

Implementation of the Levels of Care (LOC) Payment Model in King County During the
COVID-19 Pandemic: The Provider Perspective

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Abstract

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The LOC payment model was implemented in King County in July of 2020. Based on a Population Health Stratification Model (PHSM), the LOC payment model was developed with the intention of benefiting both the client and provider through a more accurate identification of the appropriate level of care and payment aligned with service intensity. Given the timing of implementation of the LOC payment model, it is likely that the co-occurrence of the pandemic had an impact on the ability of providers to adapt to the new model. Moreover, changes in policies or procedures that occurred in response to both the payment model and the pandemic are thought to have had an additional impact on the experience of providers with this new model. This research sought to understand the barriers and facilitators that impact the experience of behavioral health providers in adapting to the LOC payment model, including those that are a result of changes that occurred in response to the pandemic both organizationally and outside of the organization. The researcher utilized a case study qualitative research design, which included a brief electronic survey, individual interviews, various publications, and recorded webinars to understand the experiences of providers responsible for counseling, therapy, case management,

or peer support services in King County. Ultimately, this study resulted in three key themes that demonstrate some of the challenges and facilitators that providers in King County have experienced in relation to the implementation of the LOC payment model and the co-occurrence of the COVID-19 pandemic. Additionally, this research informs recommendations to alleviate some of the observed challenges.

Keywords: King County, behavioral health, mental health payment model, Level of Care payment model, population health stratification model, providers, community mental health

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despite the challenges that they face.

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Implementation of the Levels of Care (LOC) Payment Model in King County During the COVID-19 Pandemic: The Provider Perspective

The Level of Care Payment Model

The LOC payment model was developed in 2019 by the King County Integrated Care Network (KCICN) and partners. Despite the onset of the COVID-19 pandemic, which resulted in significant disruptions to clinical practice, the KCICN elected to proceed with the implementation of the new payment model in July of 2020. (King County, 2019) This payment model is based on a Population Health Stratification Model (PHSM) that generates a risk score from multiple sources to determine assignment to the appropriate LOC and payment level. (King County, 2020a) Clinical factors considered in the scoring model include acute care utilization (hospitalizations and emergency department (ED) visits), markers of severe substance use disorder (SUD) (residential care or withdrawal management encounters, and involuntary treatment evaluations), and concurrent physical health comorbidities (diabetes, cardiovascular disease, asthma, COPD), with a greater number of risk factors resulting in a higher score. Social determinants of health, including housing status, history of incarceration, and length of incarceration are also factored into a risk score. Clients who have been incarcerated for greater than two consecutive years in the last five years are assigned a higher point value. Lastly, the PHSM takes into account a client's performance on the Level of Care Utilization System (LOCUS) instrument, with a high LOCUS score leading to a higher PHSM score. The PHSM differs slightly for youth. For example, the Child and Adolescent Level of Care Utilization System (CALOCUS) instrument replaces the LOCUS assessment and social determinants of health are evaluated based on the history of foster care.

Per contracts with Managed Care Organizations (MCO), clients must be assessed via specific tools to ensure they meet criteria for care, or medical necessity in terms of their mental health. (King County Behavioral Health and Recovery Division, 2020) For adults eighteen years of age or older, the LOCUS is one tool that is often utilized to determine medical necessity. (King County Behavioral Health and Recovery Division, 2020) The LOCUS assessment was developed by the American Association of Community Psychiatrists, and it considers six dimensions to identify an individual's level of care. These include the same dimensions as considered in the CALOCUS. (American Association of Community Psychiatrists, 2009; American Association of Community Psychiatrists, 2010; Deerfield Behavioral Health, Inc., 2021) Individuals with a score that is less than 10 on either the LOCUS or CALOCUS do not meet criteria for services as they are considered to have only mild to moderate acuity. (King County Behavioral Health and Recovery Division, 2020)

To calculate one's score, each factor in the PHSM is assigned a point value. These are then added together to produce a score. For more information, including the specific point values per each data element, refer to Appendix 2 and 3. Based on this data, each client will receive a score. Clients with a score of 5-10 points will be stratified to the medium LOC. Lastly, clients with a score of 11 points or more will be stratified to the high LOC. (Appendix 4)

Each LOC then has a predetermined expectation in terms of service utilization hours. A client that is stratified to the low LOC is expected to engage in 1.5 billable service hours each month, whereas a client stratified as a medium LOC should engage in 2.5 service hours per month. A client stratified to the high LOC should engage in seven billable service hours per month. For each level, any combination of billable services within the mental health outpatient program will count toward service utilization hours, i.e., individual treatment, counseling,

therapy, case management, peer services, medication management, etc. (King County, 2020a; King County, 2020b) (Appendix 5)

Although payment through the LOC payment model is based on a case rate that is determined by the client's LOC, it is further adjusted based on service delivery adherence (SDA). (King County, 2020a; King County, 2020b) (Appendix 5) As such, an agency will receive full payment when SDA is met, or the client has engaged in 85% or more of the expected service intensity as determined by their LOC stratification. For example, as a client stratified to the high LOC is expected to engage in seven billable service hours per month, if they engage in 5.95 (85%) billable service hours over the course of a single month, the agency will receive the full case rate. If a client engages in less than 85% of their expected service intensity, the agency will receive a decreased payment. (King County, 2020a; King County, 2020b) As no services are rendered over a four-month span, the agency will continue to receive a grace period of decreased payment before payment will end all together. (King County, 2020a; King County, 2020b) During this grace period, the agency is expected to complete outreach and engagement efforts to encourage the client's participation in services. (King County, 2020a; King County, 2020b) Though this grace period provides incentive for engagement, SDA expectations are felt to be unattainable for assorted reasons, including the limited capacity of providers and clients, the lack of client voice or agreement to service intensity, and the lack of consideration of clinical discretion.

Payment for Mental Health Services in King County

As both the previous payment model and the new payment model are based on a case rate, the notable difference between the two is the concept of SDA and use of the PHSM. As such, non-adherence to service intensity expectations did not impact payment in the previous

payment model. This meant agencies received reimbursement in alignment with the specified case rate regardless of the client’s engagement in services. This included if the client engaged at all. As an authorization lasted for twelve months, payment could continue throughout the remainder of the client’s authorization regardless of if the client discontinued engagement at any point in time. Given this structure, the previous model provided incentive for starting clients in services though did not incentivize or hold agencies accountable for maintaining engagement with clients. In the LOC payment model, providers are accountable for delivering services in alignment with the client’s stratification level in order to receive full payment. Ultimately, this new model has the potential to lead to improved client outcomes and reduced spending as client’s are more likely to receive the right volume of service in accordance with their needs. A challenge that providers face in the LOC payment model, however, is that sometimes the identified service intensity per the PHSM does not align with the provider’s determination or the client’s choice. Further, clients may experience barriers or be unwilling to engage in treatment at the level they are assigned. Which the LOC payment model, can lead to reduced payments for reasons that are outside of the control of providers.

Table 1.

Comparison of the previous payment model and the LOC payment model

	The previous payment model	The LOC payment model
Process for Stratification	Stratification occurs through a single yearly mental health assessment. Within this assessment, agencies were required to provide data relevant to various sociodemographic factors, functional criteria for SMI or SED, as well as justification of the client’s service intensity needs via the LOCUS assessment for adults or the CALOCUS assessment for youth.	Stratification occurs based on a PHSM that considers clinical risk factors from multiple sources to determine stratification to the appropriate LOC. Such risk factors include acute care utilization, social determinants of health, and chronic health conditions, in addition to the LOCUS or CALOCUS assessments.

Levels of Care	2X: 1.25 billable service hours 3A: 2.5 billable service hours 3B: 7.5 billable service hours	Low: 1.5 billable service hours Medium: 2.5 billable service hours High: 7.0 billable service hours
Financial Structure	A case rate that is based on the client’s stratification.	A case rate that is that is based on the client’s stratification and further adjusted by SDA.
Reimbursement	Non-adherence to service intensity expectations did not impact payment. Thus, agencies received reimbursement in alignment with the specified case rate regardless of the client’s level of engagement in services, including if the client engaged at all.	An agency will receive full payment when SDA is met, or the client has engaged in 85% or more of the expected service intensity. If a client engages in less than 85% of their expected service intensity, the agency will receive a decreased payment. As no services are rendered over a four-month span the agency will continue to receive a grace period of decreased payment before payment will end altogether.
Episode of Care	A twelve-month span following the date that the client initiated services. This is renewed once yearly through completion of a mental health assessment update	An open episode that is continued by ongoing engagement and completion of a yearly mental health assessment.

Note. This table demonstrates the similarities and differences between the previous payment model and the LOC payment model.

Landscape of Mental Health Service Delivery and Payment

Reimbursement models for mental health services billed through Medicaid can vary between states and between counties. For example, in Washington State, the payment model utilized for Medicaid mental health services in King County differs from the payment model utilized in neighboring counties such as Snohomish or Pierce County. Despite variation, there are common models that are often adapted at the county or state-level to facilitate payment for Medicaid mental health services. For example, fee for service (FFS) is a well-known payment model in which states set specific provider payments depending on the services delivered. Per

the Social Security Act, payments for services rendered through a FFS model must be efficient and economical in terms of delivery, based on quality care, and ensure equitable access for the general population. (Medicaid and CHIP Payment and Access Commission, 2022) Despite benefits to Medicaid FFS models, many providers expressed concerns about low reimbursement rates in comparison to Medicare reimbursement rates. (Medicaid and CHIP Payment and Access Commission, 2022) Moreover, given the limitations of FFS payment models, health care payers are gradually adopting new models that focus on value-based payment (VBP) instead. VBP models incentivize high-quality and cost-effective care as opposed to the volume of services delivered. (Bailey et al., 2019) As the adoption of a VBP model is a significant shift for providers, it is imperative to consider factors that enhance or promote provider engagement and adherence to the new model. Similarly, barriers to the adoption of a new payment model should be considered in advance and a system in place to ensure barriers to adoption can be addressed in a timely and efficient manner.

Without any solution or plan in place to address evident drawbacks of the LOC payment model in King County, as well as recognizing the lack of provider input into the development of the model or in conversations to improve the model, this qualitative research sought to understand the barriers and facilitators that impact the experience of mental health providers in adapting to the LOC payment model. This includes those that are either a result of or are related to changes that occurred both organizationally and outside of the organization in response to the COVID-19 pandemic. As such, the researcher sought to answer the following research questions.

Research Questions

- What are the barriers and facilitators to adapting to value-based care through implementation of the LOC payment system?

- How have organizational changes in response to the COVID-19 pandemic acted as a facilitator or barrier to the adoption of a value-based care model through implementation of the LOC payment system for community behavioral health providers in King County?

Ethical Considerations/IRB Approval

The University of Washington Institutional Review Board (IRB) reviewed and approved this research (IRB approval ID: STUDY00014606). The ethical review board also determined that this research qualifies as human subjects research that is exempt from federal human subjects regulations, including further IRB approval and review, per Category 2 exemptions. All study participants provided informed verbal consent to participate in an individual interview.

Background

Community Mental Health Services in King County

In 2016, there were six community behavioral health organizations that were responsible for more than 60% of all Medicaid claims for outpatient behavioral health services across King County. (Healthier Here, 2017) Those agencies included Valley Cities Counseling and Consultation, Therapeutic Health Services, Sound Mental Health, Evergreen Treatment Services, and Community Psychiatric Clinic. (Healthier Here, 2017) Cumulatively, these agencies received reimbursement for 1.2 million Medicaid claims relative to behavioral health equating to an estimated average of 34 claims relevant to mental health over the course of 2016 for each client engaged in services. (Healthier Here, 2017) In addition to these organizations, there are numerous smaller organizations that provide mental health services in King County with Medicaid. (King County, 2022c)

While organizations may be similar in part, they differ in terms of their size, structure, services that they offer, and the population or age group that they serve. For example, Rhyther

specializes in youth services whereas Navos provides a unique and comprehensive program for at-risk infants, young children, and their parents or caregivers. (King County Community Health Needs Assessment, 2022; Navos, 2021) Conversely, Valley Cities has a distinctive partnership with HealthPoint, a primary care provider in King County, through which mutual clients are able to access a specific care coordination program to receive greater support for both their mental and physical health conditions. (King County Community Health Needs Assessment, 2022; Navos, 2021) Aside from some of the unique or specialty services provided by each organization, there is overlap in terms of basic community mental health supports. Generally, these include counseling, therapy, case management, care coordination, peer support, and psychiatric services. The intention of the case study involving providers from Valley Cities Behavioral Health (VCC) is to illuminate the perspective of mental health providers in King County.

Valley Cities Behavioral Health (VCC)

VCC was established by community members in 1965 as a single clinic that offered mental health outpatient services in Auburn, Washington. With few staff to start and a single clinic, over the years, VCC has grown to include 11 outpatient mental health clinics and two inpatient clinics in King County. (Valley Cities Staff, 2021; Valley Cities Staff, 2022) What's more, VCC now employs more than 500 staff as of 2021. (Valley Cities Staff, 2021; Valley Cities Staff, 2022)

VCC offers mental health counseling for all ages, VCC provides substance use disorder treatment services, housing programs, homeless outreach services, school-based services, and veteran's services among other specialty care services and programs. VCC embraces a team-based approach in which clients have the opportunity to connect with multiple team members.

