised less than 20% of the 295 meeting participants and therefore is likely not representative of County demographics.

Question 1: What do you think are the top 5 areas that should be measured to know that you/your family members are getting high quality behavioral health care? [Pick up to 5]

Participants were asked to choose from twelve options. Of the options provided, respondents focused on: Ease of finding and accessing care, an improved sense of health, social and emotional well-being, achieving measurable improvement toward personal and clinical goals and meeting basic needs.

Answer Choices	%	# (N=51)
It's easy to find a provider, get an appointment, and be seen for care	80%	41
Improved sense of health (mental and physical)	67%	34
Improved social and emotional well being	59%	30
Making measurable improvement toward personal and clinical goals	57%	29
Improved ability to meet basic needs	41%	21
Improved life satisfaction	37%	19
Improved self-sufficiency	35%	18
Improved satisfaction with emotional and social support.	31%	16
Improved ability to be or stay employed	25%	13
Improved connection to social activities	20%	10
More days of happiness each week	16%	8
Improved spiritual well being	14%	7

Question 2: What other areas should be measured to know if you/your family members are getting high quality behavioral health care? [N=34]

Participants provided an array of responses with three overall areas of focus: Access to Care, Provision of Services, and Measurement and Outcomes, with many participants identifying overarching measures of Quality of Life and Social Determinant of Health. [Please note that Question 2 was intended to elicit more personal and individual level measures, while Question 4 was intended to focus on the behavioral health system of care more broadly. Participants' responses to these two questions are generally consistent and aligned.]

Access: 16 of 34 responses to this question included components of access to care that need to be addressed and measured. The following are summary examples of the components identified:

- Awareness of services and cultural/linguistic competencies
- Barriers of cost and insurance status/type
- Continuity of care and consistency of provider(s)
- Provider availability and timeliness of care

Provision of Services: 14 of 34 responses to this question included elements related to provider and system capacity for a full array of consistent, client-centered, evidence-based services delivered by well trained, culturally competent providers. The following are summary examples of the service provision elements that were identified:

- Adequate array of needed services – crisis, psychiatry, inpatient, long term care, telephonic, in home, groups, etc.
- Appropriate training for work force
- Client centered care with full engagement (including family and natural supports, as appropriate) in treatment planning using evidence-based and community generated practices
- Collaboration and information sharing across provi
- Consistent screening tools, risk assessments, and treatment protocols
- Cultural/linguistic competencies (including LGBTQ+ and homelessness)
- Focus on improvement in coping skills and resilience; improvement in protective factors
- Provider empathy
- Trauma informed care

Overarching Measures of Quality of Life and Social Determinant of Health

- Employment, housing, education, social circle, meaningful life activities, hobbies, volunteer opportunities
- Everyone has the opportunity to use their talents and gifts to help others in the community
- Improved relationships; stronger sense of purpose in life; feelings of self-worth.
- Opportunities for ongoing recovery and connection in

Measurement and Outcomes: 19 of 34 responses to this question related to measurement and outcomes from services. It is important to note that the access and provision of services issues identified by participants above are central to positioning a system that can deliver the needed outcomes.

Participants identified the following measurement and outcome topics as key components of knowing they/their family members are getting high quality behavioral health care. The following are summary examples of the measurement and outcomes components identified:

- Client and family satisfaction
- Communication and coordination with clients, families and other providers; care coordination

- Emergency department utilization and length of stay
- Engagement in treatment, including therapy and/or medication as appropriate
- Grievance and subsequent outcome monitoring and reporting
- Improvement in symptoms of individuals' mental health diagnoses
- Improvement in the 9 areas of life functioning
- Monitoring of symptom resolution or improved functioning that is tracked over time so that one can see the progress made.
- Post discharge status assessment for all services, including Alcohol and Drug (SUD)
- Progress toward personal and clinical goals
- Rate of crisis utilization
- Recidivism rates
- Reducing public, institutional, and self-stigma related to mental health conditions and treatment
- Suicide reduction
- Treatment adherence and general functioning
- Workforce turnover

Question 3: What do you think are the top 5 areas that should be measured to know that Orange County's behavioral health care system is delivering high quality care for the community? [Pick up to 5]

Participants were asked to choose from eleven options. Of the options provided, respondents focused on: Ease of finding a provider, getting an appointment and seen for care, Improving care coordination across providers, Decreasing avoidable psychiatric and medical hospitalizations, High or Improving patient/family satisfaction (measured with consistent tool), and Decreasing number of people experiencing homelessness.

Answer Choices	%	# (N=51)
Clients are increasingly able to easily find a provider, get an appointment, and be seen for care	76%	39
Improving care coordination across providers	67%	34
Decreasing avoidable psychiatric & medical hospitalizations	65%	33
High or Improving patient/family satisfaction (measured with consistent tool)	51%	26
Decreasing number of people experiencing homelessness	51%	26
Decreasing clinical Symptoms	49%	25
Improving completion of provider referrals (and measured)	33%	17
Decreasing incarcerations	27%	14
Increasing provider use of standardized tools to monitor symptoms	25%	13
Improving employment rates for clients receiving care	22%	11
Decreasing absenteeism at work	0%	0

Question 4: What other areas should be measured to know if Orange County's behavioral health care system is delivering high quality care for the community? [N=31]

> "People feel capable to reach out to help a friend or family member who they suspect is going through a mental health crisis"

As with Question 2, above, participants provided an array of responses with three overall areas of focus: Access to Care, Provision of Services, and Measurement and Outcomes, with many participants identifying overarching measures of Quality of Life and Social Determinant of Health. [Please note that Question 2 was intended to elicit more personal and individual level measures, while Question 4 was intended to focus on the behavioral health system of care more broadly. Participants' responses to these two questions are generally consistent and aligned.]

