Riverside University HEALTH SYSTEM

INNOVATION PROJECT PROPOSAL

EATING DISORDER INTENSIVE OUTPATIENT AND TRAINING PROGRAM

"Do you know the last time I sat down with my family and ate a meal? I want to be able to do those things. And with this eating disorder, it's not possible, unless I get help" –

Tre Brown, Person of Color with ED; PBS NewsHour, Amna Nawaz, YouTube 3-28-22

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 eating disorders, but as a group, the challenge remains that EDs 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
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☐ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
☒ Local Mental Health Board Approval Approval Date: January 3, 2024
☒ Completed 30-day public comment period Comment Period: November 27 – December 27, 2023
☐ BOS approval date Approval Date: _TBD_____ If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: March/April 2024 *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: February 22, 2024 ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***

County Name: Riverside County

Date submitted: January 19, 2024

Project Title: EATING DISORDER INTENSIVE OUTPATIENT AND TRAINING PROGRAM

Total amount requested: 29,139,565 million dollars

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. 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 complex problem has been the lack of a full continuum of care for eating disorders with integrated service for physical health. 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 integrated eating disorder Intensive Outpatient Program (ED-IOP) which functions as a day treatment program is a level of care not currently available within the Riverside County system. It is not typical in County systems to provide an ED-IOP program, and especially not one with integrated physical health.

Additional challenges with providing eating disorder services have included; 1) difficulty coordinating behavioral health care with primary medical care; 2) the need for 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.

Integrated Care

As the County began to train treatment staff in eating disorder services and began treating clients, challenges in the outpatient clinic setting became apparent. The need for a model of practice that integrated behavioral health care and medical care to create truly 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 that includes integrated physical care. When clients need to step down from the hospital to a lower level of care the currently available outpatient services do not provide sufficient intensity. When a client is in outpatient services and needs more intensive services, hospitalization is most often the only option for a step up to a higher level of care. In the current RUHS-BH outpatient eating disorder program referrals for youth from the County

Managed Care Plan to RUHS-BH specialty mental health services have increased. In 2021, there were 39 eating disorder referrals. In 2022, there were 68 referrals, and in 2023 there were 66 referrals received.

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 are inadequate for treatment. When the need for a higher level occurs and hospitalization is not indicated, RUHS-BH attempts to establish care with out of county private ED-IOP or residential programs. Placing consumers in out of county intensive programs creates many barriers for families, and further complicates the communication and coordination of care with the County outpatient ED program, which is where the consumer would resume care after discharge from the private ED-IOP. Using private providers is also challenging as the programs may be full and may prioritize more lucrative reimbursement from private clients. 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 shortage in adequate access to intensive outpatient care services makes accessing ED care difficult for those on public insurance and uninsured. *(Eating Disorders in Minority and Marginalized Populates, 8-1-22, Jennifer Leah Goetz.*

Physician Training

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 deaths[2]. The authors noted that training about 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 rate[2]. In addition, a recent survey of emergency medicine physicians and residents found only 1.9% completed a rotation on eating disorders during residency[3]. 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.[3] 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 Department[4]. Outpatient ED clinicians in Riverside County expressed similar challenges when referring clients with eating disorders to local emergency departments for medical needs.

A recent National Institutes of Health 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 treatment[4].

Intertwined with the educational needs of medical staff are issues for diverse cultural groups. Any training utilized needs to consider 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 binging 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 African American women 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).*

Community and Family Education

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.

Seeking treatment for eating disorders has been noted in the literature as a systemic problem[7]. Unmet need for eating disorder treatment has been estimated to be quite large among community populations.[7] In one published systematic review of multiple studies on treatment seeking, the authors found that between 67% to 83% of community cases with a diagnosable eating disorder did not seek specific eating disorder treatment[7]. Interestingly this same study noted a "paradox" in that people with eating disorders seek medical services for weight loss, but not mental health services specifically designed for treating eating disorders[7]. In addition, high rates of eating disorders occur among traditionally underserved groups, including minority race/ethnic groups, and people identifying as LGBTQ[8]. A National Institutes of Health study on eating disorder prevalence and service utilization in U.S. ethnic groups found that service utilization was lower among the ethnic minority groups studied[8]. Males have also often been noted in the literature as underserved for eating disorders[8]. Culturally tailored public awareness campaigns and community education on early intervention of eating disorders is clearly needed to increase help-seeking at the earliest signs of a developing disorder.

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.

The proposed Innovation project is focused on developing system-wide best practices for establishing an integrated eating disorder IOP program in a County public mental health system. Integrating physical and behavioral healthcare in eating disorder treatment within an ED-IOP will establish a model to continue developing coordinated physical and behavioral healthcare throughout RUHS-BH ED treatment services. This 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) that will also function as an eating disorder training hub. Establishing an ED-IOP program as a training hub will provide the opportunity to train practitioners and to learn how to operate a complex higher-level of care facility 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. A county-operated ED-IOP clinic site is the best method to develop training and provide the clinical context for staff to put that training into practice. This can only be accomplished by directly operating an ED clinic site.

Integrated Care: Eating Disorder IOP within a Public Health Care System

The ED-IOP will provide the opportunity to learn how to implement an integrated eating disorder program in a county system, while increasing access to an ED-IOP level of service for individuals with eating disorder issues. Currently, there are no ED-IOP programs available to Medi-Cal beneficiaries in the County. There is often a waitlist to get into an eating disorder IOP since services are only available from out-of-county private providers.

> Youth with public insurance were one-third as likely to receive appropriate treatment as youth with private insurance. Additionally, Latinx and Asian patients were half as likely to receive appropriate treatment as White youth. These findings highlight the importance of not only improving access to mental health care for patients with eating disorders but also addressing the systemic causes of disparities in care for youth of color and those with public insurance. – Page 2, *Disparities in access to eating disorders treatment for publicly-insured youth and youth of color: a retrospective cohort study, Ruby Moreno, Sara M. Buckelew, Erin C. Accurso, and Marissa Raymond-Flesch*

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 for 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 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; however, treatment plans can vary resulting in a shorter or longer stay. Services will include experiential group, individual and group therapy, crisis stabilization, and various milieus to address eating disorder symptoms. Additionally, services will be augmented by medical, dietary and substance use or other co-occurring disorder services, as needed.

In the intake process, the Clinical Therapist will conduct a thorough clinical assessment to get psycho-social 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 to gain 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 evaluations 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 ED-IOP Consumers receiving emergency room or higher level of services if needed. Integrating physical healthcare into ED-IOP will address 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.

The goal will be to establish a custom clinic site that can accommodate the ED-IOP program and some space to accommodate meetings and training. The custom designed clinic location is planned for inclusion in the RUHS-BH Wellness village location which is a campus with many other RUHs-BH program services in one location slated to open in 2026. Until that site is built the program will be established in rented space. 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.

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 from both sources 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 a 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 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.

Physician and Allied Professionals Training

Educating primary physicians and department staff on eating disorders will improve collaboration, and coordination, and increase general knowledge of how to work with the eating disorder population. The ED-IOP Education Specialist 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). RUHS-BH is working directly with the RUHS Medical Center Psychiatry Residency Training Director, Dr. Jean Griffith, and Family Medicine, Resident Director Dr. Nathan McLaughlin, to incorporate training on ED disorders into the Medical Center Residency Program, and to provide a clinical training elective option

for both the medical and psychiatry residency programs. Psychiatric and Family Medicine Residents will gain intimate knowledge of the ED field of work through their medical rotation and/or treatment involvement at the integrated ED-IOP site. 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. 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 program will serve as a hub for eating disorder training for county staff, contract providers, community educators, and medical practitioners. Creating a robust, culturally sensitive training structure within the ED-IOP program, will break down silos and bring professionals that work with the eating disorder population together. Riverside County is a diverse county with a rich multicultural population. It is essential to train professionals and paraprofessionals to understand better the cultural perspectives of the community we serve. This approach will ultimately lead to better coordination, collaboration, and treatment options for consumers.

Community and Family Education

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 will 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.

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, inclusion, and access 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.

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

RUHS-BH ED Innovation Plan 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 and Training Project that serves as a learning and treatment hub. The proposed County-run ED-IOP program will combine medical and behavioral healthcare, 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.

The diversity of Riverside County and the specific needs of its cultures present a challenge in providing services that reflect these varying approaches. To address this issue, we are interested in creating an intensive outpatient treatment program for eating disorders that can reach the diverse population of Riverside County. We are proposing providing a county-run facility that serves as a treatment, training, and educational hub to address these underserved communities. We also recognize that little to no research on culture-centered ED-IOP therapy exists, and we want to contribute to the learning of the ED and medical communities. To this end, we have structured the program with a strong staff, training, and education 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 ED-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 youths 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 FBT, CBT, DBT, EMDR, micro-training, and cultural competency training, it is expected that

approximately 60-75 behavioral health and medical professionals will be trained. In the second year, it is expected that approximately 150 additional individuals will receive training. It is anticipated multiple RUHS physician residents will cycle through the program on an annual basis. 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 the largest 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 physicians and behavioral health staff, the community at large, and youth with life-altering eating disorders. Having the ability to treat underserved youth earlier in their illness before they are in danger of severe medical distress aligns with the BHSS modernization focus on early intervention. Involving medical and behavioral professionals, family and friends also strengthens the intervention.

The ED-IOP eating disorder treatment program will serve adolescents aged 12-18 years old, which is a population where the onset of eating disorders occurs frequently. Please note, that while it is our hope that we will be able to expand IOP services in the future to serve adult consumers, we don't foresee that occurring as part of this current innovation project. 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. Additionally, youth identified in RUHS-BH traditional services can also be referred to an eating disorder clinician or are served in outpatient clinics with support from other trained eating disorder clinicians.

Demographic characteristics of the youth currently served in outpatient eating disorder services closely align with the race/ethnic proportions represented in the overall County youth population. The majority of Riverside County youth 12-17 years old are Hispanic/Latinx (63%), followed by Non-Hispanic White youth (22%), Non-Hispanic Black/African American youth (5.4%), Non-Hispanic Asian/Pacific Islander youth (5.3%), Non-Hispanic Multiracial youth (4%), and Non-Hispanic American Indian/Alaska Native youth (0.42%). It is expected that ED-IOP treatment services would be provided to the youth with the highest need for that level of care. However, race/ethnicity will be closely tracked to monitor for disproportionality. Those served in the ED-IOP should be reflective of the County youth population.

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.[9] Black and Hispanic teens have a higher prevalence of disordered eating patterns compared to their white peers.[10,11]

Given that challenges have been noted in the literature for traditionally unserved and underserved race/ethnic groups of all ages, community education presentations and media awareness campaigns will target specific race/ethnic groups and the LGBTQ+ community. Media awareness campaigns and community education presentations will be developed that are tailored to specific cultural groups.

The target population for training on eating disorder practices will include primary care physicians, family medicine residents, emergency department physicians and nurses, psychiatry residents, and behavioral health staff working at the ED-IOP and the County outpatient clinics.

The Educational component will have the broadest target population and most far-reaching touch providing anyone interested in learning more about eating disorders and how to support themselves or others suffering from the illness. The outreach and market campaign along with the provision of resources through the resource library will promote broad community understanding and education but will target those communities that have been historically underserved.

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 Bernadino 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 is based on the concept of a treatment, training, and educational hub that is located in a central location of an IOP. This IOP is unique in that it will be County-run and will use a culture-centered approach to care, which recognizes the importance of incorporating culture into treatment through knowledge acquisition by those who treat and support consumers battling eating disorders. The program will target the underserved cultural communities that make up a large portion of Riverside County's population.

Riverside County aims to establish the first county-operated Eating Disorder (ED) Intensive Outpatient Program (IOP). Currently, all IOP providers in the state are privately owned and operated. By offering this essential service, Riverside County anticipates cost savings and improved outcomes for ED consumers. Despite constituting less than 5% of the total behavioral health population, ED consumers often require higher levels of care. For example, a 2014 study in Pediatrics shares that the mean cost of hospitalization for depression was around $13,000 compared to $46,000 for eating disorders.

Eating disorders (ED) affect both mental and physical health. Integrating primary care providers directly into the ED Intensive Outpatient Program (IOP) ensures timely attention to clients' physical health needs. By fostering close coordination between physicians and the clinical treatment team, we can break down the silos that often arise when working with ED patients. Traditionally, the physical health side remains unaware of the behavioral health side's actions with ED consumers, and vice versa. The innovative approach of collaborating and coordinating treatment by bringing physicians and clinical teams together addresses this challenge.

Riverside County is in a unique position to provide this integration. Most larger counties operate their allied health agencies as independent operating departments. Siloing care allows for greater expertise, but also results in rigid, often never intersecting, services that only treat the person from each system's individual expertise. For years now, Riverside County has operated as the Riverside University Health System – one system that unites public health, the county medical center, detention health and behavioral health -- under one organizational structure. Recently, under the direction of the Riverside County Board of Supervisors, our county has adopted "RivCo One," an integrated service delivery initiative, with the goal to create a single integrated services delivery model within various service environments. This Whole Person Care planning is at the heart of the ED-IOP proposal: truly co-locating physical and behavioral health care in one program at one location. This co-location and intersection of specialties will have its own challenges; challenges that will inspire innovative approaches of systems alignment that can potentially be used across greater health care and help service delivery. This genuine integration is an essential element of MHSA.

The Intensive Home Base Services (IHBS) program involves paraprofessionals, including Peers, Parent Partners, and Rehabilitation Specialists, who directly assist consumers in improving targeted behaviors. These paraprofessionals engage with clients and family members outside the clinic, working on behaviors in their natural environments such as school, home, or the community. This unique service ensures that the skills and behaviors learned in the Intensive Outpatient Program (IOP) setting are reinforced at home or in the community with the support and assistance of paraprofessionals. Unlike organizations that offer IOP services with limited case management, RUHS-BH IHBS services for ED consumers in the IOP program will stand out.

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 propose 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.

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, through training, education and an IOP that acknowledges 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?*

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.

The Community Cultural Liaisons conducted literature reviews that highlighted 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.

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 and Training Project 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 education for the family of youth in eating disorders services and education aimed at the broader Riverside County community. Operating an ED-IOP will provide the experiences and learning opportunities to develop the best method for educating and providing support for family members of the individual in eating disorder services. Community education presentations that have been culturally tailored to traditionally underserved groups will be developed to increase help-seeking and reduce stigma and barriers to accessing care.

Learning Goals:

Will the establishment of a county-operated ED-IOP program that integrates behavioral and physical health care increase access to high-quality eating disorder services for diverse groups of youth in Riverside County?

Will the establishment of an ED-IOP clinic that functions as a hub for integrated ED training and ED consultation increase the knowledge, confidence, and competency of RUHS primary care physicians, psychiatric residents, emergency department doctors and nurses, and behavioral health staff?

Will the development and provision of family support groups and education that incorporates parent(s)/caregiver(s) voices increase continued engagement in treatment services, and reduce stigma?

Will the development of culturally tailored community education presentations increase knowledge of eating disorders among specific cultural groups, decrease stigma, and increase attitudes toward help-seeking?

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

The learning goals are specifically designed to address the three key components outlined in this ED Innovation plan, including the ED-IOP integrated services within a training hub site, provider training, and family and community education. Each element of the proposed project has a specific learning question and a set of data that will be collected to address the evaluation questions posed. Annual evaluation reports will include each of the components, the evaluation questions, and the outcomes data results for each component.