This includes peers, case managers, clinicians, therapists, and/or psychiatry providers, among other supports, depending on the client's preferences, treatment needs, and recommended care pathways. Regardless of an individual's care team or services they may choose to engage in, all staff at VCC are trained in Trauma-Informed Care (TIC) and all policies, procedures, services, programs, and treatments embrace TIC principles. Similarly, VCC embraces all eight of the Guiding Principles of Recovery. These include the viewpoint that recovery emerges from hope, should be person-driven, occur through many pathways, and remain holistic and supported by both peers and allies. Further, treatment should be based on mutual respect, be culturally relevant, supported through relationships and social networks, and recognize that recovery not only involves individual strengths and responsibility, but also, one's family and community. (Substance Abuse and Mental Health Services Administration, 2019)

A total of 20,551 clients were served by VCC in 2021, amounting to 732,826 total services. Of which, 83% of those served were between 20 to 64 years of age. (Valley Cities Staff, 2021; Valley Cities Staff, 2022) Additionally, 14% of clients served were between the ages of 0 to 18 and just 3% were over the age of 65. (Valley Cities Staff, 2021; Valley Cities Staff, 2022) It was estimated that 64% of clients had no source of income (64%), 22% had an income ranging between \$1 to \$17,000, and 14% had an income that exceeded \$17,000. (Valley Cities Staff, 2022) Forty-three percent of clients identified as white/Caucasian, 14% identified as Black or African American, and 2% identified as American Indian/Alaska Native or African (Ethnic). (Valley Cities Staff, 2022) All other races reported (Indian, Cambodian, Chinese, Filipino, Japanese, Korean, Laotian, Thai, Vietnamese, other Asian, Middle Eastern, Native Hawaiian, Guamanian or Chamorro, Samoan, or other Pacific Islander) made up 2% or less of the total population of clients served by VCC. Race or ethnicity was not reported or unknown for 1% and

5% identified as some other race/ethnicity. (Valley Cities Staff, 2022) Just under 10% of clients identified as having Hispanic heritage. (Valley Cities Staff, 2022)

VCC experienced challenges as a result of the growing mental health crisis and the COVID-19 pandemic. Lingering uncertainty, grief, loss, and residual trauma experienced by staff as a result of the ongoing pandemic contributed to a record-breaking number of resignations and challenges filling vacant positions, similar to that of what has been observed elsewhere. (Sound, 2021) Along with these challenges, VCC along with other community mental health providers in King County contracted with the MCOs and KCBHRD, had the unique challenge of adapting to an entirely new payment system within months after the COVID-19 pandemic began.

Mental Health in Washington State and King County

Despite investments and actions to improve mental health treatment and access to care throughout Washington State prior to the pandemic, both adults and youth throughout the state report mental illness at a higher rate than the national average. Washington State ranks 16th in terms of access to mental health care and 31st in terms of the prevalence of mental illness and rate of accessing mental health treatment. (Mental Health America, 2020) A year prior to the COVID-19 pandemic, it was estimated that approximately 300,000 or 4.25% of adults living in Washington State had a diagnosis relevant to SMI and by February 2021, 46.3% of adults reported symptoms of anxiety and/or depression. (Forecasting and Research Division, 2015; Substance Abuse and Mental Health Services Administration, 2019; Kaiser Family Foundation, 2017; National Alliance on Mental Illness, 2021a; U.S. Department of Housing and Urban Development, 2020) Of all adults with SMI who sought mental health care or had a referral for treatment, 36.6% reported barriers to accessing care, equating to an estimated 133,000 adults who did not receive needed mental health treatment in Washington State (National Alliance on

Mental Illness, 2021a; Kaiser Family Foundation, 2017) Similarly, in the year prior to the pandemic, an estimated 82,000 youth 12 to 17 years of age living in Washington State were diagnosed with depression and of those, 52% did not receive care in the last year. (Substance Abuse and Mental Health Services Administration, 2019; Kaiser Family Foundation, 2017; Dupéré, 2018) It is unsurprising, therefore, that an increase in the prevalence of SMI following the start of the COVID-19 pandemic has contributed to more individuals seeking mental health services and consequently, individuals are experiencing growing barriers to care. (Centers for Disease Control and Prevention, 2021b; Healthier Here, 2017; Gattman et al., 2017; Sound, 2021)

In King County alone, 12% of adult residents reported frequent mental distress in 2019. (County Health Rankings & Roadmaps, 2021) This is an increase from the average across 2014-2018 in which 10.8% of adults in King County reported frequent mental distress. (King County Community Health Needs Assessment, 2022) Recent data also demonstrated evidence of inequities across groups. (King County Community Health Needs Assessment, 2022) In terms of youth in King County, the prevalence of depression has steadily increased over the past decade. On average 31.4% of King County youth in grades 8th, 10th, and 12th, experienced depressive feelings per data from 2016 to 2018. (King County Community Health Needs Assessment, 2022) This data demonstrated an increase in the prevalence of youth who experienced depressive feelings with each grade level. (King County Community Health Needs Assessment, 2022)

While the devastating impacts of the COVID-19 pandemic in terms of morbidity and mortality were apparent, the collective trauma as a result of the COVID-19 pandemic was less often considered. (Substance Abuse and Mental Health Services Administration, 2020) Increased isolation, loneliness, financial hardship, housing and food insecurity, and tremendous loss of

loved ones and normalcy in general, have contributed to higher levels of stress, depression, and anxiety. (Substance Abuse and Mental Health Services Administration, 2020) As such, per 2020 data, 55% of adults who experienced SMI stated that the pandemic had a negative impact on their mental health. (Substance Abuse and Mental Health Services Administration, 2020) Considering these factors, it is not surprising, that there has been an increase in symptoms of depression and anxiety, nearly triple of what was observed prior to the COVID-19 pandemic. (Centers for Disease Control and Prevention, 2021b)

It is assumed that some of these issues are a result of barriers in accessing care. Which, barriers to accessing mental health care pre-date the pandemic although have also worsened as a result of the pandemic. (Vahratian et al., 2021; Cusick et al., 2022) For example, the behavioral health workforce has faced a longstanding history of low pay, insufficient benefits, high caseloads, high acuity clients, and time-consuming documentation requirements that overwhelm the workforce and contribute to retention and recruitment challenges. (Healthier Here, 2017; Gattman et al., 2017) The pandemic is assumed to have increased the stress experienced by providers due to shifts in service delivery requirements, regulations for billing, and swelling caseload sizes, exacerbating the challenges mental health providers already face. Additionally, it is assumed that the COVID-19 pandemic contributed to further exodus from the community mental health field and greater challenges filling vacant positions. (Healthier Here, 2017; Gattman et al., 2017; Sound, 2021) For individuals who are able to access care, it is likely the workforce shortage negatively impacted clinical care. (Gattman et al., 2017) For example, of all U.S. adults in need of mental health care, 1 in 10 or 4.9 million adults conveyed barriers to accessing needed care and further, reported that barriers to accessing care worsened their mental health. (Substance Abuse and Mental Health Services Administration, 2020) Moreover, an

estimated 60% of youth across the U.S. report barriers to care despite a diagnosis of depression. (Mental Health America, 2020) Of the youth with severe depression who were able to access mental health care, 47% reported inconsistent mental health care evidencing a negative impact on clinical care. (Mental Health America, 2020)

Research Purpose

While the mental health crisis continues to grow, shifts in payment and policies that impact the mental health field press on. With this in mind, Gattman et al. emphasize the timing of shifts in payment and policy as having an impact on the effectiveness of implementation. Thus, it is assumed that the payment model itself, as well as the co-occurrence of the COVID-19 pandemic and implementation of the LOC payment model, had a detrimental effect on clinical care and service delivery. Further, such impacts are assumed to have affected multiple levels of the mental health system, including prospective and current clients, providers, and agencies. In particular, changes as a result of the LOC payment model are assumed to have contributed to additional stress, burnout, and ultimately, further exodus from the mental health field. Additionally, policies and changes that occurred in response to the COVID-19 pandemic are also assumed to have had both positive and negative impacts on the implementation of the LOC payment model. Namely, in terms of provider adherence, uptake, and perceived effectiveness.

Two years after implementation of the LOC payment model, substantial flaws persist that contribute to negative impacts for clients, providers, and agencies. Thus, the overarching aim of this research was to develop recommendations that are reflective of the opinions and experiences of community mental health providers in King County, to improve provider engagement with, and ultimately the effectiveness of the LOC payment model. This qualitative research also highlighted the impact of the COVID-19 pandemic on the adoption of the LOC model.

The Theoretical Domains Framework

To explore the various barriers, facilitators, and behavioral determinants of providers as they adjust to the new payment model, the design of this study was shaped by the researchers own experience with this topic as well as with consideration to the second iteration of the Theoretical Domains Framework (TDF(v2)). For example, the TDF(v2) helped inform the research questions, semi-structured interview guide, and lens for which the data was analyzed. The TDF was developed by a group of behavioral scientists and implementation researchers with the intent of consolidating the most commonly utilized theories and theoretical concepts relevant to determinants of behavior pertaining to implementation into one framework. The TDF supports researchers to identify determinants of behavior among health professionals in the implementation of evidence-based recommendations and assess implementation challenges to develop interventions or strategies to address those challenges. The original TDF was published in 2005 however, less than a decade later, a group of independent behavioral experts worked to further consolidate the framework. As a result, a second version of the TDF was published in 2012, known as TDF(v2). Although this framework has primarily been utilized to determine factors that influence clinical behaviors of healthcare professionals and to inform the development of interventions in healthcare settings, it has also been widely applied to other purposes and settings as well. For example, the TDF has been utilized to understand the determinants of health-related patient behaviors as well as non-health related behaviors and Atkins et al., suggest this framework can also be utilized in public health or occupational health settings as well. (Atkins et al., 2017) In this study, rather in relation to an evidence-based practice (EBP), the TDF(v2) was considered more generally in terms of the behavioral determinants that impact the ability of providers to adapt to the LOC payment model.

Methods

Study Design

The researcher utilized a qualitative case study research design consisting of a brief survey, individual interviews, and thematic analysis. The design of this study was shaped by the researchers own experience with this topic as well as with consideration to the second iteration of the Theoretical Domains Framework (v2).

Study Population

This research sought to understand the perspectives and experiences from community mental health providers impacted by the LOC payment model. As case management, counseling/therapy, peer services, and medication management are considered essential mental health services in King County, this study specifically sought to recruit participants who provided such services, with the exception of medication management. Study participants were recruited based on their role, i.e., peer, case manager, clinician and/or therapist. Participants who moved between roles within the last two years, i.e., a case manager who became a clinician, were attributed to the group in which the majority of their experience was related. In addition to providers, the researcher included agency leaders to understand from their perspective, the barriers and facilitators for providers in adapting to the LOC payment model. It is assumed that agency leaders will have a different perspective than that of providers given a difference in the manner of which they interact with the LOC payment model. All study participants were recruited from VCC.

Analysis Team

The principal researcher of this study is a second year Master of Public Health student at the University of Washington and is trained in public health intervention, mixed methods

research, health systems, and policy. The researcher has worked within the community mental health field for six years, at VCC. Thus, the researcher is familiar with VCC, community behavioral health services in King County, the LOC payment model, and the payment model previously in place in King County.

The research team also consists of a second student and two thesis committee members. The second student is also a second-year MPH student in the department of Health Systems and Population Health. This individual helped to develop and refine the codebook, as well as helped to ensure consensus and reliability among codes. Both thesis committee members are faculty members with the University of Washington in the Department of Health Systems and Population Health. Thesis chair, Anne M. Turner MD, MPH, MLIS, is also affiliated with the Department of Biomedical Informatics and Medical Education and is particularly experienced with qualitative research. Amber Sabbatini MD, MPH, FACEP, is also affiliated with the Department of Emergency Medicine and is knowledgeable about payment systems and mental health in King County.

Data Collection Methods

Participant Recruitment

This study utilized a purposive sample of community mental health providers recruited through use of the snowball sampling technique. (Patton, 1990) As such, the researcher started by identifying a provider in each role. From there, participants identified additional individuals to recruit. To assist, the researcher provided potential participants with an electronic flyer that included information about the study, a brief electronic survey, and a link to a Doodle Poll. Participants were encouraged to share this for potential participants to anonymously schedule an individual interview.

The researcher intended to obtain a sample that is representative of the total proportion of providers in each role. As community behavioral health agencies typically employ more clinicians and therapists compared to other roles, the researcher sought to obtain a sample with 40% of respondents being a clinician or therapist. With this same reasoning in mind, the researcher sought to obtain a sample consisting of 30% case managers, 20% peer support specialists, and the remaining 10% being agency leaders.

Recruitment occurred throughout February to April 2022. While no participants elected to drop out, five ultimately declined and one was lost to follow up. Of those who declined, three stated they wanted to participate but did not feel they had the time or capacity to do so or there were other barriers to scheduling that prevented their participation. One expressed interest but stated due to their impending departure from the field they didn't feel it was worth their time. Lastly, another individual expressed interest but left the agency prior to scheduling thus, no longer met eligibility criteria. It is assumed that high demand, stress, low capacity, and burnout likely contributed to low recruitment. Outside of the five that declined, one participant completed the electronic survey but did not respond to attempts to schedule an individual interview. Given the proximity between potential study subjects and the researcher, the researcher made an intentional effort to participate minimally in recruitment efforts to prevent undue influence to participate.

Data Sources and Collection Processes

Primary data sources for this research included transcripts from individual interviews and information obtained through the electronic survey. Secondary data sources included gray literature, peer-reviewed publications, webinar trainings, and personal experience. All data collection methods and tools were reviewed by a provider at VCC and the thesis committee.

interviews were conducted, they were transcribed by the researcher within one week. After the second interview, the researcher and second coder met regularly to develop and refine the codebook as well as to analyze the data obtained thus far.

Electronic Survey. The electronic survey was developed, managed, and collected using REDCap electronic data capture tools hosted by the University of Washington. (Harris et al., 2009; Harris et al., 2019) Research Electronic Data Capture or REDCap is a secure, web-based software platform that designed to support researchers with data collection activities. REDCap provides an intuitive interface for validated data capture, which includes features to track the manipulation of the data, seamless data downloads to common statistical packages, and procedures in place for both data integration and interoperability with external sources.

The electronic survey generally took participants between five to ten minutes to complete. (Appendix 8) The survey inquired about longevity with VCC as well as the size and acuity of the respondent's caseload. Agency leaders were asked an additional set of questions that specifically considered the distribution of clients per stratification level across the entire mental health outpatient program. Consent was not obtained for the electronic survey as an individual's decision to complete the survey was assumed consent.

Semi-structured Interview Guide. Individual interviews were conducted with the use of a semi-structured interview guide that was developed with consideration to numerous domains of the TDF. A particular focus, however, was centered around the environmental context and resources domain, as well as the emotion and reinforcement domains. Thus, questions sought to understand implementation challenges and facilitators through the lens of each of these domains to understand behavioral determinants of providers that impact their engagement with the LOC payment model. (Appendix 9)

Interview questions were adapted over time in an effort to match the language used by participants and in response to the different ways in which each role interacts with the payment model. Similarly, interview questions were adapted in response to differing levels of knowledge about the model or experience in terms of direct versus indirect experience with delivering services under the LOC payment model. At the conclusion of each interview, the researcher made notes of general observations and memorable reactions not captured in the transcript.

Key Informant Interviews. Prior to an interview, potential study participants were informed about the researcher's background and affiliation to the topic, as well as the purpose of the study, what to expect, and about any potential risks. Study participants were asked to provide verbal consent for participation, including consent for the researcher to record and transcribe the interview, as well as utilize direct quotes in the final analysis. Given the researchers proximity to staff, as an existing VCC employee, participants were reminded in the context of this research to keep personal health information (PHI) confidential. No potential study participants declined to consent. Individual interviews lasted an average of 46 minutes and were conducted via Zoom to accommodate social distancing measures and provider preference.