Access to Care: 12 of 31 responses to this question included components of access to care that need to be addressed and measured. As in Question 2, there was a focus on building community awareness and ensuring overall capacity. The following are summary examples of the components identified:

- Access for low income and minority communities and others who may not know where to look for behavioral health care
- Adequate and appropriate housing and financial resources to support health and care
- Adequate capacity and array of needed services (including crisis and inpatient)
- Community knowledge of available services
- Help for all regardless of finances
- Timely access to care

Participant Suggestions for Supporting High Quality Behavioral Health Care System

- Data monitoring system to reflect patients' access to care as well as graduation or termination from care once an episode of care is complete
- Monitoring staff burnout and providing tools/resources to

Provision of Services: 11 of 31 responses to this question included elements related to provider and system capacity for a full array of consistent, client- centered, evidence-based services delivered by well trained, culturally competent providers. The following are summary examples of the service provision elements that were identified:

- Clients being able to choose the route of their continuing care (no one-size-fits-all / this is the only option routes).
- Collaboration and information sharing across providers, with transparency to consumers and family members
- Communication and coordination with clients, families and other providers
- Follow up to ensure family/client follows up with linkages

- Increasing staff access and ability to attend trainings (i.e., there need to be more frequent trainings available and staff should be allowed time to attend).

Measurement and Outcomes: 20 of 31 responses to this question related to measurement and outcomes from services. Participants showed consistent interest in measuring client and family engagement and satisfaction, reducing stigma and suicide, and decreasing crisis and emergency department utilization, among other key outcomes and measures. The following are summary examples of the measurement and outcomes components identified:

- Client and family engagement and satisfaction
- Stigma reduction
- Suicide reduction
- Decrease in crisis interventions and emergency department utilization
- Decrease in substance use disorders
- Referral completion (and time to complete)

Question 5: What questions and considerations do you have about this project (Behavioral Health System Transformation Innovation Project: Part 1)?

Participants identified an array of questions and considerations that generally fell under the topics of Engagement, Process, Measurement and Planning, and System of Care. The following responses are direct participant quotes, provided within the categories they most aligned with:

Engagement Questions and Consideration

- *Communication is poor and not designed for CCC participation*
- *Could you please put the goals, progress, and meetings of each working group on-line so we can see progress and know how to get involved.*
- *How can I be involved? I have filled out the contact form on the website explaining my experience. I am part of the LGBTQ+ community, I am a pro-housing advocate, and I have several years of social media and digital marketing experience.*
- *How can the OC Shrinks community be of service and become more involved? We are on board 100% and have access to over 2K therapists in OC that are available to be of service.*
- *how to be part of working group?*
- *Is there any outreach to community college health centers for input or participation in this process?*
- *This is my first introduction to BHST and the Be Well project. As a person from the community without much prior background in the mental health system, I am learning a lot because of a family member with Schizophrenia. Just becoming familiar with the systems and how to navigate them is very overwhelming and frustrating at times. I am so hoping that the innovations will transform this broken mental health care system and fill in the voids where individuals have been forgotten or given up on. I would love to somehow be a part of the changes and projects, but I honestly don't know where someone from the community can be of help. Maybe that*

will become more clear to me as I try to become more involved. I would so appreciate people from your organizations reaching out to show us where we can participate and help.

Process, Measurement and Planning Questions and Consideration

- *Are county contract monitors and other staff aware that these changes are being made? Are they involved in the discussions? (just curious)*
- *How do you measure something so "subjective" How do you define ratings clearly?*
- *The discussions with the state need to be supported by a well-informed, well-articulated, and transparent reform agenda created by the entire Be Well movement rather than a handful of players. To be well-informed there needs to be a process of developing a policy change agenda that involves a broad range of stakeholders. Otherwise, we will miss the opportunity for developing a significant Orange County coalition to advocate for the statutory and regulatory changes that will be needed.*
- *The recruitment, staffing and funding piece of all of this is still a little amorphous in my mind. Also, the care collaboration and sharing of data after each episode of treatment through our CSU's is also an enigma.*
- *Where will the centers be located and when? What will the procedure to get care look like from the client's perspective?*
- *Will primary care clinics with behavioral health staff be a part of this transformation?*
- *Will you consider thinking outside the box?*

System of Care

- *Exactly what is the protocol for housing those unable to be self sufficient*
- *How are those who believe they are not in need of care, yet unable to care self, engaged?*
- *How is this project assuring non-profits and other behavioral healthcare programs will be employed once this program comes into play?*
- *I just want to see it come to fruition.*

Question 6: Did you participate in the March 19th Be Well Coalition Web Meeting?

Answer Choices	%	# (N=51)
Yes	90%	46
No	10%	5

Question 7: What sector are you representing? (Please mark one)

Answer Choices	%	# (N=51)
Behavioral health	47%	24
Consumer, Family Member, or Other*	29%	15
Health care	14%	7
Education	10%	5

*The "Other" category was provided to encompass general community members.

Question 8: What community/population group are you representing[1]? (mark all that apply)

Answer Choices	Responses	# (N=50)
Adults (26-59 years)	68%	34
Youth (16-25 years)	58%	29
Older Adults (60+)	54%	27
Children (0-15 years)	46%	23
Mental Health w/ Substance Use	38%	19
Mental Health w/ Medical Conditions	38%	19
Veterans	34%	17
Racial/ Ethnic Groups	34%	17
LGBTQ	28%	14
Monolingual/ Limited English	28%	14
Homeless	26%	13
Students at Risk of School Failure	26%	13
Other -- please specify your Racial/ Ethnic Groups and/or language(s)	24%	12
Criminal Justice Involved	20%	10
Foster Youth Parent/ Families	16%	8

Respondents who chose to enter information for "Other -- please specify your Racial/ Ethnic Groups and/or language(s)" indicated the following: Buddhists; Catholics; Dependent adults 18+; Hispanic/Latino, Persian, Asian, African American; I do not represent a specific racial/ethnic group. I put myself down as the entire general public; Latinos; Low-income generally; Representing all populations; Schizophrenia spectrum disorders; Spanish; Women

Recommendations

- Develop an FAQ or similar summary document (as indicated) that synthesizes responses to participants' Engagement; Process, Measurement and Planning; and System of Care Questions and Considerations
- Continue using this survey and similar instruments to gather community input on measurement
- Identify opportunities to engage stakeholders in thinking about outcomes from services, while acknowledging that issues of access remain paramount for many
- Ensure broader engagement of key demographic groups representative of Orange County in general and those with greatest needs for behavioral health services
- Continue to hone and specify potential measures for consideration by stakeholders, while continuing to gather community input

