



DRAFT

INNOVATION PROJECT PROPOSAL

EATING DISORDER INTENSIVE OUTPATIENT AND TRAINING PROGRAM

***"Do you know the last time I sat down with my family and enjoyed a meal?
I want to be able to do that." – Unknown***

Because eating disorders thrive in secrecy, those suffering often do not seek care. It is imperative that we, as clinicians, screen for and provide access to treatment that is culturally competent and informed to those in need.

Eating Disorders in Minority and Marginalized Populates, 8-1-22, Jennifer Leah Goetz, MD

Each underserved group has its own challenges – treatment, diagnosis, and varied EDs, but as a group, the challenge remains that Eating Disorders are neither a widely recognized illness nor commonly understood within the respective communities. We aim to have a knowledge campaign that combats this.

**INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE**

COMPLETE APPLICATION CHECKLIST
<p>Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:</p>
<p><input type="checkbox"/> Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors.</p> <p><i>(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)</i></p>
<p><input type="checkbox"/> Local Mental Health Board Approval Approval Date: <u>Scheduled presentation</u> <u>January 3, 2024</u></p>
<p><input type="checkbox"/> Completed 30-day public comment period Comment Period: <u>November – December,</u> <u>2023</u></p>
<p><input type="checkbox"/> BOS approval date Approval Date: <u>_TBD_____</u></p> <p>If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: <u>March/April 2024</u></p> <p><i>Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.</i></p>
<p>Desired Presentation Date for Commission: <u>February 22, 2024</u></p> <p><i>Note: Date requested above is not guaranteed until MHSOAC staff verifies <u>all requirements</u> have been met.</i></p>

County Name: Riverside County

Date submitted: January XX, 2024

Project Title: EATING DISORDER INTENSIVE OUTPATIENT AND TRAINING PROGRAM

Total amount requested: 40 million (40,000,000)

Duration of project: Five (5) Years

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that “the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports”. As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- Applies a promising community-driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person’s living situation while also providing supportive services on-site

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- Increases access to mental health services to underserved groups
- Increases the quality of mental health services, including measured outcomes

- Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

PRIMARY PROBLEM

The primary problem the proposed innovation plan addresses is the lack of an effective and integrated treatment approach for eating disorders (ED) in the safety-net County behavioral health system.

In the highly privatized eating disorder treatment arena, research reflects that community-centered healthcare programs with expertise in eating disorders are few and far between in the United States. This makes it difficult for those on public insurance and those who are uninsured to access ED care. (Eating Disorders in Minority and Marginalized Populates, 8-1-22, Jennifer Leah Goetz, MD)

Eating disorders have the second highest mortality rate of all mental health disorders, surpassed only by opioid addiction.¹ Treating eating disorders in the RUHS-BH outpatient system of care has been challenging for many reasons. One particularly difficult problem has been the lack of a full continuum of care for eating disorders. Currently eating disorder clients have only one level of care available in the RUHS-BH County system, outpatient services with trained Eating Disorder staff. When acute inpatient hospitalization is needed, the managed care and mental health plan split the cost and step-down clients to the County system-of-care outpatient services at hospital discharge. An eating disorder Intensive Outpatient Program (ED IOP) which functions as a day treatment program is a level of care not currently available within the County system.

Additional challenges with providing eating disorder services have included; 1) difficulty coordinating behavioral health care with primary medical care; 2) the lack of integrated ED training for psychiatrists and physicians; 3) the lack of eating disorder training that incorporates effective eating disorder practices for diverse groups, 4) a lack of knowledge on how to best work with families from diverse backgrounds to increase engagement and follow through with treatment recommendations, and 5) a lack of knowledge of eating disorders and treatment options in diverse and underserved communities.

As the County began to train treatment staff in eating disorder services and began treating clients, challenges in the clinic setting became apparent. The need for a model of practice that integrated behavioral health care and medical care to truly create collaborative care and effective communication between the complementary care systems became apparent. The treatment staff in the County who provide services for individuals with eating disorders discovered that their services were disconnected from the necessary medical services required for their complex clients. The existing levels of care need

to be improved to provide a complete continuum of care. When clients needed to step down from the hospital to a lower level of care the currently available outpatient services did not provide sufficient intensity. When a client was in outpatient services and needed more intensive services the only option for a step-up to a higher level of care was a hospitalization.

The problem of coordination of care with primary medical care is multifaceted. Trained eating disorder County staff have shared the challenges outpatient programs face when attempting to communicate and access medical care for their clients with eating disorders. Some of the most challenging areas were access to timely communication with their client's primary care doctor, and a lack of effective care coordination to ensure the ED staff's observations are taken seriously when they request a medical evaluation for their clients. This problem is further compounded when the client may not meet the criteria for an acute hospitalization but outpatient services alone are not sufficient to meet the treatment needs. While RUHS-BH has an outpatient ED treatment program, we must send our more severe consumers to outside Intensive Outpatient Programs as we currently do not offer this level of care. Unfortunately, many of the programs are full and have a long waiting list. Our belief is that by also providing care at the intensive outpatient level, the consumers will have timely access to a broader continuum of care and therefore mitigate the need for an even higher level of care. Having the IOP as part of the continuum will also allow for smoother transitions of care within the system and allow for the consumer's ED practitioners to remain involved in their care.

A large proportion of youth in Riverside County are Medi-Cal beneficiaries due to low income and poverty⁷. Therefore, an overriding importance is the need for direct access to an affordable IOP. Counties and local governments may provide funding or support for mental health and eating disorder treatment programs through partnerships with healthcare providers, which is what Riverside County currently does for more intensive care; however, it's not common for counties to directly administer intensive outpatient programs (IOPs) for eating disorders. Eating disorder treatment programs, including IOPs, are often provided by private mental health facilities or specialized eating disorder treatment centers. The uniqueness of providing ED IOP care through the County challenges the traditional IOP privatized model. Examining the differences and needs of a county-run IOP is imperative as we look to the future to incorporate this model into our and hopefully other county systems.

Another challenge associated with medical care coordination relates to training needs for primary care doctors and psychiatrists. Psychiatrists, during residency, may have very limited exposure to patients with eating disorders, and training for primary care doctors in eating disorders is similarly limited. A recent research article on the topic found a serious lack of training about eating disorders among doctors is contributing to avoidable deaths². The authors noted that training on the subject of eating disorders is limited to "just a few hours". Other studies have also noted that medical students receive a limited amount of training on eating disorders. This lack of in-depth training on eating disorders is concerning given that eating disorders are mental illnesses with a high mortality rate². A recent NIH qualitative study focused on identifying the learning needs and challenges of physicians when caring for patients with EDs. The study authors reported four main themes including improving communication when treating a patient with ED; more effective screening and diagnosis in primary care practice; management strategies when waiting for more intensive treatment availability; and distress experienced by physicians when trying to manage access to specialty eating disorder treatment³. Adding a culture-centered perspective inclusive of underrepresented communities intensifies the physician learning needs and challenges. In addition, a recent survey of emergency medicine physicians and residents found only 1.9% completed a rotation on eating disorders during residency⁴. The survey also found that 93% were unfamiliar with the American Psychiatric Association's Practice Guideline for the

Treatment of Patients with Eating Disorders, and 95% were unfamiliar with the publication “Emergency Department Management of Patients with Eating Disorders” by Trent et al.⁴ The majority surveyed were not aware of resources for patients with eating disorders including community resources, such as support groups, local treatment programs, and the National Eating Disorders Association. Additionally, 85% of the physicians surveyed indicated they wanted more education on the assessment of patients with eating disorders in the Emergency Department⁴. This need mirrors Riverside County outpatient ED clinicians expressed challenges with emergency medical response when they have referred clients to a local emergency department for their medical needs associated with their eating disorder.

