A MESSAGE FROM THE

Chief of Mental Health and Recovery Services

Thank you for your interest in Orange County (OC), Behavioral Health Services (BHS) Mental Health Services Act (MHSA) Annual Plan Update for Fiscal Year 2024-25 (Annual Update). I would like to take this opportunity to continue to thank the stakeholders for their collaboration as we continue to build on the updated community planning process, embrace community input, and give voice to those with lived experience. For several decades MHSA funding has been a key revenue source and vehicle to improve the public behavioral health safety net, expanding the system of care from a fail-first model to a comprehensive continuum of services spanning from prevention, early identification and intervention, and an expansion of the continuum of outpatient services.

The timing of this Annual Update is critical. As a result of the voters' approval of Proposition 1 on the March 5, 2024 election, the public behavioral health system continues to change and adapt in response to significant policy changes. Proposition 1 enacts an update of the MHSA, changing the name to Behavioral Health Services Act (BHSA), shifting categorical components and use of funds, updating the target populations to be served, and redistributing local dollars to support state implementation of Prevention and Workforce activities. With change comes opportunity. BHSA provides an opportunity to reimagine the system of care and guide stakeholders through a process that informs the entire behavioral health system through the development of a Behavioral Health Integrated Plan.

At the same time, Behavioral Health will continue to implement the existing MHSA Three-Year Plan through its conclusion of June 30, 2026. As we approach this period of opportunity and reimagining, it is important that we prepare for the transition. As such, the highlight of this Annual Update is the inclusion of a comprehensive Innovation concept intended to support a creative, comprehensive system redesign of OC public Behavioral Health Services. The proposed Innovation concept intends to redesign public behavioral health services to include a re-boot of Full Service Partnership programs; create infrastructure and programming for complex care for individuals whose co-morbid conditions requires complex coordination across different systems; develop capacity and implement specialty mental health clinic services in coordination with diverse community-based organizations that provide mental health services to cultural populations and include community-defined evidence-based practices (CDEPs); investing in innovative workforce strategies that have been successful in other systems, to include creation of a countywide behavioral health workforce initiative; and a clinical redesign project to test how space and delivery models impact service delivery/outcomes.

Our progress to date would not be possible without the support and guidance of diverse stakeholders, the Orange County Board of Supervisors (BOS), Behavioral Health Advisory Board (BHAB), representatives across all of our systems, our contracted provider organizations, the OC Health Care Agency (HCA) staff and, the multitude of consumers and family members.

Thank you for taking the time to review and provide feedback on this plan. The Orange County Behavioral Health Services Department looks forward to receiving your feedback at MHSA@ochca.com.

Sincerely,

Veronica Kelley, DSW, LCSW
Orange County Health Care Agency
Chief of Behavioral Health Services

Executive Summary

MHSA BACKGROUND

In November 2004, California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA). The Act implements a 1% state tax on personal income over $1 million and emphasizes transforming the mental health system to improve the quality of life for individuals living with a serious behavioral health condition and their families. With MHSA, Mental Health Plans ensure that key community stakeholders have the opportunity to provide input into program development, implementation, evaluation, finance and policy resulting in public behavioral health programs that have been tailored to meet the needs of diverse individuals, families, and communities across California. As a result, local communities and their residents are experiencing the benefits of expanded and improved mental health services.

Since the inception of MHSA, Orange County Health Care Agency, Behavioral Health Services (BHS) has used a comprehensive stakeholder engagement process to develop local MHSA programs that range from prevention and crisis services, through an expanded continuum of outpatient services, to crisis residential care. Central to the development and implementation of all programs is the focus on community collaboration; cultural competence; consumer and family-driven services; service integration for consumers and families; prioritization of serving the unserved and underserved; and a focus on the importance of mental wellness, recovery and resilience. The current array of services was developed incrementally, starting with the planning efforts of stakeholders in 2005 and continuing to present day.

This Executive Summary contains a synopsis of progress from the first year of the MHSA Three Year Plan for Fiscal Years 2023-24 through 2025-26, as well as planned changes being proposed in Orange County's MHSA Annual Update for FY 2024-25 (Annual Update). This MHSA Annual Update includes an overview of the ongoing Community Program Planning process (CPP), component program descriptions including target populations, budget projections, data, and supporting documentation in the Appendices.