Data Analysis

The researcher utilized constant comparative analysis techniques to code participant transcripts and to compare data across transcripts. (Glaser, 1965) Similarly, constant comparative analysis techniques were used to identify patterns. Throughout this phase, the researcher considered the various domains of the TDF(v2) to understand the potential factors that impact provider behavior and engagement with the LOC payment model. Following this, the researcher utilized thematic analysis to interpret meaning from the patterns identified across data. This

phase ensued over multiple weeks. During this time, the researcher met regularly with the second coder and one thesis committee member (AT) to analyze and discuss findings.

Coding and Late-stage Analysis

Codes were developed both deductively and inductively through an iterative approach. The initial codebook was developed prior to analysis with key concepts in mind, i.e., barriers, facilitators, and recommendations. The codebook included codes to distinguish the perspective and experiences specific to individual roles, as well as the pandemic vs. the LOC payment model. The codebook was expanded upon and adapted following the first, second, and third transcripts. Upon the fourth transcript, consensus on the codebook was reached and no new codes emerged. The researcher and the second coder agreed on specific coding strategies and met regularly to review differences in the use of codes and make amendments to the codebook or coding rules as necessary.

The researcher and second coder dually coded four of the 11 transcripts (36%) utilizing Atlas.ti version 22. In total, the final codebook consisted of 51 codes across six categories. After the final codebook was determined, the researcher re-coded earlier transcripts. Following this, the researcher utilized Atlas.ti to further analyze the coded transcripts, including a review of the patterns within and between categories and a review of common views across roles. For example, the researcher compared the common barriers and facilitators between each role type, as well as those that were common across each role. The researcher continuously consulted with the second coder, thesis committee, and the TDF (v2) throughout this stage.

Findings

Electronic Survey

Participants included two agency leaders (18.2%), two peers (18.2%), three case managers (27.3%), and four clinicians/therapists (36.4). For the purpose of this research, agency leaders were defined as individuals in a director, manager, or supervisory role who did not have an active caseload at the time of this study. Notably, of the participants not categorized as an agency leader, three held both a leadership role and an active caseload. Due to their active caseload however, they were attributed to their service role rather than categorized as an agency leader. Another participant held a lead role that did not fit the definition of agency leader as utilized in this study, but again, as their primary function was direct service, they were attributed to their service role.

Length of employment amongst participants ranged from 1 year to 16 years with the average being 9.2 years. Of those who reported an active caseload, 75% reported a caseload of 81 clients or more. Half of study participants reported that the majority of their caseload was stratified to the medium LOC, whereas the other half reported that the majority of their caseload was stratified to the high LOC. No study participants reported a caseload with clients primarily attributed to the low LOC.

One agency leader provided a response regarding the distribution of clients across stratification levels. As such, they estimated that approximately 44% of all clients engaged in the mental health outpatient program are assigned to the medium level of care, compared to 38% of clients who are stratified to the high LOC, and just 18% of clients who are stratified to the low LOC.

Individual Interviews

In response to being asked about the challenges participants faced in adapting to the LOC payment model, participants spoke most often about the design of the LOC payment model and

the policies or procedures that were implemented in response to the new payment model. For example, the majority of participants expressed challenges relevant to the PHSM calculation, including the lack of clinical discretion and frequency of mis-stratification. Additionally, all participants acknowledged challenges pertinent to productivity standards that were applied in tandem with implementation of the LOC payment model. Participants were also asked about changes that occurred either in relation to the LOC payment model or in relation to the pandemic that were seen as helpful for providers in adjusting to the LOC payment model. While facilitators were less often mentioned in general, participants did note the allowance of telehealth and phone services, as well as organizational changes that increased support for providers, as being helpful for adjusting to the LOC payment model.

In comparing the challenges and facilitators noted by participants, the researcher observed subtle differences in how each role perceived or experienced a challenge or facilitator. For example, relative to productivity, case managers emphasized feeling as if their work is not always considered in the productivity calculation. One participant provided examples of this being pertinent to locating and researching community resources. While productivity was a common challenge expressed amongst majority of participants, no other role expressed feeling as if a part of their work goes unaccounted for. Conversely, a peer expressed challenges meeting productivity because of feeling limited by SDA in a manner that is unlike any other role. For example, peers receive fewer referrals compared to case managers or clinicians in general, and clients who are stratified to a low or medium LOC are less likely to receive a peer referral. Thus, peers have less clients to work with and experience a unique challenge in meeting productivity standards as they often work with clients who may experience greater challenges to continued engagement.

In terms of the differences observed across roles pertinent to facilitators, most clinicians and therapists emphasized team meetings and consults as a helpful support for adapting to the LOC payment model. Other roles however, expressed the action of scaling back some of these meetings to be more helpful.

Key Themes

In addition to these findings, three key themes emerged from the data.

1. The LOC payment model has had a negative impact on clinical care and services, affecting both providers and clients.
2. The LOC payment model as it is designed, contributes to discomfort and concern among providers, clients, and agencies.
3. The co-occurrence of the COVID-19 pandemic and implementation of the new payment model presented unique challenges and benefits for both providers and clients in adapting to the LOC payment model.

Theme 1: The LOC payment model had a negative impact on clinical care and services, affecting both providers and clients.

Participants expressed numerous challenges adapting to the LOC payment model because of the perceived negative impacts to clinical care and service delivery that affect both providers and clients. For example, multiple participants emphasized the LOC payment model to be at odds with their clinical knowledge and expertise. This is evident through a frequent mismatch between the client's LOC stratification and the providers own determination of the client's needs pertinent to service intensity or therapeutic interventions. This has contributed to frustration on behalf of the provider as participants stressed a negative impact on clinical care due to reduced ability to deliver effective and clinically indicated services. Providers also emphasized barriers to access and concern that clients are not receiving the services or care that they need as a result of

the LOC payment model. Similarly, participants emphasized a lack of client voice or clinical discretion. The perceived negative impact from these issues on clinical care poses a significant challenge for providers in adapting to the LOC payment model.

Sub-theme: Participants emphasized the LOC payment model to be at odds with training, specific evidence-based practices, and client-centered treatment. Participants acknowledged a disconnect between the LOC payment model and their experience and training, including training pertinent to evidence-based practices or therapies for specific diagnoses and symptoms. For example, multiple participants shared examples of when they felt a client could have benefit from a particular treatment or support, however, due to their stratification level, the client was unable to engage or was unable to do so at the intensity they needed. This was a notable shift from the previous payment model in which participants expressed greater ability to exercise their clinical discretion, knowledge, and skills pertinent to their use of specific evidence-based practices and treatments. Participants acknowledged SDA as a specific element of the LOC payment model that is both new and considered to be a source of this disconnect.

“I don't feel like it's effective, I don't feel like it's healing, I don't feel like it's conducive with anything that I went to school for.”¹

Some participants provided examples in which clients had achieved a certain level of stability and wellness in their life thus, they were stratified to the low LOC. Participants expressed it was because of that stability however, that some clients felt ready and motivated to engage in a particular evidence-based therapy (EBT). Due to the client's stratification level though, regardless of clinical indication and motivation on behalf of the client, they may not be able to engage in a specific EBT. This issue is further complicated when a client is engaged in a

¹ Note: phrases such as “like” and “you know” have been removed from quotes.

combination of services to maintain stability, i.e., peer support, case management, or medication management services. When this occurs, care team members must collaborate to determine how to stay within the clients SDA limit. Unsurprisingly, this can slow the client's progress towards treatment and recovery as some services may be reduced so that the client can engage in others.

“If somebody's stratified as low, then we get reimbursed to see them one and a half hours a month. So, if we were to try to see them every other week that EBP that you're supposed to do... for one hour a week, now is half an hour every other week... and oftentimes that is the person who is now in a place where they're stable enough to maybe pursue trauma treatment... Could you imagine trying to process your trauma for just one hour once a month? That's not going to be effective. You can't create those new neuropathways in that short span of time...”

Although a client-centered approach is an effective manner for enhancing positive outcomes in therapy and is a key component of the principles of recovery, nearly all participants acknowledged a shift away from a client-centered approach as a result of the LOC payment model. (Cloninger & Cloninger, 2011) Some participants acknowledged this shift in relation to the PHSM acting as the driving force in care versus the assessments that the provider has completed with the client, with the exception of the LOCUS or CALOCUS. Similarly, participants noted the lack of consideration to the client's treatment plan which is built around the client's goals and preference for service intensity given their unique situation and abilities. While participants emphasized different ways in which they've observed a shift away from the client-centered approach, majority of participants expressed frustration at the lack of client voice in the PHSM itself. Further, majority of participants who acknowledged this shift expressed greater discontent when there was a disagreement between the client's expected service intensity,

as determined by their stratification level, and the client's own desire or what is clinically indicated per the providers assessment.

“For me to be an effective provider, I actually need to meet my clients where they're at and provide services accordingly and no one knows what that looks like better than me my client.”

Sub-theme: Participants stressed that the LOC payment model contributes to access challenges for individuals in need of services in King County. Participants expressed concern that the LOC payment model contributes to access challenges for individuals in need of mental health care in King County in two major ways. First, participants emphasized a shift in the way King County community members are able to access mental health services. More specifically, participants expressed concern that clients seeking care will observe limitations around what they can access, unlike it has been in the past. This issue particularly impacts clients that are stratified to the low or medium LOC and need a higher level of service intensity than prescribed by their LOC stratification.

“I imagine a lot of clients don't recognize when they try to come into a place like us, that there are limitations as far as what is feasible... how this all works... we're gonna be wildly disappointing to people if they think that they can just come in and get the help that they need if we're having to adhere very tightly and strictly to SDA.”

“With SDA the way that we provide services has had to drastically change in response to the new payment structure... it used to be that... we could offer weekly appointments for clients who are doing certain types of therapy and who we're motivated and really wanted that. Now we can't offer that to just every client.”

Second, a couple participants expressed access challenges due to limited capacity among providers. While it is likely this is in part due to the COVID-19 pandemic, participants also stated belief that high turnover may be a result of the changing environment and system because of the LOC payment model. Nonetheless, such turnover results in prospective clients having a hard time establishing care and current clients finding they are unable to establish care with particular providers or engage in certain services due to limited capacity among providers. Providers expressed frustration and discomfort with this, especially when barriers to access were related to limitations caused by the LOC payment model.

“The clients aren’t getting started. I mean it’s as simple as that. And the ones that we are seeing aren’t getting the level of services that they’re needing to recover and there are people who are in desperate need of our services that can’t get in.”

Theme 2: The LOC payment model as it is designed, contributes to discomfort and concern among provider, clients, and agencies.

Participants expressed multiple ways in which the communication about the LOC payment model was insufficient and contributed to staff, clients, and agencies feeling unsupported in their efforts to adapt to the LOC payment model. For example, nearly all participants acknowledged the lack of support from KCBHRD to inform their Medicaid members which contributed to confusion and discomfort on behalf of both the client and the provider. Participants also acknowledged a lack of sufficient communication from KCBHRD or KCICN with agencies and providers experiencing additional confusion and discomfort around the LOC payment model. In addition to feeling like there has not been sufficient communication about the payment model, participants emphasized the lack of follow through regarding feedback from providers and agencies. Inaction in response to feedback further contributed to discomfort

and concern that there is little effort being made to address the pitfalls of the LOC payment model, further contributing to barriers in adapting to the LOC payment model.

Sub-theme: Participants noted communication about the payment model has left staff, clients, and agencies feeling unsupported, uncomfortable, and frustrated. Participants acknowledged the lack of support from KCBHRD to inform Medicaid members, including currently engaged clients, that their benefit has changed. As a result, providers are having to inform clients about this change which can be uncomfortable and challenging due to a lack of tools and resources available, as well as frustration on behalf of the client.

“...they should be informing all of their members... here's what your benefit is, here's what it will get you. Instead, they've really put that on providers to do all of the communication to very unhappy individuals.”

Participants also acknowledged the lack of sufficient communication, training, and support from KCBHRD or KCICN as adding to confusion and discomfort around the LOC payment model. For example, participants emphasized a lack of follow through relative to feedback from providers and agencies to improve the LOC payment model. Participants also stressed the lack of opportunity or avenue for providers to express their concerns or feedback about the LOC payment model. Currently, providers are relaying their thoughts to agency leaders with the hope that those leaders will bring it to the attention of King County. Which, agency leaders noted feeling as if they are in a fragile position because the lack of response to feedback from KCBHRD can at times, be perceived as non-action on behalf of agency leaders.

“...when they were given very clear direct feedback repeatedly, from lots of different people, in lots of different forums. They did nothing with it like that still has gone

nowhere... I would say they haven't been very feedback-informed in their decision making, and there has been an absolute lack of transparency, which has made it difficult at the agency level to be transparent, because... there's just so much unknown.”

Multiple participants provided examples of when they and the client disagreed with the client’s LOC stratification. One provider provided an example in which both the client and the provider disagreed with the client’s level of care stratification, however, as there was no mechanism for the provider to advocate for a change to the client’s stratification, the client decided to call their insurance company. The client was then provided with misinformation that contributed to even greater confusion and frustration for the client. Consequently, providers continued to bear the brunt of the ongoing conversation and dissatisfaction on behalf of the client regarding the LOC payment model.

“I had one client who's also a low she would like to see me weekly and I think that it is clinically indicated... She called her insurance company and they said, “oh no, you should be able to have counseling once a week” and I said, “sorry but that's not how it works. Here's the number to call...” It's confusing for the client getting mixed messages.”

“That's probably the biggest challenge that I’ve had to face, explaining it to a client.”

“Those of us left, we're having to really bear the brunt of a lot of systemic problems and to be an agent of another problem, at least for some people, that in itself feels like a problem.”

Sub-theme: Participants emphasized poor reimbursement through the LOC payment model threatens the sustainability of the mental health workforce and agencies.

Participants stressed two major ways in which the LOC payment model contributes to poor

reimbursement and as a result, poses barriers to the sustainability of the mental health workforce and agencies alike. Primarily, this is due to financial penalties that can occur when a client does not receive the expected service intensity as specified by their LOC stratification. For example, participants noted numerous observations of clients stratified to a higher LOC than they felt was clinically indicated and higher than the client desired or felt they needed themselves. As a result, clients in this situation did not meet SDA thus, the agency did not receive full payment. Some providers expressed feeling a personal responsibility when their clients did not achieve SDA and challenges supporting clients to meet SDA, leaving them feeling discouraged.

