HMA

HEALTH MANAGEMENT ASSOCIATES

Mental Health Services Act Program Review: Findings and Recommendations

PREPARED FOR
THE COUNTY OF ORANGE

BY
GINA ECKART, NICOLE LEHMAN, KATHRYN NGO,
SERENE OLIN, AND DEBBIE WITHAM

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Table of Contents

Project Background 1
MHSA Review Approach and Methodology 1
MHSA Background 1
MHSA Components 2
Prevention and Early Intervention 2
Community Services and Supports 2
Innovation 3
Workforce Education and Training 3
Capital Facilities and Technological Needs (CFTN) 4
MHSA Governance 4
State Governance 4
County Governance 5
Governance Role of MHRS 5
Governance Role of Behavioral Health Advisory Board 7
Governance Role of Board of Supervisors 8
Governance Role of Orange County Executive Finance Office 8
Findings 9
Recommendations 9
Community Program Planning (CPP) 10
Historical Approaches to CPP 10
Current CPP Approaches 11
Culturally and Linguistically Congruent Approaches 11
Feedback from Stakeholders 12
Review of Plan 13
Findings 13
Recommendations 13
MHSA Contracting and Contract Oversight 14
Contract Procurement 14
Contract Oversight 15
Workforce Challenges 16

- Findings 16
- Recommendations 17
- Fiscal Administration 18
  - Reserves 18
  - Reversion 19
  - Findings 20
  - Recommendations 21
- Data Collection and Analytics 21
  - Data Systems 22
  - Data Governance 23
  - Performance Metrics 23
  - Findings 24
    - Data Systems 24
    - Data Governance 24
    - Performance Metrics 24
  - Recommendations 25
    - Data Systems 25
    - Data Governance 25
    - Performance Metrics 25
- Conclusion 26
- Acknowledgements 27
- Appendix A: MHSA Timeline 28
    - MHSA Detailed Timeline 29
- Appendix B: Interviews 31
- Appendix C: Documents Reviewed 32
    - Background 32
    - Contracts 32
    - Strategic Plan Documents 32
    - Financial Documents 32
    - Policies and Procedures 33
    - Stakeholder Engagement 33
    - Current metrics, dashboards, and reports 33

Other 33
Appendix D—Stakeholder Engagement Meetings Attended 34
Virtual Meetings 34
In-Person Meeting 34

Project Background

HMA was engaged by the County of Orange (County) to conduct a strategic review of the Health Care Agency's (HCA) Mental Health Services Act (MHSA) administrative processes and programming to evaluate the effectiveness of the MHSA governance structure; MHRS's ability to identify and track appropriate performance measures for each MHSA program; alignment with County of Orange strategic priorities and initiatives such as OC Cares, Be Well Initiative, Homelessness, and Housing; and compliance with MHSA's mandates, goals and objectives. This report is intended to provide an update on the overall performance of the County's MHSA program that can be used as a baseline and provide recommendations to enhance efforts to determine funding priorities and improve future program performance.

MHSA Review Approach and Methodology

As part of the evaluation, HMA collected and reviewed both qualitative and quantitative information about the MHSA program. Specifically, HMA requested and reviewed multiple documents associated with HCA's Mental Health and Recovery Services' (MHRS) administration of the MHSA program, including but not limited to organizational charts, policies and procedures, program reports, and reports by other auditors. A complete list of the information requested can be found in Appendix C. In addition, HMA conducted multiple interviews with both internal and external stakeholders to further support an understanding of the County's process for administration of the MHSA funding and compliance with their contract with the state. Lastly, external stakeholders were interviewed to gain specific feedback on stakeholder engagement in the planning and monitoring processes for the MHSA program. This was accomplished though attendance at multiple community meetings intended to elicit public comment on the MHSA FY2023-2024-FY2025-2026 Three Year Program and Expenditure Plan. A list of these meetings, as well as individuals who were interviewed is provided in Appendix B. This report includes findings and recommendations from the review that may serve as administrative opportunities for MHRS and specifically the MHSA staff.

MHSA Background

Proposition 63 was approved by California voters on November 2, 2004, creating the MHSA Program within the state of California. The MHSA was designed to expand California's public mental health programs and services through funding received by a one percent tax on personal incomes in excess of $1 million. Counties are required to use this funding for projects and programs for prevention and early intervention (PEI), community services and supports (CSS), workforce development and training (WET), innovation (INN), and capital facilities and technological needs (CFTN).[1] The program has evolved since its inception. This includes transferring state MHSA functions from the former Department of Mental Health to the Department of Health Care Services (DHCS) in 2012; requiring the state to conduct program reviews of county performance, and post all three-year program and expenditure plans in

[1] MHSA requirements are outlined in multiple sections of Welfare and Institutions Code, including 5800, 5820, 5830, 5840, and 5845

2016; and funding amounts allowable in reserve, and/or subject to reversion in 2017, 2018, and 2019.[2] The State Controller distributes MHS Funds to the counties to plan for and provide mental health programs and other related activities outlined in a county's three-year program and expenditure plan or annual update. MHS Funds are distributed by the State Controller's Office to the counties on a monthly basis. In addition, DHCS monitors the County's use of MHS Funds to ensure that the County meets the MHSA and MHS Fund requirements, including triennial oversight reviews.

MHSA Components

The MHSA directs funding to five required components representing prevention, early intervention, and service needs as well as providing funding for infrastructure, technology, and training for the community mental health system. All components have general requirements specific to funding allocation, oversight, and accountability. Plans for new services and supports, as well as reporting on previous activities for each component, is included within the required three-year Program and Expenditure Plans. As such each component is included in the required community planning process which is often referred to as the "sixth component" of the MHSA.

Prevention and Early Intervention

The PEI component provides funding to programs designed to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for individuals who are underserved.[3] The PEI component of MHSA requires that programs address individuals across the lifespan, with at least 51% of the funds allocated for youth aged 25 years and younger. Further, PEI interventions must address disparities in access for underserved communities and are generally of low intensity and short duration except for those experiencing first onset psychosis associated with serious mental illness. The OC MHRS includes a high level of collaboration across the multiple programs designed for children and youth. MHRS's PEI division has administered their activities supported by programmatic and fiscal partnerships that exist with the Orange County Department of Education, HCA and CalOptima (the County's Medi-Cal Managed Care Plan). Evaluation of the impact of PEI funded initiatives focuses on indicators appropriate to the programs, including outreach efforts, referrals and successful linkage to treatments, timely access to services to reduce duration of untreated mental illness, stigma and discrimination reduction, and suicide prevention.

Community Services and Supports

The Community Services and Supports (CSS) component provides funding for direct services to target populations that include adults and older adults with serious mental illness (SMI), children and youth with serious emotional disturbance (SED), veterans, and individuals impacted by a natural disaster or "severe local emergency." Specific criteria are outlined in Welfare and Institutions Code section 5600.3 and include diagnostic and functional impairment criteria, as well as target populations within these broader groups. CSS has the largest funding allocation across the MHSA components and includes three required service categories, Full Service Partnerships (FSPs), Outreach and Engagement Services (O&E),

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[2] Represents legislative changes captured in historical information document accesses at Appendix 1 Historical Information.pdf on February 7, 2023.

[3] Specific PEI requirements are outlined in Welfare and Institutions Code 5840. Law section (ca.gov)

and General System Development (GSD).The flexibility for use of CSS funds has evolved over time, including more recent ability to leverage these funds to match Medicaid funded services, as well as helping counties leverage housing funds in local partnerships to build and renovate housing units for individuals with serious mental illness who are homeless or at risk of homelessness. With these opportunities to blend funding comes additional administrative responsibilities to ensure the funding requirements of all payers, including Medicaid, are met. These CSS intersections, with federal, other state, and local funding streams, and their shared target populations, has led to integration of administration of this component with other MHRS programs and services.

For MHRS, in general, maximizing funding while maintaining compliance with payer of last resort requirements, must be balanced with attention to populations with need, who may have limited to no eligibility under various payers. In other words, leveraging the federal financial participation under Medicaid, by using CSS dollars as state matching funds, increases the total dollars available for services. However, not all individuals are Medicaid eligible. Therefore, counties must ensure that some CSS funds are available for provision of services to individuals who are under/uninsured for a similar set of services in order to meet requirements of this component area.

Not surprisingly, the CSS component has historically been the one most frequently impacted by policy changes since MHSA implementation. As previously mentioned, approved use of funding has changed, often adding additional flexibility. Another example includes a change in 2016 which allows use of funds for crisis services, and recent guidance on use of these funds for assisted outpatient treatment. While flexibility may be welcomed, each change triggers a broader review and potential reallocation of the aforementioned blended funding streams. This in turn triggers the necessary resulting administrative activities such as contract amendments. The rigid timelines within a MHSA three-year planning cycle add to the challenges in administration of this component.

Innovation

The Innovation (INN) component provides funding to projects that test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of the INN component is to bring into practice new, effective mental health approaches. The overarching goal of this component is that when promising practices are found to be effective through a county's implementation, that practice can be adopted by other counties throughout California. These projects may focus on increasing access to underserved groups, increasing the quality of services including measurable outcomes, promoting interagency and community collaboration, or increasing access to mental health services.

Unlike the other component areas of the MHSA three-year plans, county plans related to Innovation projects must be reviewed by the Mental Health Services Oversight and Accountability Commission (MHSOAC). Evaluation data, including project elements contributing to outcomes and a disparities assessment, must be reported as part of the Annual Innovative Project report.

Workforce Education and Training

The Workforce Education & Training (WET) component is intended to support and sustain a diverse mental healthcare workforce that is reflective of the community they serve and that is linguistically and

culturally competent. The County of Orange WET program offers education and evidence-based trainings to behavioral health county staff and contracting community partners, as well as to Orange County community members and faith-based leaders with the goals of promoting wellness, recovery, and resilience. Emphasis is placed on developing and maintaining a culturally responsive, bicultural/bilingual behavioral health workforce. Efforts funded under this component also include training for behavioral health professionals that are designed to meet requirements for Continuing Education and Continuing Medical Education credits, in an effort to retain these workers within the County.