[1] In recognition that participants were responding from many perspectives, including personal, professional, organizational, advocacy, and others, the word "representing" was used to capture the broadest possible array of stakeholder identification/representation

Appendix V – Summary Findings from NAMI Groups

Behavioral Health System Transformation:
Summary Findings from NAMI Groups (June-July 2020)

Background

Orange County's Behavioral Health System Transformation MHSA Innovation project involves the development of Performance / Value-Based Contracts. This time-limited project runs from October 2019 through June 2022. The Health Care Agency (HCA) has contracted with Mind OC to work collaboratively and with community stakeholders (e.g., consumers, family members, providers, etc.) to plan for strategies for value-based contracting and associated funding sources. The goal of shifting toward value-based contracting is to improve quality of and access to culturally responsive and inclusive behavioral health (mental health and substance abuse) services for all Orange County residents, regardless of insurance type.

To accomplish the goals of BHST-1, two streams interconnected activities are underway:

Community Planning: Ongoing meetings with consumers, family members, and providers to identify community values and desired performance standards and outcomes

System Assessment & Capacity Building for Clinical & Financial Design: Ongoing meetings with HCA Behavioral Health, CalOptima, commercial insurance plans, managed behavioral health organizations, health systems, and other related provider organizations to identify potential desired clinical model(s) and explore potential rate structures, braided funding strategies, provider requirements, and incentives, as well as legal, fiscal and regulatory requirements that support the clinical model(s)

Approach

As part of the initial community planning activities, Mind OC arranged to participate in six regularly held online NAMI OC (National Alliance for Mental Illness Orange County) groups for family members living and/or assisting loved ones through the Mental Illness and Wellness journey. This approach allowed for community/family members to participate in a dual-purpose activity of both a support group and a focus group. By joining these existing sessions, Mind OC was able to fit into the lives of approximately 100 Orange County residents, rather than burdening them with participation in additional meetings. (See Attachment 1 for a listing of the meetings and associated attendance)

Each meeting began with the regular NAMI facilitator welcoming participants and providing introductions to the Mind OC staff and a brief explanation of their presence. Mind OC staff then introduced themselves and presented the context of BHST, noting the vital importance of consumers and family members in the planning work. Mind OC staff noted that they were participating in several of these groups as well as additional community planning activities and would be compiling the information and sharing it back to the participants and others. Additionally, staff noted that an optional survey would be sent

following the session to gather additional information (See Attachment 2 for the survey). Within that context, Mind OC staff invited participants to share their experiences with the behavioral health system— particularly any areas that should be considered in order to verify that their family members were getting high quality behavioral health care. NAMI facilitators then conducted the meetings, managing the amount of time each participant had and ensuring that everyone had the opportunity to contribute.

Participants

The sessions provided exceptional opportunity to hear from family and community members with direct experience with behavioral health services. Participants ranged from those newly in contact with behavioral health services to those who had been engaged for many years with a family member with extensive needs. Participants had experience with an array of services, including dual diagnosis, outpatient, inpatient, partial hospitalization, intensive outpatient and residential services. The majority of participants were parents of children aged 14-45 who required services, though some were grandparents, spouses, as well as other relatives and natural supports. While the groups were conducted in English, several participants noted that English was their second language. Recognizing that language is a significant barrier, additional community planning will be conducted in community threshold languages and with specific outreach to special populations – including family members and natural supports as well as consumers and clients themselves living with mental illness and directly accessing services.

Summary Findings

Most participants expressed having experienced significant benefits from behavioral health services, while also noting an array of areas where the system had fallen short, with heartbreaking consequences for family members. Participants identified extensive barriers related to access and information about services, as well as many challenges that all too often come with living with mental illness. In terms of what should be considered to verify that their family members were getting high quality behavioral health care, participants were generally focused on simply *getting* care. Access to care issues spanned challenges with engaging family members in services and maintaining that engagement, as well as limitations on the availability of services.

Overall, participants were clear that having information accurately communicated at each point of contact with behavioral health services was all too often missing, but where it was provided, it was invaluable. Having a resource (an individual or an organization) to help navigate through the process/system, and knowing where to call next was an important and necessary tool. Participants found supportive services focused on recovery, socialization and reintegration, such as those provided by organizations such as NAMI, to have been helpful for many of the participants moving through the wellness and recovery process. Most needed was access and availability of local services, knowing what services exist and how to access the appropriate services in a timely manner appropriate for the level of need and acuity. In addition to access to care, a common theme heard was the growing challenge to support and be part of the wellness and recovery continuum

experienced by family and loved ones, mostly citing issues related to age of the client and privacy.
Below is an aggregated summary* of participant feedback regarding strengths in the current system, needs and gaps, as well as barriers and challenges.

Strengths in Current System

The following programs and approaches were noted as areas that the community would want to see expanded and, as appropriate incentivized for achieving successful outcomes:

- Client/Family/Caregiver Supports
- NAMI classes, NAMI Warmline
- Programs encouraging socialization and meaningful contribution for Seriously Mentally Ill and disabled loved ones
- Recovery focused programs such as College Hospital Services and Drug Court Program
- Support focused tools such as OC Links

Needs and Gaps in Current System

These were areas that the community found potential to address the gaps with incentives that could enhance alternative scenarios and mitigate for these limitations. Family and caregivers suggested the need for some type of roadmap to explain the care process and what to expect. In addition to knowing what to expect, being able to support the client/loved one through the process was cited as being a challenging endeavor with age, insurance, privacy, and patient's rights serving as protection and a barrier to the process. Case management or clinical touchpoints throughout the process to ensure clients are receiving needed care and making progress toward recovery were seen as especially important. In general, there was a noted lack of supports for clients, family, and caregivers to ensures the effectiveness and quality of care.