“I think we're going to run a lot of clinicians out of this work, out of the community mental health field, just because if we can't meet SDA by design... then agencies can't pay us at a rate that is livable... And so, if we are a situation or a system where we're having to feel degraded ourselves and feel as if we are degrading clients for little money, it's not going to be a real recipe for longevity... that impacts care.”

Providers also emphasized poor reimbursement as contributing to low wages. Although poor reimbursement rates have historically plagued the community mental health system, in the context of inflation, the pandemic, and social unrest, providers are expressing less motivation to bear the financial impact of remaining in a field where they are underpaid for a reason that is not sufficient.

“The payment model is really flawed, and we're being penalized in a way that just doesn't make sense... Why does that mean for the rest of the year, now she's not going to meet SDA for an issue that doesn't make sense.”

Ultimately, participants emphasized a growing concern that such poor reimbursement is likely to have a negative impact on the sustainability of community mental health agencies in general.

“As an agency as a whole, we're not hitting the numbers that we need to hit to be able to keep our doors open. This is not sustainable.”

“I see the benefit of it, I also see more agencies closing not being able to provide services for people... there's a disconnect in what they're promising and what they're delivering. And really, they can't deliver because of how they've set up the model.”

Theme 3: The co-occurrence of the COVID-19 pandemic and implementation of the new payment model presented unique challenges and benefits for providers in adapting to the LOC payment model.

Participants stressed the co-occurrence of the COVID-19 pandemic and implementation of the LOC payment model as causing significant challenges for providers in adapting to the LOC payment model due to the challenges they endured in their personal lives and work, from the pandemic. Conversely, providers emphasized the ways in which the pandemic benefited providers in adapting to the LOC payment model. Namely, through the allowance and opportunity to provide services via telehealth and phone.

Sub-theme: Participants emphasized the co-occurrence of the COVID-19 pandemic and implementation of the LOC payment model as contributing to a negative experience for providers in adapting to the new payment model. Participants emphasized the challenges they endured in their personal lives due to the COVID-19 pandemic, in addition to challenges they experienced as a result of pandemic on their work, as contributing to a negative experience adapting to the LOC payment model. Additionally, participants acknowledged the impact that

the COVID-19 pandemic had on staffing which contributed to higher caseloads and increased pressure as clients are not receiving the service intensity they should.

“Although we knew that these changes were coming in 2020, having it coupled with COVID and then wanting this adherence and productivity, and all this during COVID when we're really kind of dying on the inside. In some ways, it was very, very challenging.”

“Just the pandemic alone and trying to absorb that and understand what that means for you and your family is enough to put somebody at the edge of their allostatic load, where they really can't absorb any more at that point or adjust to anymore, and then we have this change and that change, and SDA, and productivity, it's just too much.”

Participants also acknowledged the impact that the COVID-19 pandemic had on staffing. While it is challenging to disentangle turnover that is purely a result of the COVID-19 pandemic or due to the changing landscape of community mental health from the LOC payment model, it was perceived that the pandemic had a significant role in the increased turnover. Participants expressed growing challenges for the providers that remain, as high turnover causes higher caseloads and consequently, increased pressure. This also contributes to additional access barriers for clients as providers have even less capacity to serve new or current clients at the level prescribed per their LOC stratification.

“I think some of the boundaries are the limits that we have right now. Because of COVID, we don't have enough staffing to actually serve the clients. When they have a high-level stratification, we don't have staff, we can't meet those hours...”

Sub-theme: Participants noted the ability to provide services by telehealth, due to the COVID-19 pandemic, as beneficial for engaging clients in services and adapting to the LOC payment model. Despite challenges in adapting to the LOC payment model due to the COVID-19 pandemic, the shift to telehealth or phone services was considered to be helpful for providers in adapting to the new payment model. For example, participants noted the use of telehealth as helpful for reducing the rate of no-shows and cancellations and has increased access for individuals who typically experience greater barriers to engagement. As a result of this, providers acknowledge greater ability to meet SDA and adapt to the LOC payment model. Additionally, multiple participants emphasized the ways in which telehealth reduces barriers for providers as well, particularly in relation to their experience with the pandemic. Participants acknowledged that without the COVID-19 pandemic, a shift to telehealth would likely not have occurred in the near future or at the very least, participants felt that telehealth and phone services would not be as widely available as they are currently.

“I do think that the ability to quickly pivot to Telehealth and phone appointments has helped with service delivery. We have had significantly less cancellations and no shows since being able to offer Telehealth and phone services in a more robust kind of way, so that means we’re then more easily able to meet SDA.”

“I think access to telehealth during COVID has really been a game changer in terms of client engagement.”

“It removes barriers for an awful lot of people and it’s my hope that it has helped with staff mental health, maybe not staff morale but certainly mental health and emotional wellbeing and all of those types of things.”

Sub-theme: Participants acknowledged that changes in agency policies and actions in response to the COVID-19 pandemic had both positive and negative effects on providing support for providers adjusting to the LOC payment model. Given challenges that providers faced due to the COVID-19 pandemic, participants stressed the importance of flexibility in the workplace. Multiple participants expressed having the option for a hybrid schedule as especially helpful for those with families or living in a shared space. Hybrid schedules provided the space to accommodate the unique needs of providers and offers an opportunity for relief, especially for providers who have continued to meet with clients in-person. Ultimately, participants acknowledged this flexibility as having a positive impact on their ability to take in new information and make change, including change that is relevant to the LOC payment model.

“If I hadn’t been able to work from home via telecommuting and flex my hours the way that I have been, there would have been no way I could have kept my job, so it’s been hugely helpful.”

In addition to increased flexibility, participants described the development and access to new tools and resources as especially helpful for adapting to the LOC payment model. For example, the Valley Cities continuous quality improvement team developed a communication tool for providers that could be used to explain the LOC payment model to clients. Providers found this tool to be particularly helpful in discussing the payment model with clients as there are no other communication tools available to support these conversations.

“I think having language to use is helpful... it’s definitely better than having to just come up with that stuff from scratch.”

Participants acknowledge the ability to use of various tools for tracking client engagement and other data, to be especially helpful for understanding how clients are progressing and to keep track of clients who may be at a higher risk, have higher service needs, or were lost to follow up. The ability to track and understand what is happening with clients, allowed providers to express greater ability to tailor their support and services to better meet the needs of clients. Namely, providers expressed access to a specific report that tracks SDA for clients as especially helpful for tracking utilization and further tailoring service intensity as needed.

“I think one thing that’s been beneficial on this, I would say is the ability to see and understand what is happening with your clients, like the data side.”

“It makes it easy to understand where we’re at with meeting that need for the client.”

Participants expressed that the shift in agency culture to provide more therapeutic groups had a positive effect on providers ability to adhere to the LOC payment model and meet the needs of a large population amidst a significant workforce shortage. Through leveraging the use of group therapy, clients who are stratified to a medium or high LOC are more likely able to meet SDA. Although group therapy is not a new service at VCC, a combination of both the impacts from the COVID-19 pandemic and implementation of the LOC payment model have encouraged providers to find creative solutions for meeting the need of clients and SDA.

“We had been trying to ramp up for groups for years and then, after COVID happened and the payment model has changed, it has turned on the switch for culture change. It really helps for the staff if we've got that culture.”

Participants also mentioned productivity standards, in particular, as presenting a challenge to adapting to the LOC payment model. For example, participants acknowledged how the productivity standards and policy have contributed to burnout among staff due to increased pressure and stress.

“With the high turnover and the high caseloads... there’s a fault line. And the systemic burnout, it’s something that’s ongoing and needs to be talked about more.”

“There is this burden to be at a certain level of productivity that creates a certain stress for staff at times when some of the things are out of their control, like someone not answering.”

“We lost a lot of good staff because of some of the pressures for productivity.”

This pressure, in tandem with other stressors relevant to implementation of the LOC payment model have had a detrimental impact on staff morale.

Discussion

Relevant literature describes both structural and policy-related barriers that can impact the adoption of new practices, policies, or procedures for providers. (Bailey et al., 2019; Atkins et al., 2017; Cane et al., 2012) This includes the implementation of a new payment model. This research reinforced that knowledge through demonstration of the various barriers that impact the ability of providers to adapt to the LOC payment model. As such, it is not surprising that all participants expressed concern of the financial impact of the LOC payment model given the historical issue of low reimbursement and the resulting low wages that contribute to poor retention and recruitment in the community mental health field. (Gattman et al., 2017) Moreover, all participants emphasized components of the PHSM as contributing to the issue of mis-

stratification. Namely, participants emphasized the data that is included or not included in the PHSM as a factor that can result in mis-stratification. Participants also emphasized the lack of ability to petition or advocate for re-stratification. While frustrating given the lack of provider voice or discretion, participants also acknowledged how this issue further drives reimbursement challenges and simultaneously contributes to increased pressure on providers to meet SDA even when it may be clinically inappropriate as doing so, maximizes payment.

The unique combination of a longstanding history of poor reimbursement for community mental health services in King County, the impact from the LOC payment model itself, and the impact from the COVID-19 pandemic, led to a precarious situation for the mental health system in King County. Namely, given increased financial concerns due to inflation and the pandemic, low wages combined with growing stress are likely to contribute to continued turnover. While 2022 legislative priorities for King County include an increase to Medicaid payment rates for all mental health services by 7%, it's likely this increase alone will not address all of the structural challenges that impact the community mental health field. (Jackson & Nicholson, 2021) Nor will this address challenges that are relative to the design of the LOC payment model itself.

As the primary researcher recognized a lack of provider involvement in the development or implementation of the LOC payment model as well as a lack of consideration of provider feedback following implementation. Thus, it was not a surprise to hear about the impact that this had on providers in terms of their comfort and ability to adapt to the model. All participants expressed communication as a challenge for adapting to the LOC payment model. While communication barriers were relevant to the communication between agency leaders and their staff, such barriers were also found between the county and their beneficiaries. Moreover, participants acknowledged the lack of communication between the KCBHRD and providers as a

challenge for adapting to the LOC payment model. Namely, the lack of ability for providers to communicate their feedback directly to KCBHRD or hear directly from KCBHRD, left providers feeling unheard and disvalued in their attempts to improve the current model. This in turn, has had a negative impact on the ability and comfort of providers to adapt to the LOC payment model. Previous research aligns with this finding as participation of providers throughout the development and implementation of a new payment system has been identified as a key consideration for successful implementation. (Bailey et al., 2019; Atkins et al., 2017) Studies have shown that providers work more effectively under a payment model shift when they feel like their concerns about the operational details of the model have been addressed. (Bailey et al., 2019; Atkins et al., 2017; Cane et al., 2012; Friedberg et al., 2015) In this case, all roles expressed instances of feeling left in the dark and as if their concerns have gone unheard.

Further, this research underscores the complex relationship between the COVID-19 pandemic and implementation of the LOC payment model. In addition to the challenges and facilitators as previously mentioned, it's imperative to acknowledge the immense level of change that providers have had to endure as a result of this occurrence. During a time filled with unpredictable and unprecedented changes due to the COVID-19 pandemic, providers have had to withstand numerous changes that affected all aspects of their work. Although the timing of this cannot be altered, going forward, increased support, communication, and transparency with staff would likely have a positive impact.

Recommendations

The following recommendations were developed based on a combination of the qualitative data and the primary researcher's knowledge and personal experience with the LOC payment model.

Adapt the PHSM to prevent mis-stratification.

Aside from improved reimbursement itself, improvements to the PHSM are likely to alleviate some of the financial pressure and stress that providers experience as a result of inaccurate LOC stratification. Further, in adapting the PHSM, providers are likely to feel less pressured to meet an SDA expectation that are unrealistic or irrelevant to a client's service intensity needs. In consideration of this, participants emphasized four major recommendations.

1. Greater discernment of acute care utilization so that routine medical visits do not impact stratification as significantly;
2. Flexibility in the PHSM so that a client's LOC stratification can be adapted to accommodate a clinically indicated EBP;
3. Consideration of the client's voice and choice in terms of what they want and are willing to engage in; and lastly,
4. Consideration of the providers clinical discretion in terms of clinical need, including treatment intensity.

Develop a mechanism to allow for re-stratification in a timely manner.

Upon mis-stratification, a mechanism to re-stratify a client in a timely manner could benefit providers. Namely, through allowing greater opportunity to correct issues and align SDA with the client's true service intensity needs as defined by the client and their care team, the PHSM can alleviate some of the pressures and stress that providers experience when a client is mis-stratified.

Increase communication and transparency between providers and the KCBHRD.

As flaws with the LOC payment model continue to be addressed, a space for providers to communicate their ideas and concerns directly to KCBHRD is highly recommended. This can be

in the form of a monthly, bimonthly, or quarterly virtual forum. Alternatively, an electronic discussion board or even a dropbox in which providers can submit their feedback electronically can be utilized. There are numerous options outside of these as well. Regardless of the space that is chosen, transparency is imperative. A quarterly newsletter, accessible meeting minutes and recordings, as well as responses on a discussion board, are all options for transparent responses and clarification of action or inaction. This recommendation will allow providers a space to feel heard and a voice in addressing some of the challenges with the LOC payment model as it is.

Consider the collective trauma that is a result of the COVID-19 pandemic.

The COVID-19 pandemic is certainly an unprecedented factor in the provider experience adjusting to the LOC payment model. Thus, it's important that both KCBHRD and agencies alike, consider this. Namely, through a trauma informed lens, as collectively, we have all experienced a massive trauma that continues to impact our daily lives. Increased communication from KCBHRD can help providers and clients feel more grounded. Agencies should be more attentive to the ways in which policies and procedures may impact staff given their current capacity and depleted resiliency. Continued flexibility on behalf of agency leaders in terms of hybrid schedules is also likely be helpful for alleviating some of the stress that is a result of the LOC payment model as noted by study participants.

Additional research is needed.

In addition to the above-mentioned recommendations, future research is recommended to understand the financial sustainability of the LOC payment model and the impact of the LOC payment model on client outcomes and access.

Limitations

As the primary researcher (KR) has experience with the LOC payment model and is an employee with Valley Cities, it is possible that personal biases may have affected the interpretation of the results. To minimize this, the primary researcher consulted with her thesis committee and second coder throughout data analysis, as well as the TDF(v2) framework. Additionally, although participant recruitment was low, and did not include the perspective of psychiatric providers or providers from other organizations, this research collected valuable insights from a small group of providers of various role types from one of the largest community mental health agencies in King County.