MHSA COMPONENTS AND FUNDING

To further define the use of this categorical funding, MHSA is broken down into six components, each identifying a targeted population and/or allowable use. The PEI and CSS components provide direct services. The descriptions below also provide an estimate of the cumulative number of individuals to be served for across the three-year timeframe of the plan:

- **Prevention and Early Intervention (PEI)**: PEI in intended to provide supports or interventions as early as possible to prevent a mental health condition from becoming severe and disabling. The majority of PEI must be directed toward children and youth aged 25 and under and their families/caregivers. Approximately 230,000 individuals are expected participate in a PEI service over the three-year plan period. This number does not include the anticipated numbers of people that may contact the OC LINKS call center or be exposed to large scale campaigns.
- **Community Services and Supports (CSS)**: This component provides programs and services geared toward individuals living with serious mental illness, including an allowance for MHSA Housing and a requirement that half of the funds be directed to support intensive outpatient services called Full Service Partnership programs. It is anticipated that over 94,000 individuals will benefit from a CSS program over the course of the current three year plan.
- **Innovation (INN)**: Innovation is intended to allow the testing and evaluation of new and/or changed practices or strategies in the field of mental health. This short term, learning focused projects, strive to improve an aspect of the public behavioral health system.
- **Workforce Education and Training (WET)**: Qualified and competent staff are an essential ingredient to the success of MHSA. WET supports the recruitment, training, development, and retention of public behavioral health employees.
- **Capital Facilities and Technological Needs (CFTN)**: CFTN further supports the infrastructure of the public behavioral health system through funding that helps modernize data and information systems and provide funds to build out space to provide MHSA mental health services.
- **Community Program Planning (CPP)**: MHSA requires Specialty Mental Health Plans to participate in meaningful stakeholder engagement in the development, implementation, and analysis of MHSA programs. The stakeholder process allows for continuous communication between HCA and stakeholders to allow for real time adjustments and quality improvement. A complete overview of the CPP activities that occurred for the development of this plan can be reviewed in its entirety in the Community Program Planning Section of this Plan.

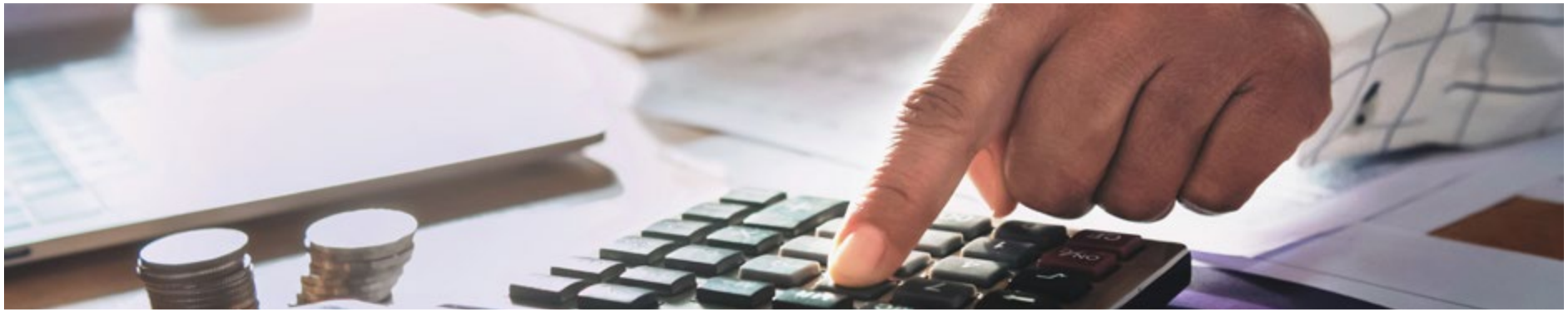
Regulations provide large counties three years to spend their annual MHSA allocation. After the three-year period, funds revert to the state for redistribution. The values and available funding amounts proposed in the MHSA Annual Update are determined through a budget "true up" process, which helps to identify available funds. The fiscal review includes a detailed process of aligning existing component program budgets more closely with actual program expenditures from the most recent fiscal years. The annual budget "true up" allows BHS to identify cost savings for programs that could be utilized to cover costs of other programs within the same MHSA component. It also supports necessary adjustments to decrease budgets when revenue is not received at the levels anticipated. In addition, the MHSA Administrative team, HCA Finance, and representation from the

County CEO office, meet quarterly with a State Financial Consultant to closely monitor three years of MHSA projections, and explore additional state initiatives and legislation changes that could potentially impact MHSA funding. Each quarter, a summary of projections is presented at the OC Behavioral Health Advisory Board Community Meetings. Finally, BHS managers, fiscal leadership, and the MHSA Administrative team met regularly during Fiscal Year 2023-24 to coordinate and evaluate program development progress, budgets, expenditures, and proposed plans. An overview of the proposed Annual Update funding level for each component is provided in the table below.