- **Roadmap to care and available supports** to understand the process and steps in the process to care and recovery & how to access available services and supports and who qualifies
- **Family /Caregiver Involvement support and education** at every contact with system, including in treatment with a need for all providers to see the full family as part of the client's system
- **Provider education and awareness of other services** time to come together
- **Wrap around services** as appropriate such as employment and housing options
- **Lack of specific treatments** such as DBT that are most appropriate for certain conditions
- **High quality evaluation** with connection to needed services and high-quality support
- **Continuity and Coordination of care and services** through continued engagement and feedback loop (follow up care at pre-, post- and interim points in time), with a significant need for Case Managers

Barriers and Challenges in Current System

The following areas that the community found as limitations to quality care and also could address system, organizational and policy levels through incentives for practice changes leading to improved outcomes.

Access	• Long wait times and limited options for help and services • Need for one number to access care during a crisis • Delays to care and Inappropriate referrals to ED/ER for care resulting in increased crisis response needs
Transitions and Approach to Care	• Crisis response accompanied by police/guns escalates situation • Transitions and repetitive paperwork process, (medical history and misinformation) that leads to inappropriate care between multiple providers & impacts treatment consistency/maintenance • The roles of Family / Caregiver are often not considered for sick, adult patients and maintenance of care • Drug changes, medication maintenance, and staying consistent with therapy are challenging in terms of adults caring for adult patients, prognosis of care and relative to HIPPA barriers
Insurance Challenges	• Challenging period for Parents & Caregivers when youth reach 18 but still covered by Parent's insurance • Assistance with insurance, finance, and ways to get services paid for • Too much confusing paperwork

*The aggregated summary above is presented with a BHST focus; issues of the illnesses themselves, and broader issues such as homelessness are not highlighted here despite being central to participants' stories.

Survey Results

Survey results from 13 respondents aligned with the information above and will continue to be aggregated with additional responses over the course of this project.

Attachment 1: Listing of Meetings and Attendance

June 14, 2020, 6:30-8:00 pm: 14 participants
June 15, 2020, 7:00-8:00 pm: 23 participants
June 18, 2020, 6:45-8:30 pm: 11 participants
June 23, 2020, 7-8:30 pm: 12 participants
June 29, 2020: 7:00-9:00 pm: 21 participants
July 2, 2020 6:30-8:00 pm: 19 participants

Attachment 2: Survey

Community Input: Toward an Orange County Behavioral Health Value Proposition

Thank you for participating in planning for Behavioral Health System Transformation for Orange County. Feedback gathered through this survey will be shared at other community and stakeholder input sessions over the next several months to help advance the goals of the Behavioral Health System Transformation Innovation Project: Part 1

Please take a moment to review the following questions and then proceed to answer them in the survey below.

Questions

1. What do you think are the top 5 areas that should be measured to know that you/your family members, friends, or community are getting high quality behavioral health care? [Pick up to 5]

2. What other areas should be measured to know if you/your family, friends, or community members are getting high quality behavioral health care?

3. What do you think are the top 5 areas that should be measured to know that Orange County's behavioral health care system is delivering high quality care for the community? [Pick up to 5]

4. What other areas should be measured to know if Orange County's behavioral health care system is delivering high quality care for the community?

5. What questions and considerations do you have about this project (Behavioral Health System Transformation Innovation Project: Part 1)?

Thank you!

1. Name:

2. Organization (if applicable):

* 3. What do you think are the top 5 areas that should be measured to know that you/your family members, friends, or community are getting high quality behavioral health care? [Pick up to 5]

- [ ] It's easy to find a provider, get an appointment, and be seen for care
- [ ] Making measurable improvement toward personal and clinical goals
- [ ] Improved ability to be or stay employed
- [ ] Improved ability to meet basic needs
- [ ] Improved self-sufficiency
- [ ] Improved sense of health (mental and physical)
- [ ] Improved satisfaction with emotional and social support.
- [ ] Improved connection to social activities
- [ ] Improved life satisfaction
- [ ] More days of happiness each week
- [ ] Improved social and emotional well being
- [ ] Improved spiritual well being

4. What other areas should be measured to know if you/your family members, friends, or community are getting high quality behavioral health care?

* 5. What do you think are the top 5 areas that should be measured to know that Orange County's behavioral health care system is delivering high quality care for the community? [Pick up to 5]

- [ ] Improving completion of provider referrals (and measured)
- [ ] Improving care coordination across providers
- [ ] High or Improving patient/family satisfaction (measured with consistent tool)
- [ ] Clients are increasingly able to easily find a provider, get an appointment, and be seen for care
- [ ] Decreasing avoidable psychiatric & medical hospitalizations
- [ ] Decreasing incarcerations
- [ ] Decreasing number of people experiencing homelessness
- [ ] Improving employment rates for clients receiving care
- [ ] Increasing provider use of standardized tools to monitor symptoms
- [ ] Decreasing clinical Symptoms
- [ ] Decreasing absenteeism at work

6. What other areas should be measured to know if Orange County's behavioral health care system is delivering high quality care for the community?

7. What questions and considerations do you have about this project (Behavioral Health System Transformation Innovation Project: Part 1)?

8. What sector are you representing? (Please mark one)

- ( ) Health care
- ( ) Behavioral health
- ( ) Education
- ( ) Consumer, Family Member, or Other

9. What community/population group are you representing? (mark all that apply)

- [ ] Children (0-15 years)
- [ ] Youth (16-25 years)
- [ ] Adults (26-59 years)
- [ ] Older Adults (60+)
- [ ] Foster Youth Parent/ Families
- [ ] LGBTQ
- [ ] Homeless
- [ ] Students at Risk of School Failure
- [ ] Veterans
- [ ] Criminal Justice Involved
- [ ] Mental Health w/ Substance Use
- [ ] Mental Health w/ Medical Conditions
- [ ] Racial/ Ethnic Groups
- [ ] Monolingual/ Limited English
- [ ] Other -- please specify your Racial/ Ethnic Groups and/or language(s)

Appendix VI – Steinberg Institute Agenda & Discussion Items

Orange County Behavioral Health Systems
Transformation Project

The Orange County Health Care Agency received MHSA Innovation funding to support planning to move towards a public-private, performance/value-based payment system for behavioral health services.