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.

Learning Goal 1

Will the establishment of a county-operated ED-IOP program that integrates behavioral and physical health care increase access to high-quality eating disorder services for diverse groups of youth in Riverside County?

Objectives	Intended Outcomes	Measurement/Data Collection
Increase timely access for diverse groups of youth	Riverside County youth from diverse groups will have increased timely access to a local ED-IOP program when a higher level of ED care is needed either as a step down after acute hospitalization or as a step up from outpatient ED care.	Process data will include the number of youth accessing services, timeliness to intake into the program, service utilization, and treatment retention/successful step-down to a lower level of care. Demographic data (age, gender, race/ethnicity, LGBTQ+) will be used to determine who is receiving services and will inform efforts to ensure traditionally underserved groups are accessing care.
Improved Physical Health	Youth served in the ED-IOP program will have improved weight restoration (increases in BMI) and decreased hospitalizations	Weight gain measured at intake into the program and across time. Physical symptom monitoring (atypical lab results). Youth self-report of physical symptoms, for example, weakness, dizziness, gastrointestinal issues). Hospitalizations will be monitored to determine if there are decreases in acute hospitalizations after participation in the ED-IOP.
Improved Mental Health	Youth served in the ED-IOP will have improved mental health functioning with reductions in eating disorder behaviors and attitudes, and improvements in general mental health functioning.	Pre to post scores on the Eating Disorder Examination Questionnaire (EDE-Q 6.0). A pre- to post-general mental health functioning measure will be determined in consultation with ED staff and could include the OQ Outcomes Questionnaire, a depression or anxiety measure.

Enhanced care coordination between physicians and behavioral healthcare staff	Collaborative care with key communication and decision-making shared among all the multi-disciplinary staff.	Surveying and interviewing staff from the multi-disciplinary team to determine the level of perceived interprofessional communication and collaboration.

Learning Goal 2
Will the establishment of an ED-IOP clinic that functions as a hub for integrated ED training and ED consultation increase the knowledge, confidence, and competency of RUHS primary care physicians, psychiatric residents, emergency department doctors and nurses, and behavioral health staff?

Objectives	Intended Outcomes	Measurement/Data Collection
Implement multidisciplinary training to increase provider capacity to appropriately treat eating disorders.	Increase knowledge, competency, confidence, and cultural sensitivity among RUHS Primary Care Physicians, Psychiatry Residents, Family Medicine Residents, Emergency department doctors/nurses, and behavioral health staff to increase eating disorder quality of care.	Development of training materials. Data on training implementation to include the total number of providers trained and the type/role of providers attending. Knowledge-based surveys will be utilized to gather information on the effectiveness of the training. Satisfaction with the training will also be collected with a post-training survey.
Increase opportunities for providers to gain practical experience treating eating disorders.	Establish an ED-IOP clinic site that will function as a training hub. Psychiatry and Family Medicine residents will have the opportunity for rotations through the ED-IOP clinic site to gain practical experience.	A systems development approach will be used to describe the incorporation of physician residents into the operation of the ED-IOP clinic. Data collected will include the number and type of residents that provide services in the new ED-IOP clinic, data will also be collected on the amount of time residents spend in the ED-IOP clinic setting. Surveys will be developed to gather information on the physician residents experience in the
Increase consultations on physical and/or behavioral health needs among multi-disciplinary staff	Increase opportunities for County behavioral health providers to consult with physicians and/or a dietician to enhance support for those treating eating disorders in the outpatient system.	Staff will be asked to log the consults that are received from the ED-IOP physicians and dietician. Annually, staff will be surveyed on their perceptions of support gained through their

		consult experiences from the training hub.

Learning Goal 3

Will the development and provision of family support groups and education that incorporates parent(s)/caregiver(s) voices increase continued engagement in treatment services, and reduce stigma?

Objectives	Intended Outcomes	Measurement/Data Collection
Increase family support and engagement in treatment services.	Families engaging in the support groups will have an increased understanding of their youth's eating disorder, and the methods of appropriate treatment available, and will gain information and strategies to support their youth in recovery from an eating disorder.	Basic process data will be collected on the number of families participating in family support groups and psychoeducation. Survey instruments will be utilized along with qualitative information from focus groups or structured interviews to measure outcomes for families participating. The focus of survey measurement will include examining increases in parents/caregivers' perceived ability to cope and manage the care of their youth, increases in knowledge and understanding of eating disorders, decreases in psychological distress, and decreases in a sense of burden.

Learning Goal 4

Will the development of culturally tailored community education presentations increase knowledge of eating disorders among specific cultural groups, decrease stigma and increase attitudes toward help-seeking?

Objectives	Intended Outcomes	Measurement/Data Collection
Increase knowledge of eating disorders and reduce barriers to help-seeking in Riverside County communities, particularly among traditionally underserved cultural groups.	Riverside County residents participating in a community education presentation will have an increase in their knowledge of eating disorders, the resources available to access care, and their willingness to seek help for	Process data collected will include the number of community presentations held and which cultural groups were the target audience for each presentation. Demographic data collected will include age, gender, race/ethnicity, and identifying as LGBTQI+. The

	themselves or a family member or friend.	presentation's location and region of the County will also be collected. Outcomes data collection will focus on measuring increases in knowledge of eating disorders, treatment options, shifts in attitudes toward help-seeking, and changes in beliefs about the effectiveness of treatment.

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?

RUHS-BH will directly operate the ED-IOP program services 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 County's Community Program Planning process for an Innovative Project is a collaborative endeavor that prioritizes stakeholder inclusion and cultural diversity. As part of the MHSA public forums, which take place in each of the three Riverside County regions, stakeholders are provided the opportunity to learn about MHSA, including updates on each of the plan component activities, and ask questions, and share ideas and challenges. Prior to the formal presentation, stakeholders are provided an opportunity to visit each information station where they can learn more intimately about each component and speak to a representative of that unit.

The idea of addressing eating disorder challenges was introduced as a potential Innovation project during the 3yr Annual Update FY23/24 forums.

The planning process commenced with discussions that identified three potential research areas. Subsequent meetings and research on eating disorder (ED) prevalence, services, and their impact on underserved populations in the county were conducted by the Innovation Lead. In consultation with the MHSA Administrator, it was determined that further examining the potential of an ED Innovation project would be the most timely and relevant project.

The next critical step involved assembling a multidisciplinary team. This team included:

- ED Champions
- TAY Peer Support Specialists

- Parent Partners
- Psychiatric and Medical Professionals
- ED Outpatient Clinicians
- Innovation and Cultural Competency Staff and
- RUHS Administrators representing various departments

Our journey began with extensive discussions addressing various eating disorder challenges specific to Riverside County. We reached out to clients, communities, and fellow staff members to gather additional insight regarding challenges in the ED arena and explore innovative ideas for affecting positive change in the field. After reviewing the literature and analyzing the demographics of our county, our team began exploring the possibility of creating a culturally centered Eating Disorder Intensive Outpatient Program (ED-IOP).

The next crucial step involved presenting the proposed ED Innovation concept to a broader stakeholder community. Our outreach efforts have engaged a wide spectrum of participants, including:

- Eating Disorder Consumers
- Community-Based Organizations
- Behavioral Health Program Providers
- Eating Disorder Consumers and their Support Systems
- Riverside County Staff, Clinicians, Physicians, and Psychiatrists
- Eating Disorder Professionals
- Underrepresented Communities: 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.

Currently, RUHS-BH has a team of **Eating Disorder (ED) Champions**, comprising experienced practitioners and paraprofessionals dedicated to working with eating disorder consumers. These champions provide crucial consultations to consumers and support to fellow practitioners across the department, specifically addressing eating disorders. As referrals for eating disorders have increased, the department has extended training and assistance to contract provider agencies affiliated with RUHS-BH, all committed to serving this growing population.

The ED Champions play a pivotal role by amplifying the voices of ED consumers and their families during project development. Their firsthand accounts are invaluable, especially considering that consumers often hesitate to acknowledge their illness, and their loved ones may lack awareness or understanding of the challenges posed by eating disorders. By witnessing the rising number of eating disorder cases, these frontline champions are acutely aware of challenges, including the need for next-level care, comprehensive training, education, and robust support systems for consumers, practitioners, families, and the broader community.

Their wealth of knowledge generously shared through extensive discussions, has been instrumental in shaping the project's conceptualization. Moving forward, these ED Champions will remain integral to the care of ED consumers and will actively contribute to the ongoing evaluation and refinement of the three components of the ED Intensive Outpatient Program (ED IOP) project. We expect the same continued involvement from our valued managed care providers, Kaiser, Molina, and IEHP, from whom we also sought input to gain insight from their perspective on the ED-IOP process and gather feedback on our 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.

We conducted three types of surveys, a general one to learn the taker's basic ED knowledge level (and thoughts on the proposal idea), a more in-depth one geared toward consumers and/or providers, and the final one to get feedback on the proposed project. 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.

Meetings with these stakeholders resulted in uncovering professional needs. Presentations, focus groups, shared links, and surveys on the proposed project resulted in valuable feedback, ideas, and reflections:

- Focus group with ED consumers and caregivers – with ASL interpreters provided, 8.31.23
- Transitional Aged Youth ED consumers survey responses provided by LCSW, CTII
- Link to ED proposal shared with ED consumers by Senior Peer Specialist
- Multiple Meetings/Discussions 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
- 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
    - WADE, Wellness & Disability Equity Alliance — September 1, 2023
    - CAGSI, Community Advocating for Gender and Sexuality Issues — September 19, 2023
    - AAFWAG, African American Family Wellness Advisory Group — September 20, 2023
    - MENA, Middle Eastern and North African — September 20, 2023
    - HISLA, Hispanic, Latinx — September 28, 2023
    - Spirituality & Faith-Based — October 10, 2023
    - Deaf & Hard of Hearing — October 10, 2023
    - AATF, Asian American Task Force — November 14, 2023
    - Native American/American Indian Wellness Advisory Group — December 18, 2023

- CCRD, Cultural Competency Reducing Disparities Committee – 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, 9.13.23.
- 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, 8.30.23.

- Riverside County Regional MHSA public forums (Western, Mid-County, and Desert) - shared developing ideas, 6.20.22, 6.27.23, and 6.29.23.
- Public forum and Presentation at Riverside County Behavioral Health Commission, Approved by BHC on January 3, 2024

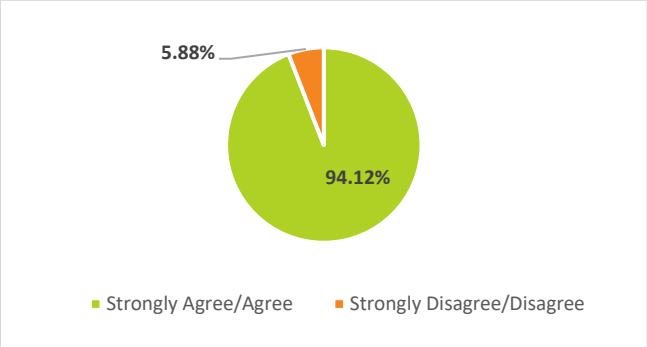
The Draft Eating Disorder Intensive Outpatient and Training Program plan was posted for public review and comment from November 27 – December 27, 2023. Followed on January 3, 2024, by a public meeting of the Riverside County Behavior Health Commission where the proposal was presented and approved. The document remains posted as we continue to gather valuable information to help combat the growing ED numbers and address the knowledge chasm that has been identified.

The County's Community Program Planning process for the Eating Disorder Intensive Outpatient Program (IOP) Innovative Project has been a comprehensive and collaborative approach that has ensured the involvement of diverse stakeholders and reflects the cultural, ethnic, and racial diversity of the community. **Please review additional stakeholder reflections, survey summaries, and support letters in the Appendix.**

Public posting targeted points: **detailed results of the survey are located in the Appendix**; following are some targeted results addressing the clarity of purpose and activities of the project along with fund utilization:

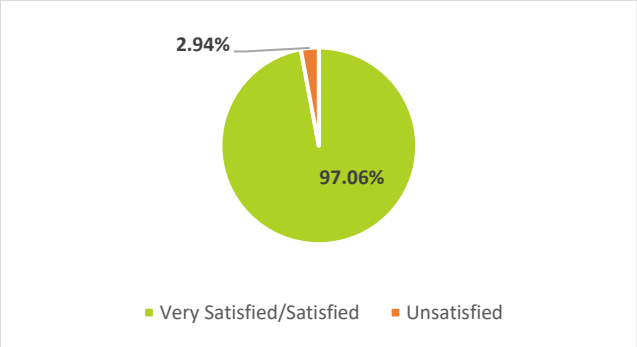
Purpose of ED Project is clear:

Strongly Agree/Agree	32	94.12%
Strongly Disagree/Disagree	2	5.88%



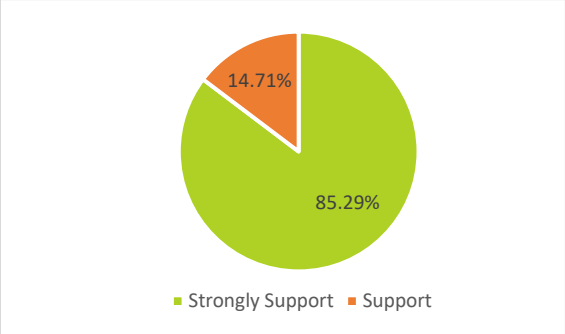
Satisfied with Innovation Project Activities:

Very Satisfied/Satisfied	33	97.06%
Unsatisfied	1	2.94%



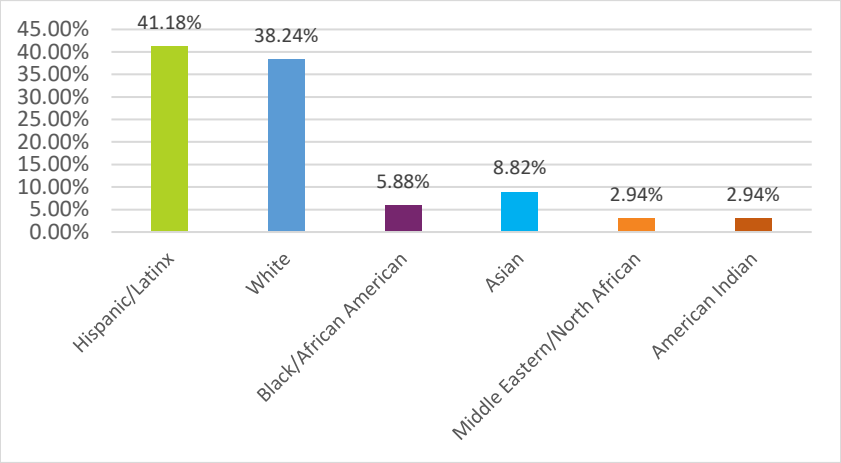
Do you support RUHS-BH using funds to implement this Eating Disorder Innovation project?