Intertwined with the educational needs of medical staff are diagnosis and treatment issues for diverse cultural groups. Any training utilized needs to take into account the cultural groups in Riverside County and the literature on the needs and issues of these diverse groups. Studies have shown despite similar rates of eating disorders among non-Hispanic Whites, Hispanics, African-Americans, and Asians in the United States, people of color are significantly less likely to receive help for their eating issues.⁵ Studies have found black teenagers are 50% more likely than White teenagers to exhibit bulimic behavior, such as bingeing and purging.⁵ Another study showed when presented with identical case studies demonstrating disordered eating symptoms in White, Hispanic, and African-American women, clinicians were asked to identify if the woman’s eating behavior was problematic. 44% identified the white woman’s behavior as problematic; 41% identified the Hispanic woman’s behavior as problematic, and only 17% identified the black woman’s behavior as problematic. The clinicians were also less likely to recommend that the African American woman should receive professional help.⁶ Implicit biases and lack of awareness play out across both medical and behavioral health settings; one of the goals of this proposal is for the training content developed to include cultural considerations in diagnosis, treatment, and daily interactions.

Many in marginalized communities do not access care due to not fitting the cultural stereotype and fearing that others may not take their illness seriously. (Page 2, *Eating Disorders in Minority and Marginalized Populates*, 8-1-22, Jennifer Leah Goetz, MD).

Another problem the project will address is focused on family support and education. County clinicians providing eating disorder treatment have found that parent/caregiver and family involvement can be challenging and can negatively impact continued engagement in treatment and ultimately client outcomes. Families have limited knowledge about eating disorders and the impact on the client’s health and may not believe the eating disorder is a problem. Reducing stigma among family members can be particularly challenging. Often parents/caregivers can minimize the eating disorder and may disengage from treatment services prematurely. Cultural needs can also play a role in seeking and continuing treatment. Culturally tailored family education and support are needed. Spanish language treatment and resources for consumers and their families must also be offered with the Riverside County youth population at 59% Hispanic/Latino and many speaking only Spanish or speaking English less than very well⁷.

The gap that exists in the literature regarding culturally competent treatments for eating disorders, along with client and family cultural barriers that may adversely impact understanding, acceptance, and support of eating disorders treatment, supports the need for additional education for not only the

medical community but the community-at-large, including schools where educational programming can be shared with the target age group and their family, and in partnership with Community-Based Organizations (CBOs) already doing work there. Diverse and underserved communities must also be made aware of the potential need and availability of eating disorder treatment and services. The effectiveness of the IOP for the entire Riverside County community ensures increased awareness and understanding of EDs and treatment opportunities. The project offers the opportunity to learn about a more culture-centered ED IOP approach and to then share this information with the medical, behavioral health, and eating disorder communities through professional conferences, meetings, and discussions.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensure the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

This proposed Innovation plan is focused on developing system-wide best practices for establishing an eating disorder IOP program in a County public mental health system. The proposed Innovation project will add to the RUHS-BH continuum of care for Eating Disorder treatment by establishing an Eating Disorder Intensive Outpatient Program (ED-IOP). Establishing an ED-IOP program will provide the opportunity to learn how to operate a complex higher-level of care in a County system while increasing access to high-quality eating disorder services designed to meet the treatment needs of Medi-Cal beneficiaries and uninsured youth and honor the diversity of our community. The ED IOP program will serve three functions. First, it will provide IOP level of services for individuals with eating disorder issues. Currently, there is an insufficient number of IOP programs to accommodate the needs of consumers needing services, with none offered through the county system of care. There is often a waitlist to get into an eating disorder IOP. Second, the eating disorder IOP program will serve as a hub for eating disorder training for county staff, contract providers, community educators, and medical practitioners. Creating a training structure within the IOP program, will break down silos and bring professionals that work with eating disorder populations together. This will lead to better coordination, collaboration, and treatment for consumers. Third, the IOP program will be a center for outreach and education for community and family members to reduce stigma, increase knowledge, and provide early treatment to individuals with eating disorder issues. Lastly, the overarching diversity, equity, and inclusion umbrella incorporating a culture-centered care approach will integrate cultural knowledge, awareness, and understanding into service delivery and information sharing to the three functions of the IOP program.

The proposed Eating Disorder Intensive Outpatient Program (ED-IOP) will serve adolescents ages 12 to 18 years old with eating disorder diagnosis-related issues requiring a higher level of care services, and who meet certain criteria. Individuals in the ED IOP program will be medically stable to the extent they don't need intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests, have no intent or plan to harm self, are at 80% or greater body weight, and have fair motivation to recover including having some insight, and ability to control obsessive thoughts. In addition, individuals in the IOP program can reduce purging behaviors in non-structured settings and have adequate family or caregiver support who live nearby. ED IOP referrals will be from outpatient programs or county contract provider agencies with eating disorder consumers needing step-up services to an IOP program or from

local managed health plans (IEHP, Molina, or Kaiser) with Medi-Cal members stepping down from eating disorder partial hospitalization programs (PHP). Referrals will be screened to ensure consumers meet the criteria eligibility before enrollment in the ED IOP program.

The ED IOP program will have a ratio of 1 Clinical Therapist to every 4 consumers. Each consumer will start out services 3 days a week for 6 hours a day on Monday, Wednesday, and Thursday and titrate down as appropriate. It is expected ED IOP consumers will be in the program for up to 6 months but no longer than 9 months. Services will include experiential group, individual and group therapy, crisis stabilization, and various milieus to address eating disorder symptoms.

In the intake process, the Clinical Therapist will conduct a thorough clinical assessment to get psychosocial history, family history, school history, and relevant information to develop a robust treatment plan that will include the services of the primary care Physician, Psychiatrist, Dietitians, Case Workers, and paraprofessionals like Transitional Age Youth (TAY) Peer Support Specialists and Parent Partners. ED IOP consumers will also receive psychological testing by a Staff Psychologist for the purpose of gaining insight into the person's behavior and psychological makeup to identify strengths and weaknesses related to cognition and emotional reactivity that could lead to a more effective individual eating disorder treatment milieu for the consumer. Unlike other eating disorder IOP programs, the RUHS-BH ED IOP program will have the added benefit of Family Medicine and Psychiatry residents working in the program to increase coordination and collaboration between behavioral health and primary care. Family Medicine Residents will provide regular ongoing medical monitoring and address any medical issues that might come up for consumers onsite. Consumers will receive regular physical examinations, routine medical consultations, and monitoring of their eating disorder and address any medical complications associated with their eating disorder. The primary care provider will work closely with the clinical team and psychiatry resident who will conduct psychiatric evaluation to assess for any comorbid mood disorder that may require psychopharmacological treatment and ongoing monitoring and adjustment of medications. Having Family Medicine and Psychiatry Residents onsite will expedite the process of getting ED IOP Consumers to emergency room or higher level of services, if needed. Addressing the communication and coordination challenges that can lead to delays in getting consumers with eating disorders into the right level of care.