It is noted that these draft Component budgets and values are based on projections and not actual funds received. MHSA funds have historically been volatile and subject to change. More recently MHSA revenue has been less than what was anticipated when the 3-Year MHSA Plan was developed. Based on the information available at the time of this report, an overall reduction in funding is expected for the remaining two years of the 3-Year Plan. Based on the projections, the plan reflects component adjustments across each component.

OVERVIEW OF PROPOSED FUNDING TO SERVE OVER 100,000 INDIVIDUALS PER YEAR

COMPONENT	3 YEAR PLAN FY 2023-24	PROPOSED BUDGET FY 2024-25	DIFFERENCE
Prevention & Early Intervention	$82,273,482	$72,087,856	-$10,185,626
Community Services & Supports	$257,467,229	$198,323,313	-$54,593,916
Innovation	$7,323,668	$48,383,668	+$41,060,000
WET	$8,758,368	$7,871,705	-$866,663
Capital Facilities & Technological Needs	$30,159,857	$21,401,488	$10,000,000
Total	**$377,224,235**	**$358,068,030**	**-$24,586,205**



The MHSA Three Year Plan was developed based on stakeholder input received through the community program planning process, legislative changes, state policy updates, and with consideration of Orange Counties local initiatives. This MHSA Annual Update (Annual Update) for FY 2024-25 was developed during a time of uncertain legislative change.

Californians living with serious mental illness and/or addiction can face many obstacles to receiving both behavioral health and medical care. As a result, these individuals may die decades earlier than the general population. The factors that can contribute to the challenge include barriers to transportation, age and cultural factors, beneficiaries needing to navigate separate delivery systems to access care, and , limitations in data sharing/care coordination.

To address some of these factors, the state of California, under the direction of the Department of HealthCare Services (DHCS), is implementing the California Advancing and Innovating Medi-Cal (CalAIM) initiative. CalAIM is the state's long-term commitment to transform Medi-Cal, with the intention of making the program more equitable, coordinated, and person-centered to help Medi-Cal beneficiaries maximize their health and life trajectory. The intention of this multi-component initiative is a more integrated and flexible behavioral health system that is currently being implemented through improvements to behavioral health policy and payment reform. In addition to CalAIM, many other policy changes are being implemented, pushing changes in the delivery of behavioral health care for a system that has been in place for decades with in a relatively short period of time. A summary of some of the most recent changes includes:

- Mobile Crisis – changes how and when crisis response teams deploy to community members experiencing a behavioral health crisis.
- CARE Act – creates a collaborative court for individuals living with untreated schizophrenia spectrum disorders who require intensive collaboration and participation in voluntary treatment.
- Senate Bill 43 – changes the legal definition of grave disability to include persons living with severe substance use or co-occurring mental health disorders without any simultaneous or preemptive investments in infrastructure.
- Peer and Recovery Services – mandates the inclusion of peer support services with specializations in Medi-Cal, crisis, justice-involvement, housing, and supervisory roles.
- Passage of SB-326 – A several hundred-page bill that makes significant changes to the Mental Health Services Act, upon voter approval, and mandates the development of a Behavioral Health Integrated Plan that includes every single funding source and program used for public behavioral health services. The updates make broad sweeping changes to existing statute. No Information Notices or Plan Letters have been issued by the Department of Healthcare Services as of the date of this Plan to provide direction for implementation of these changes.
- Passage of AB-531 – Upon voter approval, establishes a $6.4 billion bond to build treatment facilities, Veterans housing, and permanent supportive housing for individuals who are experiencing or at-risk of homelessness and living with a serious mental illness and/or substance use disorder.

All of these significant changes are happening during a time of a national shortfall in the Behavioral Health Workforce that has impacted the ability to meet the behavioral health needs of communities across the country.