Strongly Support	29	85.29%
Support	5	14.71%

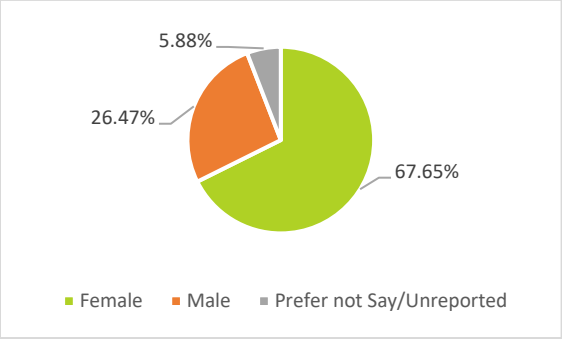


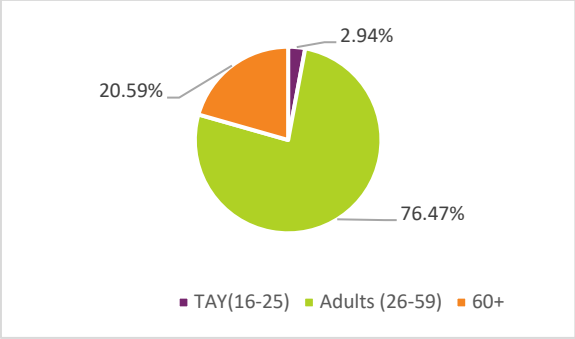
And the demographics of our respondents:

Hispanic/Latinx	14	41.18%
White	13	38.24%
Black/African American	2	5.88%
Asian	3	8.82%
Middle Eastern/North African	1	2.94%
American Indian	1	2.94%
	34	100.00%



Female	23	67.65%
Male	9	26.47%
Prefer not Say/Unreported	2	5.88%





TAY (16-25)	1	2.94%
Adults (26-59)	26	76.47%
60+	7	20.59%

35% responding care for a youth under 25

18% LGBTQ+ Community

After receiving feedback from our stakeholders, it appears that we have successfully incorporated the major themes shared by them. No adjustment to the proposal was needed; however, numerous ideas have been gathered to be revisited during the implementation phase.

Throughout the entire development process, Eating Disorder Consumers, healthcare partners, caregivers, community-based organization staff, medical and behavioral health professionals and staff, and the general public shared their thoughts and ideas about the proposed project. They shared both challenges and ideas about how to best meet our County's ED needs. They all agreed that there is a need for treatment, training, and education.

Select Stakeholder feedback, input, and questions regarding the ED-IOP proposed project:

Comment: I just want to say thank you so much for developing an ED outpatient program for Riverside County. We often discuss in our meetings at OPSH, the need to have no/low-cost ED programs for families and TAY within the county. So, thank you for doing the work to see this hopefully to fruition! We appreciate it!

Response: Thank you for your support of this innovation proposal. We too see the need and are excited about the possibility of examining the many learning opportunities through the implementation of this project.

Comment: Wondering if trauma healing will be included with OP services. I have lived experience with ED and the recovery journeys. I believe that work and collaboration must be done to shift an entire culture to affect helpful change. Having to leave your entire community and support system to get care can be lonely and traumatic because family and chosen family oftentimes are unable to travel to visit and support. This factor also minimizes the chances of whole system support and education being attainable for the family/chosen family. **Comment:** Congratulations to MHSA Innovation for having such a great program as it is hard to find treatment in the area; I had to send my clients to a clinic in the San Diego Area.

Response: This program includes trauma therapy. By being located in Riverside County and including Intensive Home-Based Services (IHBS), participation by the consumers' support system is encouraged.

Comment: Can there be some digital literacy support around social media and cultural pressures to meet the elusive body ideal? KM: It would be great to have material about that including how this affects the Transgender population when they transition and how that can detrimentally affect this group of individuals.

Response: These topics can be covered in group therapy and also included in the education resource library for reference.

Comment: Public financing is best utilized in building community capacity to engage and provide culturally relevant messaging and learning support where residents exist.

Response: It is the goal of the training and education components of this project to build community capacity through educating and training local medical and behavioral health professionals, community-

based organizations, consumers, families/caregivers, and the greater Riverside County Community. Education is intentionally culturally informed to better recognize and appreciate cultural differences in engagement and understanding as it pertains to treating the whole person.

Response: Our project is designed to provide integrated care to address the medical and behavioral challenges of individuals from varying cultural backgrounds from the earliest stages of intervention to a more intensive stage.

Comment (a recent inquiry from a local Unified School District): We have had an increase in students and even reports of parents with eating disorders. I am looking for a way to help them understand eating disorders and also interventions they can do. When looking for support in this area I have hit a lot of walls due to lack of programs.

Response: The training component of the project includes training allied professionals including School Counselors, School Social Workers, School Psychologists, and School Nurses.

Comment: There is a stigma in the African American community causing fear of speaking up and seeking help for eating disorders. There is also a need to train more doctors and therapists to understand the needs of different communities, especially African Americans. There needs to be more research on the different cultures as well as affording resources for African Americans and the need to hire diverse clinicians.

Response: The project recognizes the need to improve diagnosis and treatment of under and un-served communities which equates to cultural education, training, and research to inform current medical staff and outreach to hire diverse staff; these components are included in the project.

Comment: It's important to collect data to help understand and serve each [cultural] community**.**

Response: The CCLs, trainers, Residents, and Guidance Council will be tasked with keeping abreast of the latest ED and culture-related whole-person treatment, to varying degrees.

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 able 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 the 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 concerning 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 Competence 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.

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-center ED-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 a 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 and to foster a continuum of care.

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-center ED-IOP 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. This team will be comprised of a range of representatives for example, physician, nurse, psychiatrist, dietician, current and/or past ED consumers, ED program staff, community members, Cultural Competency program representatives, family, friends, and others with lived ED experience. 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 meetings will be an opportunity to connect and collaborate and keep abreast of recent developments in eating disorders research and the work of the ED-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, both of whom will also work with the Research Specialist to ensure continuous evaluation. 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.

As Riverside County has a high Hispanic/Latinx population, Spanish language survey versions will be available for consumers, families, and the community. Additional language offerings will be made available as needed/determined. Continuous involvement and utilization of the CCLs cultural reach will ensure target communities' needs and experiences are known and represented.

The **RUHS-BH Cultural Competency Program** will be involved throughout the implementation of the project. The Cultural Competency Program includes both County staff and the contracted Cultural Community Liaisons (CCLs) who represent the diverse Riverside County community and work as part of the Cultural Competency Team. RUHS-BH has CCLs representing 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. The CCLs are a connection to the community. They are contracted to actively assist with improving stakeholder knowledge about the needs of the cultural group they represent and to promote understanding and awareness of behavioral health services throughout Riverside County. Collectively, the expertise of the Cultural Competency program and the CCLs will be tapped to share their cultural knowledge for behavioral health and physician staff training to ensure cultural sensitivity is represented across the project implementation. In addition, since the plan is to create culturally tailored public education campaigns the CCLs will be integrally involved in creating those materials. CCLs will distribute information to their community through outreach and cultural subcommittees. The CCLs will also be members of the Guidance Council to represent their respective communities, identify community needs, and make any recommendations on improvements in service, training, or public education.

As part of the evaluation, we will be soliciting information on increased cultural knowledge based on training and education; thereby obtaining information from medical professionals and the community at large on their ED and cultural competency levels then making adjustment to the training and educational programming accordingly.

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, we intend to study the public versus private IOP framework 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. We will also examine the availability of outside grant funding opportunities and partnerships as a sustainable funding model, in addition to redirecting of the Medi-Cal dollars previously paid out for 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*

Year 1: Initial Planning and Development
(Quarters 4 & 1, April-September; (Year 1, FY 2023/2024 – FY 2024/2025)

ACTIVITIES	MILESTONES/DELIVERABLES
Identify, set up, and certify clinic location	• Lease signed • Facility reworked, and furnished, and supplies and equipment ordered and delivered • Site Medi-Cal Certified to provide treatment
Training work plan and schedule development	• Executed contracts for ED training consultants • Consultations, CBT, FBT, DBT, EMDR training, and micro training on ED topics scheduled and initiated • Contract to get clinical therapists trained in Eye Movement Desensitization and Reprocessing treatment completed and signed • Schedule for Family Practice & Psychiatry Residents program rotations developed
ED IOP program administration work started	• Policy and procedures developed • Workflow and job expectations developed for each role • Hiring and training of IOP staff completed • Criteria determined for quarterly staff mental health/satisfaction check-ins • Community Health Center physician identified • Guidance Council (GC) members identified and invited, and the first GC meeting planned • Education, Outreach, and Resource Library planning commenced in anticipation of GC and partner involvement • Evaluation schedule and plan developed • IOP infrastructure examination plan started

Year 1: Initial Planning and Development
(Quarters 2, 3 & 4, October-June; (Year 1, FY 2024/2025)

ACTIVITIES	MILESTONES/DELIVERABLES
Training with the ED consultant	• Consultations scheduled for every other month • Outreach started for Training of ED champions, medical professionals, ED IOP staff, and community • Outpatient program training and Micro training on ED topics determined • Partner and training initiated with existing Promotores groups to educate the public on eating disorders • Established training cycle for Medical Staff at Community Health Centers (CHC)s
"Wrap night" educate, celebrate, with "chosen" family caregivers and families (and community)	• Designed Wrap night activities and model • Determined semi-annual training offerings • Conducted educational classes (i.e., meal planning) for consumers, families, and community members
Develop staff mental health/satisfaction plan	• Staff quarterly survey on work satisfaction developed and administered • Mental health support system measurement developed • Conduct first quarterly satisfaction survey Q4
First quarterly Guidance Council meeting	• Orientation provided, including introductions of staff and GC members • Overview of project and Council responsibilities, etc. shared • Introduction of subcommittees/first subcommittee meetings Q4 • Quarterly council meeting goal to learn and get feedback to improve ED IOP program discussed
Accept referrals to IOP program	• Goal of 8 consumers Q3, 16 for Q4 • Collaborated and coordinated with county clinics and county contract providers with eating disorder programs for step-up or step-down eating disorder services.
Outreach to Cultural groups on ED	• Q3, LGBTQ+ Develop and initiate Outreach & Education Plan • Q4, Veterans Develop and initiate Outreach & Education Plan
IOP staff to attend annual ED conference	• Increased ED knowledge base • Sharing of learning by staff through presentations and conversations

	• Development of resources and professional contacts
Begin Intensive Home Base Services to consumers/families after training	• At-home/on-site education and support started for some consumers • Gained understanding by the clinician of the home environment
Information Sharing Plan	• Plan created to share information @ conferences & meetings (ED and general health-oriented) and within the Riverside County community and beyond, and with CBOs and other interested parties
PROJECT EVALUATION	• Planned quarterly evaluation schedule implemented for IOP project components based on data collection

Years 2-5: Ongoing Operations, Implementation and Expansion
Quarter 1 - 4: April 2024 – March 2025 (Years 2-5, FY 2024/2025 – FY 2029)

ACTIVITIES	MILESTONES/DELIVERABLES
Training with the ED consultant	• Add-in Consultations every other month with IOP ED staff and County outpatient program ED Champions • Micro training provided on ED topic, alternate month • Maintain updated training and support needs for individuals associated with eating disorder cases • Maintained scheduled training for Community Health Center doctors/Psychiatry Residents
"Wrap night" educate, celebrate, with "chosen" family caregivers and families (and community)	• Wrap night educational component determined and completed • Wrap night celebration conducted
Quarterly check-in on staff mental health/satisfaction	• Survey completed and Reviewed • Curative action taken and benefits accessed
Refresher staff training	• Refresher training completed for ED staff on FBT for ED, CBT for ED, and DBT for ED
IOP enrollment	• Meet the goal of 20 open cases • Maintain 20 open cases
ED training and outreach to Community Health Center doctors/Psychiatry residence	• Demonstrated increase in both training and outreach • Maintained training
Intensive Home Base Services to consumers/families.	• Increased At-home/on-site education and support provided to all consumers • Gained understanding by the clinician of the home environment
Quarterly council meeting	• Feedback and input to improve the ED-IOP project

	• Ongoing evaluation of IOP, Training, and Education components
Quarterly targeted outreach to Cultural groups on ED	• Assessed and revamped outreach and education plans, continuously • Work with Promotores and other culture-specific groups, as available, for outreach • Outreach to People with DisAbilities cultural group on ED • Outreach to Spirituality/Faith-based cultural group on ED • Outreach to Deaf and Hard of Hearing cultural group on ED • Work with Promotores group to outreach to Hispanic cultural group on ED • Work with Promotores group to outreach to Asian/Pacific Islander cultural group on ED • Outreach to Native Americans cultural group on ED • Work with Promotores group to outreach to African American cultural group on ED • Outreach to Middle Eastern/North African cultural group on ED
IOP staff to attend annual ED conference	• Q4, ED Resources gained • Networking conducted with other eating disorder providers and clinicians • Participation in presentations and discussions by ED staff
Annual and ongoing EVALUATION	• Reviewed program outcome • Analyzed data and prepared a report of findings
Educational and Library Resources	• Growth in the number and variety of resources in Library Resources • Development of new resources

*Timeline activities will be augmented as the project proceeds, and we continue to learn

Section 4: INN Project Budget and Source of Expenditures

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)

INN PROJECT Budget Narrative

This trailblazing program, specifically tailored for youth aged 12-18 years old, seeks to holistically address eating disorders with a **budget of $29,139,565.28 over five years**. At its core, the program features a County-run Intensive Outpatient Program (IOP) that integrates medical and behavioral health services. Our three-pronged approach encompasses culturally centered treatment, professional training, and community education. Targeting ED consumers, medical professionals, caregivers, and the broader

Riverside County community, the proposed budget reflects the expressed needs of our stakeholders. As we ventured into uncharted territory, we meticulously researched all expenditures to ensure accuracy and effectiveness.

The primary funding for the project will come from MHSA Innovation funds, supplemented by a smaller contribution from **Medi-Cal reimbursements in the amount of $2,599,091.86**. However, determining the exact Medi-Cal reimbursements has proven challenging. Unlike private Intensive Outpatient Programs (IOPs) that bill insurance companies or rely on direct client payments, county-run IOPs face unique reimbursement dynamics billing Medi-Cal.

Innovation Funds Subject to Reversion – RUHS has identified **approximately $7 million** in MHSA Innovation funds that may be subject to reversion. The approval of the proposed plan will allow those funds to be encumbered and avoid reversion.

PERSONNEL

The Administrative Staff is comprised of the following. **The Program Manager (.25 FTE)** will ensure the goals and objectives of the INN program are met by providing strategic direction for the evolving program; the **Program Coordinator (1 FTE)** will supervise and coordinate the multidisciplinary team while providing daily operations administration of the program and monitoring learning objectives progress; the **Behavioral Health Services Supervisor (1 FTE)** will supervise and coordinate the clinical team, providing daily administration of the IOP, and serving as Chair of the Guidance Council (GC); and the **Education Coordinator (1 FTE)** will lead the design of the training, educational and outreach efforts developing both a training and an education plan along with the education library in partnership with the respective team members. The EC will also serve as the point of contact for the medical center family medicine and psychiatry residency directors.