The ED IOP treatment milieu will focus on creating an emotionally and physically safe environment for consumers to address their eating disorder symptoms. This includes recognition of and attention to cultural variables that may exist. The consumer and staff will practice mutual respect and open communication to enhance the consumer's self-esteem, healthy boundaries, and healthy relationships with people and food. When it comes to learning about food, the Clinical Dietitian and Dietitian Technician will; provide ongoing assessment and monitoring of the consumer's food intake, identify barriers to feeding or eating difficulties, assess for potential nutrition deficiencies, and provide recommendations as needed. The Dietitian and Dietitian Technician will also lead cooking demonstrations, create meal plans, and educate consumers and their support system on healthy foods. They will also be available to consult with outpatient programs and contract providers with eating disorder consumers. Currently, connecting outpatient eating disorder consumers to Dietitian services is difficult as Dietitians or Dietitian Techs are not readily available through managed care partners.

ED IOP treatment will occur on Monday, Wednesday, and Thursday. On Tuesdays and Fridays, when consumers are not engaged in primary milieu services for formal IOP services, IOP staff will focus their attention on training physicians and other department personnel. They will also spend time educating the public and doing outreach to increase awareness of eating disorders. For ED IOP consumers needing

additional services outside the three days of IOP services, staff will use these two days to provide individual therapy, family therapy, parenting groups, and individual home-based services (IHBS) for clients and families at home or in the community.

Educating primary physicians and department staff on eating disorders will improve collaboration, coordination, and a general increase in knowledge of how to work with the eating disorder population. ED IOP education specialists will take the lead in planning and developing formal and informal training for doctors, medical residents, and interns connected to the community health centers (CHCs). The training will occur regularly throughout the year addressing treatment, diagnosis, coordination of care, and ongoing collaboration on eating disorder cases. Doctors, department staff, and contract providers with eating disorder consumers will have the opportunity to consult the ED IOP program regarding treatment options for their eating disorder consumers and coordinate stepping up to ED IOP or stepping down from ED IOP services as needed.

The eating disorder IOP Education Specialist will also take the lead in working to educate the public and community members to bring awareness on eating disorder topics and reduce the stigma of eating disorders. They will work to develop and create information materials and work with Promotores groups and department Community Cultural Liaisons (CCLs) targeting underserved populations. Targeted education and outreach to these communities promote early diagnosis and treatment of eating disorders. Early intervention will mean people will have access to help when their eating disorder can be managed at an outpatient level of service versus beyond.

The eating disorder IOP staff will also focus on providing individual follow-up treatment for the consumer and their family in the form of additional support and services. Clinical Therapists and the Substance Abuse Counselor will provide individual therapy, family therapy, and substance abuse-related counseling. Paraprofessional staff will use Tuesday and Friday to provide intensive home-based services at the client's home or community to focus on skills building and activities the client and family need to promote wellness. Parent Partners will conduct parent groups and work closely with parents on ways to motivate and encourage their children to address issues that get in the way of their child's eating disorder progress. Parent Partners or Case Managers will take the lead in creating and scheduling family team meetings (CFT) and intensive case management (ICC) for consumers in the ED IOP program. CFT and ICC are important to keep all those involved in the ED IOP consumer's life aware and involved with treatment and treatment planning. The additional services provided by the paraprofessional outside the IOP treatment days are not provided in other ED IOP programs.

All ED IOP staff will be trained in or familiar with Family Based Therapy (FBT) for eating disorders, Cognitive Behavioral Therapy (CBT) for eating disorders, and Dialectic Behavioral Therapy (DBT) for eating disorders. The clinical Therapist will also be trained in Eye Movement Desensitization and Reprocessing Treatment (EMDR) to address trauma that is often highly correlated with eating disorder diagnosis. Past trauma prevents consumers from healing and moving forward with their lives. Additionally, Daily life stressors are triggers for eating disorder behaviors. To get to the root of eating disorder problems, trauma therapy will be a part of the IOP services. All eating disorder consumers in the program will also be enrolled in the eating disorder Recovery Record App to aid in treatment, monitoring, and tracking of the client's progress. RUHS-BH will continue the use of this eating disorder Recovery Record mobile-based app that was piloted in a previous Innovation project to support best practices in ED treatment. The Electronic Health Management Record (ELMR) will also track eating disorder cases to gauge the effectiveness of treatment. Information will be used to inform and further the department's future training and development of the eating disorder program. The Eating Disorder

Examination Questionnaire (EDE-Q) score will enable review of treatment effectiveness and inform training and IOP programming. Lastly, the ED IOP program supervisor will lead quarterly meetings with the Guidance Council, made up of stakeholders from various cultural and community groups and behavioral health and medical staff, to provide sub-committee updates, discuss program progress, and provide recommendations to improve the overall ED IOP program.

The RUHS-BH eating disorder support structure and services are unique in that Riverside County is the only county in the state with a firm and robust outpatient eating disorder services program. Our experience provides a strong base from which to launch an ED IOP program. We have provided training and guidance to staff to support them in their ED work enabling us to provide timely outpatient eating disorder services to anyone who needs it at the base level.

Recognizing the need for an affordable welcoming County-run IOP, along with our skill, knowledge, and commitment to providing exceptional ED care, we seek to now create the next level of care through this ED IOP program. Being able to address our more complex consumers who are at high risk for hospitalization, requires more intense care by a multi-disciplinary team that can address the consumer's medical and psychological concerns. Bringing together medical professionals, managed care providers, community-based organizations, ED professionals, families, friends, and care providers of those suffering from EDs, and interested members of the Riverside County community in one location, an IOP run by the County and connected to the other County resources and services can provide accessible, high-quality, affordable care for a consumer while also providing the continuity of care in their own community and home. In an effort to look to the future, for sustainability and potential expansion, we will take the opportunity to examine the unique public versus private frameworks seeking an IOP program model that can be best replicated.

CULTURE-CENTERED

Our vision is for a “culture-centered” or “culturally competent” approach to care. We will incorporate the culturally centered care essential components of cultural awareness, cultural knowledge or competence, cultural humility, and cross-cultural skills throughout the ED IOP program.