We appreciate the expertise you will be sharing to inform this project moving forward. Using the following set of questions, we would like to solicit your input and advice on key considerations to advance this work.

Questions:

1. Past, Present and Future engagement with CalAIM planning activities
2. Advocacy on legislation focused on prevention and early intervention, integrated care, and the workforce shortage
3. Issues related to Mind OC's priorities:
    a. Parity for Mental Health and Substance Use Care
    b. Integrated care
    c. Peer specialist certification
    d. Behavioral health workforce shortage
    e. State budget priorities in response to COVID-19 impact on state's behavioral health system
4. Regulatory obstacles and potential solutions to mental health reform activities

Appendix VII – DRN Consumer Workgroup Slides & Summary

Slide Deck--Consumer Session #1

Why are "we" here?

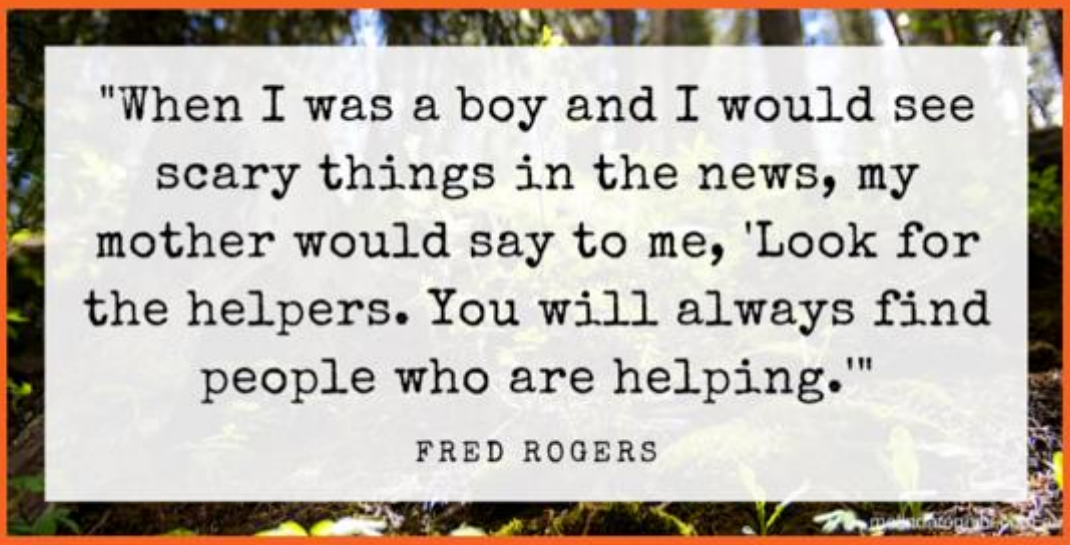
Together we are working to design a *Health Resource Navigator* for residents of Orange County to find and utilize services they need across public and private settings.

Principles of Participation

1. Respect - "agree to disagree"
2. Two-way knowledge exchange
3. Co-leadership

Goal?

To inspire each and everyone of us to reimagine a model for care that takes into account the whole person/whole community approach.



What to expect...

3:00 - 3:20: Ice breaker

3:20 - 3:10: Conversation

4:10 - 4:20: Reflection

4:20 - 4:30: Closing remarks

Recordings & Notes

Recordings will be used to verify notes and destroyed within 10 business days of meetings. We will not identify people by name but by role (e.g. administrator, consumer, service provider, advocate)

Options

1. Record. State "Off the record" when asking to stop recording / note-taking. And restart afterwards
2. Don't record meetings. Only note-taking.

Ice breaker

15-minutes

Key Exercise

Conversation Starters:

Use the Zoom chat feature to add additional comments.

1. Who are your helpers?
2. What qualities, attributes and characteristics make up this helper?
3. How does this helper help you, and what key resources or tools do they utilize?
4. What kind of support do you rely on from this helper?
5. How do you communicate and follow up with this helper? Vice versa, if at all?
6. What challenges do you or your helper face in identifying resources?

Report Back & Reflection

Use the Zoom chat feature to add additional comments.

What are similarities, differences and patterns we value in our helpers?

Thank you.

Closing remarks?

Who are the Helpers?

Consumer and Family Member Perspective

Where do consumers and family go for help?

Summary

- The Internet
- Informal and personal network (family, friend, barber, faith leader, etc.)
- Professionals who connect to other resources (nurses, case workers, etc.)
- Government sites such as 211 & OCLinks
- Social media

Application to the OC Navigator

- The language and interface of the OC Navigator should be usable across diverse groups of professionals, consumers, and family members.
- Social media platforms can be used to increase awareness of the OC Navigator and other resources.

How do they search for resources?

To find resources, individuals...

- Use keywords to find the most relevant resources
- Filter by location, price, and ratings or reviews

Application to the OC Navigator

- The OC Navigator should include this information to help users find the appropriate resources for themselves or their loved ones.

What do they want to see in a website?

They want...

- Reliable information
- Clear instructions with minimal text
- Visible phone number to reach a person
- Help navigating the site
- Multilingual assistance
- Filter system to narrow down search

They don't like...

- Intimidating or formal language or layout
- Text-heavy web pages and drop-down menus
- Small font and technical diction