Conclusion

This research highlights the challenges that providers in King County have experienced in adjusting to the LOC payment model while also shedding light on some of the actions that have been helpful for providers. This research also illuminated the complex relationship between the co-occurrence of the COVID-19 pandemic and implementation of the LOC payment model. Ultimately, this study resulted in three key themes. First, the LOC payment model has had a negative impact on clinical care and services, affecting both providers and clients. Second, the LOC payment model as it is designed, contributes to discomfort and concern among providers, clients, and agencies. Lastly, the co-occurrence of the COVID-19 pandemic and implementation of the new payment model presented unique challenges and benefits for both providers and clients in adjusting to the LOC payment model. Adjustments to the LOC payment model are needed. Such changes are possible and are likely to improve the experience of providers, agencies, and clients.

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Appendix

Appendix 1. Definitions

Acuity	Brennan and Daly defined acuity as “a measure of the severity of illness of the patient and the intensity of care the patient requires.” (Brennan & Daley, 2009) In the context of this study, acuity refers to the LOC or level of service intensity indicated per the client’s score from the population health stratification model.
Agency	In this study, agency refers to community behavioral health organizations that are licensed to provide behavioral health services to individuals and families across King County under funding from the King County Integrated Care Network (KCICN) and/or Behavioral Administrative Health Organization (BH-ASO). (King County Behavioral Health and Recovery Division, 2020)
Authorization	In this study, authorization refers to the approval or determination that a client meets criteria for care, thus medical necessity, to receive services funded by the KCICN or BH-ASO. (King County Behavioral Health and Recovery Division, 2020)
Behavioral Health and Recovery Division (BHRD)	The BHRD is a division within King County’s Department of Community and Human Services. In addition to other responsibilities, the BHRD is responsible for the administration and provision of all behavioral healthcare services for individuals in King County. (King County Behavioral Health and Recovery Division, 2020) The BHRD

	includes the BH-ASO and KCICN. (King County Behavioral Health and Recovery Division, 2020)
Case Rate	A case rate refers to a specified payment to providers. In the LOC payment model, the case rate is based in part, on the client’s LOC stratification and is then further adjusted based on the clients age, culture, and language. (King County Behavioral Health and Recovery Division, 2020)
Child and Adolescent Level of Care Utilization System (CALOCUS)	Per contracts with MCOs, clients who receive services under these contracts must be assessed by specific tools to ensure they meet criteria of care, or medical necessity, in terms of their mental health. (King County Behavioral Health and Recovery Division, 2020) For youth under eighteen years of age, the CALOCUS is one tool that is often utilized to determine medical necessity. (King County Behavioral Health and Recovery Division, 2020) The CALOCUS assessment was developed by the American Association of Community Psychiatrists and considers six dimensions to identify an individual’s level of care. These include: 1) Risk of Harm; 2) Functional Status; 3) Co-Morbidity; 4) Recovery environment; 5) Treatment and Recovery History; and 6) Engagement and Recovery Status. (American Association of Community Psychiatrists, 2009; American Association of Community Psychiatrists, 2010; Deerfield Behavioral Health, Inc., 2021) Per contracts with MCOs, individuals that score less than 10 do not meet

	<p>criteria for services as they are considered to have only mild to moderate acuity. (King County Behavioral Health and Recovery Division, 2020)</p>
Community Mental Health	<p>Community mental health in the context of this study refers to mental health services that are provided at an outpatient community-based organization and more specifically, a behavioral health organization that can serve client who are authorized for BHRD funded mental health services. (American Psychological Association, n.d.)</p>
Fully Integrated Managed Care (FIMC)	<p>Through FIMC, MCOs as provide all Medicaid-funded physical and behavioral health services for enrollees. (King County Behavioral Health and Recovery Division, 2020)</p>
Healthier Here	<p>Healthier Here is the Accountable Community of Health in King County and is funded by the Medicaid Transformation Waiver.</p> <p>Healthier Here works collaboratively across multiple sectors, i.e., the behavioral health, physical health, and social service fields, as well as with the community; to support integrated care efforts. (King County, 2020c)</p>
King County Integrated Care Network (KCICN)	<p>The KCICN is a unique coalition formed by providers, agencies, and the KCBHRD with the intention of acting as an integrated behavioral health network, capable of providing the Medicaid State Plan Services as well as maintaining contracts with the designated Medicaid MCOs in</p>

	the King County Regional Service Area. (King County Behavioral Health and Recovery Division, 2020)
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Levels of Care (LOC)	<p>LOC is the name of the new payment model implemented in King County in July of 2020. LOC also refers to the service intensity needs of an individual as determined by the PHSM. (King County Behavioral Health and Recovery Division, 2020) Per the LOC payment model, a client can be attributed to a low, medium, or high LOC. (King County, 2019; King County, 2020a; King County, 2020b; King County Behavioral Health and Recovery Division, 2021; King County Behavioral Health and Recovery Division, 2020) For example, a low LOC client is expected to receive 1.5 service hours per month, whereas a medium LOC client should receive 2.5 service hours per month, and a high LOC client 7 hours per month. (King County, 2019; King County, 2020a; King County, 2020b; King County Behavioral Health and Recovery Division, 2021; King County Behavioral Health and Recovery Division, 2020)</p>
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Level of Care Utilization System (LOCUS)	<p>As mentioned, per contracts with MCOs, clients served under these contracts must be assessed via specific tools to ensure they meet criteria for care, or medical necessity in terms of their mental health. (King County Behavioral Health and Recovery Division, 2020) For adults eighteen years of age or older, the LOCUS is one tool that is often utilized to determine medical necessity. (King County Behavioral</p>
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Health and Recovery Division, 2020) The LOCUS assessment was developed by the American Association of Community Psychiatrists, and it considers six dimensions to identify an individual’s level of care. These include the same dimensions as considered in the CALOCUS. (American Association of Community Psychiatrists, 2009; American Association of Community Psychiatrists, 2010; Deerfield Behavioral Health, Inc., 2021) Individuals with a score that is less than 10 on the LOCUS do meet criteria for services as they are considered to have only mild to moderate acuity. (King County Behavioral Health and Recovery Division, 2020)

Population Health	The case rate and authorization or LOC is assigned based on the PHSM.
Stratification model (PHSM)	Specific data points are assessed quarterly using the PHSM. Data considered in the PHSM differs between adults and children/youth, although regardless, clients are attributed to a low, medium, or high LOC. (King County, 2019; King County, 2020a; King County, 2020b; King County Behavioral Health and Recovery Division, 2021; King County Behavioral Health and Recovery Division, 2020)

Providers	In the context of this study, providers refer specifically to case managers, peers, clinicians, therapists, and medication management providers employed in the mental health outpatient program at a community mental health agency in King County.
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Service Delivery Adherence (SDA) SDA refers to the expected hours a client should receive as indicated by their assigned LOC. (King County Behavioral Health and Recovery Division, 2020) SDA is calculated as “the ratio of the number of services a client received relative to the amount requested for all clients at a certain benefit level during a period. If clients received less than 85% of the expected service hours, a certain percent of payment is deducted from the case rate.” (King County Behavioral Health and Recovery Division, 2020)

$$\text{SDA \%} = \frac{\text{Prorated monthly service hours}}{\text{Number of monthly hours expected}}$$

Appendix 2. The PHSM—Adult Mental Health

PHSM – Adult Mental Health		
<i>Acute care utilization</i>		
Hospitalization or ED visits, SUD withdrawal management, ITA, SUD residential (all causes) in last 12 months	0 encounters	0 points
	1-2 encounters	1 point
	3-5 encounters	5 points
	6+ encounters	11 points
<i>Social determinants of health</i>		
Housing stability	Stable housing	0 points
	Homeless	7 points
Jail utilization (all types of incarceration) volume	None in last 6 months	0 points
	1-2 incarcerations in last 6 months	2 points
	3+ incarcerations in last 6 months	3 points
Jail length of stay	Any one incarceration >2 consecutive years in last 5 years	1 point
<i>Chronic conditions</i>		

Presence of diabetes, cardiovascular disease, asthma, or COPD	None of these conditions	0 points
	1 of these conditions	2 points
Assessments		
LOCUS	13 and below	1 point
	14-16	4 points
	17+	8 points

Note. (King County, 2020a; King County, 2020b)

Appendix 3. The PHSM— Child/Youth Mental Health

PHSM – Child/Youth Mental Health		
Acute care utilization		
Hospitalization or ED visits, SUD withdrawal management, ITA, SUD residential (all causes) in last 12 months	0 encounters	0 points
	1-2 encounters	5 points
	3-5 encounters	11 points
Social determinants of health		
Foster Care	No history of foster care	0 points
	History or current foster care	3 points
Chronic conditions		
Presence of diabetes, cardiovascular disease, asthma, or COPD	None of these conditions	0 points
	1 of these conditions	2 points
	2+ conditions	3 points
Assessments		
CALOCUS	13 and below	1 point
	14-16	5 points
	17+	11 points

Note. (King County, 2020a; King County, 2020)

Appendix 4. PHSM Scoring, LOC, and Expected Utilization Hours

PHSM Score	PHSM Levels of Care	Service Utilization Hours
0-4 total points	Low	1.5 hours/month

5-10 total points	Medium	2.5 hours/month
11+ total points	High	7.0 hours/month

Note. (King County, 2020a; King County, 2020b)

Appendix 5. SDA and Reimbursement.

<i>Service Delivery Adherence</i>	<i>Payment</i>
Expected Service Hours	Full payment for LOC
Fewer than expected service hours	Decreased Payment
No Services	Grace period of decreased payment before payment ends

Note. (King County, 2020a; King County, 2020b)

Appendix 6. The 14 Theoretical Domains of the TDF (v2)

Theoretical Domain	Definition
<i>Knowledge</i>	An awareness of the existence of something
<i>Skills</i>	An ability or proficiency acquired through practice
<i>Social/professional role and identity</i>	A coherent set of behaviors and displayed personal qualities of an individual in a social or work setting
<i>Beliefs about capabilities</i>	Acceptance of the truth, reality, or validity about an ability, talent, or facility that a person can put to constructive use
<i>Optimism</i>	The confidence that things will happen for the best or that desired goals will be attained
<i>Beliefs about consequences</i>	Acceptance of the truth, reality, or validity about outcomes of a behavior
<i>Reinforcement</i>	Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus

<i>Intentions</i>	A conscious decision to perform a behavior or a resolve to act in a certain way
<i>Goals</i>	Mental representations of outcomes or end states that an individual want to achieve
<i>Memory, attention, and decision processes</i>	The ability to retain information, focus, selectively on aspects of the environment and choose between two or more alternatives
<i>Environmental context and resources</i>	Any circumstance of one's situation or environment that discourages or encourages the development of skills or abilities, independence, social competence, and adaptive behavior
<i>Social influences</i>	Interpersonal processes that can alter one' their thoughts, feelings, or behavior
<i>Emotion</i>	A complex reaction pattern involving an experiential, behavioral, and psychological element, by which an individual attempts to deal with a personally significant matter
<i>Behavioral regulation</i>	Anything aimed at managing or changing objectively observed or measured actions

Note. (Squires et al., 2014)

Appendix 7. Electronic Survey

<i>All respondents</i>
<ul style="list-style-type: none"> - Do you work within the mental health outpatient program? - What is the title of your current position? - Are you in a leadership role (i.e., manager, supervisor, or director)? - How many years have you worked for Valley Cities? - Do you currently have a caseload? - How many clients are on your caseload? - How many clients on your caseload are stratified to the LOW, MEDIUM, and HIGH level of care?
<i>Agency leaders</i>
<ul style="list-style-type: none"> - Considering all clients in the mental health outpatient program, what is the approximate distribution of clients stratified to the LOW, MEDIUM, and HIGH levels of care?

Appendix 8. Intended Recruitment Compared to Actual Recruitment

Role	Intended N (%)	Actual N (%)
Agency Leaders	10%	2 (18.2%)
Case Managers	30%	3 (27.3%)
Clinicians/Therapists	40%	4 (36.4%)
Peers	20%	2 (18.2%)

Appendix 9. Initial Semi-Structured Interview Guide

Background

1. Can you tell me a little about your role and the work that you do?
2. How long have you been with Valley Cities?
3. Have any aspects of your practice changed, such as workflows, the types of services you deliver, etc.? What do you think are some of the reasons for this change?
4. Has the stratification or acuity level of your caseload changed? What do you think are some of the reasons for this change?

Defining gaps and strengths

Implemented in July of 2020, the LOC payment model is based on a PHSM that considers clinical risk factors from multiple sources rather than the LOCUS/CALOCUS assessment alone to stratify clients to the appropriate LOC. Each LOC predetermines the expected intensity of service delivery as well as informs the baseline payment for services rendered. Payment is then further determined by the client's utilization or SDA, differing from the previous model in which payment was based solely on a case rate.

1. Considering the new payment model, do you think this impacted your practice in any way? Or do you feel like you're doing things differently than you would otherwise because of the payment model?
 - a. Are there any other ways the new payment model may have impacted your practice? Have you observed an impact on the delivery of services or clinical care?

2. Thinking of the last few months, what are some of the specific challenges you've experienced as a result of the new payment model?
 - a. Can you explain how these challenges impacted your experience in the delivery of services or clinical care?
 - b. In what ways do you think these challenges may have impacted clients?
3. What has been done at the agency level to address these challenges? How about at the county or state level?
4. What are some of the recommendations you have for addressing these challenges?
 - a. (Agency leaders) Are there additional recommendations you've heard from staff or in discussion amongst agency leadership? If so, what are the recommendations you've heard?
5. Thinking of the last few months, what are some of the welcome or positive changes you've observed as a result of the new payment model?
 - a. Can you elaborate on how these have positively impacted your experience in the delivery of services or clinical care?
 - b. How do you think these changes impacted clients?

Exploratory questions

1. Thinking of COVID-19 and the numerous organizational changes that occurred in response to the pandemic (*i.e., ability to work from home, altering the availability and operations of services and/or supports, etc.*), what organizational changes, if any, helped to improve your experience or the experience of staff with the LOC payment model?

- a. In what ways, if any, do you think these organizational changes impacted the experience of clients?
2. Considering policy changes that occurred outside of the organization, for example—the option of new forms of service delivery such as phone and telehealth or the ability to obtain verbal consent, how did these or other policy changes positively or negatively impacted your experience (and the experience of staff) with the LOC payment model?
 - a. In what ways, if any, do you think these policy changes impacted the experience of clients?
3. Considering all that we've discussed and acknowledging that agencies and providers are still adjusting, are there any benefits or harms you foresee in the long run because of the new payment model?