The most impactful policy initiative is the anticipated passage of Proposition 1. Proposition 1 combines portions of SB-326 and AB-531 as in a singular proposition that is trending as approved based on preliminary results of a California ballot measure on March 5, 2024. The proposition repurposes the Mental Health Services Act (MHSA), changing the name to the Behavioral Health Services Act (BHSA) and updates the priority populations and use of the funding.

The BHSA Eliminates the MHSA component funding for Community Services and Supports, (76% of the fund that includes the ability to set aside funds for Workforce Education and Training and Capital Facilities and Technological Needs), Prevention and Early Intervention (19%), and Innovation (5%). Instead, BHSA requires 35% of funds to be directed toward Full Service Partnerships (FSP), 30% of funding for Housing Interventions, and 35% for Behavioral Health Services and Supports (BHSS).

The BHSA expands the priority population by including individuals with substance use disorders and prioritizes individuals at risk of or experiencing homelessness, justice involvement, child welfare involvement, and/or institutionalization/conservatorship. The BHSA is set to be enacted January 1, 2025, to begin the updated community program planning process. The MHSA is anticipated to sunset June 30, 2026, and require all counties have approved BHSA Integrated Plans approved by local Boards before July 1, 2026. The BHSA does not include a specific component for Innovation. Based on current language included in SB-326, approved Innovation Component projects can continue to be implemented past the July 1, 2026, start date.

Many programs contained within the Annual Update are proposed for "right-sizing." Right sizing is a process that adjusts program budgets based on the actual amount of MHSA funding that was used to support a program over the last year. Right-sizing can help identify unspent MHSA funds that can then be invested to expand existing programs or develop new programs within the same component. The process can also allow program budgets to be reduced when state revenues are lower than anticipated. The Annual Update reflects reductions based on right-sizing. Should revenue continue to be received at lesser values than anticipated, further component program reductions or eliminations may take place through an amendment to the Plan.

The only component reflecting an increase in the Innovation component. Innovation funds may only be used according their categorical use as described above and may not be used to backfill shortfalls for other component programs.

Highlights of Innovation projects contained in the plan include a newly proposed project to support the ability to respond to intensive legislative mandates and changes, expansion of existing projects and possibly investing in the second part of the statewide Psychiatric Advanced Directives project.

Innovation

The following is a description of a newly proposed Innovation project concepts planned to be introduced and implemented during this reporting period. Upon local approval in this Plan, the draft Innovation Component Projects will be further developed for state approval and presented to the Mental Health Services Oversight and accountability Commission (MHSOAC).

Progressive Improvements of Valued Outpatient Treatment (PIVOT) – New Project

The current multitude of state initiatives will have unknown impacts across the public Behavioral Health system. The current system of care is not currently designed to easily integrate these changes.

Therefore, the need to modify how OC BHS conducts business and delivers services must be updated.

The multiple initiatives make is clear that the state is envisioning an updated paradigm for public behavioral health services, especially those services provided through the specialty mental health plan (MHP). County specialty mental health plans need to respond and reimagine their systems of care in order to meet the requirements. The "re-imagining" of the overall system, along with the testing of new processes is proposed under the **Progressive Improvements for Valued Outpatient Treatment (PIVOT)** project.

The overall Innovation, the **Progressive Improvements for Valued Outpatient Treatment (PIVOT)** project, proposes to redesign the OC-BHS system and create and test service models where the delivery, care coordination, and payment for care is aligned to make a seamless and integrated experience for behavioral health clients that result in improved client outcomes. The project also intends to test innovative approaches to workforce recruitment and retention that have worked in other systems to strengthen the pathways to becoming a clinical service provider and incentivize retention of highly qualified staff.

This multi-component project will result in an overall system redesign while simultaneously addressing key areas in the current BH system of care and allows pilot projects intended to identify and develop successful behavioral health approaches that can be integrated across the system of care. The pilots, or components, include:

- Innovative approaches to Delivery of Care
- Full Service Partnership Re-Boot: Testing a Social Finance Approach to Improve Client Outcomes
- Integrated Complex Care Management: Testing Whole Person Approaches for Care in the Older Adult Population
- Developing Capacity for the Delivery of Specialty Mental Health Plan Services in Diverse Communities
- Innovative, Countywide Workforce Initiative

Innovative Approaches to Delivery of Care

In the current system, Primary Care (physical health), substance use disorder, and mental health systems operate according to each systems charting, billing, and regulatory requirements. Despite state movement toward a more integrated model, the simultaneous changes and initiatives have not allowed time for County systems to respond and think through the ways the systems need to be redesigned. The current structure limits access to wholistic, integrated services forcing clients to navigate bifurcated systems to meet their healthcare needs. Even clinical space is often set up according to the system that primarily funds the clinic limiting access to person-centered approaches to care.