Capital Facilities and Technological Needs (CFTN)

The Capital Facilities and Technological Needs (CFTN) component provides funding for projects that strengthen or expand the infrastructure needed to support the behavioral health system, which includes improving or replacing existing technology systems and/or developing capital facilities to meet increased needs of the local system, including those supporting the other MHSA components. Due to their size and scope, projects under the CFTN component involve executive leadership in planning and support broader county strategic initiatives.

MHSA Governance

MHSA is a state funding source generated from tax revenue but administered at the local level, and as such the program includes state oversight in addition to multiple components of county level governance. This multitiered structure contributes to the complexity and resources necessary to administer the program and in some cases contributes to confusion for stakeholders. As with any state-county partnership, flexibilities exist to intentionally allow for local adaption of requirements while at the same time maintaining fundamental “must-dos.” Balancing between these realities requires the County staff to maintain ongoing knowledge and understanding of the program requirements, processing, and adapting when regulation changes occur, and serving as a subject matter expert for those who are not in the weeds of this information daily, but have invested interest in the program.

State Governance

State oversight of the program is conducted primarily by the California Department of Health Care Services (DHCS). In addition to the DHCS MHSA contract with the county, MHSA is also governed at the state level by state statutes and administrative codes that outline specific requirements associated with administration of the MHSA funds. When assessing the county’s processes for MHSA administration, it is important to review these activities in the context of these requirements and the flexibility or lack of flexibility they provide. Many of the activities that require the resources of county staff are directly correlated with these state fiscal and other reporting requirements. A list of overarching requirements includes:

- Welfare and Institutions Code (WIC), Section 5899(c), which requires counties to submit a completed Annual Revenue Expenditure Report (ARER) to DHCS by January 31st each year. The purpose of the ARER is to identify Mental Health Services Act fund expenditures, identify interest earned and unspent funds, and determine reversion amounts.

- WIC 5847(b)(7), which requires counties to establish and maintain a prudent reserve to ensure children, adults, and seniors can continue receiving services at current levels in the event of an economic downturn. The Prudent Reserve is funded with monies allocated to the Community Services and Supports component and cannot exceed 33% of a county's average distribution for the previous five years. Per Section 5892 (b)(7), counties are required to assess and certify their local prudent reserve every 5 years, beginning in FY 17-18.
- Welfare and Institutions Code section 5848(e), requires the DHCS to annually post on its Internet Website a summary of the performance outcome reports submitted by the counties. These reports mirror the outcomes reporting within county three-year planning and annual update documents.

DCHS conducts triennial oversight reviews of each county's compliance with the Mental Health Services Act (MHSA) and state regulations, as well as the Performance Contract. The state provides the county with a written Performance Contract Review Report which includes a description of each finding, suggested improvements, a description of any corrective action(s) needed, and timeframes required for the county to come into compliance. Counties are required to submit a Plan of Correction (POC) to DHCS within 60 days of the county's receipt of the Performance Contract Review Report for all items found out of compliance. In addition, the Mental Health Services Oversight and Accountability Commission (MHSOAC) has the responsibility of reviewing county spending of MHSA funds under the PEI component, as well as distribution of the Innovation component funding through approval county Innovation plans.[4] Both state and county performance related to the MHSA program has also been subject to audit by other state agencies including the California Department of Finance, The California State Auditor, and the State Controller's office. The scrutiny of the program, including audit findings at both state and local levels, has contributed to changes in the program over time.[5]

County Governance

With the passing of the MHSA, Orange County had to identify and allocate ongoing resources toward implementing MHSA and incorporating this significant funding stream, and its associated regulations, within their existing behavioral health system of care. Governance at the county level reflects a combination of state MHSA requirements along with an ongoing evolution of the MHSA components and required functions within the county organizational structure, and adherence to local regulations and requirements. This results in a multi-layered governance structure, involving multiple county stakeholders.

Governance Role of MHRS

Mental Health Recovery Services (MHRS) is service area within the Orange County Health Care Services Agency with direct responsibility for administration of the MHSA program. This responsibility is integrated within MHRS' broader role to provide access to a robust continuum of publicly funded behavioral health services within the county. Findings and recommendations throughout this report

[4] AB 1467, chaptered in June 2012, reinstated the MHSOAC's authority to approve INN funding plans.
[5] A high level history of these changes is available in Appendix A Historical Information.pdf.

highlight the administrative complexity involved with the intersection of MHSA funding and regulation with other MHRS funding streams, responsibilities, and requirements. MHRS has positions dedicated to MHSA functions, as well as positions that support both MHSA functions and other MHRS responsibilities. These positions collectively support MHRS' role as the planner, implementer, and evaluator of the MHSA three-year plans, while maintaining compliance with state requirements. While the community of county stakeholders has a significant role in informing the plan, MHRS is responsible for the final decisions regarding the programs and funding associated with the MHSA Three-Year MHSA Program and Expenditure Plan.

While the MHRS and MHSA Coordinator positions are focused primarily on administration of the broader system of care and county MHSA program respectively, there are opportunities to influence and impact MHSA program policy at the state level. This engagement is especially important in addressing pain points caused by state requirements or lack of flexibility. This is especially important in the near term as Governor Newsom has indicated a desire to restructure elements of the MHSA program.[6] Fortunately, Michelle Smith, Orange County's current MHSA Coordinator, participates as the Co-Chair for the County Behavioral Health Directors Association of California (CBHDA) MHSA Committee and Dr. Kelly and other county executives are active and engaged with the California State Association of Counties (CSAC) and their lobbying efforts associated with the MHSA Program.

MHRS Reorganization

During the course of this MHSA program review, MHRS submitted a reorganization request with the County Executive Office. Drivers of the reorganization include the achievement of specific goals for the administration of the MHSA program. HMA requested, received, and reviewed copies of the current and proposed MHRS organizational charts as well as a supplemental narrative document associated with the request. In addition, HMA conducted four individual interviews with MHRS staff, including Dr. Ronnie (Veronica) Kelley, Annette Mugrditchian, Sharon Ishikawa, and Michelle Smith to gather additional information regarding the desired impact of the changes specific to MHSA. During subsequent interviews, MHRS staff were asked for feedback regarding the proposed changes.

Under the reorganization, the Research and Outcomes service line will be responsible for building and sustaining robust reporting and data analytics capabilities to meet the growing expectation of MHRS being a data driven system of care. Prevention and Intervention services (P&I) is also directly impacted by the proposed reorganization, moving this program from under Children and Youth Services. This move is intended to highlight the need for P&I services across the age spectrum, inclusive of older adults, and to support collaboration across other MHSA components under its proposed new position within the MHSA Program Support & Division. Consolidating core MHSA program components will also facilitate ongoing administrative tasks associated with MHSA requirements. This newly proposed structure supports a broader goal of ensuring that the MHSA program is being administered as required and aligning within the broader MHRS structure as changes occur with CalAIM and other initiatives. The MHSA Director serves as the subject matter expert of MHSA and this structure will support necessary

[6] Governor Newsom Proposes Modernization of California's Behavioral Health System and More Mental Health Housing | California Governor

planning for the evolving changes associated with payment reform and provide oversight and guidance on the proper use of MHSA funds during these broader agency changes and transitions.

Feedback from the MHRS staff interviewed indicate positive feedback overall regarding the reorganization. At the time of the interviews there were some staff who indicated they had not seen the details of the request, and others reported that while they understood the rationale for changes, only time would indicate whether or not they would achieve the desired impact. Specific feedback from staff directly impacted by changes indicated optimism that the reorganization would reduce the breadth of areas of responsibility and allow for more focused work with a specific population or program. MHRS leadership indicated the need to ensure subject matter expertise in management positions, to support ongoing development of both programs and staff. Management staff concurred with the need to allow for concentration of effort and understanding by managers in order to support improved timeliness in response to external and internal inquiries about MHSA programs.

Governance Role of Behavioral Health Advisory Board

The Behavioral Health Advisory Board (BHAB) has a broad set of responsibilities within the county, and specific activities outlined in Welfare & Institutions Code 5604.2. The goal for these local boards is to serve in an advisory role to the county Board of Supervisors and the Behavioral Health Director on all aspects of local mental health and SUD programs; advocate for individuals with serious mental illness (SMI) and substance use disorder (SUD); and review programs and services within the local behavioral health system. The review of programs and services includes reviewing and improving MHRS' stakeholder engagement strategies with county planning, as well as reviewing and providing feedback on data, contracts and grants, and candidates for MHRS executive leadership positions. Activities specific to the MHSA program, as outlined in statute, are to conduct a public hearing on the Mental Health Services Act (MHSA) program and expenditure plan and annual updates at the close of the 30-day comment period.[7]

Information gathered through interviews indicated that the BHAB has historically played a role in convening stakeholders for the purposes of MHSA planning, including the creation of an MHSA steering committee to support these activities. Feedback indicated this structure was well intentioned and included representation of individuals with lived experience in receiving services. However, it was reported that over time, the role of the MHSA Committee as advisor to MHRS, versus decision maker, became blurred. In addition, the structure of meetings transitioned to MHSA funded provider presentations and critiques as opposed to open and inclusive discussion of planning priorities and system needs. Feedback also indicated that committee meetings had become at times contentious, with presenters often feeling openly criticized and attacked and some participants feeling they no longer had a voice in the meetings. The committee structure was discontinued and all those interviewed spoke positively about the new community program planning approaches implemented in the last year. These changes to the planning process will be discussed in further detail later in this report. Interviewees indicated that at times, BHAB members have also misunderstood the role of the Board specific to MHSA, attempting to take on more of a decision maker role for content in the plan as opposed to

[7] Required by subdivision (a) of WIC 5848.

recommendations. New leadership at MHRS provided training to the Board during the past calendar year which was reported to be well received and alleviated some of the role confusion.