Appendix 10. Codebook

Code	Code Definition	Inclusion/Exclusion Criteria	Examples
<i>Category: Facilitator</i>			
Communication tool	Statements referencing a communication tool, standard messaging, scripting, or written materials, for communicating information about the LOC payment model.	Include statements about communication tools or materials regardless of who developed the tools or materials; as well as statements about the lack of helpful communication tools or materials.	<ol style="list-style-type: none"> 1. "I think, having language to use is helpful and I think, at the same time, it's hard to kind of craft these responses or to be very effective with them without adequate time. I think there's a lot of factors that make it hard, but I guess it's definitely better than having to just come up with that stuff from scratch." 2. "I'm not sure how useful a tool that is, I feel the same way about the client facing brochure like that's a helpful tool if you use it, and if you decide that it's going to be a helpful tool."
Communication w/ Staff	Reference to various methods of communication with staff regarding the LOC model, including organizational changes that impact the payment model.	Utilize this code for statements in reference to communication with staff regarding the LOC model, particularly when communication was determined to be helpful. Exclude statements about communication with staff when it is determined to be unhelpful, inadequate, or nonexistent.	<ol style="list-style-type: none"> 1. "I think we did better than other agencies in communicating to our employees what was happening. And that it was happening from King County. This wasn't just us making changes I know people don't fully trust that. But other agencies, you know the model had been live for like six, nine months, and their employees hadn't even been informed yet... Which just blew my mind, like, I felt like we did a good job of telling people as much as we knew when we knew it." 2. "I feel like they try with like the town hall meetings, and they hear us out and they try to explain everything as to why they do it."

Data	Statements in reference to the utilization of information to guide clinical decisions, clinical care, and/or service delivery.	Include reference to information, data, and/or reports as a helpful factor in guiding clinical decisions, clinical care, and/or service delivery. For statements that reference data pertinent to the PHSM, utilize the code “Challenge: PHSM” instead.	<ol style="list-style-type: none"> 1. " It makes it easy to understand where we're at with meeting that need for the client." 2. "...being able to track when the last billable service was, everything on there. It makes it easy to understand where we're at with meeting that need for the client." 3. “One thing that's been beneficial on this, I would say is the ability to see and understand what is happening with your clients, like the data side.”
External Change	Statements referencing an external change as helpful for supporting staff in adjusting to the LOC payment model	Include reference to statements about external changes both directly and indirectly related to the LOC payment model, when stated to be helpful for staff in adjusting to the LOC payment model. Exclude statements specific to organizational level changes or changes that were stated to be unhelpful. For statements referencing telehealth, when a facilitating factor, utilize both this code and 'Facilitator: Telehealth.'	<ol style="list-style-type: none"> 1. "I think it's again positive, because I think sometimes literally the barrier between you and you know talking to a very important person relative to the client, in certain circumstances, is literally a piece of paper. So, I think being able to have that opportunity has been really helpful." 2. "I think Medicaid loosening up... did nothing but benefit us... Being able to get a verbal consent was ginormous... I think it's been nothing but advantageous. " 3. “The O&E’s have been awesome. If I have a cancellation, I'll just go through my caseload and see who hasn't been called in a while and then that's an O&E attempt. And so that's getting me productivity.”

Flexibility	Reference to flexibility on behalf of the agency, direct managers, and supervisors, when stated to be helpful for staff in adjusting to the LOC payment model.	Include statements about flexibility from individual managers, supervisors, or the agency stated to be helpful for adjusting and adhering to the LOC payment model. Exclude statements about flexibility on behalf of individual providers or stakeholders external to Valley Cities, i.e., Center for Medicaid Services, KCBHRD, MCOs, etc.	<ol style="list-style-type: none"> 1. "...if people can have choice about where they're working, about how they access work, a little bit more flexibility around their work hours, that has been huge... if I hadn't been able to work from home via telecommuting and flex my hours the way that I have been, there would have been no way I could have kept my job..." 2. "We set everybody up electronically to be able to work from home. We set up our offices electronically so that services could be delivered anywhere...we changed our resources rooms to be intake room. So even if I don't have an intake specialist in that clinic, they can be in the clinic and still have an intake... That's all that's been a gift...being really flexible with staff... and making more allowances that we might not normally do."
Groups	Reference to groups as helpful, supportive, or beneficial in terms of clinical care, experience delivering services, perceived experience of clients, and ability to meet SDA.	Include reference to groups when identified as a useful option to improving clinical care, experience delivering services, the perceived experience of clients, and ability to meet SDA. Exclude statements about groups when identified as unhelpful or presenting a challenge. Instead, refer to code 'Challenge: Groups.'	<ol style="list-style-type: none"> 1. "...we're listening and referring clients to groups, whether it's health management, anxiety and self-esteem, or depression, or an evidence-based therapy group, like DBT or CBT. All of these kinds of things, where we can group clients together help for the client, to be able to meet their hours, in addition to staff meeting productivity... and I think it's been a cultural shift at our agency... after COVID happened and the payment model has changed, it has turned on the switch for culture change. It really helps for the staff if we've got that culture." 2. "Some clients prefer...telehealth groups and staying connected and reducing isolation."

Organizational Change	Statements referencing organizational change as regarded to be helpful or supportive for staff in adjusting to the LOC payment model.	Include statements referencing organizational changes determined to be helpful or supportive for staff in adjusting to the LOC payment model, i.e., policy or workflow changes, implementation of the Town Hall, etc. Exclude statements about organizational changes that were not determined to be helpful or changes that occurred external to Valley Cities, i.e., billing changes, etc.	<ol style="list-style-type: none"> 1. "We created a system to talk to the staff as opposed to just putting the hammer down." 2. "... I really appreciate the TIC training that has been provided directly from the Vice President. I think that has really helped." 3. "It definitely impacts how we do business and how we're doing business and, from my perspective, moving from care coordination to case management, where we used to do more administrative work and now we're doing much more face to face, this is great, but it is a shift, and it also has some risk with it in terms of having to operate like that during COVID. It means more time with clients, some face to face, but thankfully organizations have had flexibility for people to work remotely."
Pandemic	Statements referencing the pandemic as a facilitating factor for bringing about changes that have been helpful for staff and/or clients in adjusting to the LOC payment model.	Utilize this code for statements pertaining to the pandemic as a facilitating factor for causing change that has improved the experience of staff and/or clients in adjusting to the LOC payment model.	<ol style="list-style-type: none"> 1. "I think like us being able to offer remote offerings is something that I don't think we would have ever done without the pandemic, to be perfectly honest. So, I think that, overall, it is a positive thing and that allows us to maybe capture time with clients that maybe would be more apprehensive about coming into clinic otherwise. 2. "COVID shifted everything to remote services. Which I think has been by and large, a positive change for our clients... our clients seem to find that as a pretty positive shift."
Support from Manager/ Supervisor	Statements referencing support provided	Utilize this code for statements that reference support provided by managers and/or	<ol style="list-style-type: none"> 1. "...with all the different changes with telehealth, things like that, they understand how challenging it is

	by managers and/or supervisors when regarded as helpful for staff in adjusting to the LOC payment model.	supervisors to staff, when regarded as helpful for staff in adjusting to the LOC payment model. Exclude statements that reference support provided outside of managers and/or supervisors.	and how confusing it is and so they're with us every step of the way so far." 2. "I really see the core work of stabilizing again, coming from supervisors of clinics. Some supervisors, making sure that every staff has a certain number of hours that they are committed to meeting with them administratively as well as clinically to make sure that they have those kind of supports... when enriched by our leaders, we're able to continue to do good work."
Telehealth	Statements referencing Telehealth or phone services as a facilitating factor in adhering or adjusting to the LOC payment model.	Include statements that reference Telehealth and phone services a support for clients in accessing or engaging in services as well as for staff in adjusting or adhering to the LOC payment model.	1. "...it's been nice too... we could engage more people... so, it's been kind of easier to do telehealth too and to engage more people." 2. "I think telehealth has been a great tool to stay engaged... I think accessing telehealth during COVID has really been a game changer in terms of client engagement." 3. "I would say if they wouldn't have had the state laws change for us to do full phone and telehealth it would have been horrible for clients and it would have been horrible for staff."
Category: Challenge			
Client Choice/Client Centered	Reference to the lack of client choice or voice within the PHSM model, or lack of client-centered approach in the	Include reference to client choice, voice, or lack of a client-centered approach when discussing this as a challenge or barrier. For reference to relevant recommendations, use code "Recommendation:	1. "...it's their voice and choice when they want to come in and receive those services. So, it's kind of hard with this payment model when we're telling them, "You need to come in ... when people need to come in and see a peer, they should be able to come in and see a peer whenever they want."

	LOC payment model.	Client Choice/Client Centered.”	2. “I’ve shifted a little from client-focus to productivity-focus, like I have this worry on my shoulders, like where it's affected where I’ve been told that I can't serve certain clients and I can only see them for 30 minutes once a month so they can see their clinician a couple times a month.”
Clinical Care/Service Delivery	Reference to a challenge or barrier to clinical care or service delivery as a result of the LOC payment model.	Include challenges to clinical care or service delivery that can be attributed to the LOC payment model. Do not include challenges to clinical care or service delivery that can be attributed to the pandemic.	<ol style="list-style-type: none"> 1. "And like worrying about that number all the time, I feel like it takes away from the care that we're providing the clients." 2. “The way that we provide services has had to drastically change in response to that new payment structure. So, clients, it used to be that it was very client-centered how we provided services ... we could offer weekly appointments for clients who are doing certain types of therapy and who we're motivated and really wanted that. Now we can't offer that to just every client, we can only offer it to clients who have been stratified by King County as meeting that type services so that's been a pretty drastic shift in things.”
Clinical Discretion	Reference to barriers, lack of opportunity, or other challenges for providers to utilize their clinical decision-making expertise, insight, and/or clinical perspectives in the	Include statements that reference barriers, lack of opportunity, or other challenges for providers to utilize their clinical decision-making skills, insight, and/or clinical perspectives in the delivery of services or clinical care. Exclude reference to lack of client voice or choice.	<ol style="list-style-type: none"> 1. "For me, to be an effective provider, like, I actually need to meet my clients where they're at and provide services accordingly and no one knows what that looks like better than me my client." 2. "Either the model itself and how it goes or Valley Cities policies and procedures, responses to the payment model, have really led to a lot of burnout. A lot of people feeling really demoralized, people feeling like they can't offer the clinical care that they want to for their clients and feeling like they have just

	delivery of services or clinical care.		kind of lost control over their clinical decision making. It's been really hard for our therapists and clinicians and has resulted in people leaving the agency."
Communication w/ Clients	Reference to challenges or barriers in discussing the LOC payment model with clients.	Utilize this code for reference to challenges or barriers in discussing the LOC payment model with clients. Do not utilize this code when communication challenges are not pertinent to communication with clients, i.e., communication challenges between agency leaders and staff.	<ol style="list-style-type: none"> 1. "...that makes it hard for the client to hear that we can't see them as often. That's probably like the biggest challenge that I've had to face, like explaining it to a client." 2. "...they've really put that on providers to do all of the communication to very unhappy individuals who are finding out, look I have less benefits or different benefits than what I was anticipating or what I've had for the last 30 years... letting them know what to expect, how many hours they'll need to attend. But really, all of that burden has fallen on those individual conversations, which to me is not quite appropriate."
Communication w/ Staff	Reference to challenges or barriers in discussing the LOC model with staff.	Utilize this code for reference to challenges or barriers in discussing the LOC model with staff. Do not utilize this code when referencing communication challenges pertinent to discussing the LOC payment model with clients.	<ol style="list-style-type: none"> 1. "And so, it creates this tension that shouldn't be there because of lack of communication." 2. "One area that I'm not happy with, but like I think we did better than other agencies is actually communicating to our employees what was happening. And that it was happening from King County this wasn't just us making changes I know people don't fully trust that. But other agencies, you know the model had been live for like six, nine months, and their employees hadn't even been informed yet... But the downside of that is when you tell people what you know when you know it. The information changes and... that to me is always the

			tension of when you roll something out when it's 100% fully baked that's really hard to do in this field.”
Engagement	Statements referencing barriers to engagement in services as they impact SDA or the effectiveness of the LOC payment model.	Include reference to challenges or barriers to engagement in services among current and prospective clients, as they impact SDA or the effectiveness of the LOC payment model. Exclude statements that reference increased opportunity or improvement to engagement and/or access.	<ol style="list-style-type: none"> 1. "We do not have control over clients that do not come in for appointments. Yet, we're held responsible, and our appointments could look very full but if clients do not show up... I have to scramble to go find a list of who might be available that I need to do engagement with... That creates stress and is a burden on staff to try and make up for stuff when clients don't show up.” 2. “With people who are struck by this high if we are saying that to do our jobs properly, we have to engage with them for seven hours a month. I think that could alienate a lot of clients who don't feel able to engage with that. It could mean that they just kind of drop our services completely because they can't cope with all of this, like “please leave me alone, this is too much...”
Experience of Staff	Reference to the experiences of staff that are stated to be a barrier or present a challenge for adjusting the LOC payment model.	Include statements relevant to the experiences of staff that are stated to be a barrier or present a challenge for adjusting to the LOC payment model. Do not include challenges to the experiences of staff that can be attributed to changes that occurred as a result of the pandemic.	<ol style="list-style-type: none"> 1. "Asking people to be resilient and nimble in their learning in ways that we would have historically like yeah, our field changes all the time, but during a pandemic, like know people's ability to rapidly absorb new information and adjust and be resilient. We haven't acknowledged the diminished capacity... and the timing of this could not be more awful in terms of King County changing payment model and then two months later, the pandemic hits." 2. “I think that's what the main concerns of clients are right now... they feel like their needs are being