This approach will permeate throughout the program; prominently reflected in the three components of the program: the IOP, training, and education:

- At the IOP level, the culture-centered approach will be reflected in the: a culturally diverse staff; available translated materials and interpreters, focus on the language we utilize to speak with consumers and the community (utilizing preferred pronouns and demonstrating respect); appearance/feel of the treatment environment; advertising/promotion; broadened perspectives on body image, weight, and food choices, and welcoming hub of training and resources
- At the Training level, we will infuse cultural perspectives into the equally important aspect of designing training and professional resources for medical staff to increase their competency and confidence in eating disorder diagnosis and treatment for diverse communities, and
- At the Education level, we will target our underserved communities who have been historically affected, but undiagnosed and untreated in relation to eating disorders, and those that support and assist them in receiving information and services. Through an educational plan that includes extensive outreach, community participation, and a

resource library, our goal is to provide information and resources to combat the increasing ED numbers in all communities.

All elements will contribute toward our ultimate goal to increase access, knowledge, and treatment of Eating Disorders to the broad Riverside County community.

LOCATION

Our plan is to temporarily rent a space in southwest Riverside County prior to moving into our final location at the RUHS-BH Wellness Village, located in the same part of the county. The RUHS-BH Wellness Village, slated to open in 2026, will provide health and wellness services tailored to the community, including primary healthcare, children and youth services, and mental health and substance use disorder services, including urgent care. This state-of-the-art campus will serve children, families, veterans, and others, providing the community with new health services, recreation areas, community engagement opportunities, and other resources to promote wellness. Inclusion in the Wellness Village demonstrates RUHS-BH's level of commitment to this program. Securing this newly built space will offer us the opportunity to help design the space to meet our specifications. It will also put us in close proximity to many services that can be utilized by our consumers, including planned relaxation spaces and additional services for those with other behavioral or medical health needs.

RELEVANT PARTICIPANTS/ROLES

As discussed in section a, the following will serve as the primary staff with additional support from pivotal groups assisting in shaping and supporting the work: The Guidance Council, CCLs and RUHS Residency Program:

Program Manager, Chief of Staff/Staff Development Officer, Clinical Supervisor/Behavioral Health Services Supervisor, Medical Staff (Psychiatrist, Physician, Registered Dietitian, Dietician Technician, Registered Nurse), **Behavioral Health Staff** (Sr. Clinical Therapist, Clinical Therapists II, Behavioral Health Specialists II, Transitional Age Youth Peer Support Specialists, Parent Partners, and Psychologist), **Education Coordinator, Research Specialist, and Parent Partners and TAY Peer Support Specialists (part of the BH staff),**

The **Guidance Council** will be created to ensure continued learning, feedback, input, and accountability of the ED IOP, and training and education elements. This team will be comprised of a range of representatives that can inform the different aspects of the project, for example, physician, nurse, psychiatrist and/or psychologist, nutritionist, academic researcher, student, current and/or past ED patient, ED program staff, community member, CCLs, family, friend, and others with lived ED experience. The meetings will be an opportunity to connect and collaborate with each other and keep abreast of recent developments in eating disorders research and the work of the IOP program. And most importantly to provide invaluable input into the continued improvement and development of the ED IOP program. The group will be led by the Clinical Supervisor with assistance from the Education Coordinator. Professional development opportunities will be offered to the Council Members to extend their knowledge to bring back to the Council. The Council will meet quarterly with the membership service lengths and rotation schedule to be determined.

Cultural Community Liaisons play an integral role in ensuring adherence and development of a culture-centered IOP project. The ten liaisons represent the following diverse communities: African Americans, LGBTQ+, Hispanics/Latinx, Middle Eastern & North African, People with DisAbilities, Veterans, Asian Americans, Deaf and Hard of Hearing, Native Americans, and Spirituality/Faith-based communities. All except the Veteran liaison, who is a member of the RUHS-BH cultural competency staff, serve as independent contractors. The CCLS are contracted to actively assist with improving stakeholder knowledge about County services and promoting understanding and awareness throughout RUHS-BH.

The CCLs have been involved in the project development from the onset and will continue their involvement throughout the project via the Guidance Council and their subcommittees ensuring stakeholder awareness, input, and continual evaluation. They are committed to elevating the voices of underrepresented members of the Riverside County community, identifying needs in their target community, recommending improvements in service delivery and Behavioral Health information dissemination, and promoting training, and accessibility, sensitivity, and responsiveness to the needs of diverse communities. The CCL team's mission is to make wellness accessible to everyone, even if it's one person at a time.

Residency program involvement

Working directly with the RUHS Medical Center Psychiatry Residency Training Director, Dr. Jean Griffith, and Family Medicine, Resident Director Dr. Nathan McLaughlin, we will be partnering with our Medical Center Residency Program to become a clinical training elective option for both the medical and psychiatry residency programs. These programs subscribe to the ideals of fostering a culture within the program that will support each individual resident in reaching his or her personal, professional, and life goals. Psychiatric and Family Medicine Residents will gain intimate knowledge of the ED field of work through their medical rotation and/or treatment involvement. In addition to providing needed education and training to future medical professionals, this exposure to the ED field is an effort to assist with developing a staffing pipeline encouraging new entrants into the discipline. Working directly with the Medical Center demonstrates the advantage of our integrated RUHS system comprised of Behavioral Health, Community Health Centers, the Medical Center, and Public Health.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

Riverside County will make a change to an existing practice in the field of mental health, including but not limited to, application to a different population by establishing an Eating Disorder Intensive Outpatient Program that serves as a learning and treatment hub. This County-run ED IOP program, will combine medical and behavioral health care, in one location, supported by training and education through a culture-centered approach.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

Recognizing the diversity of Riverside County and the continued challenge of providing services that reflect the varying approaches and specific needs of these cultures. In addition to the diagnosis and treatment challenges of these groups mentioned earlier, fueled our desire to

create an intensive outpatient treatment program for eating disorders that can reach our diverse Riverside County population. We want to examine providing a county-run facility that serves as a treatment, training, and educational hub to address these underserved communities.. Additionally, looking at the ethnic and cultural makeup of the county, and learning that little to no research on culture-centered ED IOP therapy exists, we recognized the additional need to contribute to the learning of the ED and medical communities. We recognize there is a lot to learn about implementing a new County-led IOP; therefore, we have structured the program with a strong staff, training to address knowledge needs, and an informed support group to assist with the inevitable challenges that will arise.

We presented the project idea to numerous stakeholders who overwhelmingly embraced the culture-centered approach to address the diagnosis disparities of diverse cultures. They also agreed that including medical staff in a larger treatment and IOP team will provide support and encouragement for continued ED and cultural education. They also provided additional input on the timely need for ED education. After extensive discussion and feedback, the idea of developing a welcoming ED IOP program, where Riverside County's diverse cultures are reflected in the staffing, the physical environment, the meal planning, weight charts, and body image discussions, to start, was evident. With culture being a prominent part of what makes us who we are, as individuals, we are excited to examine the questions surrounding designing and running an ED project centered on culturally informed treatment and education.

Through surveys, focus group conversations, and targeted cultural group discussions, a clear need for more ED education in the Riverside County community surfaced. Experience shows us that community and consumer education is the bedrock and feeder to a program in addition to being the method by which stigma and barriers are addressed and understanding is heightened, encouraging treatment, awareness, and support. Our approach provides the opportunity to obtain quality ED care, training, and education in one place.