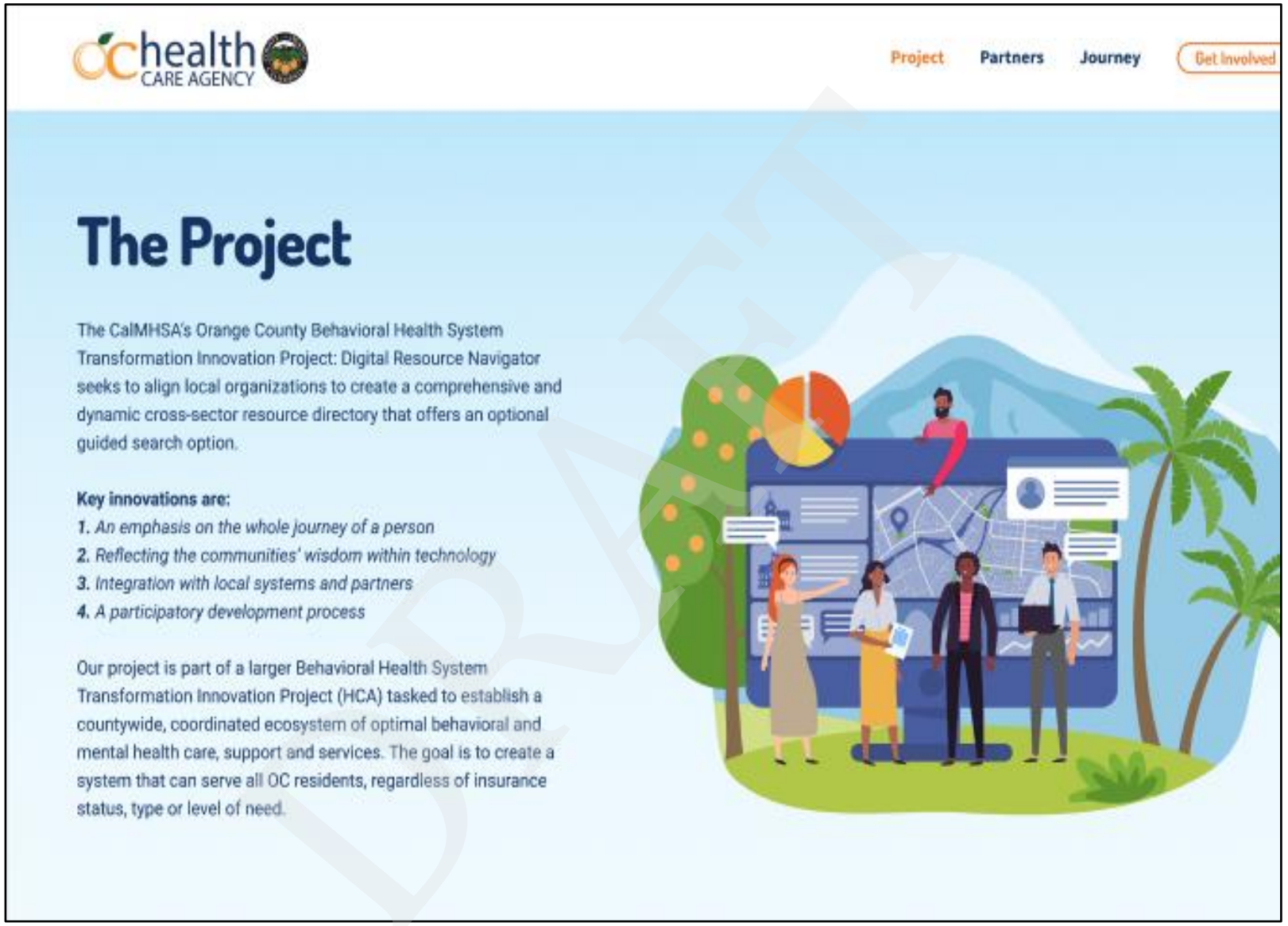
Appendix VIII – DRN Draft Website

Project Website Homepage

The homepage is a starting point for individuals to begin learning about the project, connect with the project team if interested, and browse articles related to the project learnings and updates.

Participatory Process

This page outlines the approach, process and core values of the project.



Partner Page

The partner page lists all project stakeholder partners.

Article Page

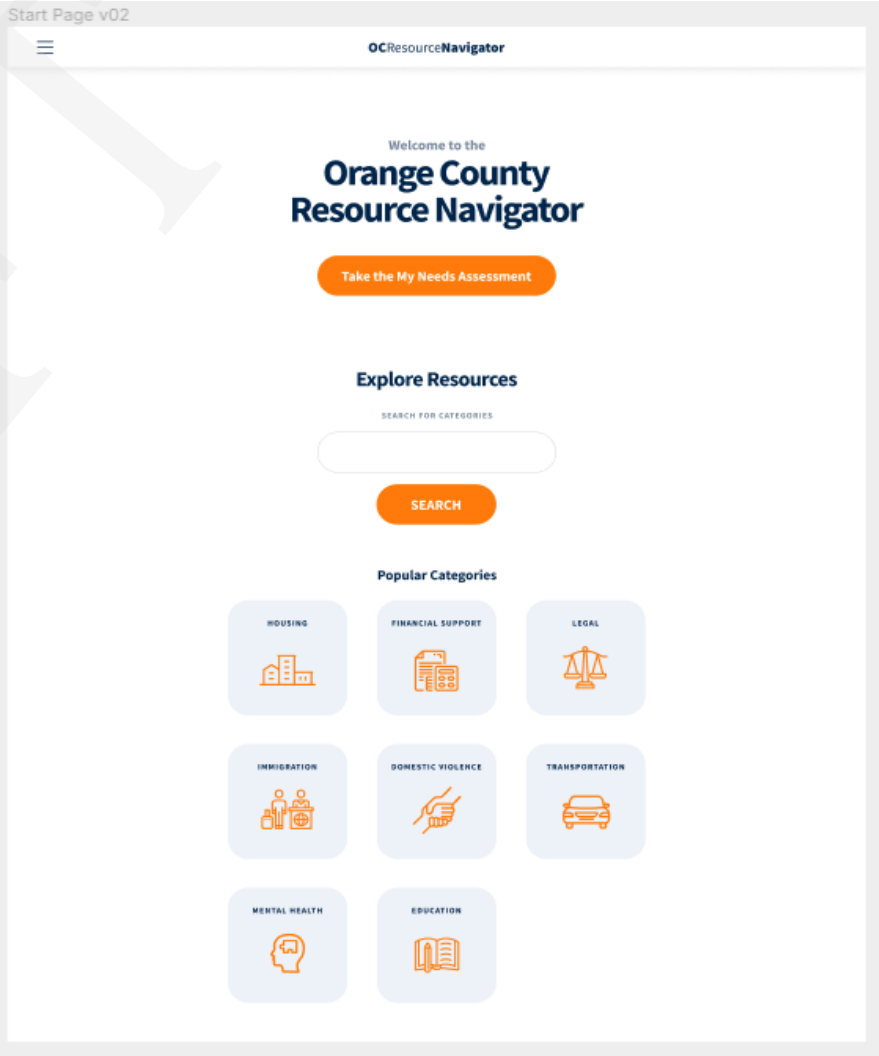
Articles are used to provide updates related to learnings from the project to share with broader stakeholders in Orange County.