Governance Role of Board of Supervisors

The county Board of Supervisors (BOS) has the responsibility for approving the three-year Program and Expenditure Plan for each planning cycle. In 2011 Assembly Bill 100 removed a requirement that the state approve county MHSA plans. Specifically, Welfare and Institutions Code (WIC), Section 5847(a), dictates that each county mental health program must prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services within 30 days of the adoption. In addition, the BOS provides approval of HCA/MHRS contracts. This can sometimes be a challenging task given the MHSA time constraints, changing funding levels, and constant flow of behavioral health initiatives at the federal and state level that require updates to county provider contracts. Tension created by these challenges has reportedly been felt in BOS meetings.

Governance Role of Orange County Executive Finance Office

Approximately six years ago, during a transition in MHRS leadership, the responsibility for the MHSA ledger was moved from the HCA to the Executive Office's Finance Office. It was indicated that the change was prompted by concerns that the county was rolling over too much funding and "not spending the money." Mitigating reversion risk continues to be a focus as well as maintaining an appropriate level of reserves. Staff interviewed reported this change created a partnership between the Executive Finance office, HCA Finance and Program Support Services, and MHRS in providing oversight of MHSA funds. Staff from these offices, including the MHSA Coordinator, meet monthly to discuss MHSA budgets, expense reports, and prepare the quarterly BHAB finance presentations. The HCA's Financial and Program Support Services office prepares the budgets and assists with contract monitoring of financial information, leveraging financial data provided by the Executive Finance Office. A more detailed discussion of MHSA reserves and risk/history of reversion can be found later in this report. However, it is important to note that despite changes in the financial governance of the program, stakeholders continue to share concerns, and sometimes misinformation about MHSA funds being reverted or reserves exceeding limits.

Overview of MHSA Governance Roles and Responsibilities

Roles and Responsibilities

Entity	Statute
Behavioral Health Advisory Board (BHAB)	WIC 5604.2(a)(4): The local mental health board shall: review and approve the procedures used to ensure citizen and professional involvement in all stages of the planning process.
	Host Public Hearing
Board Of Supervisors (BOS)	The local BOS maintains approval of the plan as codified in statute via AB 100 (2011).
Mental Health & Recovery Services (MHRS)	Adopt the MHSA General Standards in planning, implementing, and evaluating the programs and/or services provided with MHSA funds.
	▪ Community Collaboration (9 CCR § 3200.060) ▪ Cultural Competence (9 CCR § 3200.100) ▪ Client-Driven (9 CCR § 3200.050) ▪ Family-Driven (9 CCR § 3200.120) ▪ Wellness, Recovery, and Resiliency (WIC § 5813.5(d)) ▪ Integrated Service Experience (9 CCR § 3200.190)
	Title 9 CCR- Section 3300 Must involve clients & family, provide training about MHSA and CPP, involve identified stakeholder groups, 30-day Public Posting and Comment, Public Hearing, BOS Approval
DHCS	Compliance with Performance Contract, Conduct Program & Fiscal audits.
MHSOAC	Receive MHSA Plans, Approve INN projects.

SOURCE: MENTAL HEALTH SERVICES ACT COMMUNITY PROGRAM PLANNING FY2022-2023. PRESENTATION TO THE BEHAVIORAL HEALTH ADVISORY BOARD ON MARCH 26, 2022.

Findings

- Various stakeholders within the County have confusion about the roles of various entities with responsibility for MHSA administration and advisement
- Role confusion has contributed to tension between various stakeholders, including reports of contentious meetings when presenting MHSA content
- Recent attempts to educate MHSA stakeholders on roles, responsibilities, and program requirements has had a positive impact and served to reduce recent challenges
- Despite these attempts, retention of information and understanding by lay persons of the often-complex financial reporting and ever-evolving policies at the state level related to MHSA will likely remain a challenge. This is further exacerbated by the changing membership of the BOS/BHAB (term limits)

Recommendations

- Provide (or incorporate into existing curriculum) training for BHAB and BOS members specific to roles (advisory vs. management) and responsibilities as a BHAB/BOS Board member, including an MHSA Overview and conflict of interest training, on recurring basis to assist with ongoing retention of information.
- Make MHSA Overview training a component of HCA/MHRS new employee onboarding to ensure assimilation of program changes and updates at the state level, as well as general understanding of the role MHSA has in the broader mission and responsibilities of MHRS.

The multi-level MHSA governance structure and previous community engagement process has contributed to “audit fatigue” for some MHRS staff; however, this has often been met with high levels of resiliency and passion for serving the community. This, paired with new Leadership and an MHRS reorganization focused on implementing more targeted roles and responsibilities, puts the County of Orange in a unique position optimal for successful outcomes.

Community Program Planning (CPP)

Often referred to as the “sixth component” of MHSA, counties must provide for a Community Planning Process (CPP) as the basis for developing the Three-Year Expenditure Plans and updates. To assist in meeting this requirement, counties must designate positions, such as an MHSA Coordinator, and/or offices responsible for the overall planning process. Of utmost importance is ensuring stakeholders have the opportunity to participate and that these stakeholders reflect the diversity and demographics of the County. To facilitate the involvement of clients and their family members, as well as other stakeholders in all aspects of the process; training, as needed, must be provided regarding the stakeholder process itself. This includes training for staff with responsibilities related to CPP. The resulting plan has statutorily required content regarding the performance of existing services and supports under each of the program components, as well as plans for new initiatives in the upcoming funding cycle. The intent for stakeholder involvement is two-fold, ensuring transparency of current performance while gathering input to inform and finalize updates to the local MHSA component areas.

Historical Approaches to CPP

According to those interviewed, a MHSA committee was formed under the previously existing Mental Health Board to assist with the MHSA CPP. While this structure was well intentioned, providing designated opportunities to convene stakeholders who aligned with representation requirements, the lack of adaptation of this structure over time resulted in an ineffective process. The committee served as the primary, if not only opportunity for stakeholders to be formally engaged in MHSA planning. Due to the size of the committee, estimated by those interviewed to range between 55-60 people, stronger and more assertive voices were heard, while others failed to find opportunities to actively participate. Stakeholders also indicated that the meeting structure became more of a reporting out of various MHSA program metrics combined with funding requests. This further limited individuals and families with lived experience to actively participate. Placement of this committee under the Mental Health Board unintentionally created misunderstandings as to the role of the Board, creating confusion for many. The Board’s role is review and approval of the CPP, as opposed to overseeing the CPP. Staff reported that meetings became less productive and more critical of presenters. This was reported to have created significant stress for staff and other presenters, undermining the spirit of the CPP. More importantly, because the committee meetings centered around (both county and community) provider performance, the opportunity for intentional and genuine community and stakeholder input in planning for future cycles was significantly reduced.

MHRS had begun to transition the CPP approach when the mental health and substance use disorder boards merged into the current BHAB. However, during the COVID-19 pandemic all meetings were

transitioned to a virtual format and MHRS, following public health emergency protocols, relied greatly on surveys to gather stakeholder feedback during that time.

The BHAB is required to approve the planning process, however, per some stakeholders, approval of the process was not sought until planning began and felt they lacked opportunity for meaningful input in an advisory capacity. One suggestion was that aspects of CPP be shared as the process is being developed as opposed to reacting to a completed draft plan, with limited time for providing feedback or having changes made.

Current CPP Approaches

At the time of this review, MHRS had new leadership at the MHRS Executive Director level, as well as a new MHSA Coordinator. The aforementioned reorganization request was in part to support a new CPP approach. A core element of the approach is to create ongoing and real-time engagement throughout MHSA funding cycles to inform future plans. This process differs from previous approaches where a significant portion of structured stakeholder meetings occurred seeking response to an already drafted plan. The approach also attempts to meet with smaller groups of stakeholders, representing specific populations groups in the county to allow for focused discussions regarding their particular needs. MHSA staff propose to accomplish this by attending regularly scheduled meetings by these organizations, including having staff participate in working groups or in other standing meetings within the stakeholder agency in addition to county-hosted feedback sessions specific to three-year plan drafts and/or annual updates.

The latest three-year plan was posted for public comment during the period of this MHSA program review. This year's planning process began the transition to the new CPP process, which included a "Planning Summit" with the BHAB and other key stakeholders. Additionally, the current MHSA coordinator began attending regularly scheduled meetings with various stakeholders engaging them earlier in the planning cycle and in smaller scale, population specific meetings. Once the plan was developed and drafted, the MHSA team hosted and led 9 virtual meetings. They additionally attended 12 standing meetings held by key community leaders (7 virtual, 7 in-person and 1 hybrid) to engage community members, persons with lived experience and family members in settings where they were comfortable and familiar.[8][9] During this time the plan was posted for public comments (with comments due April 18th).

Culturally and Linguistically Congruent Approaches

It was initially difficult to ascertain how someone for whom English is not their primary language is notified of the planning process. It was later clarified that notices are sent in threshold languages, though the current MHSA coordinator would like to expand the number of languages. When a stakeholder receives the notice, they can request translation services that will be arranged by the MHSA team. The MHSA team maintains a pool of translators. In some instances where stakeholders did not

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[8] The in-person meeting schedule is posted at CPP Community Meetings - Virtual and In Person Schedule (1).pdf (ochealthinfo.com) and was accessed on April 24, 2023.

[9] Virtual meeting schedule was posted on the MHSA website and was accessed here on April 24, 2023. CPP Virtual Meetings Final.pdf (ochealthinfo.com)

have translation services this may contribute to a challenge in full engagement in the presentation. While the full plan is predominantly in English the Executive Summary is posted in 6 additional languages, including Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese.