To be responsive to the changes envisioned by the state, Orange County (OC) Behavioral Health Services is proposing a comprehensive project to redesign clinical care with an opportunity to focus on multiple pilot projects within the redesign. Each component focuses on areas of the system that have been identified as benefitting from focused attention to resolve ongoing challenges. The learning from each pilot will be evaluated and integrated into a new overall system of care and OC BHS will update policies and processes to support and integrate system updates.

Full Service Partnership Re-Boot: Testing A Social Finance Approach For Improving Client Care And Outcomes

The Mental Health Services Act (MHSA) currently requires the majority of the Community Services and Supports (CSS) funding be directed toward Full Service Partnership Programs. Full Service Partnership (FSP) programs provide intensive outpatient services and case management for individuals living with serious behavioral health conditions. The full-service partnership framework is based on a "no fail" philosophy and does "whatever it takes" to meet the needs of clients, and when appropriate their families, including providing supportive services. This framework builds strong connections

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

Proposition 1, voted for and passed by California voters on March 5, 2024, requires 35% of the total MHSA budget be directed toward FSP programs. Orange County currently funds FSP programs for all age groups that are implemented through a combination of contracted provider agencies and County clinics. While the FSP framework is similar across all programs, there are differences in the details of contracts and variation in the cost per service recipient.

In addition, there are differences in the way FSPs are managed and in the service capacity/capability of both contracted providers and County-staffed teams. Even with those differences, FSPs across the County have very similar objectives and, overall, make up a homogeneous service. While this "whatever it takes" approach is successful, it also conflicts with the state expectation that as much Medi-Cal as possible should be billed to draw down revenue for delivery of these services. While "whatever it takes" drives the model, "whatever can be billed" becomes incentivized. This places counties in a quandary as the sustainability of the services relies on generating revenue.

The FSP Re-Boot concept will focus primarily on Program Performance and Performance Management that is implemented through real-time technical assistance with County staff and contracted providers. The enhanced service will test various approaches to performance-based contracts and improved performance management. As a place holder, the three possible approaches to piloting performance-based contracts include:

- A new, purpose-led outcomes contract running alongside FSPs;
- An amendment to FSP contracts to create a Follow-On program;
- A new, place-based outcomes contracts (jail and/or encampment community).

The FSP Reboot may become a statewide Innovation project that provides the ability to explore alternative ways for performance and payment through testing a social finance approach for client care. At the time of the posting of this plan, OC is conceptualizing the project solely for implementation in this County.

Additional details for this component will be co-created through the stakeholder process and included in the project plan write up that is presented to the MHSOAC.

Integrated Complex Care Management: Testing Whole Person Approaches For Care In The Older Adult Population

In 2023, the Orange County Older Adult Behavioral Health Advisory Board (BHAB) Committee identified the need to improve care for older adults living with co-morbid neurocognitive and behavioral health conditions. The group identified that older adults are the fastest growing population in OC. Long-term stable housing, treatment and services are often inaccessible, inadequate, or unavailable to older adults who are homeless or at risk of homelessness and living with dual mental health conditions and dementia. Additionally, care for this population is split between the managed care system and specialty mental health plan, with each system responsible for specific portions of care. Each system utilizes different screening and assessment tools and views the treatment of the co-morbid condition through the lens of their system.

he purpose of this proposed component is to begin to develop and plan a system of care for older adults living with both behavioral health and physical/neurocognitive conditions which may include individuals who are homeless or at risk of homelessness.

The project is grounded in three objectives:

1. ***Outreach and Engagement***: To create a process for identifying older adults considering the challenges and barriers reaching and engaging this unserved/underserved population.

2. ***Assessment***: Engage experts in the field to create a different model for assessment that is recognized across the various systems.
3. ***Complex Care Management/Navigation Plan***: The multi-disciplinary team will collaborate on funding structures and care strategies to meet the comprehensive needs of older adults.