Appendix IX – OC Resource Navigator Draft Design and Features

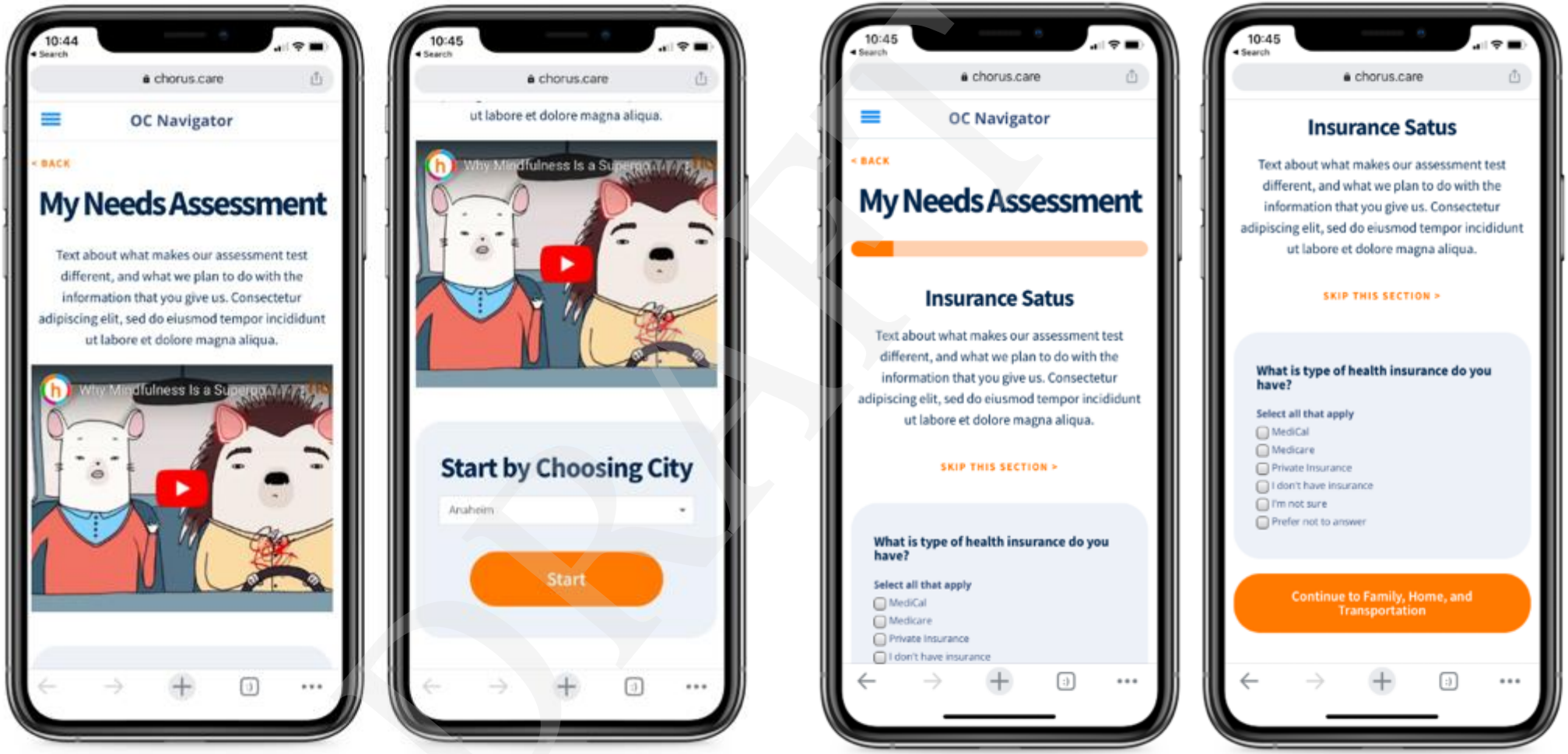
Digital Resource Navigator Home Page

Draft Mobile Layout

Draft Desktop and Tablet Layout



SDoH Screener Survey Design and Questions

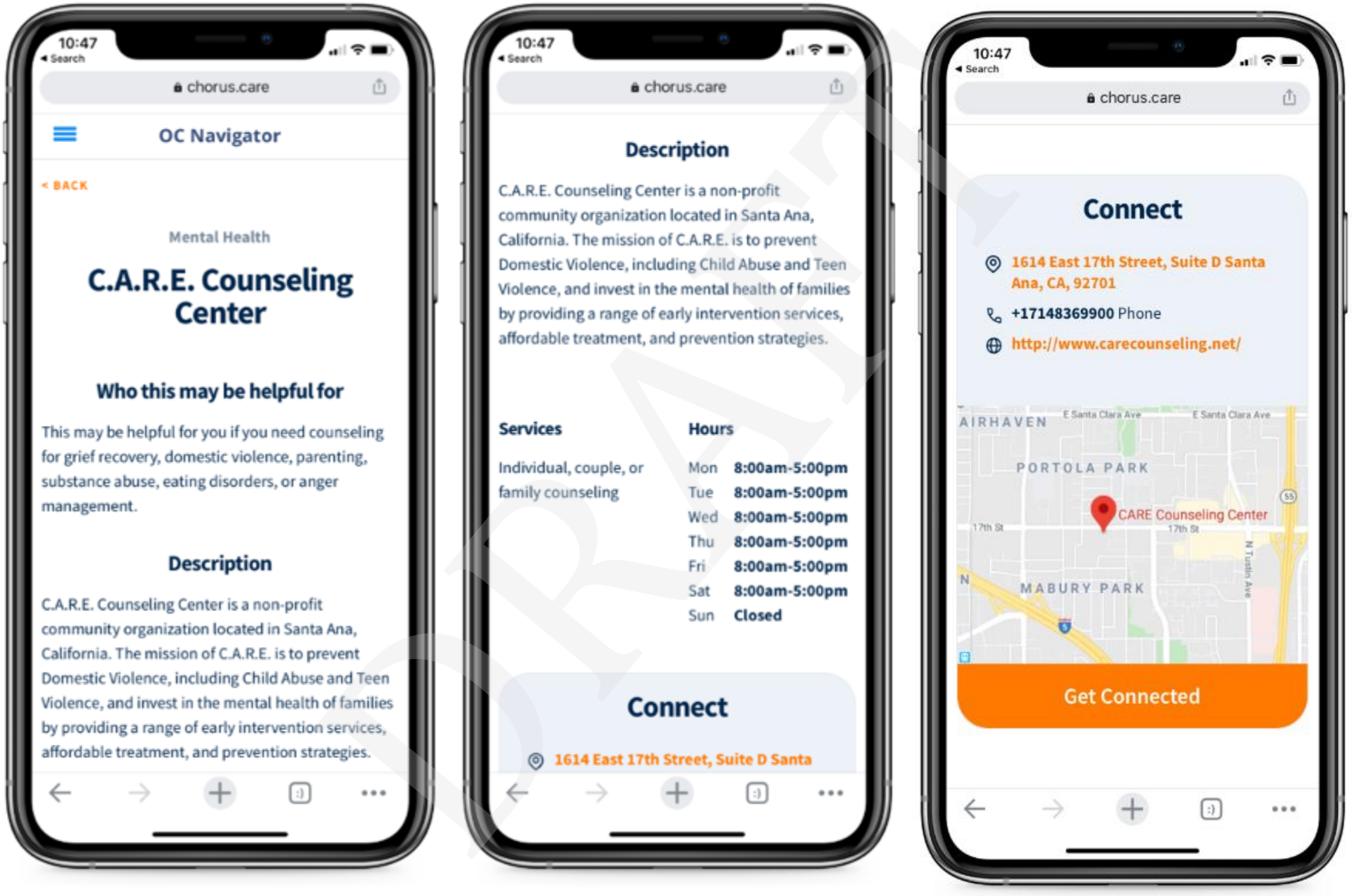


SDoH Screener Results Page

Mobile Layout

Desktop and Tablet Layout

Resource Listing Detail Page



Appendix X – Draft Social Determinants of Health Screener

Demographics

How old are you? ----------years

Gender?

1. Are you Hispanic or Latino?
Yes
No
I choose not to answer this question

2. Which race(s) are you? Check all that apply.
Asian
Native Hawaiian
Pacific Islander
Black/African American
White
American Indian/Alaskan Native
Other (please write):
I choose not to answer this question

3. Have you been discharged from the armed forces of the United States?
Yes
No
I choose not to answer this question

4. What language are you most comfortable speaking?

English
Language other than English (please write)
I choose not to answer this question

Family & Home

5. How many family members, including yourself, do you currently live with? _____
I choose not to answer this question

6. What is your housing situation today?
I have housing
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
I choose not to answer this question

7. Are you worried about losing your housing?

Yes
No
I choose not to answer this question

8. What address do you live at?
Street:_____ City, State, Zip Code: _____

Money & Resources

9. What is the highest level of school that you have finished?
Less than high school degree
High school diploma or GED
More than high school
AA
BA
Masters
Doctorate
I choose not to answer this question

10. What is your current work situation?
Unemployed
Part-time or temporary work
Full-time work
Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver)
Please write:
I choose not to answer this question

11. What is your main insurance?
None/uninsured
MediCal (e.g. CalOptima)
CHIP MediCal
Medicare
Other public insurance (not CHIP)
Other Public Insurance (CHIP)
Private Insurance

12. During the past year, what was the total combined income for you and the family members you live with?
This information will help us determine if you are eligible for any benefits. _____
I choose not to answer this question
How many family members including you live on this income?

13. In the past year, have you or any family members you live with been **unable** to get or had difficulty getting any of the following when it was **really needed**? Check all that apply.

Possible others? Internet access, mobile/cell phone; caregiver support, transportation