The Treatment Staff is comprised of the following who will be responsible for the medical health of the IOP consumers and liaising with the Behavioral Health staff for comprehensive seamless care. The **Psychiatrist (1 FTE)** will provide evaluation, monitoring, tracking, and medication services for consumers while The **Physician (1 FTE)** and **Registered Nurse (1 FTE)** will provide much of the same but from a medical perspective, and in partnership with the other IOP Project team members. The **Dietitian (1 FTE)** and **Dietitian Tech (1 FTE)** will ensure consumers are aware of proper nutrition and knowledge of food to improve their health including meal planning and cooking demonstrations and providing lunch and snacks for the IOP consumers. **Psychiatric and Family Medicine Residents** will gain intimate knowledge through their Eating Disorder rotation, share ongoing research, and provide supervised patient care. The **Sr. Clinical Therapist (1 FTE), Clinical Therapists II (4 FTE), Behavioral Health Specialists II (2 FTE), Substance Abuse Counselor (1 FTE), Transitional Age Youth Peer Support Specialists (2 FTE), Parent Partners (2 FTE), and Psychologist (1 FTE).** They will be responsible for the daily operations of the Intensive Outpatient Program. They also play an important role work with parents and individual consumers to support them as they go through treatment, assessing daily what adjustments or modifications are needed in the programming and care of the consumers and caregivers and establishing and running support groups. Parent Partners and Peer Specialists will also conduct outreach campaigns, and liaise with community-based organizations and the general public. All Team members

will partner with the Education Coordinator in the development of comprehensive outreach and educational plans.

The Support Staff is comprised of the: **Research Specialist (1 FTE), Office Assistants (2 FTE), Community Services Assistant/driver (1 FTE), and Administrative Services Analyst (1 FTE)).** They will collaborate with and support the work of the administrative and behavioral teams assisting respective of their positions. The dedicated Research Specialist will tailor research approaches, and monitor and evaluate the progress and performance of the program components and learning goals.

All Staff and Staff Teams will partner with the other IOP Project Staff to inform the training, education, and care of the targeted stakeholders in support of a continuum of care model.

OPERATING EXPENDITURES - For the proposed five-year duration, we have included the following expenses as essential for the day-to-day operation of the Eating Disorder Intensive Outpatient Program Project: two vehicles, interpreter and translation services, office expenses/supplies/equipment, clinic supplies, educational supplies, marketing materials, food, communication expenses, cleaning supplies and services, Recovery Record App, building rental and utilities, computer and software maintenance, client transportation & excursions, staff & volunteer professional development, staff support, and guest speaker honoraria.

OTHER EXPENDITURES – The other expenditures category is a contingency based on budgetary experience that will allow us to purchase items to ensure the overall success of the program in accordance with the project scope.

CONSULTANT COSTS/CONTRACTS - Consultant, Dr. Kerri Boutelle, a Professor of Pediatrics, Herbert Wertheim School Public Health and Longevity Sciences, and Psychiatry at UC San Diego, will serve as the lead eating disorder trainer. As a Trainer, certified Family Based Treatment Therapist (FBT), and licensed clinical psychologist, she has been working with youth who have eating disorders for over 27 years. She also has experience with adults. **Additional trainers** will be secured as needed to augment the various training areas. Additionally, **Community Cultural Liaisons (CCLs),** Nine liaisons, will be contracted for cultural training, cultural community resources, professional contacts, introduction to alternative cultural health experiences (i.e. Native American walking spirit), and to serve on the Guidance Council, to represent the voice of their specific cultural community.

INDIRECT ADMINISTRATIVE COST - These incurred expenses support the overall functioning of the program by the County, apart from listed operating expenditures. This includes salaries/benefits for additional administrative staff who support the project, human resources, finance, and management personnel, technology support, insurance, accounting, compliance, and other expenses not detailed in the budget.

NON-RECURRING COSTS - The non-recurring costs are associated with setting up the IOP facility/HUB location. These expenses include: Initial facility modification, furniture, laptops and workstations, appliances, kitchen supplies, and staff Quiet/Haven Room

MEDI-CAL REIMBURSEMENT – RUHS will seek Medi-Cal reimbursement for eligible services. The amount of projected revenue is reflective of the program implementation and service delivery growth over the life of the project.

TOTAL PROJECT ESTIMATED BUDGET – Forging a new path by examining new ideas through the implementation of an innovative and new project presents the challenge of developing a budget, hence an "estimated budget". We feel confident that as we have researched the proposed innovative project, we have done the same for the budget.

ADDITIONAL BUDGET NOTES

Evaluation Expenses: As this is a research project, rigorous evaluation is crucial to measure impact. The budget has been designed to include funds for data collection, surveys, and internal evaluation staff, services, and support by a Research Specialist (1 FTE), whose salary is included in Personnel. Additional evaluation expenditures are dispersed throughout other operating expenditures and indirect administrative expenses.

Project development and dissemination funds have been allocated through the proposed staffing and the indirect administrative and other operating costs.

A 4% annual increase has been applied to each subsequent year to address inflation and salary and benefit increases. A raise allows for competitive compensation, retains talent, and motivates staff. Potential program expansion, covering unforeseen expenses, and the ability to pursue research and development of related innovative ideas is also possible with the allocated 4% annual increase.

Budget Cost Allocation Summary: 5-year budget

- 58.30% Personnel (Salaries and Benefits)
- 10.69% General Operating Expenditures
- 14.13% Consultant Costs/Contracts
- 2.48% Other Expenditures
- 12.84% Indirect Administration Costs
- 1.56% NON-Recurring Costs
- 100% Total Estimated Budget

By thoughtfully allocating resources, engaging stakeholders, honoring culture, and emphasizing innovation, we aim to create a sustainable and impactful program that transforms the landscape of eating disorder treatment in our County.

B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)

MHSA Innovation ED IOP Program Proposal Budget						
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Personnel Costs (Salaries and Benefits)	$ 3,416,508.36	$ 3,553,168.69	$ 3,695,295.44	$ 3,843,107.26	$ 3,996,831.55	$ 18,504,911.29
Operating Costs	$ 626,250.00	$ 651,300.00	$ 677,352.00	$ 704,446.08	$ 732,623.92	$ 3,391,972.00
Consultant Costs/Contracts	$ 828,000.00	$ 861,120.00	$ 895,564.80	$ 931,387.39	$ 968,642.89	$ 4,484,715.08
Other Expenditures	$ 145,425.00	$ 151,242.00	$ 157,291.68	$ 163,583.35	$ 170,126.68	$ 787,668.71
Indirect Costs	$ 752,427.50	$ 782,524.60	$ 813,825.59	$ 846,378.61	$ 880,233.76	$ 4,075,390.06
Total	$ 5,768,610.86	$ 5,999,355.29	$ 6,239,329.51	$ 6,488,902.69	$ 6,748,458.79	$ 31,244,657.14
NON Recurring Costs	$ 494,000.00	$ -	$ -	$ -	$ -	$ 494,000.00
Total Budgeted Costs	$ 6,262,610.86	$ 5,999,355.29	$ 6,239,329.51	$ 6,488,902.69	$ 6,748,458.79	$ 31,738,657.14
Medi-Cal Reimbursement	$ (355,600.00)	$ (528,320.00)	$ (549,452.80)	$ (571,430.91)	$ (594,288.15)	$ (2,599,091.86)
Total Estimated Budget	$ 5,907,010.86	$ 5,471,035.29	$ 5,689,876.71	$ 5,917,471.77	$ 6,154,170.64	$ 29,139,565.28

C) BUDGET CONTEXT (If MHSA funds are being leveraged with other funding sources)

RUHS will seek Medi-Cal reimbursement for eligible services. The amount of projected revenue is reflective of the program implementation and service delivery growth over the life of the project.

ENDNOTES

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APPENDIX

Support Letters

Survey Summaries
General Information Survey
Public Posting Comment Survey

Consumer story

TAY Eating Disorder Consumer Responses

Community Cultural Liaisons Information Page

Stakeholder Education - PPT Presentation

UC RIVERSIDE UNIVERSITY OF CALIFORNIA | School of Medicine

UC Riverside Psychiatry
3125 Myers St
Riverside, CA 92503

January 15, 2024

Re: Riverside University Health System (RUHS) Behavioral Health ED-IOP Innovation Project

To Whom It Concerns:

It is with great enthusiasm and great hope that I write this strong letter of support for the Riverside University Health System Behavioral Health's proposal to bring an innovative county operated integrated intensive outpatient program(IOP) for eating disorders to the residents of Riverside County. The project will fill a vital and important need for life saving specialized eating disorder treatments for our diverse county of over 2 million people including 600,000 youth.

I have been working as a child psychiatrist in RUHS outpatient children's clinics for the past 15 years. I have also been an Associate Medical Director at RUHS for the past 9 years. As an Asian American, I have also been a member of our Asian American Task Force through the office of cultural competency at Riverside University Health System. RUHS has also sponsored several psychiatry training programs, and I have served as the Program Director for the first and only ACGME accredited Child and Adolescent Psychiatry Fellowship in Riverside County sponsored by the UC Riverside School of Medicine where I also am an Associate Professor of Psychiatry. Our fellowship has been trying to increase the number of practicing child and psychiatrists in the Inland Empire and has successfully graduated 10 child psychiatrists.

Treatment of eating disorder, anorexia nervosa(AN) in particular, remains one of the greatest challenges in the field of behavioral health and psychiatry. Even for families who are well resourced, finding specialized treatment for AN remains very challenging as there are very few programs and providers who are equipped to treat severely ill anorexic patients. AN remains one of the psychiatric disorders with the highest mortality rate. Residents of the Inland Empire already have significantly less access to medical and psychiatric services due to the shortage of providers, and for AN, there are no specialized programs in our large county. Existing health care disparities for our large LatinX, African American and Asian American populations are magnified in this most serious psychiatric disorder.

AN causes severe medical co-morbidities and access to specialized pediatric care and medical care is vital for good outcomes. In AN, the cause of mortality is often due to the effects of malnutrition on the body, particularly the heart. Our clients also have limited access to well trained primary care providers to manage all these medical co morbidities and to maintain wellness. Thus our innovation project also has a training component to train both medical and psychiatric physicians in the care of AN in a state of art integrated treatment program that meets both the medical and psychiatric needs of our patients.

UC RIVERSIDE | UNIVERSITY OF CALIFORNIA | School of Medicine

UC Riverside Psychiatry
3125 Myers St
Riverside, CA 92503

I really could write endlessly on the importance of this program for our county residents. I have dedicated my professional career to serving the residents of Riverside County via direct service, administration and education, and in my mind, this project is one of our most important to date and addresses one of our greatest needs. I have full confidence about our ability at RUHS to execute our plans and provide state of the art care for Eating Disorders. If our program proves successful, I am hoping that we can provide a model for other counties in our great state of California.

Sincerely,

Richard Lee, MD
Board Certified in General and Child and Adolescent Psychiatry
Health Sciences Associate Clinical Professor of Psychiatry
Program Director Child and Adolescent Psychiatry Fellowship
Associate Program Director, Psychiatry Residency Program
UC Riverside School of Medicine
Staff Psychiatrist IV
Associate Medical Director
Riverside University Health System

Trenton Hansen, Ph.D.
Superintendent
4850 Pedley Road, Jurupa Valley, CA 92509 T (951) 360-4100

January 8, 2024

To whom it may concern,

I write in support of Riverside University Health System – Behavioral Health's (RUHS-BH) proposal to develop and implement an Eating Disorder (ED) IOP and training program.

As Director, overseeing a variety of programs in Jurupa Unified School District (JUSD), I direct services and programs involving parent engagement, behavioral health, and community engagement. As a direct service provider for several years, we at JUSD are very integrated with our community and all our partner agencies. We have worked collaboratively with RUHS-BH for nearly a decade to increase access and services to the community of Jurupa Valley.

With the IOP, functioning as a culturally sensitive eating disorder training hub designed to reach those currently suffering from an eating disorder, those who diagnose and treat them, and those who support them, we have several clients in our community that would greatly benefit from the ED IOP project.

ED services are for all intense purposes, specialty services. We at JUSD currently lack the capacity to adequately provide ED services and must often refer out. With transportation as a barrier as well as stigma for more intense service, we may have clients that do not receive the required care. With the IOP three prong approach, JUSD would receive the training to support our staff in identifying signs of ED and increase referrals for services. It would allow our clinicians to receive the training to provide outpatient service prior to required hospitalization and it would create a seamless continuum of care allowing for more intense services to be accessed as needed. RUHS-BH's proposed approach would greatly benefit JUSD and the surrounding community.

Sincerely,

Jose Campos, Director
Parent Involvement & Community Outreach / Behavioral Health Services
(951) 360-4175

LEARNING WITHOUT LIMITS

UC San Diego
SCHOOL OF MEDICINE

December 22, 2023

To whom it may concern

I am writing to express my strong support and enthusiasm for the development of an Intensive Outpatient Program for eating disorders (ED-IOP) for the Riverside University Health System (RUHS). I am a licensed clinical psychologist in the state of California and have been treating and conducting research among patients with eating disorders since 2002. I train and supervise clinical staff on the treatment of eating disorders in California, across the US, and across the globe. I have been consulting with the team at RUHS for 8 years and my role has been to conduct trainings in the empirically supported models for the treatment of eating disorders and consulting with the Eating Disorder Champions at RUHS. In general, I meet with this team once a month but at times, it can be more. Thus, I am in a unique position to comment on the professionalism and competence of this team for RUHS.

I have been incredibly impressed by the focus and leadership at RUHS on the treatment of eating disorders for patients in Riverside County. Eating disorders are one of the deadliest psychiatric disorders, and Anorexia Nervosa has one of the highest mortality rates of any psychiatric disorder. A competent therapist for patients with eating disorders needs to have competence in psychological treatments as well as in medical and psychiatric comorbidities. Thus, it can be a challenge to find competent therapists in eating disorders, let alone competent therapists who accept insurance and Medi-Cal. The issue with access to competent therapists is compounded by staff turnover in systems that take insurance and Medi-Cal. This team at RUHS, led by Novahn Xayarath, has developed a training and supervision program that utilizes experts in the field to train the RUHS therapists on evidence-based treatments and provides continual training and supervision for new therapists by the ED Champions. This model is incredibly innovative and as far as I know, Riverside county in the only county in the country that is using this model to provide competent care for low income eating disorder patients. As you may be aware, other counties in California are considering adopting this model, which highlights the innovation and thoughtfulness in the development of this program.

There are several levels of care for eating disorder patients due to the severity and dangerousness of the symptoms. Currently, RUHS is providing outpatient weekly therapy for eating disorder patients, which is the first step for treatment. When these patients are not responding psychologically or have increasing medical comorbidities when in weekly therapy, they are often stepped up to an ED-IOP to avoid deteriorating. As you know, I work at UC San Diego, and our program, like many others, does not take Medi-Cal patients and these much-needed ED-IOPs are few and far between. Without an IOP, these patients can get worse, and the danger of medical comorbidities

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increases. Additionally, there are higher level programs for the more severe cases, including day treatment, inpatient, and residential. In the process of stepping down from these programs, it is important to have an ED-IOP to reduce the intensity of care slowly and with support. Thus, this ED-IOP would fill an unmet need, especially for Medi-Cal patients.

I have the utmost confidence that this team will succeed in the implementation of the ED-IOP and that it will provide an important resource for the residents of Riverside County. I am honored to be part of this team and give my highest support for this program. It will truly increase the reach of evidence-based treatment for eating disorders to the patients who are in greatest need.