			unmet and we're feeling overworked and like we have a lot to keep up on.”
External Change	Statements referencing an external change as unhelpful or presenting a challenge for staff to adjust to the LOC payment model	Include statements that reference external changes either directly or indirectly related to the LOC payment model, when stated to be unhelpful or present a challenge for staff in terms of adjusting to the payment model. Exclude statements specific to organizational level changes. For statements referencing telehealth as a challenging factor, utilize both this code and 'Challenge: Telehealth.'	<ol style="list-style-type: none"> 1. "I think lately there's been more challenges with like the way things are billed. With the new changes and like the over the phone and whether it's in person, that is a huge challenge to try to figure out like the way to bill a service." 2. “My perspective is that we have added a lot of administrative burden and that externally, things have been added to our plates that are then created administrative burden for our staff.”
Feedback w/ No Action	Reference to feedback provided to agency leaders or the KCBHRD when there has been no follow up, changes, or evidence that the feedback was considered or acted upon.	Utilize this code for statements that reference feedback provided to either agency leaders or KCBHRD when there has been no follow up, changes, or evidence that the feedback was considered or acted upon. Exclude statements that reference feedback resulting in change.	<ol style="list-style-type: none"> 1. "I know that our senior leadership meets with King County regularly to give them feedback...I have not heard about any action that has actually been taken based on any of that feedback." 2. "We are being told that in meetings with the county that our concerns are being brought up. That's certainly better than nothing. But have we seen any kind of meaningful change that filters down to the provider level? Not that I'm aware." 3. “I'm a little disappointed, because when I started attending trainings through the county on this system, they reiterated a lot that they would be wanting this feedback that they would make changes on this

			feedback, that this was just their initial way to get started. I hear that we are offering the feedback, but I haven't seen any changes in the system implemented based on any of that feedback.”
Reimbursement	Reference to payment or reimbursement through the LOC model as presenting a challenge or barrier for the agency and/or staff to adjust and adhere to the LOC payment model.	Utilize this code in reference to payment or reimbursement through the LOC model as presenting a challenge or barrier for the agency and/or staff to adjust and adhere to the LOC payment model. Exclude reference to payment or reimbursement through other payor sources, as well as when not relevant to a barrier or challenge.	<ol style="list-style-type: none"> 1. "...as an agency as a whole, we're not hitting the numbers that we need to hit to be able to keep our doors open. This is not sustainable." 2. "I think that the payment model may be affecting the wages that Valley Cities is able to offer. Consequently, we have, from what I understand, trouble hiring clinicians because we are frequently on the lower end of the scale for salary." 3. “There becomes a disparity in service and people falling through the cracks because you will focus where the money is per se.”
Lack of Support/ Communication from KCBHRD	Reference to a lack of support or communication from KCBHRD to support agencies, staff, and clients to adjust to the LOC payment model.	Include statements that reference to a lack of support or communication from KCBHRD to support agencies, staff, and clients in adjusting to the LOC payment model. Do not utilize for reference to the lack of support or communication from agency leaders. Instead, refer to "Challenge: Communication w/ Staff."	<ol style="list-style-type: none"> 1. “At the beginning, they were really strong in messaging out that we’ll have the opportunity to contest or change it as we felt was clinically relevant and then it never materialized. Nothing ever happened. We kept hearing about it and nothing happened, highly theoretical. Very aspirational but not materializing at any point.” 2. “I hope at some point we talk about the lack of support that King County has given around this because that to me is something that they should be informing all of their members... Instead, they've really put that on providers to do all of the communication to very unhappy individuals...”

Misaligned w/ Education, Training, and/or EBP	Statements that reference misalignment between the LOC payment model and the education and training of staff or, evidence-based practices.	Utilize this code for statements that reference misalignment between the LOC payment model and the education and training of staff or, evidence-based practices.	<ol style="list-style-type: none"> 1. "I think overall, SDA is really at odds with trauma informed care... that's also a really big challenge for providers, especially those who have a vested interest in being trauma informed and being you know, mindful and aware of the different factors for clients..." 2. "I don't feel like it's effective, I don't feel like it's healing, I don't feel like it's conducive with anything that I went to school for."
Mismatch	Instances in which the client's LOC stratification does not correlate to the client's presenting needs or preference.	Utilize this code for statements that reference the client's LOC stratification as not correlating with the client's presenting needs, preference, or the providers clinical assessment/opinion. Do not utilize this code in reference to appropriate LOC stratification.	<ol style="list-style-type: none"> 1. "...it's frustrating to have this system where a successful graduation, who really is still a successful graduation, is coming back into services and coming back into them at a level of care that they are absolutely not needing." 2. "I feel like the intention behind it was good and that kind of roping in more data around clients makes sense, but that there has been a complete fail on connecting the kind of care—like the providers clinical assessment of client need with the county's assessment. I have clients that are low... but they need to be seen every week... only an hour and a half of services per month... that is not clinically adequate. At the same time, I have mediums who need more care."
Organizational Change	Statements referencing organizational change as unhelpful or presenting a	Include reference to statements about organizational changes either directly or indirectly related to the pandemic or LOC payment model, when stated to be unhelpful or	<ol style="list-style-type: none"> 1. "That could be one of the reasons why people leave sometimes is like how much the agency has changed with the pandemic." 2. "The accountability with staff and really having staff take a look at how they're spending their time. That's

	challenge for clients and/or staff to adjust to the LOC payment model, i.e., policy changes, workflow changes, etc.	presenting a challenge for staff in terms of adjusting to the LOC payment model. For changes that occurred externally, refer to code “Challenge: External Change.”	been very difficult because nobody wants to be told what to do, and you're taking— the whole paradigm shift has been very difficult for some staff.”
Pandemic	Reference to the pandemic, as presenting challenges for providers in adjusting to the LOC payment model.	Utilize this code to identify challenges for staff relevant to the pandemic. Exclude statements referencing the LOC payment model or other factors not directly relevant to the pandemic that may have presented barriers/challenges for staff in adjusting to the LOC payment model.	<ol style="list-style-type: none"> 1. "I think staff being sick, client’s being sick, I mean I think care has been a little impacted that way...Right, so there's probably been more cancellations and that can be frustrating." 2. “With COVID, there's a lot of people who aren't able to engage. They don't want to come in person or are not able to do telehealth.” 3. “Although we knew that these changes were coming in 2020, having it coupled with COVID and then wanting this adherence and productivity, and all this during COVID when we're really kind of dying on the inside, in some ways. It was very, very challenging.”
PHSM	Reference to challenges or barriers relevant to the Population Health Stratification Model.	Utilize this code for reference to challenges or barriers, directly related to the PHSM, i.e., the calculation itself, components of the calculation, the perceived effectiveness of the calculation, etc. Exclude statements referencing the LOC model more broadly.	<ol style="list-style-type: none"> 1. "... if somebody has a heart attack, is in the hospital, and now needs extra support because their depressions increased, that's understandable. But to need extra support just because I had a routine medical... that's really flawed." 2. “It is truly hurtful to have someone in front of you who says “hey, I'm having a really, really bad time. I'm struggling.” And having what we know is a pretty flawed tool... decide for this person that yeah, that's how much help you can get. Especially starting out, I

			don't think is okay... It doesn't seem helpful, especially like if we have people who are new to therapy.”
Productivity	Reference to challenges or barriers relevant to the number of billable services or productivity, that each clinical staff member is expected to achieve.	Include statements that reference challenges or barriers relevant to the number of billable services or productivity, that each clinical staff member is expected to achieve. Exclude statements that reference facilitating factors or supports for staff to achieve expected productivity.	<ol style="list-style-type: none"> 1. "With the high turnover and the high caseloads and it's a stress on that, you know, there's a fault line. And the systemic burnout, it's something that's ongoing and needs to be talked about more and this kind of drives that hard-working productivity model that's going to run us into the ground I think." 2. "I do know that plenty of staff have left working in community mental health during the time that I've been here, and during COVID, we lost a lot of good staff because of some of the pressures for productivity and feeling like you're kind of a broken record for clients and not able to move forward in some of the ways that would be meaningful for them."
SDA	Reference to the expected service intensity or billable services a client should engage in as defined by their LOC stratification.	Utilize this code in reference to the expected service intensity or billable services a client should engage in as defined by their LOC stratification. Exclude statements that reference service delivery in general, such as the format or method of service delivery.	<ol style="list-style-type: none"> 1. "Serving clients based on, at our organization, care packages, and with adherence policies where if the county rates clients, at a certain level, then we have to serve them at a certain level or not serve them at a certain level that they might be requesting and so definitely, how we serve clients has been impacted..." 2. "...like the diagnoses aren't reflected in the SDA so if we have a person who you know there's a certain EBP that would make sense given their diagnosis, but they're only rated to come in a certain amount, like there's this kind of tension between what is clinically indicated and what insurance is deemed to cover."

Shift in Focus/Work	Statements referencing a change in the priority or focus of work as a result of the LOC payment model.	Utilize this code in reference to a change in the priority or focus of work as a result of the LOC payment model., i.e., focus on serving high LOC clients, reduce services for low LOC, etc. Exclude statements pertinent to a change in priority or focus of work when a result of the pandemic.	<ol style="list-style-type: none"> 1. "There's been a lot more emphasis from leadership on productivity, for our clinical staff as well, which has been a very difficult shift for a lot of people and I think that that has sometimes been to the detriment of our evidence-based therapy programming." 2. "...feeling like you're actually doing what you signed up to do really doesn't help because, like I'll say for myself, for example, it's felt like a therapy factory the last couple of years..."
Staff Wellbeing	Statements referencing the wellbeing/wellness of staff relevant to their ability to adjust to the LOC payment model.	Include mention of the wellbeing/wellness of staff relevant to their ability to adjust to the LOC payment model, i.e., added stress, pressure, poor morale, or culture, etc. Exclude similar comments pertinent to clients.	<ol style="list-style-type: none"> 1. "You will lose staff if you're not in the know of what your staff needs are and doing your best to provide for them within the context of what's available..." 2. "I feel like it's taken a little bit of the team morale away. And that plays a big role in people's work in my opinion." 3. "I kind of liked being more productive, I mean I liked that it was showing me I'm doing well, but I burnt out."
Staffing	Statements referencing challenges or barriers that impact staffing, i.e., low, or inadequate wages.	Utilize this code in reference to challenges pertinent to the retention and hiring of staff including staff shortages, reduced capacity, inability to hire, and low wages or lack of competitive pay.	<ol style="list-style-type: none"> 1. "I think some of the boundaries are the limits that we have right now... we don't have enough staffing to actually serve the clients. When they have a high-level stratification, we don't have staff, we can't meet those hours because we're not staffed to meet those hours." 2. "I think we're going to run a lot of clinicians out of this work, out of the community mental health field, just because if we can't meet SDA by design... then agencies can't pay us at a rate that is livable."

Workload/Staff Capacity	Reference to an overwhelming workload, high caseload, and/or reduced staff capacity due to turnover among other reasons, etc.	Include statements that express challenges or barriers pertinent to an overwhelming workload, high caseload, and/or reduced capacity as a result of high turnover or other factors. Exclude statements that do not express a challenge in workload or the capacity of staff.	<ol style="list-style-type: none"> 1. "When staff don't feel heard, when they don't feel supported, and don't feel well compensated, and they feel burnt out, they leave... when that happens... the staff that's remaining get more clients and have an increased caseload and feel less able to serve everybody because they're being given too many clients and they can realistically handle." 2. "If I scheduled all of my high strat clients every week as they were you know, kind of intended to do, I would not have enough time to serve my medium and low clients. So sometimes the highs get underserved so that the lows and mediums can get any time at all."
Category: Key Stakeholder			
Agency Leader / Organization	A perspective, action, or statement when an agency leader or organization is the target audience.	Include reference to a perspective, action, or statement that is unique to agency leaders or the organization as the target audience, when relevant to the LOC payment model. Agency leaders include clinic managers, supervisors, leads, and senior management. Exclude reference to perspectives, actions, or statements unrelated to the LOC payment model as well as reference to specific individuals or groups.	<ol style="list-style-type: none"> 1. "There's been a lot more emphasis from leadership on productivity." 2. "I think there's increasing pressure to adhere to the model, that message is starting to come down much harder. It used to be that we were told to use our clinical discretion, that we were the ones on the front lines, that we knew what the clients needed through our assessment. And now it's like nope, it's a managed care environment, you tell them "this is what their insurance covers plus groups..." Fortunately, at least so far, I have found support from my supervisors when I'm over-serving. If I can tell them why I'm doing it, they basically back me up."

KCBHRD	A perspective, action, or statement when the KCBHRD is the target audience.	Include reference to a perspective, action, or statement that is unique to KCBHRD as the target audience in the statement and when relevant to the LOC payment model. Exclude reference to individuals outside of the KCBHRD or reference to perspectives, actions, or statements unrelated to the LOC payment model.	<ol style="list-style-type: none"> 1. “I see the benefit of it, I also see more agencies closing not being able to provide services for people. When King County has said anybody that wants to get these services can get these services, but they're also not allowing space for people to actually do this in any sort of thoughtful way. So it's kind of like... there's a disconnect in what they're promising and what they're delivering. And really, they can't deliver because of how they've set up the model.”
Staff	A perspective, action, or statement relevant to clinical staff when staff are the actor/target audience.	Include statements or reference to staff as the target audience, when relevant to the LOC payment model. Exclude reference to individuals who are not Valley Cities staff and utilize code “Key Stakeholder: Agency Leaders/Organization” when relevant to agency leaders. Exclude reference to perspectives, actions, or statements unrelated to the LOC payment model.	<ol style="list-style-type: none"> 1. “I think when you have numbers in front of staff, I think that can make them feel really good. To know how much work they're doing, how their clients are doing. So, the new payment model has forced us to utilize data more and that data I think has been wonderful for staff to see and for clinics to see.” 2. “You will lose staff if you're not in the know of what your staff needs are and doing your best to provide for them within the context of what's available and being creative in thinking about using the resources that you have to meet your staff needs in this changing environment...”
Category: Recommendations			
Client Choice/Voice	Recommendations pertinent to the consideration of client voice and	Utilize this code for recommendations pertinent to the consideration of client voice and choice in the LOC	<ol style="list-style-type: none"> 1. "I would say that maybe a very important question they could add to the data is “what level of services do the clients want to access?” As part of how they figure out their stratification level so rather than just