D) *Estimate the number of individuals expected to be served annually and how you arrived at this number.*

The IOP program will begin implementation with a smaller caseload to ensure that training and program development proceeds concurrently. In the current RUHS-BH outpatient eating disorder program referrals for youth have increased over the last 3 years. It is expected that referrals for the proposed IOP level of care will similarly build over time as the program develops. The IOP program will begin with about half the typical expected caseload of 15 youths at any one point in time. The length of stay in the IOP program will impact the number of youth that can be served annually. It is expected that the program length of stay would be at least 4 months and potentially could be 6-9 months, depending on the complexity of the eating disorder. Given the length of treatment needed, the annual number served could vary between 30-40 youth once the program is fully operational. Additionally, it is expected that the annual number served will also include the parents/caregivers of youth in the program which could result in an additional 80-100 people.

The training component directed toward medical professionals and ED practitioners will also contribute to the annual number served. The first year, with bi-monthly training groups and EBT, CBT, DBT, EMDR, micro-training and cultural competency training, we expect to reach approximately 60-75 ED and medical professionals. We anticipate the second-year numbers

doubling to approximately 150 additional individuals as outreach extends and more training is developed. It is expected multiple Residents will cycle through the program on an annual basis, gaining invaluable first-hand training and knowledge however, as this will be a new rotation, the actual numbers have not been determined.

The community outreach and education component is expected to serve a large number of Riverside County residents, annually. We expect to execute a vibrant marketing campaign targeting schools to churches, RUHS community health centers (CHCs) to the RUHS Medical center, and emergency rooms to clinics, to ensure we become the “go to” place for ED IOP treatment, training, and education in Riverside County.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The target populations to be served align with the three key areas of the proposed program including: youth with eating disorders, physicians and behavioral health staff, and the community at large. The IOP eating disorder treatment program will serve adolescents aged 12-17 years old, which is a population where the onset of eating disorders occurs frequently. As the program becomes established it is possible an adult IOP track could be added at a later time. In the current RUHS-BH outpatient eating disorder program referrals for youth have increased over the last 3 years. In 2021, there were 39 eating disorder referrals. In 2022, there were 68 referrals, and in 2023 through October there were 62 referrals received. In the two most recent years 55% of the referrals received were requests for youth under the age of 18 with the majority between 12-17 years old. Thirty percent of the referrals for adults were youth between 18 and 25 years old.

We will welcome all genders, cultures, races, ethnicities, sexual orientations, and languages. We will work to accommodate non-English language speakers through the use of translators and skilled staff, anticipating Spanish speakers and ASL users as our largest population based on Riverside County's demographics.

Due to historical un-diagnosis, there will be a concentrated effort to reach the traditionally un- or under-served communities represented by the CCLs with an additional targeted outreach focused on LGBTQIA+, Hispanic/Latinx, Asian, and African American communities based on higher documented ED numbers in these communities.

The Unique Challenge for Minority Populations

Individuals of color and those in the LGBTQ+ community often face unique challenges that may place them at greater risk for developing eating disorders. Research suggests that starting at age 12, gay, lesbian, and bisexual teens may be at higher risk for binge eating and purging compared with their heterosexual peers.² Black and Hispanic teens have a higher prevalence of disordered eating patterns compared to their white peers.^{3,4}

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Much like San Bernardino's 2020 ED innovation plan, it is our intention to both educate and improve upon our County's approach to meet the needs of people suffering from EDs. Having spoken to the San Bernardino team, it's clear both our programs reflect the importance of training, informational materials, and multidisciplinary teams to meet our goal of affecting change in the ED numbers in our region. However, that's where the similarity ends, and even within these areas, there are differences. Our project rests on the idea of a treatment, training, and educational hub that is housed in a central location of an IOP. This County-run IOP, the only one of its kind, will utilize a culture-centered approach to care, recognizing the importance of infusing culture into treatment via knowledge acquisition by those who treat and support consumers battling eating disorders and, targeting the under-served cultural communities that make up a large portion of Riverside County's population.

Recognizing the intensity of this type of work and the importance of skilled staff, our proposed salaries fall in the upper quarter compensation range. This is not only an effort to reflect the higher level of expertise required of the staff but to both secure and retain the quality staff needed to promote a strong sustained team, addressing a challenge San Bernardino County shared in relation to their ED project. An added component of maintaining a strong staff is to ensure we also address their mental health and morale. We proposed to do this by providing a space where they can step away from the pressures of the work. We will start with a quiet room, accessible to all staff to decompress, relax and rejuvenate in a calming space and expand from there based on the expressed needs of the staff. Recognizing that our success in determining how we can foster healthy happy staff will result in longevity, consistency, and sustainability of our professional resources and knowledge base.

Furthermore, we don't want the question to be should we include cultural components in the IOP program, we recognize it is imperative we include consideration of the differences of culture if we are to provide service acknowledging the cultural representation of our Riverside County community and an important component of what makes each of us who we are. Our goal is to remove health service barriers that stem from cultural differences, combat mistrust of county service providers, and ensure awareness information reflects the whole person.

B) *Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address?*

C)
IOP TOUR

Online research was conducted viewing program websites to gain an understanding of IOP programming. However, the most useful information was gained through TEAMS meetings that ultimately resulted in a facility tour of Valenta, a private outreach eating disorder clinic. The tour consisted of a RUHS group representing, physicians, therapists, administrators, peer partners, community cultural liaisons, ED practitioners, and innovation, and cultural competency staff. It includes a full facility tour, providing access to the consumer and staff areas. We also spent time discussing both the administrative and clinical aspects of starting and running an IOP.

Our team is indebted to Valenta for opening their doors to us to share their invaluable knowledge and expertise in running an Intensive Outpatient facility that offers medical expertise as well as clinically proven therapeutic modalities, addressing the underlying factors, not just the symptoms. Providing direct access to an experienced treating medical professional, Dr. Jeffrey Mar, who is credentialed and

certified in Psychiatry, Child Psychiatry, Pediatrics, and as an Eating Disorder Specialist, was an invaluable education for the RUHS team. Valenta's expressed enthusiasm about our potential culture-centered learnings provides an avenue to a continued partnership. Through the proposal development process, we have begun a relationship with Valenta that we hope will continue. We expect to delve into incorporating and addressing cultural aspects of consumer care, training, education, and community outreach, and starting and running an ED IOP.

(COMMUNITY CULTURAL LIAISONS (CCLS))

Community Cultural Liaisons conducted a literature review that reflects gaps in the ED treatment literature related to their specific cultural community. Documents and references were old and often difficult to locate due to age. They also led ED presentations and discussions with their respective communities to determine the level of knowledge and need in their community. Many of the meetings resulted in personal disclosure of EDs by participants and honest, open, in-depth, discussions. Additionally, two CCLs have participated in development meetings, with one serving as the CCL representative continuously providing information on EDs and the underrepresented communities. The CCL's lived experience and perspective as a former Peer Support Specialist and insight from the IOP tour attendance also added value to the ED IOP program development.