Please feel free to reach out with any questions.

Kerri Boutelle, Ph.D.
Professor
Department of Pediatrics, Herbert Wertheim School of Public Health and Human Longevity Science, and Psychiatry
Director, Center for Healthy Eating and Activity Research
University of California San Diego
9500 Gilman Dr, MC 0874
La Jolla, CA 92093
kboutelle@ucsd.edu

December 27th, 2023

Kevin Phalavisay
Cultural Community Liaison – LGBTQ+ Consultant
280 S. Avenida Caballeros #209
Palm Springs, CA 92262
Kphalavisay@gmail.com
(951) 756-8648

Riverside University Health System – Behavioral Health
Innovations Department
2085 Rustin Ave.
Riverside, CA 92507
Attn: Leah Newell

To whom it may concern:

This letter is to express my support for the Mental Health Services Act (MHSA) Innovation Eating Disorder Intensive Outpatient Program by Riverside University Health System – Behavioral Health (RUHS-BH) Innovations. Understanding the high prevalence of eating disorders in the queer community, it is with great enthusiasm to be a collaborator on this much-needed IOP.

In my role as a Cultural Community Liaison for LGBTQ+ communities, I serve RUHS-BH as a subject matter expert in engaging our queer communities and chair the Community Advocating for Gender and Sexuality Issues (CAGSI) subcommittee; a Riverside County LGBTQ+ behavioral health advisory group dedicated towards wellness and health equity. I have contracted with RUHS-BH for three years in advising best practices when reaching our queer Riverside County residents and have been invited to be a part of the development of this project. My support and collaboration entail engaging awareness, input, and continual evaluation from stakeholders who are members and community leaders of the queer community to identify barriers and needs to inform best practices in developing this one-of-a-kind ED IOP.

According to the National Eating Disorders Association, queer individuals experience higher rates of eating disorders compared to their heterosexual and cis-gender counterparts. Furthermore, studies show that the majority of queer individuals who do receive eating disorder treatment have a negative experience for a lack of affirming programs and providers. Additional financial barriers that hinder access for the LGBTQ+ community are lack of programs accepting insurance, costly programs, poverty, and rates of unemployment.

The proposed project is unique as it aims to address these issues that impact service delivery and barriers by utilizing a whole-person approach and integrated mental-medical care. The infrastructure of this IOP integrates culturally centered care as a core component to service delivery by prioritizing awareness and understanding of our marginalized communities. I am confident that this ED IOP has high potential to bridge gaps in serving our most vulnerable populations and develop data and procedures that will be pivotal in replicating more affirming and effective ED IOPs.

CAGSI remains committed to continuing to work together with RUHS-BH Innovations in development of the MHSA Innovation Eating Disorder Intensive Outpatient Program Project.

Sincerely,

Kevin Phalavisay
Cultural Community Liaison – LGBTQ+ Consultant
Community Advocating for Gender and Sexuality Issues (CAGSI)

From The Desk Of
Dakota Brown
WADE Alliance Chair

Dec 19, 2023

To Whom It May Concern:

I am writing to express my support for the RUHS-BH Eating Disorder Intensive Outpatient and Training Program Innovation Project which will provide cutting-edge help to people struggling with eating disorders.

This revolutionary project couldn't have come at a better time. My work as a Peer Support Specialist for RUHS-BH taught me that maladaptive coping behaviors play a large role in derailing people from living the lives they want. As a former consumer of the county's behavioral health services, I understand what it means to be driven by emotional pain, and the helplessness and hopelessness that result. As a person in recovery from an ED, I can say that help in this realm has been challenging to find.

The brilliant idea of a county-run Intensive Outpatient Program (IOP) supported by training and education for the medical community and public will make ED treatment accessible and consumer-friendly. And that's an awesome stigma-reducer! Working as a Cultural Community Liaison to People with Disabilities has taught me that you can have exemplary services – but if they're not accessible, they won't be used. I was pleased to be asked to serve on the proposal development team for this project and to garner input and feedback from the community. After touring the Valenta facility, I am even more committed to doing what I can to ensure this work remains culturally competent and equitable to all.

We are learning more about ED all the time; shouldn't our best practices evolve with our understanding? Please consider moving this project forward.

Sincerely,

Dakota L. Brown

Dakota Brown
RUHS-BH Cultural Community Liaison
To People with Disabilities
303-517-7250
16400 Bubbling Wells Rd. #155
Desert Hot Springs, CA

We heal and inspire the human spirit.

Riverside University Health System – Behavioral Health
Attention: Novanh Xayarath, LMFT
Behavioral Health Services Administrator – County of Riverside
3125 Myers St
Riverside, CA 92503

January 3, 2024

RE: Letter of Support for the Innovation Project Proposal of the Eating Disorder Intensive Outpatient and Training Program

Dear Mr. Xayarath,

Inland Empire Health Plan (IEHP), a Joint Powers Agency, is a not-for-profit health plan. IEHP organizes health care for 1.5 million members in San Bernardino and Riverside counties. Our mission and vision are to "heal and inspire the human spirit" by not resting "until our communities enjoy optimal care and vibrant health." Since 1998, IEHP has worked with Riverside University Health System – Behavioral Health (RUHS – BH) to establish physical and behavioral health services for Medi-Cal and Medicare Dual Choice recipients.

IEHP supports RUHS – BH's Innovation Project Proposal of the Eating Disorder Intensive Outpatient and Training Program. We believe this will provide invaluable community resources for both providers and families.

The proposed Innovation project will add to the RUHS-BH's established continuum of care for eating disorder treatment by offering another level of care for this complex disorder. RUHS-BH seeks to bring together experts in this field into one setting as well as develop a training ground to increase the number of providers who can treat eating disorders. RUHS BH's proposed program also aims to educate the community about eating disorders. This proactive approach can reach underserved populations and lead to earlier diagnosis and treatment for previously undiagnosed individuals.

IEHP supports the program RUHS-BH is proposing and believe it could help our families and members experiencing an eating disorder as well as potentially train and expand the current provider network. We are pleased to support this exciting initiative and look forward to working with you.

Sincerely,

Takashi Wada, MD, MPH
Chief Medical Officer
Administration
Wada-t@iehp.org

Helping Others Soar

Victor Treatment Centers

Victor Community Support Services

Administration
1360 East Lassen Avenue
Chico, CA 95973
530.893.0758
Fax 530.893.0502
www.victor.org

12/20/23

To: Behavioral Health Commission

This letter is written in support of Riverside University Health Systems-Behavioral Health's (RUHS-BH) proposal to create an Eating Disorder Intensive Outpatient Program (ED-IOP).

I am the Regional Director for Victor Community Support Services overseeing all of our Riverside County services. We are a contracted provider with RUHS-BH to provide intensive mental health services to "at risk" youth and their families. We have a broad array of services that serve a wide range of clients that include Transition Age Youth, Early Childhood 0-5, and a General Children's Mental Health Program that serves school age children and young adults.

I have personally worked with RUHS-BH for the past 18 years. In that time I have found them to be consistently innovative, collaborative, and focused on the well being of children above all else. They were one of the first departments in the state to identify home and field based services as a way to bring mental health services to those who could not access it and recognized early that services in a client's home have the potential to be extremely impactful. They were at the forefront of identifying the Transition Age Youth population as an underserved population and desperately in need of their own services tailored to their needs.

Approximately 2 years ago we began to see a huge increase in the identification of children and young adults with eating disorders and their need for treatment. Typical of RUHS-BH, they immediately began developing treatment protocols and training programs to assist this population. Also typical of them, they connected with several providers including Victor to maximize our ability to help these youth in need. We now have identified staff trained in the treatment of ED and standard protocols for the identification and treatment of these youth. With this in mind I believe it would be of huge benefit to us as a provider and the larger community we serve to have an ED-IOP in place. This program has the potential to increase the amount of youth we serve while at the same time improving the quality of care through the standardization of evidence based practices and identifying a more holistic treatment team for these youth in need.

Based on the aforementioned information it is without question that I would recommend RUHS-BH to create an ED-IOP. If there are any questions regarding this recommendation please feel free to contact me at 951 212 1770.

Sincerely,

John DeVries MA MFT
Victor Regional Director

Data Collection 08/30/2023 through 11/14/2023

Name	Organization	Are you familiar with Diagnosed Eating Disorders?	Do you have any experience working with someone who you suspected had an eating disorder?	Are you aware of local services available to a person with a potential eating disorder?	Do you think behavioral health services for eating disorders are isolated from the medical services needed?	For adults that have an eating disorder, is there a need for their support person to have access to support/and or education on eating disorders (whether it be a family member significant other, or friend)?	Do you think there is a need for general community education on understanding eating disorders?	Do you think doctors in general are confident, ready, and willing to participate in the physical aspects of eating disorder care?	What do you think the challenges are in providing support and/or education for parents/caregivers of children/youth with an eating disorder?	What are some of the expressed or potential challenges to access to intensive eating disorder services?	What do you think about integrating a primary care site and an intensive eating disorder program in one integrated location?	What cultural challenges might exist in the treatment of eating disorders?	Do you have any other comments, questions, or concerns?	How satisfied are you with the Proposed ED Innovation Plan?
JM	Operation SafeHouse	SW	SW	SW	Y	Y	Y	Y	Access	Distance and cost	love the idea	cultural stigmas exist in different communities so education and outreach to those areas	So excited that this is happening!	
Not Provided		N	Y	N	Y	Y	Y	N	time, fear, not knowing, knowing, stigma	time and money	like it	??	No	
DLB	CCRD	Y	Y	N	Y	Y	Y	N	Getting them to unlearn preconceptions, and also to see their place in the ED overall scheme in the family	We are steeped in a society that places a moral imperative on thinness and puts a moral value on fitness	Lovely! Should be destigmatizing.	When the entire cultural background is a celebration of disordered eating, it can be hard for folx to see the disease	Some of your strongest allys in the work will be people in the fat-positive SJ movement. Also, we need to have more focused conversations on orthorexia nervosa	
EN	Asian American Task Force	SW	SW	N	N	Y	Y	N	Cultural beliefs and practices; lack of knowledge and understanding	Program/providers not culturally competent	Much needed!!!	Already submitted the list in my report	Need to identify potential barriers	
LW	First 5 Riverside County	Y	N	N	SW	Y	Y	SW	Providing support that is culturally congruent and support that is available during times that are convenient for the family.	I'm not sure	I think that is a great idea.	I think there is misinformation around eating disorders that may need to be de-bunked among many different cultural groups.	Not at this time.	
RR	ISCUW Crisis Helpline	Y	N	N	Y	Y	Y	Y	I believe that challenges would be education on nutrition and how not enough nutrients can not only be detrimental to physical health but to mental health as well.	A challenge for access would be if a person who has medi-cal or private insurance would qualify. If not, could there be a financial agreement.	It would help with having more access to an intensive eating disorder program.	In the Hispanic or Mexican culture, it is offensive if food is offered, so I would say is not having support at home. Along with all the mental health stigma.	None	
YM	Tessie Cleveland	SW	Y	SW	Y	Y	Y	N	The lack of resources available within the county.	The lack or programs available along with costs.	It would be great.	the stigma with a diagnosis.	I would like to be informed of updates pertaining to resources available to individuals with eating disorders.	
NS	ECC	Y	Y	Y	Y	Y	Y	N	Ego	Insurance approvals or denials and having access to ED services alongside trauma treatment	Let's do that	Misinformation and judgement	Media and Hollywood persuades public opinions and judges people based on appearance.	

Data Collection 08/30/2023 through 11/14/2023

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CS	RUHS-BH C.C	SW	Y	N	SW	Y	Y	N	Yes	Challenges in understanding the different kinds of eating disorders	Yes , then after branch out and have multiple locations	Cultural aspect would be they see it as a normal thing and/or over look the situation.	Providing knowledge to the community is key point in their understanding and reaching that population.	
NP		SW	Y	N	Y	Y	Y	Y	Lack of available resources of education/Lack of data/Too much exposure to media	Finances, Mental Health support	While I support this idea, it is also hard to know if those will ED will feel as if they are a priority in a single location along with other folks who are seeing a primary care site for a different reason	Lack of support - growing up within the Asian community, it always felt like eating was the cause of make you too fat or lack of eating was making you too skinny and not feeling supported even in efforts to gain better habits.	I would love to ED programs be implemented in schools. A close friend of mine was diagnosed with ED post-high school and it took such a toll on her mental health, she nearly died by suicide. Had there been some kind of education in school programs, I believe she would have felt heard and supported	
HL	ANT Consulting	SW	N	N	Y	Y	Y	SW	Lack of resources and individuals to treat ED	Experienced medical professionals	It might be beneficial. Woulld likd yo grt onput from community	Trust and lack of Cultural professionals to address the subject	None	
KM	RUHS	Y	Y	Y	Y	Y	Y	N	Not enough education or clarity about all of the different types of ED.	Only being offered services if you have a low BMI.	I would encourage more than one location because of those out in the Coachella Valley.	Not enough understanding about cultural differences and food.	Those of us in the County also need to be trained more as well.	
NP		Y	Y	Y	SW	Y	Y	N	Cultural and linguistic barriers	Awareness of services, location, stigma of higher level of care	I would have to see the research in the matter	So many... notions of colonizati8n and eurocentrism, access to care, equity...	Great discussion	

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SH	Riverside University Health System - Behavioral Health	Y	Y	Y	N	Y	Y	SW	A lack of awareness and education. There is no public service announcements anywhere in the media today about the signs and symptoms of adolescent EDs	Lack of medical systems integration with behavioral health to ensure wraparound services for those affected by EDs	Should have happened decades ago	Cultural Stigma is so prevalent, due to a lack of information provided to the community about how eating disorders happen in people. There is no addressing to the public in cultural communities about the effects of trauma and traditional conditioning that can lead to an eating disorder. Behavioral Health stigma from the medical institutions, staff and providers perpetuates the aversion to seek	If you have a task force to strategize systems integration for the purposes of addressing EDs, I would love to take part.		
AB	RUHS - BH	Y	N	N	Y	Y	Y	SW	Not enough information	Underserved communities might have a harder time getting access	Yes having one place for all services will make it more accessible	Different cultures have different views on treatment with quite a few of them not acknowledging eating disorders at all	N/A	VS
LT	CSUSB	N	SW	N	Y	Y	Y	SW	Cultural sensitivity	lack of insurance and under diagnosis	It could be challenging for those who are not near by to get access	standards of beauty	N/A	SWS
TB		Y	Y	Y	SW	Y	Y	SW	I think the medical professional field needs more knowledge on eating disorders. The more knowledge they have, the better they can offer care and outlets to help the person that has one	I have known people to be locked up in facilities to learn how to deal with their eating disorders and to re-insure them that they are not fat or ugly a lot of eating disorders start from somebody saying something insensitive to them repeatedly to make them feel bad about them selfs to cause them to stop eating or to eat a lot at one time	I think if you have to integrate something that's not providing proper support then do it I advocate for many different causes and if I had to do it for this cause I would in a heart beat my best friend has a eating disorder and almost died it took all of us to help her and I will never give up on her and neither will her primary care I do believe primary care should act faster on these disorders instead of waiting til someone is almost dead	Eating disorders don't pick a culture it could happen to anyone	Yes we need to help them some eating disorders are caused by trauma example a loved one passed away suddenly or a chemical imbalance or mental illness like depression and or anxiety	VS
NP		Y	Y	SW	Y	Y	Y	N	stigma, lack of awareness	Out of county, not enough resources, cost	sounds like a great way to remove barriers to access	stigma	No	S