Feedback from Stakeholders

The review team attended all virtual stakeholder meetings and one hybrid meeting (two team members were on-site and one was virtual). The purpose of the meeting was to explore with those individuals present, their satisfaction with the MHSA stakeholder engagement process. Following each meeting the HMA review team asked stakeholders three questions including: 1.) What was helpful in encouraging your stakeholder participation in today's meeting? What were other positive things about the format of today's feedback session; 2.) What made it challenging to participate or engage? What could be improved to encourage active participation and inclusion of feedback from all stakeholders; 3.) For those who have participated in the past, can you share the strengths and challenges of this approach to stakeholder engagement versus the opportunities you participated in previously? This can include participation in formally scheduled meetings or other informal activities where your input was sought.

Overall, most stakeholders seemed satisfied with the process, and some noted an improvement in the process this year. Additional feedback was that it created a process for engagement and feedback to ensure equity. Others noted concern about the language access, citing that the notices were only received in English. Many liked having the virtual option as they may have mobility or transportation challenges. Others noted the importance of meeting the consumers and community members where they are and attending already scheduled meetings. The current MHSA coordinator also expressed this is one of the most effective methods to receive feedback and has planned some meetings of this type for this planning year and plans to increase this in the future.

Stakeholders also provided feedback that they are unable to provide meaningful input into the plan as the plan is developed once it has been sent to them. These stakeholders further noted that there is no data to show why programs are being developed or continued. They would like to see the success and outcomes of the programs that were continued as well as the data that drove the decision to create new programs. While it may be time prohibitive to include this reporting for all programs within the feedback session, there are opportunities to share outcomes throughout a year and in formats other than annual plan updates and/or three-year Program and Expenditure reports.

It is important to note that the stakeholder feedback was limited to those who participated in meetings associated with the three-year Program and Expenditure plan, as well as historical information shared by county staff during interviews. Many stakeholders attended more than one meeting and the stakeholders included large numbers of providers or staff from other county agencies, in comparison to consumers. Unfortunately, the process under this review for gathering stakeholder feedback leveraged these stakeholder meetings (due to time constraints) to access community input. As such individuals who did not attend meetings, perhaps due to lack of outreach or access to notices, were not able to confirm these potential challenges to participation in the CPP.

Review of Plan

The three-year Plan appeared to be comprehensive and to address and incorporate public comments from previous stakeholder engagement. As an example, previous comments asked for more resources for early childhood mental health, and this seemed to be a priority in the current plan.

While the plan addresses that services are designed to impact those who are unserved, underserved and inappropriately served the Plan uses claims data and data on individuals served in MHSA programs and thus it may not fully identify those who are most "unserved".

The reading level and general composition of the information being provided did seem to be above a recommended level and this may have contributed to the lack of engagement or response from the consumer stakeholders in attendance. Balancing comprehension with the required content is likely a universal struggle for counties due to the complexities of the MHSA program, and in particular the financing component.

Findings

- The County of Orange CPP approach is currently in transition under new MHRS and MHSA leadership. Coming out of the COVID-19 pandemic allowed the County to resume in-person engagements and also consider and incorporate lessons learned of how to effectively use virtual settings to expand access to feedback.
- While a critique of historical approaches included a lack of engagement until much of the planning had already occurred, the current MHRS, MHSA and BHAB leadership have a vision of transforming the planning process to a continuous engagement activity.
- Stakeholders noted they can see the vision and direction, but it has not yet fully been realized. It is important to note the current MHSA coordinator has been in the position less than one year; much of which was dedicated to the current MHSA three-year Program and Expenditure Plan, thus at the point of this review there was insufficient time for these changes to have been fully realized or to fully measure their impact.

Recommendations

- Continue and expand plans to increase presence at regularly scheduled community meetings in locations and times when key stakeholders are already gathering to ensure ongoing opportunities for participation and input into planning,
- Examine communication and outreach process to ensure it effectively reaches stakeholders for whom English is not their primary language
- The presentation of the plan is comprehensive and provides an overview of the County's plans for the year. Consider adapting the presentation, or providing access to MHSA outcomes in other ways, to include a narrative for how the 3-year plan takes into account community needs and program impact. Making specific connections with the data used to inform the program adjustments or additions proposed could help increase a sense of engagement from stakeholders, including consumers and BHAB/BOS members.

MHSA Contracting and Contract Oversight

Along with their partnership with the Finance and Program Support Services office, MHRS leverages additional resources within the Orange County Health Care Agency (HCA) to execute required administrative functions for the MHSA program. The Procurement and Contract Services division develops, solicits, negotiates, and administers human service contracts for HCA divisions, including MHRS. HCA contract staff as well as MHRS staff reported a strong working relationship between the HCA contract office and MHRS to procure and execute contracts necessary to meet the goals in MHSA three-year plans. More specifically, staff collaborate to develop requests for proposals (RFPs) and facilitate provider contract monitoring meetings, reporting shared accountability for gathering and monitoring outcome and financial data to assure MHSA requirements associated with these areas are being met. While program management styles may differ, MHRS has standardized this process to create relative consistency in this approach. Feedback from staff indicated that having leadership within the procurement office with a provider background has also helped create a process focused on helping the programs succeed.

Contract Procurement

A timely, effective, and efficient procurement process is essential to carrying out the MHSA three-year plans due to the time constraints of the funding, and frequent need to expend additional dollars that are infused throughout the course of the funding cycle. It is estimated that approximately 30-40% of MHSA funded programs and services are contracted through community providers. The procurement process has multiple dependencies, some with designated timeframes, for contract execution including:

- Defining a scope of work, established provider qualifications, funding estimates, and reporting requirements defined by MHRS/MHSA program staff; and
- Incorporation of these elements within the county approved format; and
- Timely posting, while still observing required procurement timelines before closing response; and
- Staff available to review and score responses and select a vendor; and
- Negotiation of the contract with the selected vendor; and
- Approval of the contract by the BOS; and
- Contract execution, which often entails review and approval of final document by vendor prior to signing.

Each of these stages has timeframes associated with completion and the majority of staff interviewed reported the lengthy process, a common challenge for governmental entities, does contribute to some of the challenges with expending MHSA funds. This is especially true when the state releases additional funding, without prior indication of specific funding levels expected, within a specific three-year MHSA cycle; or when additional (non-MHSA) funding is released and directed at services or populations currently funded under county MHSA contracts, and reallocation of funds is required. Both scenarios can also trigger contract amendments, which contribute to the timelines. Staff estimated the timeframe associated for the BOS contract approval alone is six weeks. This is exacerbated by the fact the MHSA programs are on three-year cycles with the majority (estimated at 85%) coming up for renewal and

approval at the same time. County staff provide summaries in the form of Agenda Staff Reports (ASRs), to support review, however this does not eliminate the sheer volume of information that must be absorbed and retained. Staff reported efforts to improve efficiencies in the procurement process, with early success in reducing timeframes. Specifically, the procurement team is working to reduce the length of time for contracting (goal of 20 weeks) and are down to 25 weeks, though much of this time is waiting to get before the Board. Workforce issues for both the county and vendors responding to RFPs have impacted recent performance. One staff cited a two-year timeframe for new programs, from "idea to implementation," and stated this is not unique to Orange County but is in direct conflict with three-year MHSA program cycles.

Contract Oversight

Staff across components and programs reported that the primary contract monitoring activities are the regular meetings with providers to review financial and outcome data specific to contractual requirements. In addition, program evaluations and provider site visits occur annually. These collective meetings serve, at the individual contract, MHSA component, and overall MHSA program level, to routinely monitor the expenditure of funding against MHSA requirements as well as the associated outcomes. HMA reviewed a random sample of meeting agendas, meeting minutes, financial, and outcomes reporting documents across MHSA component areas. Based on the review of sample materials, meetings with contractors occur either monthly, bi-monthly, or quarterly. Staff indicated that they meet less frequently with providers with a demonstrated history of strong contract performance than with new vendors, or contracts for new programs and services. However, for one vendor on a quarterly meeting cycle, meeting minutes indicated a risk for exceeding budget for the year. In this case, action items were included in the meeting minutes to mitigate this risk, but meeting frequency was not changed. In general, agenda and meeting minutes included opportunities for the contracted providers to share updates on the programs, including process and outcome measures to date.

MHRS and HCA contract staff provided samples of updated financial reporting for the contracts that are being utilized within the meetings. These reports include year to date (YTD) financials on contract budget, budget revisions if applicable, current budget, remaining budget, YTD actual expenditures, remaining budget, and annual projection of where the expenditures would be at the end of the annual contract cycle. Actual and projected expenditures were documented by month for the contract year. Additional agenda items included updates related to the BHAB and/or BOS and any inquiries associated with the programs, MHRS administrative updates, applicable changes in staff on either the contractor or county side, and updates on issues related to programs. These issues included requests for funding, outcome and/or expenditure variance explanations, and other relevant updates.

HCA/MHRS staff reported utilizing a "progressive discipline" approach for contract performance issues, beginning with documenting challenges within these meetings and working with the provider to correct them. If problems are not corrected, they move to a more formal process. A tenured county employee indicated that in their decades of service, an estimated five (5) providers did not have contracts renewed due to poor performance. HMA requested examples of current action plans implemented with contracted providers, and at the writing of this report there were no active plans for CY22 but as

previously mentioned there were less formal corrective action activities outlined in the individual provider meeting minutes.