CULTURE-CENTERED COUNTY-RUN IOP

After extensive searching via various search engines, we were unable to locate a county in the United States that directly administers Intensive Outpatient Programs (IOPs) for eating disorders. Much like Riverside County, some do provide funding support through partnerships with healthcare providers, while others utilize grants. However, most IOPs for eating disorders are run by hospitals, clinics, treatment centers, and private individuals.

Diverse communities and some professionals are beginning to recognize the need for culture-centered research and treatment; however, the general professional community continues to utilize existing approaches to providing treatment. Lower access to diagnosis and treatment by underserved groups may result in the literature not being reflective of the entire population in addition to potentially missing challenges and needs of a specific group. If as some say, one of the best approaches to collecting ED data is to survey current consumers, this creates a challenge if individuals from underserved communities are not being diagnosed and/or treated in high numbers. This doesn't however mean they are not silently suffering from this potentially deadly ailment.

Despite greater awareness of eating disorders in the United States, the types of individuals who experience eating disorders remain largely mis-conceptualized and highly stereotyped, leaving out most of those who struggle. Males, individuals of color, and those in the LGBTQ+ community are both less likely to be diagnosed and more likely to face significant barriers to accessing treatment for their eating disorder when/if they come to clinical attention. (Page 1, *Eating Disorders in Minority and Marginalized Populates*, 8-1-22, Jennifer Leah Goetz, MD)

Our goal is to improve the prevention, intervention, diagnosis, and treatment of EDs for underserved communities by providing access to information, training, and eating disorder care that takes into consideration their culture. It is also our intention to generate new knowledge

based on the examination of the different aspects of our proposed project which we will share with other professionals and clinicians to expand the accessibility to our learnings.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

- A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

LEARNING GOALS/PROJECT AIMS

One of the overarching goals of the proposed Eating Disorder Intensive Outpatient Program is to develop a model of intensive outpatient services that integrates an ED IOP with outpatient primary care to develop a model of integrated behavioral health and primary care for eating disorders. In order to achieve this level of integrated care it is also a goal of this project to develop and implement a training component that will not only include the proposed clinic setting directly providing services but also training that will be disseminated to RUHS psychiatry residents, RUHS family medicine residents, emergency department physicians, and other medical staff. Over the course of this Innovation project, it is expected that both the medical primary care staff and the behavioral health staff will have developed training materials and integrated protocols to determine the best methods to coordinate care for the complex needs encountered when treating eating disorders. A third overarching goal is to develop the best method for educating and providing support for family members of the individual in eating disorder services, along with educating the general public, medical and behavioral health staff, friends, caregivers, and service providers.

Learning Goals:

To develop a culture-centered model of integrated behavioral and primary healthcare for eating disorders in order to increase access to high-quality eating disorder services for under-represented groups in Riverside County.

To increase the knowledge, confidence, and competency of RUHS physicians by developing training materials and implementing integrated behavioral health training on eating disorders for a wide variety of RUHS primary care physicians, psychiatric residents, and emergency department doctors and nurses, and

To increase family and community knowledge of eating disorders to reduce stigma and increase engagement in treatment services.

- B) *How do your learning goals relate to the key elements/approaches that are new, changed, or adapted in your project?*

Eating Disorder treatment needs integrated care to address the various aspects of the illness. The co-occurring mental and medical conditions can benefit from co-management, bringing specialists together in one location, an ED IOP, to address the complexity of EDs, and moving away from the traditional siloed County approach of providing services can elevate the care. An

IOP that consciously targets the entire community and addresses the whole person, honoring their culture, ensures that all consumers are seen and treatment is adapted accordingly, and may also result in a better outcome.

Including a comprehensive training plan to increase the knowledge, confidence, and competency of RUHS medical professionals continues to strengthen our commitment to both high-quality and culture-centered care. We will also target emergency departments as we understand that many underrepresented individuals seek medical care at these locations. We want to ensure the treating staff is informed and confident in understanding and recognizing signs of eating disorders to encourage diagnosis and treatment. Our desire is to address the disparity of missed diagnosis and information that can lead to more of this population or under-represented communities being provided access to support and education. The key components of our training plan will be determined by the entire ED IOP team along with input by the Guidance Council.

Training offerings will include:

- In-person training
- video/discussion series designed to create an environment of dialogue for a specific target audience (can be utilized individually or as a series); developed for various audiences for use in school settings, parent education programs, churches, mentoring training, and caregiver training; offered in languages reflective of the community, English, Spanish, Tagalog, etc.
- Individual online classes: 2-hour courses, various components of ED
- Virtual courses designed for parents and caregivers, and
- Testimonials – various topics – on demand

Increasing family and community knowledge of eating disorders will be addressed through an education plan that includes an Eating Disorder Resource Library. The education plan will include shared information with the community, educating anyone who is interested in learning about eating disorders; what they are, the different types, treatment, medical complications, how to provide emotional support, and other eating disorder topics. The main goal is to provide accurate information and to maintain a broad current cultural offering of educational material via a resource library to target stigma reduction and increase engagement in treatment services. The library will include: educational brochures and pamphlets; books and articles; online resources; multimedia resources; nutritional and health resources and general ED topics

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

For our learning goals, we will establish baseline data before implementing the initiatives and then collect ongoing data to measure progress and make necessary adjustments to achieve the specified goals. Qualitative and quantitative data will be used to provide a comprehensive assessment of the outcomes. Following is the approach we will use for each of our learning goals:

- 1. To develop a model of integrated behavioral and primary healthcare for eating disorders in order to increase access to high-quality eating disorder services for diverse under-represented groups.**

Approach for Learning Goal 1:

Measurement

- Measure the increase in access to eating disorder services among under-represented groups, comparing data before and after the model's implementation.
- Assess the quality of care provided through the model, such as patient satisfaction, treatment outcomes, and adherence to evidence-based practices.

Evaluate the model's cultural competence through feedback from service users and providers.

Data Collection

- Collect data on the number of individuals from under-represented groups accessing eating disorder services before and after implementing the model.
 - Measure the quality of care through patient satisfaction surveys and clinical outcomes.
 - Conduct interviews or focus groups with patients to gather qualitative data on their experience and perceived improvements.
 - Collect Demographic information on consumers.
 - Monitor the model's cost-effectiveness.
2. **To increase the knowledge, confidence, and competency of physicians by developing training materials and implementing integrated behavioral health training on eating disorders for a wide variety of primary care physicians, psychiatric residents, and emergency department doctors and nurses.**

Approach for Learning Goal 2:

Measurement

- Conduct pre- and post-training assessments to measure the increase in knowledge about eating disorders.
- Use self-assessment surveys to gauge healthcare professionals' confidence and competency in diagnosing and treating eating disorders before and after the training.
- Track participation and completion rates for the training modules.