Data Collection 08/30/2023 through 11/14/2023

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SH	RUHS-Behavioral Health	Y	Y	N	Y	Y	Y	SW	Stigma - a lack of education.	Financial barriers	Wonderful idea	Lack of education and understanding how cultural stigma plays a role in not seeking help.	So excited about this program's potential :)	S
LB	rpya	SW	N	N	Y	Y	Y	SW	They're in denial of any problems, and are unsure where to begin with eating disorder education. Cultural aspects may also have an impact on views of eating disorders	Healthcare access, transportation, finances, lack of support	That sounds nice. I hate that so many aspects of care are separated, eg: dentists/vision being separate from other types of health care	Not expressing and talking about signs connected to eating disorders--anxiety and depression; what's deemed as normal or abnormal in other cultures.	Not at this time; but perhaps later	S
JH	inland caregiver resource center	SW	N	SW	SW	Y	Y	N	i dont know	n/a	good idea	n/a	n/a	S
NAP	Creative Solutions for Kids & Families	SW	N	N	N	Y	Y	N	Not enough or accessible information about the preliminary signs of eating disorders.	Low income, lack of medical insurance, lack of awareness of the signs and symptoms of eating disorders.	Not sure, I do not have experience with eating but think it would benefit all parties if client's and family members are engaged in the process.disorders	Primary cultural challenges, eating disorder are not recognized as a problem or the stigma of "what happens at home stays at home".	None	N/A
T	UCR	Y	Y	Y	SW	Y	Y	SW	Expense	Expense	Good idea	Not sure	No	S
CS	RUPREPARED2PRESENT	N	N	N	Y	Y	Y	SW	f03be894-e5a2-4b08-8047-18b7340bca4d	Lack of knowledge	i agree	lack of knowledge	N/A	S
LDW	Wright's Community and Business Development Corporation	Y	Y	N	Y	Y	Y	N	Unawareness, denial or stress	Get participation, cooperation and support	That would a great concept	Accept their condition to make a change	No	S
WL	InSite	N	SW	SW	N	Y	Y	SW	Time, resources, lack of knowledge, transportation, single parent home	Stigma, lack of education, mental health concerns	It is a creative idea	The lack of understanding about each culture group dealing with trauma issues	No	VS
V	RUHS-BH	N	SW	Y	Y	Y	Y	SW	Lack of education	Lack of services in the area	I think its a great idea	Soul food and other bad foods in the culture	None	N/A
NP		Y	Y	SW	SW	SW	Y	N	Stigma, shame, guilt, fear	unfamiliarity, expensive, not always culturally-based	Much needed	not respecting cultural perspectives/nuances	Importance of including spiritual, emotional, mental, and physical wellness components	SWS

Data Collection 08/30/2023 through 11/14/2023

Name	Organization	Are you familiar with Diagnosed Eating Disorders?	Do you have any experience working with someone who you suspected had an eating disorder?	Are you aware of local services available to a person with a potential eating disorder?	Do you think behavioral health services for eating disorders are isolated from the medical services needed?	For adults that have an eating disorder, is there a need for their support person to have access to support/and or education on eating disorders (whether it be a family member significant other, or friend)?	Do you think there is a need for general community education on understanding eating disorders?	Do you think doctors in general are confident, ready, and willing to participate in the physical aspects of eating disorder care?	What do you think the challenges are in providing support and/or education for parents/caregivers of children/youth with an eating disorder?	What are some of the expressed or potential challenges to access to intensive eating disorder services?	What do you think about integrating a primary care site and an intensive eating disorder program in one integrated location?	What cultural challenges might exist in the treatment of eating disorders?	Do you have any other comments, questions, or concerns?	How satisfied are you with the Proposed ED Innovation Plan?
JV	stakeholder	Y	Y	SW	N	Y	Y	N	1 - peeps believe ED is about food/weight. almost imposible to get past that. 2. too much attention to identified patient's health/weight, vigilant wathcing each meal, MH in a bad spot ' are you better today? constant monitoring hypervigilant, caregivers wanting recovery to be linear and quick	time off work, atypical size range may not be considered legitimate need for help/any kind of intensive treatment	great idea, save time and concentrated work with dietican need GP involved, phys need to be in tune with ED care	regional subculture issues, i.e. italian make jokes feeding each other, if u reject the food your mom is giving you, they feel like u are rejecting them	frequent (weekly) checking out reviews/survey feedback: what might you like us to do differently, so I can feel empowered in recovery,	VS
DM	RUHS-BH Research Unit	Y	N	N	Y	Y	Y	N	Not sure	Need for increased ED services access for transgender individuals as gender identity and gender dysphoria plays a unique role in eating disorders among transgender persons. Additionally, there needs to be education/awareness among medical/BH providers in terms of treating eating disorders in those who are not underweight and/or experiencing "obvious" symptoms	That would be very beneficial to those with eating disorders and would help bridge the gap between medical and behavioral health support for eating disorders. It makes things more accessible and could increase the rate of medical care follow-up alongside behavioral health services.	Eating disorder care needs to be culturally informed, such that there is an understanding in how cultural differences surrounding body image and cultural body size standards affect eating disorder development uniquely.	Just want to reiterate there needs to be accessible ED care/services regardless of someone's weight/body type, etc. Anyone can have an ED no matter their weight.	N/A
DD	First Congregational Church in Riverside	Y	SW	Y	Y	Y	Y	N	Stigma, lack of information, denial	Same as above	Great idea. Absolutely needed so there is skilled medical intervention as well.	Cultural traditions around food. Stigma around the view of my .	Stress the religious aspect as Rev Benita shared. That is new. Add a component of working with faith communities.	VS
SM	RUHS-BH	SW	Y	N	Y	Y	Y	SW	Support service is not known, eating disorder related to trauma	wanting to address the issue in a safe place	I think eating disorders should be part of whole health care, but maybe eating disorder should have its own site. I am open.	trust and cultural sensitvity	No	S
SR	Anakbayan IE	Y	SW	N	Y	Y	Y	SW	Communication, generational gap	Someone admitting they have eating disorder	Not sure	Communities not admitting eating disorders exist	None	SWS
MB	AAPIMHRC	SW	SW	SW	N	Y	Y	SW	denial by the person with the disorder	shame or cultural beliefs that it is	Could be easier for all concerned to have one location for service	stigma of associating the disorder to mental health	Need to explore further	S

Public Posting Period: 11/27/2023 through 12/27/2023

The purpose of the Eating Disorder Innovation project is clear to me.	Are you satisfied with the Innovation project activities described?	Do you support RUHS-BH using funds to implement this Eating Disorder innovation project?	Do you have any concerns about the innovation project described?	If you have any Concerns what are they?	Do you have any ideas to add to the Eating Disorder Innovation project?	Do you have any other recommendations or comments about the proposed innovation project?	Age:	Race/Ethnicity (Select all that Apply):	Are you a person with a disability? If yes, please specify.	Sex:	Gender Identity: (Girl/Woman, Boy/Man, Non-binary)	Do you identify as:	Are you responsible for caring for a child or young adult age 25 or younger?	Are you a veteran?	Name:	Which stakeholder group do you currently identify with?	If you indicated "other" above, please help us understand your Stakeholder group?
SA	VS	SS	NC	NA	I don't have any ideas to add. I love that you are looking for alternative options, and our program would love to be apart of the change!	No, I think it is positive what you are doing. I hope we can be apart of your project!	26-59	White or Caucasian	No	F	G/W	Hetero or Str	Yes	No	AC	Consumer/Person with lived experience/have mental health challenges, Family member/caregiver of person with mental illness/mental health challenges, I am the CEO of a non-profit that deals with mental health	I am the CEO/Founder of a non-profit that deals with mental health
SA	VS	SS	SC	the qualifying criteria seems restrictive so it eliminates a lot of people with the Dx	implementing virtual sessions and engagement for those that have anxiety or stigma	outings for the youth as a reward system	26-59	White or Caucasian	autoimmune	F	G/W	Hetero or Str	No	No	MV	RUHS-BH employee	NA
SA	S	S	SC	My concern is that the county is not passing through CalAIMS funding at a comparable rate to all other California counties. This gives the appearance that the county is focused on their own projects and buildouts (and this is a great one, don't get me wrong!) while neglecting to make sure the current network of contract providers remains solvent, and the overall county system of care has vitality.	Lit review suggests state of the art for ED tx involves a neurodevelopmental approach - IOP is a sufficiently intensive level of care to support such, yet I see no reference or biblio that suggests this is understood and incorporated within the county's approach.	NA	60+	White or Caucasian	NA	F	G/W	Hetero or Str	No	No	NP	Mental Health/Physical Health/Substance Use Professional/service provider	NA
SD	S	SS	NC	NA	NA	NA	60+	Hispanic or Latino/x	NA	M	B/M	Gay	No	Yes	NP	Community Based Mental Health Provider	NA
D	U	S	U	unsure where to read about the project	NA	make information easier to access and locate	26-59	Hispanic or Latino/x	NA	F	G/W	DTA	Yes	No	NP	Consumer/Person with lived experience/have mental health challenges, Family member/caregiver of person with mental illness/mental health challenges, Mental Health/Physical Health/Substance Use Professional/service provider	NA
SA	VS	SS	NC	NA	NA	NA	26-59	White or Caucasian	NA	F	G/W	Hetero or Str	Yes	No	NP	Mental Health/Physical Health/Substance Use Professional/service provider	NA
SA	VS	SS	NC	NA	NA	NA	26-59	Hispanic or Latino/x	NA	F	G/W	Hetero or Str	Yes	No	NP	RUHS-BH employee	NA
A	S	S	SC	Clinical time & Community awareness roles is too exhausting on a single clinician. There needs to be a break down of roles within each position. Specifically, clinicians needs to focus on improving outcomes and support staff should be utilized to increase community awareness and training other physicians about ED resources and the current roles of the Eating Disorders Innovation Project.	The Eating Disorders Innovation project should really survey current therapists, their offices, and clinics to gauge the current clinical needs of each area within the county.	As a clinician, it is helpful to have a clearer structure within psychiatrists, physicians, and staff psychologists for understanding their expected roles. The goal is 1 clinical therapist for every 4 consumers. How often do these 4 consumers see a psychiatrist? How many clinical staff psychologists would be hired? From work experience, a goal of 1 clinical therapist for every 4 consumers is aspirational, and the real outcome is likely double or triple for each clinical therapist.	26-59	Asian	NO	M	B/M	Hetero or Str	No	No	NP	Mental Health/Physical Health/Substance Use Professional/service provider	NA
A	S	SS	U	NA	NA	NA	26-59	White or Caucasian	NA	F	G/W	Hetero or Str	No	No	NP	Community Based Mental Health Provider	NA
A	VS	SS	U	NA	NA	NA	26-59	Hispanic or Latino/x	NA	F	G/W	Hetero or Str	No	No	GP	Community Member	NA
A	S	SS	U	NA	NA	NA	60+	American Indian or Alaska Native	NA	F	G/W	Hetero or Str	Yes	No	JA	Mental Health/Physical Health/Substance Use Professional/service provider	NA

Public Posting Period: 11/27/2023 through 12/27/2023

The purpose of the Eating Disorder Innovation project is clear to me.	Are you satisfied with the Innovation project activities described?	Do you support RUHS-BH using funds to implement this Eating Disorder innovation project?	Do you have any concerns about the innovation project described?	If you have any Concerns what are they?	Do you have any ideas to add to the Eating Disorder Innovation project?	Do you have any other recommendations or comments about the proposed innovation project?	Age:	Race/Ethnicity (Select all that Apply):	Are you a person with a disability? If yes, please specify.	Sex:	Gender Identity: (Girl/Woman, Boy/Man, Non-binary)	Do you identify as:	Are you responsible for caring for a child or young adult age 25 or younger?	Are you a veteran?	Name:	Which stakeholder group do you currently identify with?	If you indicated "other" above, please help us understand your Stakeholder group?
A	S	SS	NC	NA	no	none	60+	White or Caucasian	no	F	G/W	Hetero or Str	No	No	TS	Mental Health/Physical Health/Substance Use Professional/service provider	NA
SA	S	SS	NC	NA	No.	No.	26-59	Hispanic or Latino/x	NA	M	B/M	Hetero or Str	Yes	No	DC	Mental Health/Physical Health/Substance Use Professional/service provider	NA
SA	VS	SS	NC	NA	Add activities that support body appreciation.	NA	26-59	Hispanic or Latino/x	NA	F	G/W	Hetero or Str	Yes	No	L	LGBTQIA	LGBTQIA
A	S	SS	NC	NA	NA	NA	26-59	White or Caucasian	NA	F	G/W	Hetero or Str	No	Yes	NP	Mental Health/Physical Health/Substance Use Professional/service provider	NA
A	S	SS	NC	NA	NA	NA	26-59	White or Caucasian	No	F	G/W	Hetero or Str	Yes	No	NP	Consumer/Person with lived experience/have mental health challenges, Family member/caregiver of person with mental illness/mental health challenges, Mental Health/Physical Health/Substance Use Professional/service provider	NA
A	S	S	NC	NA	NA	NA	26-59	Hispanic or Latino/x		F	G/W	Hetero or Str	Yes	No	NP	Mental Health/Physical Health/Substance Use Professional/service provider	NA
A	S	SS	NC	NA	NA	NA	26-59	White or Caucasian	Yes, Deaf	F	G/W	Bi	Yes	No	S	Consumer/Person with lived experience/have mental health challenges, Community Member	NA
A	S	SS	NC	NA	NA	NA	60+	Black or African American		F	G/W	Hetero or Str	No	No	JT	Community Member	NA
A	S	SS	U	NA	no	no	16-25	Hispanic or Latino/x	no	M	B/M	Gay	No	No	NP	Community Based Mental Health Provider	NA
SA	VS	SS	NC	I do not have any concerns. I believe that this project will be the first within the department to offer services at this level and fill gaps of service that have historically been extremely difficult to bridge.	I believe the project is excellent as is.	I strongly support this project and believe that the community needs/deserves to be served at the level in which the project is proposing. Eating disorders have the second highest mortality rate of all mental illness (next to substance abuse as it relates to the Fentanyl epidemic) because of the severity and complexity of the medical consequences that eating disorder commonly lead to. This project supports the integration of medical and behavioral health and promotes a recovery-oriented environment that will increase the likelihood of positive treatment outcomes.	26-59	Middle Eastern or North African	No	F	G/W	DTA	No	No	SR	Consumer/Person with lived experience/have mental health challenges, Family member/caregiver of person with mental illness/mental health challenges, Mental Health/Physical Health/Substance Use Professional/service provider, Community Member	NA
A	VS	SS	C	Access for Deaf patients. They have frequent denials due to need for ASL interpreters.	Ensure access for Deaf and Hard of Hearing clients.	No	26-59	Hispanic or Latino/x	NA	M	B/M	Hetero or Str	No	No	BW	Mental Health/Physical Health/Substance Use Professional/service provider, RUHS-BH employee	NA
SA	S	SS	NC	NA	NA	NA	26-59	White or Caucasian	NA	M	B/M	Hetero or Str	Yes	No	NA	Mental Health/Physical Health/Substance Use Professional/service provider	NA
A	VS	SS	NC	None	No	NA	26-59	White or Caucasian	NA	M	B/M	Gay	No	No	KAK	Mental Health/Physical Health/Substance Use Professional/service provider	NA
SA	VS	SS	NC	NA	NA	NA	26-59	Hispanic or Latino/x	yes, deaf	F	G/W	Lesbian	No	No	LG	Dept of Developmental Services	Provide policy, funding and technical support to Deaf Plus individuals for the State of California