Workforce Challenges

At the time of this review, workforce challenges were consistently reported as a contributing factor in efficiently executing contracted elements of the MHSA program, and especially impactful to the procurement process. The contract office estimated they have been understaffed by ten (10) full-time equivalents (FTEs) over the past three years. In addition, MHRS staff indicated a current vacancy rate of 30%. The County faces challenges competing with other employers who can offer work from home options and staff reported losing potential candidates due to the prolonged hiring process. These staff vacancies result in existing staff balancing the aforementioned procurement activities in addition to other job responsibilities, naturally creating delays. It was also reported that workforce challenges are also contributing to low bidder response to MHSA RFPs. In some cases, the county has had no responses to an RFP, putting at risk the ability to successfully execute elements of the MHSA expenditure and spending plans, and/or spend additional funds unexpectedly appropriated during a three-year cycle. Staff indicated the county provider pool has decreased, with some providers negatively impacted by the pandemic and closing. When there is an open bid that does not receive a response, staff reported the bid timeline can be extended and that they also attempt outreach to potential providers within the bounds of fair contracting rules. Response to outreach confirmed that many providers are unable to expand existing or ramp-up new services due to lack of staff, in particular the time it takes to recruit, hire, and train staff is challenged by required (MHSA) timelines.

INN component opportunities, characterized as a short-term funding unless able to demonstrate positive outcomes, has some organizations hesitant to invest the time and resources to bid on and implement these projects, especially under the short demonstration cycles within MHSA. Recruitment of staff for these projects is also inhibited by current workforce shortages and exacerbated by the uncertainty of sustainable funding. The exception to these types of challenges are children and youth focused non-profits and community-based organizations, who remain in strong numbers, and this is reflected in the stronger response numbers to PEI component focused RFPs. This may also be due to the fact that some prevention programs leverage existing staff in programs, training these staff in evidence-based programs and approaches, rather than having to hire new staff to execute the scope of work. Examples include providing brief intervention training to teachers in schools or providing depression screening training to primary care staff.

Findings

- Strong partnerships exist between the MHRS/MHSA program staff and HCA contract and procurement staff to support MHSA contract management.
- While partnerships are strong, county workforce shortages have impacted timeliness of procurement and contracting activities, despite recent successful performance improvement initiatives.

- Implementation of new MHSA funded contracts within desired timelines is also challenged by the lengthy procurement and contracting steps, and this has added risk to timely contracting and expenditure of MHSA funds.
- Lack of vendor response to procurements has also increased risk to timely contracting and expenditure of MHSA funds.
- Tension is created by the requirement that the BOS provides approval of all contracts, and most contracts being up for renewal or execution at same time; this is a tremendous amount of review for BOS members in a short timeframe while managing significant pressure and intent to be thorough in the review.
- While corrective action plans are an existing tool for MHSA/MHSA contract monitoring, informal approaches through provider meetings are leveraged before formalizing action plans related to performance.

Recommendations

- To support thoughtful review and consumption of contract information, consider ways to spread contract renewals throughout fiscal years, including longer (than one FY) contract terms for established providers and programs; and consideration of thresholds for necessary review by BOS such as reviewing only renewals or amendments with new scopes of work, or above a reasonable dollar threshold.
- Conduct a time-study to confirm timeframes associated with various steps in the procurement and contracting process, as well as a review of county policies related to these activities to further identify human resources needed for timely execution.
- Create standardized processes for maintaining a pipeline of potential programs by component area for rapid implementation should unexpected funding occur.
- Consider contracting a portion of MHSA funds under Master Agreements, where a preferred list of bidders is pre-approved for bidding on specific services, reducing the content required for response, as well as review and scoring of those responses.
- The timeline for this review did not allow for a thorough review of contract monitoring documentation for all programs; consider a review of these processes to further ensure provider accountability and strengthen the ability to respond to inquiries from the BHAB and/or BOS. This should include formalizing the triggers and timelines associated with use of corrective action plans with providers to ensure standardization of application of this tool across programs, and inclusion with information shared with the BOS during contract renewal periods.
- While MHSA program timelines will continue to be a challenge, consider conducting a provider/vendor survey to inform an understanding of other barriers to provider network participation, and potential changes to procurement/contract processes (or other barriers) that would allow the county to expand the provider pool.

Fiscal Administration

The HCA Financial and Program Support Services team works directly with MHSA program leads providing budget, administrative and programmatic support in accordance with requirements established by the County Executive Office and Auditor-Controller. This includes assisting with MHSA contract oversite by providing financial reporting that assists in monitoring spenddown rates by funded programs as well as development of financial reporting for presentation to the BHAB, and inclusion in the 3-year Program and Expenditure Plan.

The finance team consists of 6 fiscal analysts who manage the operational aspects with the program managers. Three of those analysts are assigned to MHSA, with one assigned 100% to MHSA (the PEI Component); another whose majority of time is spent with MHSA (WET, CFTN, INN components) and the third is assigned 50% (CSS component). They manage the balances and provide updates to the CEO and BHAB. The analysts are trained on the regulations and complexities of MHSA.

There appears to be adequate fiscal controls in place to ensure MHSA money is spent according to the regulations and contract. The HCA fiscal team reports that moving the final budgeting decisions to the CEO office adds a beneficial level of oversight and allows for a stronger connection to the BHAB and Board of Supervisors regarding financial performance, allowing for the CEO office to manage questions and concerns that may come from the BHAB and Board of Supervisors.

Per 6.A.4.c of the County's contract with the State, the County must use local MHSA funds to pay for those portions of the mental health programs/services for children and adults for which there is no other source of funds available. However, according to some stakeholders, providers are not held accountable to optimize other funding streams, such as Medi-Cal. When other available funding streams are optimized, additional MHSA funds then may be available to increase access to services. Some stakeholders interviewed indicated the County had a significant audit finding under the Medi-Cal program and this has potentially contributed to a reported hesitancy to bill Medi-Cal and increases risk aversion. It was noted by an external stakeholder that Orange County's Medi-Cal billing is lower by comparison to other counties. However, differences in county demographics, local funding streams and other factors may contribute to differences and are not a clear indication of the potential scope of the issue.

There seems to be consistent tension within the County staff, BHAB, Board of Supervisors and other stakeholders as to how effectively MHSA funds are managed. Varied understandings and perceptions of the appropriate level of reserves are evident. Additionally, there seem to be many "urban myths" about past reversion and an ongoing risk of reversion. Some stakeholders believe that there has been reversion of MHSA funding back to the state. Concerns were also expressed that MHRS does not spend money quickly enough, creating a constant risk of reversion, with others reporting these concerns are merely a function of the MHSA funding cycle and lack of understanding that the funding is allocated to support services across multiple years, as opposed to spending as soon as possible.

Reserves

Because MHSA is funded through tax revenue on residents with incomes greater than or equal to $1,000,000, the funding level is inconsistent and cannot be predicted from year to year. Similarly, if tax

collection is delayed, there will be a subsequent delay to the County receiving notice of their projected funding amount (necessary for planning), as well as the allocation itself. As an example, due to the recent natural disasters impacting California, CFY22 tax filing is delayed, and the County will not be made aware of its MHSA funding until October. Periods of economic downturn can also negatively impact funding. To mitigate the risk to programs providing vital services, the MHSA regulations require that counties maintain a "Prudent Reserve," at a minimum level of 5% and a maximum level of 33%, of the average amount allocated to its CSS account over the previous 5 fiscal years.[10] While the CSS component represents the largest funding account, it is important to note that the reserve maximum does not take into account a percentage of total MHSA funding. Therefore, the other four component areas may be at higher risk for service and program reductions should budget shortfalls occur.

Beginning in FY17-18, the state further required, to assess and certify their prudent reserves every five years. The current assessment is to be included in the three-year Program and Expenditure Plans and include an assessment of the maximum allowable reserve amount as well as a county's actual current reserve amount. Due to the fluctuation in MHSA funding from the state that can occur, counties are permitted to reassess their prudent reserve level (based on current funding to CSS) and therefore their allowable maximum reserve level. Changes to these levels is subject to review and approval by the state.

A natural tension occurs between members of the MHSA team and other stakeholders between ensuring funding is adequate to avoid service disruptions, and the need to spend money to create additional access or expand programs and services. Some staff with significant tenure at the County recalled periods where the county faced bankruptcy and other periods of significant financial downturn. These memories have likely contributed to a conservative approach to maintaining reserves. While education on the requirements, including limits on reserves, may serve to alleviate some of this tension, questions and even frustration are likely to continue as advocates see unspent balances. However, there is a basic understanding of the concepts of reserves, including why the County of Orange may have higher amounts respective of smaller counties, which should be held by the BHAB and BOS. Additional and repeated training may be necessary for members to maintain an understanding of these complexities if they are not actively or professionally engaged in budget and finance activities. An elevated understanding of state controls on maximum reserve amounts may also serve to alleviate frustration associated with the balance. If the county faced a recession and downturn, how long could current levels of CSS funded services, which include essential services under Medicaid, be sustained on 5-33% of current funding amounts? The CEO finance team reports the new MHSA leadership seems to be effectively balancing the need to maintain reserves but also "get money out the door."

Reversion

With some exceptions, MHSA regulations require that funding under each of the component areas must be spent within the three-year cycle of a county's Program and Expenditure Plan. When these timeframes are not met the funding is at risk of reversion back to the state. Exceptions to this requirement are the encumbered funds under approved INN Project Plans, as these must be spent according to the approved timeframes, which may exceed the three-year planning cycle.

[10] This requirement is outlined in WIC 5847(b)(7).