Currently BHS and local managed care providers meet to find solutions to complex cases for older adults living with co-morbid neurocognitive and behavioral health conditions. Staff come together to determine the best course of treatment for individual cases because a system to effectively manage these cases does not currently exist. Outcomes to these cases tend to be highly individualized because of an inconsistent approach to cases, predicated by no clear funding stream or reporting structure, forcing providers to piece meal individualized treatment plans.

Developing Capacity For Specialty Mental Health Plan Services With Diverse Communities

Orange County (OC) is home to about 3.2 million people making it the third most populous County in California and the second most densely populated County in the state, behind San Francisco, and is home to diverse populations. BHS operates as both the OC Specialty Mental Health Plan (MHP) and as a provider of specialty mental health plan services, coordinating and providing specialized behavioral health services for Medi-Cal recipients and uninsured individuals who meet the criteria for medically necessary care under the MHP.

Many CSS programs leverage Medi-Cal in the delivery of MHSA services. A review of Medi-Cal beneficiary demographics can help identify underserved, unserved populations. In brief, OC penetration rates were lower than those seen statewide across all racial/ethnic groups and all age groups.

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

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

The data available through the state is limited and does not further delineate nuances between the multitude of cultural differences between Asian/Pacific Islander population, South Asia, Middle Eastern, North African (SAMENA), etc. populations. In addition, there is a lack of data concerning services around the delivery of behavioral health services for deaf and hard of hearing populations. Currently, there are existing non-Medi-Cal service providers that provide behavioral health services to these underserved populations.

This component seeks to evaluate the minimum capacity of a community-based organization to be able to become a specialty mental health plan contracted provider, review the amount of technical assistance needed to support development and implementation, and determine if embedding culturally based approaches for specialty mental health care improve both penetration rates and client outcomes. In addition, the project seeks to identify successful community defined-evidence practices (CDEPs) that can be designed to generate revenue and potentially be recognized by the state.

Additional details for this component will be co-created through the stakeholder process and included in the project plan write up that is presented to the MHSOAC.

Innovative Workforce Initiative

California's public behavioral health system has experienced a shortage of behavioral health

workers, changes in mental health occupational classifications, and underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs. WET is a program that provides training opportunities to the BHS' staff and contract agency staff, promotes the recruitment and hiring of a culturally diverse workforce, offers financial incentives, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing the workforce shortage within Orange County through utilization of various strategies to recruit and retain qualified behavioral health employees. WET carries forth the vision of the MHSA to create a transformed, culturally competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

The OC WET component programs have experienced much success over the years, contributing to the development of a highly skilled workforce. However, some institutional barriers still exist, creating roadblocks for establishing integrated pathways to BHS employment. In the most recent MHSA 3-year Plan, BHS identified the need to establish a centralized internship program that included paid internship positions, an employee 20/20 program, and streamlining the path from internship to employment. Despite efforts, barriers exist that limit the success of the existing program, including but not limited to:

- Competition amongst systems. For example, hospitals, education, criminal justice and managed care plans all compete for the same qualified staff and interns.
- Limited ability to update minimum qualifications for entry level Behavioral Health Clinicians, including necessitating that applicants possess a BBS registration number prior to start date.
- Delays between graduation, hiring, and ability to start in BHS.
- Inability to establish the 20/20 program.

In addition, there is not an established coordinated, countywide behavioral health pipeline and pathway to support the development of the larger provider network.

The solution BHS has designed to overcome a portion of these barriers exists in other systems that utilize apprenticeship programs. Apprenticeships combine paid on-the-job training with classroom instruction to prepare workers for highly-skilled careers. Workers benefit from apprenticeships by receiving a skills-based education that prepares them for good-paying jobs. In addition, apprenticeship programs help employers recruit, build, and retain a highly skilled workforce.

The BHS Innovative Workforce Initiative will take successful strategies from both internship programs and apprenticeship programs and may utilize a third party vendor as the "employer of record" to support payment of incentives for participating in the internship program.

Because apprenticeships are longer than a typical internship, individuals participating in BHS internships will have the option to extend their paid learning opportunity beyond their educational requirement. A standard pay scale will be developed that incentives longevity and continues to provide incentives during the period between graduation and the receipt of a BBS registration number that is required to qualify for regular county positions.

Additional details for this component will be co-created through the stakeholder process and included in the project plan write up that is presented to the MHSOAC.