Public Posting Period: 11/27/2023 through 12/27/2023

The purpose of the Eating Disorder Innovation project is clear to me.	Are you satisfied with the Innovation project activities described?	Do you support RUHS-BH using funds to implement this Eating Disorder innovation project?	Do you have any concerns about the innovation project described?	If you have any Concerns what are they?	Do you have any ideas to add to the Eating Disorder Innovation project?	Do you have any other recommendations or comments about the proposed innovation project?	Age:	Race/Ethnicity (Select all that Apply):	Are you a person with a disability? If yes, please specify.	Sex:	Gender Identity: (Girl/Women, Boy/Man, Non-binary)	Do you identify as:	Are you responsible for caring for a child or young adult age 25 or younger?	Are you a veteran?	Name:	Which stakeholder group do you currently identify with?	If you indicated "other" above, please help us understand your Stakeholder group?
A	S	SS	C	Changing, eating habits, along with proper nutrition, along with caloric intake and consumption	I would like to see more focus on our senior community, with all the healthcare needs and medications that are, Elders receive along with declining mental processes and many medications to work together	NA	60+	Hispanic or Latino/x, White or Caucasian	I am legally blind and my right leg B/K Amputee	NA	NA	NA	NA	NA	WR	Family member/caregiver of person with mental illness/mental health challenges, Mental Health/Physical Health/Substance Use Professional/service provider, Community Member	NA
A	S	SS	NC	NA	NA	NA	26-59	Black or African American		F	G/W	Hetero or Str	No	No	NP	RUHS-BH employee	NA
SA	VS	SS	SC	I hope you will be able to provide services to adult women and lgbtq males.	Pet therapy as a wellness tool	no, it sounds great	60+	White or Caucasian	cancer survivor	NA	G/W	Q or Unsure	No	No	NP	Consumer/Person with lived experience/have mental health challenges	NA
SA	S	SS	NC		One issue for queer folks is lack of gender inclusive spaces; for example gender neutral facilities. Lack of these spaces can put gender expansive patients in distress in their recovery. I appreciate there being an educational component for the providers of the IOP to be culturally competent. I hope there are considerations for how to make specifically group therapeutic settings inclusive/affirming for queer patients, as there is potential for other straight/cis-gender patients to mistreat/misgender lgbtq+ patients. Having community guidelines and policies that explicitly is intolerant of discriminatory behavior to other staff/patients on basis of sex/gender identities is needed, in addition to follow-through of staff to report discriminatory behavior and intervene as necessary when misgendering/acts of discrimination take place.	Everything else sounds great! Can't wait to see the fruits of this project.	26-59	Asian	Yes, Neurodivergent - ADHD	M	N/B	NA	No	No	NP	Consumer/Person with lived experience/have mental health challenges, Community Member	NA
SA	VS	SS	NC	NA	NA	NA	26-59	Hispanic or Latino/x	NA	M	B/M	NA	No	Yes	CM	Mental Health/Physical Health/Substance Use Professional/service provider	NA
SA	VS	SS	NC	none	none	Needed in the Desert communities	26-59	White or Caucasian	no	F	G/W	Hetero or Str	No	No	NP	Community Based Mental Health Provider	NA
A	S	S	NC	NA	NA	NA	26-59	Hispanic or Latino/x	NA	F	G/W	Hetero or Str	No	No	LR	Mental Health/Physical Health/Substance Use Professional/service provider, Community Based Mental Health Provider	NA
SA	VS	SS	NC	NA	NA	NA	26-59	Asian	NA	F	G/W	Hetero or Str	No	No	NP	Mental Health/Physical Health/Substance Use Professional/service provider	NA

Eating Disorders in the Hispanic/Latinx Community: My Personal Experience

I never really thought about my relationship with food, I have always felt that it was healthy. I don't consider myself an "emotional eater," I basically eat when I'm hungry. I abide by the saying, "Eat to live, don't live to eat." However, as I was examining this topic, I slowly began to realize that my issues with food are subconscious, I was not aware of them until now.

I was born and raised in Guatemala, I was under the care of my paternal grandparents from the time I was three months old until right before my eighth birthday, and that is when my mother went back to Guatemala and brought me to live with her in California. Life with my grandparents was extremely harsh, we were poor, and I remember going without food for days at a time. I quickly found out that there was no use in complaining about the hunger pangs that ached my stomach, there was nothing that my grandparents could do. I think that is why I can go without eating for long periods of time now as an adult. There have been days when I simply forget to eat.

There was no shortage of food when I came to live with my mother, on the contrary, there was too much food. My mother would cook for my sister and me, she would put whatever amount of food she wanted on our plates, and we had to wipe our plates clean. We had to eat whatever she made, whether we liked it or not, trying to get liver and onions down my throat was pure torture for me. She would sit at the table at times with a wooden spoon in hand threatening to use it on us if we didn't finish all our food. She would guilt us by saying that there were children and other people starving in the world, that food was expensive, and therefore it was a sin to waste it. I remember there were times when I could not eat another bite and I had no choice but to force the food down my throat. My sister would sit at the table and cry because she could not eat another bite, so if by chance my mother got up from the table to go into the kitchen, I would hurry up and eat my sister's food to spare her from our mother's wrath.

I had five children of my own and I would say the same thing to them, that there were children starving in the world and they had to finish all their food, but I didn't threaten them the way my mother used to threaten me. I have found myself doing the same thing with my partner, I get very upset whenever he does not finish all his food, and I will eat whatever he leaves on his plate, even if I'm full because I still believe that throwing away food is a sin. He has told me that I need to understand that if he's full he will not take another bite. I have learned to cut back on the portions that I give him, and I have realized that my views on food were instilled in me by my family and our culture.

My mother was extremely critical of me when it came to my weight, By the way, this is very normal in our culture, she would tell me that I looked like a cow whenever I gained weight. Her comments made me self-conscious and brought down my self-esteem, I would starve myself for days at a time whenever I noticed that I was gaining weight. Once I started high school, I became even more self-conscious of my body, and I developed what I now know as an eating disorder. I guess I didn't consider it an eating disorder because I wasn't in a bathroom sticking my fingers down my throat to regurgitate my food. I wouldn't do that because I consider that wasting food, so I chose to starve myself instead. Once I became an adult, in my late 30s, I developed healthier eating habits, and I learned the importance of incorporating exercise into my lifestyle.

My mother developed non-alcoholic cirrhosis of the liver and passed away eleven years ago. The doctor who treated her explained that she had fatty liver disease and that my sister and I were genetically predisposed to developing the same thing. He said that we could control that disease through our diet, so I became Vegan. I never really liked any kind of meat, I'm allergic to eggs, pork, and dairy, so giving up animal products was not difficult for me.

I interviewed one of my daughters, she's a 28-year-old, Hispanic female. I explained to her that I was conducting research for this report, and I asked if she would feel comfortable discussing her relationship with food, she agreed. She reported that she would binge on food during her adolescent years. That's changed as she's gotten older, she now considers herself to be an emotional eater. She disclosed that she finds comfort in food whenever she's stressed out or going through a period of depression. She stated that she felt a sense of relief when binge eating, but then would experience feelings of guilt, shame, and self-loathing shortly afterward. What she reported is like what the research findings concluded.

TAY (Transitional Aged Youth) ED Consumer Focus Group Responses
Surveys Administered by LCSW, CTII,
TAY Desert Drop-in Center, Riverside University Health System – Behavioral Health

1. **What do you think about additional support for the family or support persons who care for a person with an eating disorder?**

    - Having additional support for the family or persons who care for a person with an eating disorder can help provide advice and extend knowledge about their experience.
    - I believe that the support for family/person who cares for a person with an eating disorder is great! More education for them to understand what that person with the disorder goes through.
    - I believe it would greatly benefit all parties involved
    - I think it could help a lot, especially support for the family because it could help them learn about it along the way
    - This would help a lot because my mom has her own denial about her own food issues

2. **Do your experiences in eating disorder treatment services fit with your cultural beliefs and values?**

    - Sharing to understanding information to provide me with the best help I can get doesn't affect my values.
    - Yes, because I, myself have an eating disorder
    - Yes, I don't find that I mix the two
    - Yes, I believe so
    - Yes

3. **Have you or your family members experienced any challenges with having your mental health care provider work with your physical health care provider for an eating disorder-related need?**
        - **Do you think behavioral health services for eating disorders are isolated from the medical services needed?**

    - No, my mental health providers are good at working with my physical health care providers, I just need to get an apt w/my doctor.
    - No, because I don't tell my family members that I have an eating disorder. I believe and know they might suspect something is wrong.
    - No, I have never had my mental healthcare provider work with my physical healthcare
    - No, I don't think so
    - No

4. **Do you feel parents/caregivers of children/youth with eating disorders need additional support and/or education on eating disorders?**
    - **What do you think the challenges are in providing support and/or education for parents/caregivers of children/youth with an eating disorder?**
    - Yes, I viewed eating disorders with little to no knowledge and assumed people had body image issues as the main/only cause I never would have thought "binging" was an eating disorder and marked it off as stress eating
    - Yes, I agree that people should need additional support and education on eating disorders! It's not easy having an eating disorder it's a battle almost
    - Yes, parents having a better understanding of the disorder may help all parties
    - Yes, it would help a lot and it could help them gain an understanding about eating disorders
    - Yes, my mother
    - Yes, my maternal grandmother

5. **For adults that have an eating disorder is there a need for their support person to have access to support/and or education on eating disorders (whether it be a family member significant other or friend)?**

    - Yes, as some adults may be uncomfortable sharing such information
    - If the person is aware, yes, and if they wanted the support education on eating disorders
    - Yes, It might help them understand the condition better without leaving them overwhelmed
    - Yes, it always helps to be educated
    - N/A

6. **What do you think about integrating a primary care site and an intensive eating disorder program in one integrated location?**

    - I believe these types of programs can be extremely beneficial for severe cases, and those with new diagnoses that may lead to severe cases
    - I think it's a good idea because many people's eating disorders are severe
    - I think it would be a great idea
    - It would be good and very helpful
    - I'm afraid it would be too strict and I would obsess more

7. **Do you think there is a need for general education on understanding eating disorders? Think, broad community education.**

    - Yes, because those without eating disorders don't look for that information and are left with stigmas based on their environments
    - Yes, so that we can be educated on the eating disorder and how it can hurt the one with the disorder and the loved ones
    - Yes, it will help break the stigma on them
    - Yes, eating disorders can get misunderstood easily and quickly
    - Yes

Riverside University HEALTH SYSTEM Behavioral Health
Cultural Competency

Cultural Competency Program

The Cultural Competency Program provides overall direction, focus, and organization in the implementation of the system-wide Cultural Competency Plan that addresses the enhancement of workforce development and the ability to incorporate languages, cultures, beliefs, and practices of its consumers into the services.

AAFWAG
African American Family Wellness Advisory Group

AAFWAG focuses primarily on educating and engaging the community in reducing the stigma associated with mental health.

AATF
Asian American Task Force

AATF was organized to bring the Asian American Pacific Islander (AAPI) population together with providers and resources for networking, education, advocacy, and community building.

CAGSI
Community Advocating for Gender and Sexuality Issues

CAGSI strives to eliminate disparities in the mental health system by ensuring the implementation of culturally competent services and advocating for prevention and early intervention strategies for the LGBTQ+ community.

CCRD
Cultural Competency Reducing Disparities Committee

CCRD is 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.

DEAF & HARD OF HEARING

The Deaf & Hard of Hearing Committee focuses on the Deaf & Hard of Hearing community in Riverside County.

HISLA
Hispanic, Latinx

HISLA helps the community thrive, by reducing the stigma of seeking out mental health assistance, providing education, advocacy, and support with navigating healthcare systems.

MENA
Middle Eastern and North African

MENA aims to assist the mental health system in reducing disparities in behavioral health programs and improving the livelihoods of the MENA community.

NATIVE AMERICAN

The Native American Committee focuses on the cultural needs of our vast Indigenous communities which is currently planning for future meetings.

WADE
Wellness & Disability Equity Alliance

The WADE Alliance is building trusting relationships between Riverside University Health System-Behavioral Health and the People with Disabilities community

SPIRITUALITY & FAITH BASED

The Interfaith & Spirituality Committee aims to promote optimal health and well-being for all of Riverside County's faith and spiritual communities, including behavioral health providers.

Riverside University HEALTH SYSTEM Behavioral Health
Cultural Competency

Cultural Competency Meetings

AAFWAG
African American Family Wellness Advisory Group

10 to 11:30 a.m.
Meets on the 3rd Wednesday of every month.

AATF
Asian American Task Force

3:30 to 5 p.m.
Meets Bi-monthly, on the 2nd Tuesday.

CAGSI
Community Advocating for Gender and Sexuality Issues

2:30 to 4 p.m.
Meets on the 3rd Tuesday of every month.

CCRD
Cultural Competency Reducing Disparities Committee

9 to 11 a.m.
Meets on the 2nd Wednesday of every month.

DEAF & HARD OF HEARING

4 to 6 p.m.
Meets on the last Monday of every month.

HISLA
Hispanic, Latinx

3 to 5 p.m.
Meets on the last Thursday of every month.

MENA
Middle Eastern and North African

2:30 to 3:30 p.m.
Meet Bi-monthly on the 3rd Wednesday.

NATIVE AMERICAN

3:30 to 5 P.M.
Meets on the 3rd Monday of every month.

WADE
Wellness & Disability Equity Alliance

1 to 2:30 p.m.
Meets on the 1st Friday of every month.

SPIRITUALITY & FAITH BASED

10 to 11:30 a.m.
Meets on the 2nd Tuesday of every month.

RUHS-BH

Mental Health Services Act

INNOVATION PROPOSAL

Eating Disorder Intensive Outpatient & Training Program

Novanh Xayarath

Behavioral Health Services Administrator

Western Region Children's and TAY Stepping Stones

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Leah Newell

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Cultural Competency RUHS-BH

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Innovation Project Defined

An Innovation project is defined as:

- a **Research** 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"

An Innovation project should:

- provide new knowledge to inform current and future mental health practices and approaches
- contribute to the expansion of effective practices through learnings

Innovation Project Requirements

General Criteria:

- Makes a change to an existing practice in the field of mental health system, including, but not limited to, application to a different population

Primary Purpose:

- 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

Innovation Parameters

* Nov 26 – Dec 27, 2023

** February 22, 2024

Reality

The Problem

Eating disorders have the second highest mortality rate of all mental health disorders surpassed only by opioid addiction

Risks of all-cause and suicide mortality in mental disorders: a meta-revie. World Psychiatry, 13(2), 153-160, Edward Chesney, Guy M. Goodwin & Seena Fazel

Eating Disorder

A condition characterized by irregular or abnormal eating habits

Behavioral conditions characterized by severe and persistent disturbance in eating behaviors and associated distressing thoughts and emotions…

And impairment of physical and/or mental health

Anorexia nervosa

An eating disorder characterized by relentless **drive for thinness with a fear of gaining body weight** associated with self induced behaviors towards thinness.