There are also instances where MHSA funds can be transferred from one component area to another:

- A County may transfer funds from its CSS Account into its Prudent Reserve, CFTN Account, and/or WET Account;
- within each fiscal year, that transfer amount is limited to up to twenty (20) percent of the average amount of the total funds provided to the county over the previous five (5) fiscal years;
- Counties may not transfer funding from their prudent reserves into the CSS account in order to take advantage of this transfer opportunity for additional WET or CFTN funding; and
- Once transferred, the funding may not be transferred back to the CSS account.[11]

Additional requirements and assurances exist for these transfers, including approval by the BOS and the DHCS. It was clear during this review that concerns regarding potential reversion of MHSA funds are ongoing. County staff within multiple interviews acknowledged that risk for reversion, while variable by component, does exist. The common debate was not about the risk itself, but which elements of risk can be actively mitigated through administrative processes versus risk that is inherent to the program structure and less in the control of MHRS and their county peers, and as such, a somewhat constant variable in administering the program. The DHCS MHSA Fiscal Oversight website confirms the County of Orange has had one potential reversion, in SFY2010-2011, during the entire history of the program. Stakeholders interviewed, reported this potential reversion occurred when the state audited all counties, with multiple counties cited. In response the State permitted a grace period to avoid the reversions by spending down those funds. According to reporting posted by the state, approximately $8,201,476 in MHSA funding has been reverted by other counties across California since the inception of the MHSA program compared to The County of Oranges amount of $0.[12]. MHRS staff indicated that some stakeholder anxiety regarding reversion is fueled by a misunderstanding of financial reporting. Specifically, when individuals see balances in years one and two of the cycle, they assume the dollars are not being spent. However, these balances reflect the carry-over from year to year as they need to utilize the dollars to fund all three years of the plan cycle. Review of documents associated with contract monitoring indicate that fund balances are closely monitored on a monthly basis and when funds are not being spent down accordingly, this is addressed with providers.

Findings

- The County of Orange is compliant with current minimum reserve requirements and maximum limits
- The current reserves represent only a fraction of the current MHSA funding for essential services, however this context is not widely understood by behavioral health advocates
- The County of Orange MHSA program has not reverted funds back to the state since FY 2010-2011

[11] Welfare & Institutions Code § 5892, subds. (b), (f), (h)(1)
[12] The reversion report for all counties cited in this report is available at MHSA Funds Subject to Reversion Report October 2022 (ca.gov).

- While outside the scope of this review, interviews with stakeholders indicated the county may not be maximizing Medicaid funding for some CSS services provided to Medi-Cal enrollees

Recommendations

- Conduct an analysis of contract provider application of funding streams, such as Medi-Cal, to ensure the county is optimizing other available funding streams before applying MHSA funds
- Provide recurring education on MHSA funding cycles and history of reversion; Reversion of a County's MHSA funds is a matter of public record, include this historical information when sharing financials to ensure stakeholders have an accurate understanding of the reversion history.
- Provide continued education on Prudent Reserve funding; HCA clearly outlines the reserve calculation and maximum and available reserves in the 2020-2023 Plan, as is appropriate for the 5-year cycle. Include this information in publicly facing expenditure reports and presentations as a reminder to stakeholders of the current reserve level.
- Consider providing reserve information as an overall percentage of MHSA funding to provide context for the need for reserves.

Data Collection and Analytics

MHSA regulations require collecting data to monitor implementation and effectiveness of funded services and supports. Regulatory requirements govern reporting requirements (e.g., for Full-Service Partnerships (within CSS), INN programs and PEI programs, although counties retain flexibility in defining performance metrics based on the program objectives of MHSA programs funded. For many programs, aside from reporting on demographic information of populations served, performance metrics and other outcome requirements are not well-specified nor is reporting consistently enforced to support consistent, timely or accurate reporting. Staff identified several challenges to data collection, including the lack of robust data systems, inadequate data governance, and lack of meaningful performance metrics that "tell the whole story." Recommendations for supporting a transition to a data-driven organization are outlined below to support the use of data to inform decisions about resource allocation and MHSA programming.

Currently, the work of the Research and Outcomes Division is not well connected with the Quality and Management Division, which is focused on compliance. Given the push for performance metrics, opportunities for connections between the two divisions to drive quality improvement efforts should be explored. Performance metrics are being evolved over time to align more closely to metrics that the External Quality Review Organizations furnish to Medi-Cal, such as such as timeliness to access, referrals, dropout, and closed loop referrals.

In the long term, efforts to develop and align meaningful outcomes based on stakeholder input is critical. Standardized measures for BH outcomes that are consistent across California do not yet exist. Currently, the majority of programs focus on reporting outputs (e.g., units of services, number of clients

served, number of workshops delivered, etc.) and care processes, with very limited outcome measures. The lack of meaningful outcome measures in BH is a national issue. In recognition of this challenge, MHRS funded a BH System Transformation Innovation project focused aligning county legal, fiscal and regulatory requirement to increase BH care accessibility to all county residents by integrating private and public funding. The goal was to "create a contract template that includes performance and value-based metrics to improve quality of care." Community and provider stakeholders were aligned in recognizing the importance of having performance standards and values, and highlighted the limitations of existing measurement efforts, which are inconsistently tracked. Measures are perceived as being overly complex (e.g., Daily Living Activity) or overly simplistic (e.g., follow-up after emergency room visit for mental illness) and do not adequately capture the quality of care or meaningful outcomes. Given the significant challenges encountered in such an effort, dedicated resources with input from both national and local experts could be an important next step to address the barriers identified in making progress on creating community-informed and state/nationally aligned quality metrics for monitoring county efforts in delivering MH services.

To position for BH Payment Reform under CalAIM and the Governors' new vision for MHSA (including a proposal for MHSA to support housing and SUD), the role of data and quality metrics to inform value of care and existing program effectiveness become even more urgent for driving decisions around culling ineffective programs and allocation of MHSA funds. MHRS could consider various incentive programs to support and build provider capacity to transition to value and outcome-based care. As the County works towards an aligned set of quality metrics, several immediate opportunities exist to support more robust contracting to encourage provider accountability, create transparency, and inform resource allocations including management of struggling programs.

Data Systems

MHRS, like many counties, uses a variety of record management systems to track services delivered and outcomes. MHRS provided an inventory of data systems for review by HMA. County providers rely on Cerner as their electronic health record system, as well as a multitude of record management systems. The IRIS data platform is built on top of Cerner to query and aggregate data for reporting purposes. Data from contracted providers pose a particular challenge as they are submitted in a variety of formats (including Microsoft Access, Excel sheets or pdfs) because of variations in provider electronic health records and lack of standardized templates. Various staff interview noted that the effort required to wrangle data for reporting is highly time consuming, such that reports are typically produced just in time for presentations, but with limited time for staff to create a coherent narrative for various audiences. Multiple record management systems create significant challenges for streamlined and consistent reporting. The burden of reporting on providers leads to inconsistent and incomplete reporting of data needed to provide valid information about program effectiveness. To force more standardized data collection, MHRS is in the process of modernizing data systems, culling outdated tools (e.g., excel sheet or pdfs) and building an enterprise-wide data platform to collect and report out information.

Data Governance

Staff reported that efforts are underway to centralize research functions in MHRS under a Research and Outcomes Division. This Division will be responsible for building and sustaining robust reporting and data analytics capabilities to meet the growing expectation of MHRS being a data driven system of care. Research and Outcome activities were at one time combined with the MHSA Coordinator role and managed by one person. Consolidation of data expertise from across programs means that setting up effective structures for collaboration across Program, IT and Research will be critical to support more effective use of data. For example, program staff have expertise and knowledge about specific mandates that require data to assess program compliance. This organizational change supports the goal of building an enterprise data warehouse to streamline and standardize data collection, store, and organize data in diverse formats, provide convenient access and improve the speed at which data can be queried and analyzed. The goal is to create the necessary data infrastructure to allow systemwide use of data to drive planning and decision making, not just under the MHSA program. This new area will also consolidate and house data scientists and research analysts who were previously spread across each MHSA component. This consolidation of data expertise seeks to promote the creation of data pipelines and collaboration across MHSA and MHRS programs. Importantly, these disparate research units housed under each MHSA component will now be supervised by a Director with the requisite subject matter expertise.

Performance Metrics

HMA reviewed an inventory of data and performance metrics, provided by MHRS, that are currently used to assess provider/program impact or to hold providers accountable for service delivery. The INN component was not included in this workbook as these projects are variable and time-limited, and evaluations for these have been contracted out to the University of California, Irvine. Across the three MHSA components reviewed, CSS, PEI, and WET, required metrics typically focused on *unit of services* and *client or participant counts* (particularly for PEI and WET). Outcomes for PEI programs include variable outcome metrics typically and appropriately tied to specific PEI programs. PEI outcome metrics rely on participant-reported improvements from intake to follow-up. Assessment of program effectiveness is limited only to those participants who provide data at both time points, which staff have noted could be challenging. No benchmarks are used to gauge PEI program success.

By contrast, outcome metrics and benchmarks are more common among CSS programs. These metrics include performance measures and target benchmarks (e.g., >80% of clients with no psychiatric hospital stays for those in the Full-Service Partnership Program; <25% hospitalization rate from day after discharge through 60 days for those in the In-Home Crisis Stabilization and Crisis Residential Services). Brief synopses of outcomes/data are reported in the Draft MHSA Plan posted for public comment (MHSA Three Year Plan 2023_2026 Draft.pdf (ochealthinfo.com)). There appears to be variability in MHSA staff and other stakeholder perceptions about the utility of provider and program performance metrics, and this is reflected in the inconsistent use of metrics to monitor and track program effectiveness or the success of struggling programs' proposed solutions to improve care delivery. For example, the MHSA Three-year Plan draft included many program successes, but also included several examples of missed opportunities. COVID-related impacts on program participation were appropriately

noted in the draft MHSA Plan (e.g., COVID-related decrease in graduation rates in the Supported Employment Program), but corrective actions were not consistently described to support post-COVID era outreach, which may require more active efforts to shift consumer behaviors to achieve pre-COVID participation levels.

Within the CSS components, the Children and Youth Expansion Services program noted challenges with increased incidents of depression and anxiety, consistent with national trends. However, no benchmarks or targets were described for monitoring the effectiveness of proposed programs strategies for addressing the higher incidents of depression and anxiety. Similarly, failure to meet target benchmarks for moving clients to a lower level of care or exceeding average length of stay targets in short term residential therapeutic program (STRTP) and older adult recovery services (OAS) were noted. Detailed corrective action plans including continuous improvement initiatives tied to metrics, could be helpful to monitor continuous improvement efforts to optimize the use of effective, evidence-based strategies.