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
I choose not to answer this question					

If you checked YES to any boxes above, would you like to receive assistance with any of these needs? Yes/No

14. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.
Yes, it has kept me from medical appointments or from getting my medications
Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
No
I choose not to answer this question

Social and Emotional Health

15. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
Less than once a week
1 or 2 times a week
3 to 5 times a week
5 or more times a week
I choose not to answer this question

16. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?
Not at all
A little bit
Somewhat
Quite a bit
Very much
I choose not to answer this

Optional Additional Questions

17. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

Yes/No

I choose not to answer this question

18. Are you a refugee?
Yes
No
I choose not to answer this question

19. Do you feel physically and emotionally safe where you currently live?
Yes
No
Unsure
I choose not to answer this question

20. In the past year, have you been afraid of your partner or ex-partner?
Yes
No
Unsure
I have not had a partner in the past year
I choose not to answer this question

21. Please indicate which of the following describe a concern you have about your income or benefits. You may select none or more than one answer.
Medicare / MediCal / health insurance
Disability benefits
Family First
SNAP / WIC
Unemployment benefits/compensation
Child support
Pension
Other (please specify)

22. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.
Yes/No

23. Do you want help finding or keeping work or a job?
Yes, help finding work
Yes, help keeping work
I do not need or want help

24. Within the past 12 months, you worried that your food would run out before you got money to buy more.
Often true
Sometimes true

Never true

25. Do you have concerns about any immigration matters for you or your family?
Yes/No

26. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
Never
Rarely
Sometimes
Often
Always

27. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?
I don't need any help
I get all the help I need
I could use a little more help
I need a lot more help

28. How often do you feel lonely or isolated from those around you?
Never
Rarely
Sometimes
Often
Always

29. How often do you attend religious or faith-based services?
Never or almost never
Less than once per month
1-3 times per month
Once a week
More than once a week

30. Do you have any concerns about your child's learning or development or behavior?
Not at all
Somewhat
Very much