Bulimia nervosa

Eating disorder characterized by **binge eating, followed by methods to avoid weight gain.**

Common Types

Eating Disorders: Please note there are many others

Innovation Project

Beneficiaries

Youth, targeting underdiagnosed/underserved communities

Medical & Mental Health Professionals

Consumers, their families and friends

General Public

Contract Providers

IOP

Behavioral Health Care with Primary Care Services

3-4 days/week

4-6 hours/day

Project HUB

Training

For: medical staff, ED staff, family, friends, partners, community-at large

Consultations

Cultural Perspectives

Combat Stigma

Education

For: medical staff, ED staff, family, friends, partners, community-at large

ED & Cultural Resource Library

Support Groups

Outreach

Combat Stigma

Staff care

Culture-Centered

Body type/image

Cultural Connection to Food

Meal Planning – ethnic foods

Environment

Language/words

Staff diversity

Address barriers

Varying Perspectives

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]

2. Parker LL, Harriger JA. Eating disorders and disordered eating behaviors in the LGBT population: a review of the literature. J Eat Disord. 2020;8:51.
3. Goeree MS, Ham JC, Iorio D. Race, social class, and bulimia nervosa. IZA Discussion Paper No. 5823.
4. Swanson SA, Crow SJ, Le Grange D, et al. Prevalence and correlates of eating disorders in adolescents. Results from the national comorbidity survey replication adolescent supplement. Arch Gen Psychiatry. 2011;68(7):714-723.

IOP/County-Run

Public vs Private

Infrastructure Adaptation:

to examine the **variations, choices, regulations** made to the traditional IOP privatized model at the infrastructure level

Focus Areas

The proposed Innovation project is focused on **developing system-wide best practices** for establishing an eating disorder IOP program in a County public mental health system.

This 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) that will also function as an eating disorder training hub.

Establishing an ED-IOP program will also provide the opportunity to **train practitioners and 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.

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.

The Primary Problem

Lack of an effective and integrated treatment approach for eating disorders

Need for integrated ED training for psychiatrists and physicians,

Lack of eating disorder training that incorporates effective eating disorder practices for diverse groups

Lack of knowledge of eating disorders and treatment options in diverse and underserved communities.

Difficulty coordinating behavioral health care with primary medical care

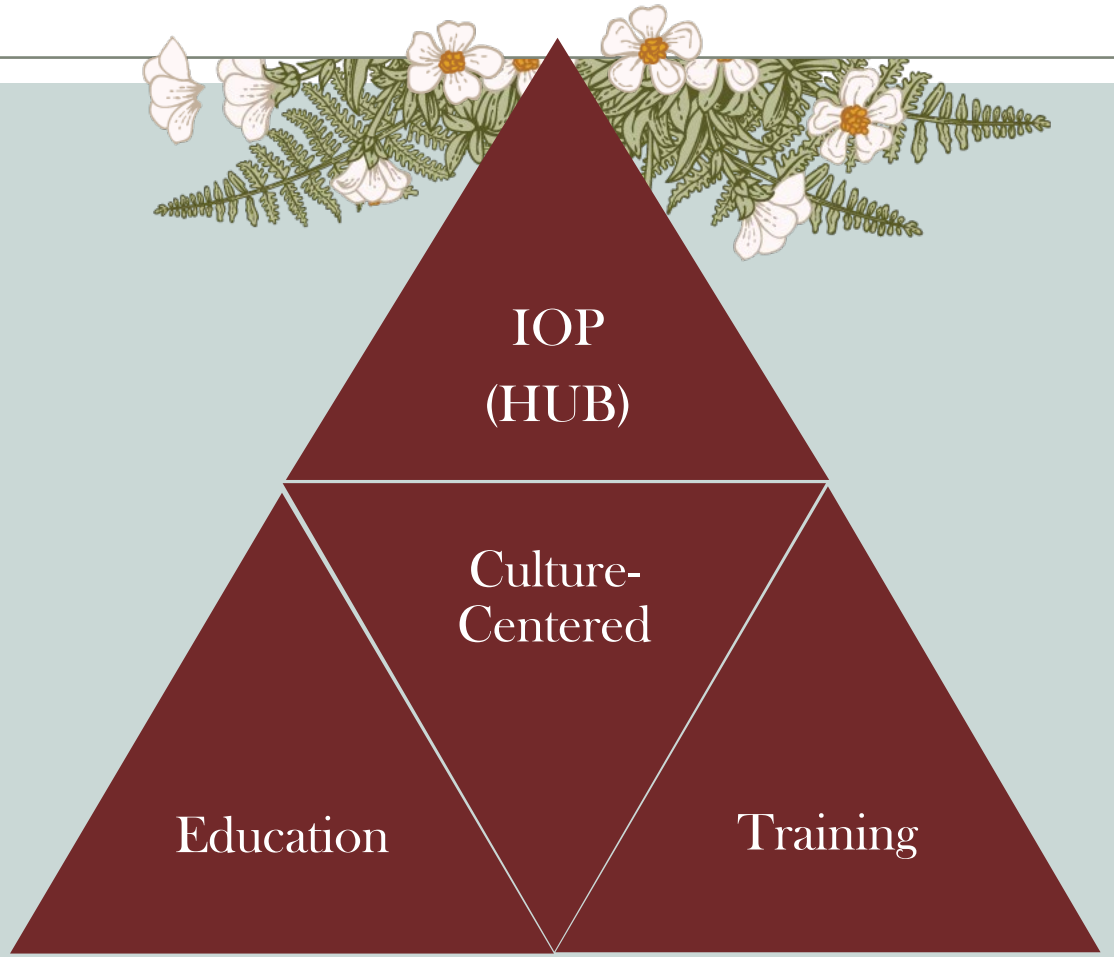
Lack of a full continuum of care for eating disorders with integrated service for physical health.

Lack of knowledge on how to best work with families from diverse backgrounds to increase engagement and follow through with treatment recommendations

Innovation Project: Learning Goals

Q1 County Operated ED IOP HUB/increase access?

Q2 ED IOP/increase knowledge, confidence, competency?

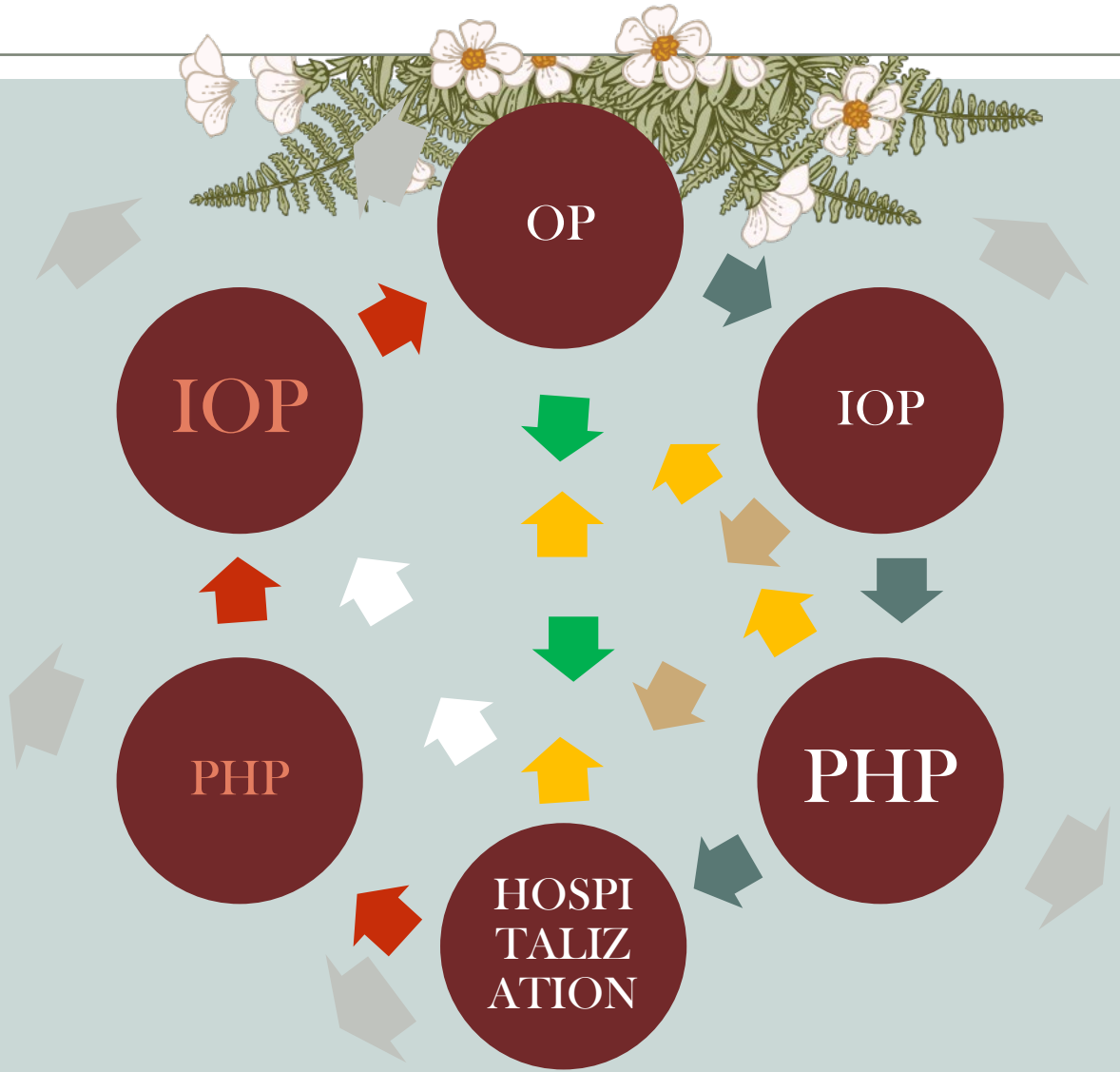


Q3 Family Support Groups/increase engagement & reduce stigma?

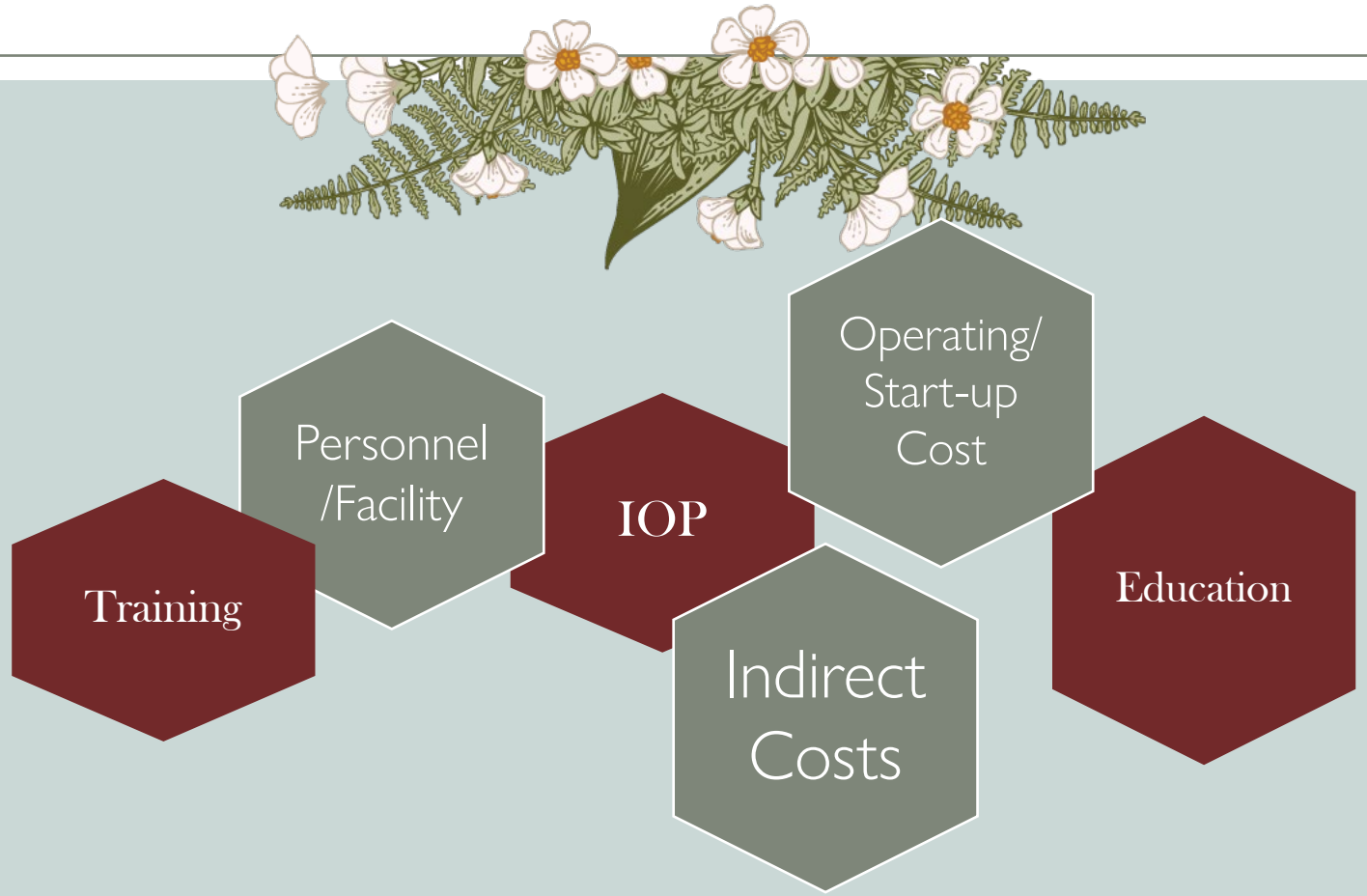
Q4 Culturally-tailored Education/increase help seeking & decrease stigma?

Innovation Project: Cycle of Care

The mean cost of hospitalization for depression was around $13,000, compared with $46,000 for eating disorders.



Innovation Project: Expenditures



*Proposed Budget: ~30 million of available Innovation Funds. Approximately 6 million per year for a 5-year research project.

Continued Community Involvement

The **Guidance Council** component is designed to **ensure continued learning, feedback, input, and accountability** of the ED IOP, training, and education elements. This team will be comprised of a **range of representatives.** The meetings will be an opportunity to **connect and collaborate** and **keep abreast of** recent developments in eating disorders **research** and **activities** of the **IOP project** and the **community**.

Most importantly, to provide invaluable input into the continued improvement and development of the ED IOP project.

We are interested in your input to ensure various voices contribute to a project fully reflective of the needs of our diverse community.

Thank you

The final proposal is posted on the MHSA Innovation websites

https://www.ruhealth.org/behavioral-health/innovation-inn

And

https://www.rcdmh.org/MHSA/Innovation

for continued public comment

We welcome your review, thoughts and remarks