Monitoring of program efforts may also help illuminate external challenges that may limit the effectiveness of program strategies (e.g., gaps in community-based services or programs to allow for safe transitions). A theme across interviews was the concern that existing BH metrics (e.g., fewer hospitalizations) do not tell the full story. While program outputs in the form of units of services or numbers served are helpful to assess program implementation and reach, there was recognition of the need to create better metrics to more fully understand programs' impact and ability to meet the needs of the community.

Findings

Data Systems

- Due to the challenges with the utilization of multiple systems combined with varying levels of provider sophistication, the utility of data for informing MHSA programming priorities is currently limited.
- MHRS is in the process of updating and consolidating systems to simplify processes for both the county and their contracted providers

Data Governance

- Historically, MHRS has lacked a working centralized enterprise warehouse to collect and report data, leading to delays in reporting and higher than necessary administrative burden
- MHRS has not had the necessary allocation of human resources to support a data driven organization or thoughtful approaches to MHSA program evaluation

Performance Metrics

- MHRS is utilizing a variety of metric including utilization, process, and outcome measures
- MHRS/MHSA programs such as INN, appropriately rely on external, independent evaluators when formal assessment is inherent to the spirit of the component-such as demonstrating a promising practice without current evidence

- Metrics are not always presented within a broader context which would better tell the story of programs' impact on populations served
- There is appropriate variability in the metrics used, however benchmarks and targets are not always explicitly included in reporting, leaving out meaningful details that highlight successful achievement of contract expectations
- Programs are not consistently using performance metric reporting to monitor corrective action plans or progress on actions being taken to improve program/provider performance
- There is a need for alignment, when possible, of core performance metrics, by the county, with state requirements to reduce burden and pave the way to value based care.

Recommendations

Data Systems

- Consolidate data systems to reduce the number of different places programs and providers need to log into for data collection and reporting
- Phase out outdated Microsoft products and migrate contracted providers into secure systems that are interoperable and allows providers to push data from their system to MHRS systems and avoid double entry of data
- Consolidate and migrate to a small set of secure data systems to allow for ready audits and monitoring of data quality (both in terms of quantity as well as quality of data submitted).
- Incorporate modern data tools (e.g., mobile friendly surveys) to facilitate timely and consistent data collection and encourage data collection at the point of care such as client experience of care or client reported outcomes.

Data Governance

- Develop a governance structure to support coordination and collaboration across MHRS units to optimize SME
- Program staff should work together with IT and research to develop solutions (such as working with IT to select data tools and research to identify performance or outcome metrics) that encourage more robust collection of data that are usable for informing program decisions.
- Expand Workforce Capacity to support an Enterprise-Wide Data System: The aspiration to become a data-drive organization is contingent on having the right capabilities and resources to support the execution of modernization efforts described above. Rapid evolution of technology and data analytic capabilities to use modern data systems to analyze and extract needed data are critical. This means creating up to date job descriptions that can attract and pay adequately for specific technical expertise (IT and data) to support the necessary changes across MHRS.

Performance Metrics

- Need for development of meaningful and standardized metrics that go beyond outputs to process and outcome measures
- Create bundles of metrics that allow a fuller understanding of program effectiveness. For example, bundles of metrics could be used to collectively track ***program capacity to meet***

community needs (e.g., through process measures such as timely access to the right level of care, fewer ED visits or hospitalizations,), provide ***high quality care*** (e.g., through the delivery of evidence-based treatments and services), and demonstrate impact through ***meaningful outcomes*** (e.g., reducing treatment dropouts, proportion of clients stepping down to a lower level of care due to improved functioning, proportion of clients in stable housing, engaged in employment or education). As appropriate, program effectiveness, could also be monitored for ***community impact through surveillance efforts*** (e.g., fewer suicides, drug overdose events, etc.).

- Allow flexibility around measuring additional outcomes tied to program objectives to help address concerns around a slate of metrics that better tells the full story of program effectiveness.
- Require continuous improvement initiatives tied to metrics to monitor continuous improvement efforts to optimize use of effective, evidence-based strategies and abandonment of ineffective strategies or identification of external challenges that may limit program effectiveness.
- Opportunities exist to partner with the state to align metric and reduce provider burden, county staff should remain active in these efforts
- Consider strengthening contractual requirements that incentivize the reporting of key performance metrics in areas where consensus exists (e.g., access to care, care coordination) and withhold payments for failing to submit data for a target threshold or institute corrective action plans.
- As providers become more accustomed and equipped to report data consistently, the county could shift from paying for reporting to paying for performance; over time the county could adjusting performance metrics and benchmarks to encourage quality improvements as part of a more robust accountability framework.
- Create methods for data sharing and promoting transparency on key quality indicators to facilitate aligned efforts towards improving care access and quality, working towards public reporting (e.g., dashboards) as data reporting becomes more consistent, complete, and accurate.

Conclusion

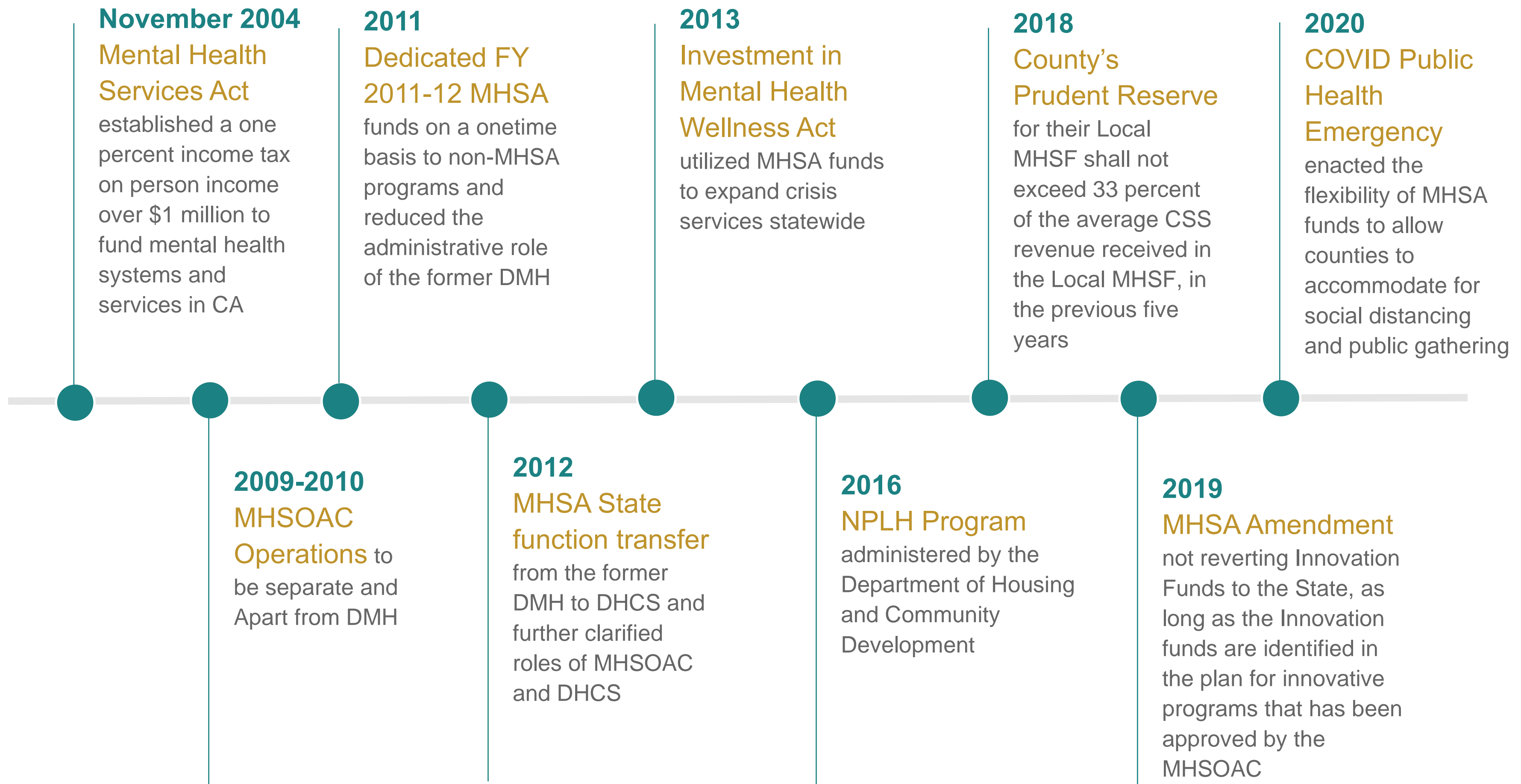
The MHSA program has provided counties with significant funding for their mental health systems. However, this funding comes with significant requirements and regulations that have changed over time. This review of the County of Orange MHSA program administration finds that, despite ongoing impacts from the pandemic and resulting workforce shortages, staff are maintaining compliance with these requirements. New leadership at MHSA has implemented changes associated with the CPP, with positive feedback from stakeholders. Other changes, supported by a reorganization plan, address some of the opportunities outlined in this report. While there was evidence of strained relationships in recent past, significant efforts to educate stakeholders on their respective roles and responsibilities as partners in the governance and planning of the three-year Program and Expenditure Plans has begun to demonstrate a positive impact. Efforts should continue to find ways to leverage most efficiently the existing, albeit limited staff, to implement MHSA plans in a timely fashion, avoiding reversion of funds at

a time where needs have increased. Plans to transition to a data driven organization are underway and should be adequately resourced to support implementation, as meaningful data collection and reporting remains one of the programs largest challenges.

Acknowledgements

The HMA team would like to extend our sincerest gratitude to the dedicated County Stakeholders, MHRS, MHSA, and HCA staff, along with the County of Orange Executive Leadership team, for their support, responsiveness, and collaboration during this MHSA program review.