Data Collection

- Develop pre- and post-training assessments to measure the knowledge gained.
 - Conduct surveys or interviews with physicians to assess their confidence and competency in dealing with eating disorders before and after the training.
 - Track the number of physicians, psychiatric residents, and emergency department staff who complete the training.
 - Monitor the frequency of referrals to specialized eating disorder services by trained physicians.
 - Gather feedback from trainees to continuously improve the training materials and method
3. **To increase parents, family, friends, caregivers, referrers, community-based organizations, and the community at large's, knowledge of eating disorders to reduce stigma and increase engagement in treatment services, incorporating the caregivers' voice and development of an educational resource library.**

Approach for Learning Goal 3:

Measurement

- Administer surveys before and after community engagement activities to assess changes in knowledge about eating disorders.
- Use surveys or focus groups to measure changes in attitudes and perceptions related to eating disorders and stigma.
- Track the usage of the educational resource library and attendance at community events.

Data Collection

- Conduct pre- and post-education surveys to measure changes in knowledge and attitudes towards eating disorders.
- Collect data on the number of referrals and engagement in treatment services from parents, family, friends, caregivers, and community organizations.
- Develop focus groups or interviews to gather qualitative data on changes in attitudes and perceptions.
- Create a feedback mechanism for caregivers to provide input on the development of the educational resource library.
- Monitor website and/or resource library usage to gauge community engagement.
- Collect testimonials or success stories from individuals who benefited from increased knowledge and reduced stigma.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

The County of Riverside, RUHS will oversee all activities and programming, and complete all reports. We have no plans to contract out any portion of the project and will complete the evaluation in-house.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic, and racial diversity of the County's community.

The community program planning process for the current MHSO Innovation project began with numerous discussions on potential solutions to various eating disorder challenges in Riverside County. The team comprised of TAY peer support specialists, parent partners, psychiatric and medical professionals, ED outpatient clinicians, innovation and cultural competency staff, and RUHS administrators representing various departments, landed on a potential culture center ED IOP program idea.

The next steps were to present the proposed ED Innovation idea to the broader stakeholder community. Thus far, we have reached out to Community-Based Organizations, Behavioral Health Program Providers, Eating Disorder Consumers and their support systems, a range of Riverside County Staff, Clinicians, Physicians and Psychiatrists, Eating Disorder Professionals, and members of under-represented Riverside County communities: including African Americans, LGBTQ+, Hispanics/Latinx, Middle Eastern & North African, People with Disabilities, Deaf and Hard of Hearing, Asian Americans, Native Americans, and Spirituality/Faith-based communities. Our plan is to post the ED proposal in late November for public review.

We met with managed care providers, with whom we partner, to gain their perspective on what they have observed and noted on their end in relation to the ED IOP process and to elicit feedback on the proposed ED project.

As mentioned previously, we contacted the San Bernardino Innovation Team currently implementing an eating disorder project to discuss their learning and challenges throughout the life of their project which was approved in March 2020. Understandably, as their program has had to contend with months of the COVID outbreak, they have encountered challenges. Nevertheless, as they are located adjacent to Riverside County, with similar populations, their work and discoveries are significant to us as is the potential to partner and share learnings.

The response from these stakeholders has been exceedingly favorable regarding the expansion of our current Outpatient Eating Disorder services into an Intensive Outpatient Program (IOP) focused on providing comprehensive Whole Person Healthcare respective of cultural considerations.

Stakeholder Interaction Details:

- Meetings with ED practitioners
- Meetings with ED practitioners, physicians, psychiatrists, residency director, Community Cultural Liaisons, Peer Specialists, Parent Partners
- Meetings and Tour with current IOP provider, Valenta
- Meetings with Managed Care Health Insurance Partners: Kaiser, IEHP, and Molina
- Meetings with Contract Providers/Community Partners, VCSS, Wylie, McKinley
- Focus group with ED consumers and caregivers – with ASL interpreters provided
- Ongoing Survey to learn about eating disorder knowledge – f/u to presentations
- MHSA Compliance and Coordination Meeting INN ED IOP program discussion
- Presentations and discussions to nine Cultural Competency CCL subcommittees
- CCRD – a collaboration of community leaders representing Riverside’s diverse cultural communities united in a collective strategy to better meet traditionally underserved communities’ behavioral health care needs
- PEI Quarterly Collaborative – Riverside University Health System – Behavioral Health, Prevention and Early Intervention (PEI); an open meeting for anyone who works with those who are impacted by PEI programming, agencies and organizations seeking to partner with PEI programs and providers, anyone interested in learning more about PEI services and their impact on the community, as well as anyone interested in having a voice regarding PEI programs
- Riverside County Regional MHSA public forums (Western, Mid-County, and Desert) - shared developing ideas
- Planned January presentation to Riverside County Behavioral Health Commission

Meetings with these same professionals resulted in uncovering professional needs, while presentations, focus groups, and surveys on the proposed project resulted in valuable feedback, ideas, and reflections.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The community collaboration process has been both cooperative and participatory, involving individuals, groups, and organizational stakeholders. The development of this idea has included a group comprised of a broad range of representatives, from medical professionals to eating disorder Champions (intimately knowledgeable about the treatment of ED consumers), Behavioral health administrators to front-line practitioners, parent partners to peer partners, community cultural liaisons (CCLs) to community-based organization staff, consumers to caregivers, managed care providers to program providers, and training staff to cultural competency and innovation staff. An effort was made to involve many voices to not only create a strong project but to ensure the many facets are equally strong and that the Riverside County community is aware of this potential future resource.

Focus groups, meetings, informational presentations, and discussions occurred with all of the above-mentioned individuals. Implementation of the ED IOP program would continue to involve these same groups through the Guidance Council and sharing of the project in detail on the MHSA and INN websites, Riverside County newsletters, reports through CCL monthly meetings, the extensive RUHS-BH stakeholder network, and via the annual MHSA updates.

We appreciate that partnering with other organizations and community organizations both extends our reach and better informs our program. We also understand the importance of sharing our learning with the medical, psychiatric, and ED communities at topic-related conferences and meetings.

B) Cultural Competency

The ability to interact with and understand people from different cultures involves ongoing learning and is the foundation of our project. We will demonstrate respect and sensitivity through the development and implementation of our IOP, training, and education components of our ED IOP program. As this project is culture-centered and targets traditionally underserved communities, the nine liaison-led cultural communities were invited to contribute their thoughts and ideas on both the project and challenges within their community in relation to eating disorders.

The CCLs will continue to play a pivotal role in the implementation of the project as they are directly connected to the communities the IOP is expecting to serve. Their assistance in promoting the development of skills, knowledge, attitudes, and behaviors that enable individuals to interact effectively and respectfully with people from cultures other than their own is valuable in the development of the IOP, training, and educational resources. Cultural Competency will be a core value shining prominently throughout the ED IOP program. It will be exhibited through the daily IOP implementation philosophy, training for increasing competency, comfort level and awareness of the role culture can play in diagnosis

and treatment, and the types of resources and educational topics shared with and made available to the various sub-sections of the Riverside County community.