Appendix A: MHSA Timeline



MHSA Detailed Timeline

November 2004: California voters passed Proposition 63 (the Mental Health Services Act or MHSA). MHSA established a one percent income tax on personal income over $1 million for the purpose of funding mental health systems and services in California. In an effort to effectively support the mental health system, the Act creates a broad continuum of prevention, early intervention, innovative programs, services, and infrastructure, technology, and training elements.

2009-2010: Chapter 20, Statutes of 2009-10 3rd Ex. Sess. (AB 5) amended W&I Sections 5845, 5846, and 5847. This law clarified that MHSOAC shall administer its operations separate and apart from the former DMH. Approval process for county plans and updates was streamlined and timeframes established for the former DMH and MHSOAC to review and/or approve plans.

2011: Chapter 5, Statutes of 2011 (AB 100) amended W&I Sections 5813.5, 5846, 5847, 5890, 5891, 5892, and 5898. This law dedicated FY 2011-12 MHSA funds on a onetime basis to non-MHSA programs and reduced the administrative role of the former DMH. To assist counties in accessing funds without delay, Section 5891 was amended to direct the State Controller to continuously distribute, on a monthly basis, MHSA funds to each county's Local MHSF.

2012: Chapter 23, Statutes of 2012 (AB 1467) amended W&I Sections 5840, 5845, 5846, 5847, 5848, 5890, 5891, 5892, 5897, and 5898. Provisions in AB 1467 transferred the remaining state MHSA functions from the former DMH to DHCS and further clarified roles of MHSOAC and DHCS. Section 5847 was amended to provide county board of supervisors with the authority to adopt plans and/or updates provided the county comply with various laws such as Sections 5847, 5848, and 5892. In addition, the bill amended the stakeholder process counties are to use when developing their three-year program and expenditure plan and annual updates.

2013: Chapter 34, Statutes of 2013 (SB 82), known as the Investment in Mental Health Wellness Act of 2013, utilized MHSA funds to expand crisis services statewide. This bill also restored MHSA state administration from 3.5 percent to 5 percent.

2016: Chapter 43, Statutes of 2016 (AB 1618) established the NPLH Program that is administered by the Department of Housing and Community Development. This bill also requires DHCS to conduct program reviews of county performance contracts to determine compliance; post the county MHSA three-year program and expenditure plans, summary of performance outcomes reports and MHSA revenue and expenditure reports; and allows DHCS to withhold MHSA funding from counties that are not submitting expenditure reports timely.

2017: Chapter 38, Statutes of 2017 (AB 114) provided that funds subject to reversion as of July 1, 2017, were deemed reverted and returned to the county of origin for the originally intended purpose. This bill also increased the time that small counties (less than 200,000) have to expend MHSA funds from 3 years to 5 years, and provided that the reversion period for INN funding begins when MHSOAC approves the INN project.

2018: Chapter 328, Statues of 2018 (SB 192) amended W&I Sections 5892 and 5892.1. This bill clarified that a county's prudent reserve for their Local MHSF shall not exceed 33 percent of the average CSS revenue received in the Local MHSF, in the previous five years. This bill required counties to reassess the maximum amount of the prudent reserve every five years and to certify the reassessment as part of its Three-Year Program and Expenditure Plan or annual update. This bill also established the Reversion Account within the fund, and required MHSA funds reverting from the counties, and the interest accrued on those funds, be placed in the Reversion Account.

2019: Chapter 26, Statutes of 2019 (SB 79) amended W&I Sections 5845, 5892 and 5892.1. This bill amended the MHSA by not reverting Innovation Funds to the State, as long as the Innovation funds are identified in the plan for innovative programs that has been approved by the MHSOAC. The Innovation funds are encumbered under the terms of the approved project or plan, including amendments approved by the MHSOAC, or until three years after the date of approval, or five years for a county with a population of less than 200,000, whichever is later.

2020: COVID Public Health Emergency—Chapter 13, Statutes of 2020 (AB 81) amended W&I Sections, 5847 and 5892. This bill enacts the flexibility of MHSA funds to allow counties to accommodate for social distancing and public gathering. This bill amended the timeframe for counties to submit their Three-Year Program and Expenditure plan, Plan or Annual Update for Fiscal Year (FY) 2020-21. This bill allowed counties to transfer Prudent Reserve to CSS and PEI components to meet local needs for FY 2020-21. This bill also allowed more flexibility for counties to allocate their MHSA funds and allowed counties to determine the allocation percentage for CSS programs for FY 2020-21. This bill also extended the reversion date for MHSA funds, including AB 114 funds, and any interest accruing on those funds from July 1, 2019, and July 1, 2020, to July 1, 2021.

Appendix B: Interviews

Dawn Smith, Director, Children, Youth and Prevention

Linda Molina, Director, Adult and Recovery Services

Ian Kemmer, Director, Authority and Quality Improvement Services (AQIS)

Flor Youseflian-Tehrani, Administrative Manager I, MHSA Innovation Projects

Brad Hutchins, Administrative Manager I, MHSA Coordination

Mark Lawrenz, Division Manager – Children, Youth and Prevention (PEI)

Bhuvana Rao, Program Manager, Suicide Prevention

Vanessa Thomas, Division Manager, Adult/Older Adult, Outpatient Services

Diane Holley, Division Manager, Adult/Older Adult Special Services

Teresa Renteria, Program Manager, MHSA Training Services

Anthony Le, Finance Manager, HCA MHRS

Julia Rinaldi, CEO Office, Finance

Clayton Chau, Agency Director, OC Health Care Agency

Karyl Dupee, Family Member, BHAB

Alan Albright, Chair, BHAB

Juan Corral, Division Manager, Procurement & Contract Services, OC Health Care Agency

Appendix C: Documents Reviewed

Background

- MHSA Historical Information
- Current Organization Chart
- Proposed Organization Chart
- MHSA Behavioral Health Advisory Board Community Program Planning FY 2022-2023
- Newly Updated Behavioral Health Advisory Board (BHAB) by-laws
- Mental Health Board by-laws (prior to merger)
- Substance Abuse Board by-laws (prior to merger)
- DHCS MHSA Performance Review Reports 2019 and 2022
- Orange County Plan of Correction 2019
- Capacity Assessment - UCSD Needs/gap analysis
- DHCS MHSA Performance Review Plans of Correction

Contracts

- Current MHSA contract/agreement between state and County of Orange
- MHSA provider contract boilerplate

Strategic Plan Documents

- MHSA Three Year Plan 2023-2026
- BHAB MHSA Update Presentation
- MHSA 2022 Plan Public Comment
- OC PADs INN Project Info Sheet
- Reorganization Memo

Financial Documents

- MHSA Revenue and Expenditure Reports
- FY 2022-2023 Plan Update
- California Health Policy Strategies OC MHSA Performance Audit—Review of Finances, Decision Making & Contracting: October 2018
    - Appendix 1: Summary of Mental Health Services Act Funding
    - Appendix 2: Orange County MHSA Program Financial Summaries by General Service Area
    - Appendix 3 and 4: Key Indicators for Orange County
- Prudent Reserve Calculation and Assessment FY 2018-2019
- Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report: FY 2019-2020
- Summary of Mental Health Services Act Funds: Projected with Actuals through January FY 2022-23
- MHSA Fund-Fiscal Update—February 2023 Presentation by CEO Budget

Policies and Procedures

- DHCS Behavioral Health Information Notice No. 20-057—January 2021
- DHCS Behavioral Health Information Notice No. 22-001—January 2022
- DHCS MHSA Fact Sheet: Homelessness
- DHCS MHSA Fact Sheet: Support Individuals Criminal Justice System
- MHSA Three Year Plan and Annual Update Template

Stakeholder Engagement

- Stakeholder Survey Reports
- Public Comment (written and oral) Summaries
- OC HCA Responses to Substantive Public Comments on the MHSA Three-Year Program and Expenditure Plan for FY 2020-21 to FY 2022-23: Comments and Responses Organized by Topic
- Mental Health & Recovery Services (MHRS) – Reorganization Proposal
- Orange County MHSA Community Feedback Survey Report—January 2020
- MHSA Proposed Stakeholder Engagement Process
- MHSA Innovation Project Update—Behavioral Health System Transformation Part II: OC Navigator
- MHRS Update to BHAB for November 2022
- MHRS Update to BHAB for January 2023
- Copies of Notices for Public Comment on MHSA related activities
- Reorganization Proposal
- Overview of Draft MHSA Three Year Program and Expenditure Plan FY 2023/23 through 2025/26

Current metrics, dashboards, and reports

- Provider metrics - MHSA
- Performance reports - MHSA
- PADS Evaluation report
- INN Evaluation Reports
- EP LHCN Evaluation Report
- Help@Hand Evaluation Reports
- MHSA Annual Reports
- MHRS Program Data Systems

Other

- Orange County Mental Health Needs and Gap Analysis
- 2023 BHAB Committee Liaison List
- MHSA Act CPP Overview 2022/23 BHAB
- OC BHAB 2023 Action Plan
- Quality Division Monitoring and Auditing Documents

Appendix D—Stakeholder Engagement Meetings Attended

Virtual Meetings

- March 13, 2023: 3:30 PM to 5:00 PM
- March 15, 2023: 9:00 AM to 10:30 AM
- March 20, 2023: 1:00 PM to 2:30 PM
- March 23, 2023: 5:00 PM to 6:30 PM
- March 27, 2023: 3:00 PM to 4:30 PM
- March 30, 2023: 9:00 AM to 10:30 AM
- April 3, 2023: 2:30 PM to 4:00 PM
- April 6, 2023: 9:00 AM to 10:30 AM
- April 10, 2023: 11:00 AM to 12:30 PM

In-Person Meeting

- April 12, 2023: 2:00 PM to 4:00 PM