Cultural competence is the ability to understand, appreciate, and interact with people from different cultures. It is a vital aspect of healthcare services that aims to increase health equality and reduce disparities by concentrating on people of color and other disadvantaged populations 12. *Find reference*

C) Client-Driven

Riverside County RUHS-BH is committed to a client-centered focus ensuring clients' needs are honored and customized as needed. The client's feedback and input are highly valued. This is important for the ED project as the various cultures may have different needs and flexibility will be needed. Additionally, as the culture-centered IOP is a new idea, we will need continuous feedback from all involved to make adjustments as we go. The Guidance Council will have client members who can inform the direction of the project on an ongoing basis. Included as part of the team are the Tay Peer Partners serving an essential role in providing information, support, assistance, and advocacy for consumers. They will also assist the consumer in navigating the ED services and resources and other County services to support their overall care.

D) Family-Driven

RUHS-BH recognizes that each family is different, that they should have a voice in their treatment and support, and that their feedback is valuable in shaping both a strong and welcoming environment. Family members will be represented on the Guidance Council in addition to access to focus groups and support groups. Parent Partners will play an important role in serving as mentors and sharing their lived experiences, providing their professional experience at meetings, facilitating parent support groups, providing one-on-one informational support, and helping parents navigate the behavioral health system. Much like the TAY Peer Support Specialist, they too will provide support, assistance, and advocacy for consumers and/or caregivers/family members of consumers of behavioral health and/or substance abuse services. They will also provide feedback and perspective on the behavioral health system relative to the impact and effectiveness of the services provided through the IOP, training, and education.

E) Wellness, Recovery, and Resilience-Focused

The project is geared toward whole-person health, for overall sustained well-being, recovery, and building strength by acknowledging and addressing potential real-world challenges. Addressing the physical, mental, and cultural aspects of one's health means looking at emotional, social, spiritual, and other components that contribute to one's overall health. Our belief is that when treatment considers the whole person there is a higher likelihood of meeting treatment goals and promoting wellness and a potentially lower likelihood of reoccurrence. By providing an Intensive Outpatient program that is supported by knowledgeable trained medical AND behavioral health professionals, supported caregivers, culture-honored consumers, families and friends, and knowledgeable community at large, we are buoying our consumers' overall physical and mental health journey toward healing and thriving.

F) Integrated Service Experience for Clients and Families

This project is developed as an extension of the current RUHS-BH Eating Disorder Outpatient program but will involve the three other members of the RUHS family: RUHS Medical Center, RUHS Public Health, and RUHS Community Health Centers to ensure staff and consumers throughout the RUHS system are aware of and can benefit from the services and resources

The creation of a Riverside County-run ED IOP program will enable us to provide our consumers and their families with seamless eating disorder care and support from our current outpatient ED services to the new IOP services. Our ultimate project goal is to improve evidence-based assessments and treatments to be more culturally sensitive and relevant. The culture-centered IOP ED program also supports this along with the ideals of Riverside County by promoting diversity, equity, inclusion, and access through understanding, valuing, and respecting the beliefs, customs, languages, traditions, and perspectives of other cultures.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

Ongoing evaluation and oversight will be the responsibility of the Guidance Council to ensure continued learning, feedback, and accountability of the IOP, training, and education components. The combined expertise and backgrounds of this diverse team of professional and community members will be well-equipped to provide relevant practical thoughtful program evaluations. The group will be led by the Clinical Supervisor who will also work with the Research Specialist to ensure continuous evaluation.

As Riverside County has a high Hispanic/Latinx population, Spanish language survey versions will be available for consumers, families, and the community. As mentioned previously, continuous involvement and utilization of the CCLs will occur to reach target communities to ensure these groups' experiences are known. We will utilize them to distribute information to their community through outreach and cultural subcommittees.

As part of the evaluation, we will be soliciting information on increased cultural knowledge based on training and education, so we will be obtaining information from medical professionals and the community at large on their ED and cultural competency levels.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

Throughout the project, it is our intention to study the public versus private IOP framework in an effort to create a financially viable and self-sustaining project. We expect the IOP ED program, to demonstrate a measurable positive effect in increasing knowledge of and combating eating disorders in Riverside County, along with improving the ED training of medical personnel.

The project is projected to begin in the Western Region of Riverside County; however, if we are successful and a financially viable model is found, it could be expanded to other regions and included in the Riverside County operating budget. Housing the program in the RUHS Wellness Village will assist with some of the operating expenditures. Recognizing the breadth to which eating disorders affect both behavioral and medical health and personal and family lives, the potential exists to access varied funding through the involvement of all four Riverside University Health System departments: Behavioral Health, Community Health Clinics, Public Health, and the Medical Center.

our plan is to involve We will also examine the availability of additional outside funding opportunities and partnerships as a sustainable funding model, in addition to the redirecting of Medi-Cal dollars from referrals to this IOP.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) *How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?*

Our Guidance Council and its members will be tasked with assisting with the development of an outreach plan leading to the dissemination of information and communication with the greater Riverside County community. We will utilize our social media platforms, MHSA/Innovation websites, informational Kiosks located throughout the county in community clinics and other select county buildings (also part of a previous MHSA Innovation project), word of mouth, community events, standing BH meeting updates, campus health centers, and BH newsletters. The CCLs will also communicate with their target communities.

We will share our findings with any other interested counties – especially, San Bernardino County, who’s also implementing an ED project. As mentioned earlier, we will also encourage the sharing of the project and its findings/learning with the broader academic, professional, and clinical communities via newsletters, conversations, conferences, posts, meetings, and any other appropriate method.

B) *KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.*

Eating Disorder, Culture-Centered Care, Intensive Outpatient Program (IOP), Physician Education, Eating Disorder Hub

TIMELINE

A) *Specify the expected start date and end date of your INN Project*

- May 2024-April 2029 (after BOS approval)

B) *Specify the total timeframe (duration) of the INN Project*

- 5 years

C) *Include a project timeline that specifies key activities, milestones, and deliverables—by quarter. TBD*

Section 4: INN Project Budget and Source of Expenditures

Draft MHA Innovation ED IOP Program Proposal Budget						
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Personnel (Salaries and Benefits)	\$ 3,851,850.77	\$ 4,005,924.80	\$ 4,166,161.79	\$ 4,332,808.27	\$ 4,506,120.60	\$ 20,862,866.23
Operating Expenses	\$ 1,733,332.85	\$ 1,802,666.16	\$ 1,874,772.81	\$ 1,949,763.72	\$ 2,027,754.27	\$ 9,388,289.80
Admin	\$ 837,777.54	\$ 871,288.64	\$ 906,140.19	\$ 942,385.80	\$ 980,081.23	\$ 4,537,673.41
Total	\$ 6,422,961.16	\$ 6,679,879.61	\$ 6,947,074.79	\$ 7,224,957.78	\$ 7,513,956.10	\$ 34,788,829.44
Start UP Cost	\$ 150,000.00	\$ -	\$ -	\$ -	\$ -	\$ 150,000.00
Total Estimated Budget	\$ 6,572,961.16	\$ 6,679,879.61	\$ 6,947,074.79	\$ 7,224,957.78	\$ 7,513,956.10	\$ 34,938,829.44

DRAFT