	choice in the LOC payment model.	payment model. Exclude recommendations pertinent to clinical discretion or staff voice.	<p>immediately doing it on the data, also taking client choice into consideration."</p> <p>2. "I would make it much more of a two-way communication between the agency and the county so when... there's a disagreement, there should be... an opportunity for us to kind of argue like, this person's a low-level person. We know the model says they're high, but we also know, based on engagement and interest..."</p>
Clinical Discretion	Recommendations pertinent to the consideration of clinical discretion or staff voice in the LOC payment model.	Utilize this code for recommendations pertinent to the consideration of clinical discretion or staff voice in the LOC payment model. Exclude recommendations pertinent to client choice and voice.	<p>1. "It should be based more on like what it is that we're doing and like what the goals and needs are, as opposed to like where this person ranks, because we could have somebody who comes in, as a medium but could benefit from DBT as like a preventive or as a kind of preparatory step for like maybe a trauma EBP or something."</p> <p>2. "I think really as long as we're you know, making sure that we're doing our regular assessments... where it makes sense for using outcome screeners, and we're not just artificially holding on to somebody. I think that's really best practice..."</p>
Communication	Recommendations pertinent to downstream communication, i.e., communication from KCBHRD to staff or clients, or communication	Utilize this code for recommendations pertaining to downstream communication, i.e., communication from KCBHRD to staff or clients, or communication from agency leaders to staff or clients. Do not use this code for upstream communication, i.e., clients or	<p>1. "I think it'd be nice to hear a little bit more from the upper management like above my clinics management, about what they're working on if they're trying to improve it, or if they're thinking about it, things like that."</p> <p>2. "I feel like more client facing education would be something that's really valuable something that comes from King County at least notifying people with Medicaid... like what if somebody came in and they</p>

	from agency leaders to staff or clients.	staff to KCBHRD or agency leaders.	saw us and King County received the information that they'd had an intake and that client immediately received a letter from the county stating here's what your mental health benefit is. Like an EOB around mental health."
Feedback Mechanism/ Re-stratification Option	Recommendations pertinent a feedback or upstream communication mechanism, i.e., feedback to KCBHRD or agency leaders, including a way to advocate for re-stratification.	Utilize this code for recommendations pertinent to a way to provide feedback or upstream communication, including a way to advocate for re-stratification. Utilize this code for feedback from either staff or clients to KCBHRD or agency leaders. Do not use this code for downstream communication, i.e., communication from KCBHRD to staff or clients, or communication from agency leaders to staff or clients.	<ol style="list-style-type: none"> 1. "I think it's really important that clients have more of a stake and like voice in this. Like genuinely being able, like at an agency level and at a county level to genuinely have a regular space to come and voice concerns or be able to kind of evaluate how things are going... In the past, we had a client advisory panel or something like that and I think just being able to have them actually hear how the services are going for clients is important." 2. "So some feedback mechanism, I think, would be really, really important and for clients, I think a client should have the right to be able to say, thank you so very much I do not want that many hours of treatment and I'm not going to engage in that many hours of treatment, one way or another, without it becoming a financial penalty to the organization, because that's essentially what it becomes... I feel like there becomes this harassment thing that I don't think is quite appropriate. Like, we need to get you in for all of this, and if that's genuinely not what you feel you want or need we're disenfranchising our clients, which makes no sense. So, some type of like petition process."
Organizational Change	Recommendations pertinent to organizational	Utilize this code for recommendations pertinent to organizational change, i.e.,	<ol style="list-style-type: none"> 1. "...focus on individual clients' SDA rather than staff productivity. That, I think, will go a long way to

	change as relevant to the LOC payment model.	policies and/or procedures, staff support, training, etc. Do not use this code for recommendations pertinent to external change, i.e., change that would need to occur at the county or state-level. Exclude recommendations unrelated to the LOC payment model.	<p>helping our staff to feel like they can manage this more."</p> <p>2. "We're gonna have to get creative, peers can do more and I think it's stressful for the agency, though."</p>
PHSM	Recommendations pertinent to the PHSM.	Utilize this code for recommendations relevant to the PHSM, i.e., data inclusion/exclusion, the calculation, etc. Do not use this code for reference to recommendations that pertain to SDA or LOC stratification.	<p>1. "The payment model is really flawed, and we're being penalized in a way that just doesn't make sense. ... He had to go in for emergency gum surgery. Why does that mean for the rest of the year, now she's not going to meet SDA for an issue that doesn't make sense... they have to take out the complex or routine medical things."</p> <p>2. "If somebody has a heart attack, is in the hospital, and now needs extra support because their depressions increases, that's understandable. But to need extra support just because I had a routine medical... that's really flawed"</p>
Reimbursement	Recommendations relevant to reimbursement through the LOC payment model.	Utilize this code for recommendations relevant to reimbursement through the LOC payment model. Do not use this code for reference to recommendations that do not pertain to reimbursement for services through the LOC payment model.	<p>1. "...like we need to be reimbursed at a rate that feels like we can stay open and so we can provide the services that people need..."</p> <p>2. "If a client is low and has a crisis, a personal crisis and ends up in the hospital and she needs more services, for six months—then move her over to a medium or a high right away vs. keeping her as a low and then being over served and us not getting paid."</p>

SDA/LOC Stratification	Recommendations relevant to SDA or LOC stratification.	Utilize this code for recommendations relevant to SDA or LOC stratification, i.e., number of expected service hours, etc. Do not use this code for reference to recommendations that pertain to the PHSM.	<ol style="list-style-type: none"> 1. "I think ways that we could improve this model would be to adjust the hours because the hours are very weird and like, in relation to like the EBPs that we're providing." 2. "I think the payment model needs to be more broad overall and the levels, need to be more of a band instead of as precise target."
Staffing	Recommendations relevant to the hiring and retention of staff.	Utilize this code for recommendations relevant to improving the hiring and retention of staff, i.e., ensuring reasonable wages/pay, etc. Exclude recommendations specific to staff wellbeing, i.e., stress, workload, etc.	<ol style="list-style-type: none"> 1. "...they need to pay us more. That's the only thing I would recommend is that we have, we are valuable people. Treat us like valuable people." 2. "I think it's an honor to do the work... and we are all working very hard to serve these folks but at the same time, the nobility of the cause doesn't help when you are looking at your retirement plan and looking at how much social security benefits you've earned when you are spending years working at a below living wage... it's not too much, I think, to ask to give providers who provide the kind of quality care that I know we do to this population... I think the county needs to change the payment model so that the agencies can in turn, pay the staff. Actually, hire and retain staff."
Staff Wellbeing	Recommendations relevant to improving staff wellbeing or wellness, both mentally and physically.	Utilize this code for recommendations relevant to improving the wellbeing of staff, i.e., ensuring a reasonable workload, reducing stress, etc. Exclude recommendations specific to	<ol style="list-style-type: none"> 1. "Focus on individual clients SDA rather than staff productivity. That, I think, will go a long way to helping our staff to feel like they can manage this more." 2. "... people being able to have a caseload and not feel overwhelmed and not get burned out."

		adequate pay. Instead, utilize code: "Recommendation: Staffing."	3. "You will lose staff if you're not in the know of what your staff needs are and doing your best to provide for them within the context of what's available and being creative in thinking about using the resources that you have to meet your staff needs in this changing environment."
Category: Role			
Agency leader	Perspective or statement shared by an agency leader.	Utilize this code in tandem with other codes to indicate statements and perspectives unique to agency leaders. This code should not be utilized when a statement is made in reference to an agency leader rather than by an agency leader. Do not use for perspectives unique to other roles.	<ol style="list-style-type: none"> 1. "I mean, frankly, in terms of the finances of it, I would say we have absolutely like every other agency in King County, have taken a financial hit as a result." 2. "I do remember that was terrible we kept changing our timeline around that because they kept telling us different things." 3. "You know the BI reports, I think, are a mixed bag I think some people really use them and other people, they just don't even exist for. And I would expect that in any organization. That doesn't surprise me too much... I'm thinking it's a little bit person-dependent on some of the tools that we rolled out as to how meaningful they were or weren't."
Case Managers	Perspective or statement shared by a case manager.	Utilize this code in tandem with other codes to indicate statements and perspectives unique to case managers. This code should not be utilized when a statement is made in reference to a case manager rather than by a case manager.	<ol style="list-style-type: none"> 1. "It definitely impacts how we do business and how we're doing business and, from my perspective, moving from care coordination to case management, where we used to do more administration work and now, we're doing much more face to face, this is great, but it is a shift, and it also has some risk with it in terms of having to operate like that during COVID. It means more time with clients, some face to face."

		Do not use for perspectives unique to other roles.	2. “I would say in the last year, things have stabilized because the year before that ... we had a major change from care coordination to case management... so since we made that change and up to now, there's been rolling changes that have come through and affected how case managers do business, how we provide our direct services.”
Clinicians and therapists	Perspective or statement shared by a clinician or therapist.	Utilize this code in tandem with other codes to indicate statements and perspectives unique to clinicians or therapists. This code should not be utilized when a statement is made in reference to a clinician or therapist rather than by a clinician or therapist. Do not use for perspectives unique to other roles.	<ol style="list-style-type: none"> 1. “...having the monthly meeting. For us, that has been super beneficial. Just to come up with new ways to get engagement in, to make sure that we're meeting criteria too, like all the ways that, that extra bit of support is significant and beautiful, and I often leave feeling inspired in ways that we can better serve our clients. I mean anytime we can have consultation to talk about what's going on and things that we can do.” 2. “I feel like I get way less burned out by me being having some transition. I do like come into the office. I like the hybrid.”
Peer	Perspective or statement shared by a peer.	Utilize this code in tandem with other codes to indicate statements and perspectives unique to peers. This code should not be utilized when a statement is made in reference to a peer rather than by a peer. Do not use for perspectives unique to other roles.	<ol style="list-style-type: none"> 1. “As peers, we provide services, you know, to individuals as a whole. And it's their voice and choice when they want to come in and receive those services. So, it's kind of hard with this payment model when we're telling them, “you need to come in...” or ...”that's all you get.” 2. “I know that I'm sharing productivity in my groups but I think of it as benefiting so many clients, that it's worth it.”
Category: Miscellaneous			

Client Example	Description of a client’s experience, from the perspective of the provider; or the provider’s experience with a client, pertinent to the LOC model	Include statements regarding a client’s experience with the LOC model, from the perspective of the provider. Alternatively, include statements that provide an illustration of the provider’s experience with a client pertaining to the LOC model. Exclude examples irrelevant to the LOC model.	<ol style="list-style-type: none"> 1. “You know, communicating with the client, that is a low but she comes into every group and once a week appointment with her counselors, therapists, peers, and having that communication with her— that you know, graduating her down. Graduating her to you know, lowering her support and that client may not feel so supported anymore.” 2. “...contacted me and asked for an appointment and it's like okay, we will do that, and she came back into services, even though she is still continuing to do really well and actually doesn't really need me all that much, but she is stratified as a medium level because she recently had a baby at the hospital... So even though in terms of her mental health, she's doing extremely well, and I feel like she probably doesn't need my services anymore, here she is coming back into services with a medium tier which would be every other week services just because she's had a baby, not because things in her life have gotten more severe.”
Client Experience	Reference to the perceived client experience as it pertains to the LOC payment model.	Include reference about the perceived client experience as it pertains to the LOC payment model. For reference to relevant recommendations, use code “Recommendation: Client Choice/Client Centered.”	<ol style="list-style-type: none"> 1. “So many of our clients, they're facing significant marginalization, massive trauma histories, attachment injuries, maybe they've been in like the foster care system. We have people come in with so much stuff and for us to just kind of look and be like here's our little boilerplate template for how you will recover—that's not good therapy.” 2. “I think that, obviously, like the turnover, it will continue to be, you know, providers are coming and going they're not feeling like their care is consistent. And then that itself will kind of create less time for

			clients, in particular by being understaffed and just not being able to provide like the proper care to clients.”
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Appendix 11. Thematic Analysis

Theme #1 – The LOC payment model has had a negative impact on clinical care and services, affecting both staff and clients.

<p>Sub-theme 1A.</p> <p>Participants reported the LOC payment model to be at odds with training, education, particular evidence-based practices, and client-centered treatment.</p>	<ul style="list-style-type: none">- “I think overall, SDA is really at odds with TIC. So, I think that's also a really big challenge for providers, especially those who have a vested interest in being trauma informed and being, mindful and aware of the different factors for clients.”- “I don't feel like it's effective, I don't feel like it's healing, I don't feel like it's conducive with anything that I went to school for.”- “I don't think that this is a model that works well for mental health. Just because... a person's psyche, trauma, and lived experience every day is so much more nuanced... I think applying this type of idea that like you get a certain amount of time, you get a certain type of thing, and that some kind of unseen person decides that for you, it really is not conducive again, with the idea of actually addressing what's happening in a way that's actually going to resolve it... if we're not actually looking at the whole picture, if we're not actually being intentional, if we're not having the room to really do what we've paid all of our student loan debt to do, then what are we doing?”
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	<ul style="list-style-type: none">- “If we can collaborate with a client, if we can create a clinical justification for why we are doing what we're doing and we make a collaborative plan with the client, that's good client care. The idea that the insurance companies or the county are dictating what that looks like, I think, is really problematic.”- “If their mental health problem is one that will be helped by DBT I can't really use that EBP. I don't think it's great that we would have to not, not have fidelity with the model of DBT... because of a person's stratification.”- “For me to be an effective provider, I actually need to meet my clients where they're at and provide services accordingly and no one knows what that looks like better than me my client.”- “When I first moved to King County and started working at Valley Cities, we had just adopted the recovery model which is all about client choice and voice. And this new method of figuring out their stratification does not take any of that into account.”- “With people who are struck by this high if we are saying that to do our jobs properly, we have to engage with them for seven hours a month. I think that could alienate a lot of clients who don't feel able to engage with that. It could
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	<p>mean that they just kind of drop our services completely because they can't cope with all of this... which means that they don't get anything which is a bad thing because it would mean that they don't get any help for their mental health problem.”</p> <ul style="list-style-type: none"> - “I think people will also find it frustrating that it doesn't really take our opinion of someone's needs into account... my clinical judgment isn't being taken into account. That's kind of demoralizing for people so they may well feel more inclined to leave.” - “I just think they haven't thought it through, I mean things as basic as, what do you do when somebody is tiered differently than what is indicated? Like the pregnant client who all of a sudden is high tier and that makes no sense. You just increased burden for somebody, frankly.”
<p>Sub-theme 1B. Participants stressed that the LOC payment model contributes to access challenges for individuals in need of services in King County.</p>	<ul style="list-style-type: none"> - “I imagine a lot of clients don't recognize when they try to come into a place like us, that there are limitations as far as like what is feasible...how this all works...we're gonna be wildly disappointing to people if they think that they can just come in and get the help that they need if we're having to adhere very tightly and strictly to SDA.” - “I know they had they already had this train running as we headed into the pandemic, but also, I think, to restrict access

-	<p>to people and the lack of voice and choice... to restrict that during a time where so many more people are in need of mental health care and are more acute just really is pretty cruel overall. I know that's not the intent but as far as the impact on clients and the impact on for providers.”</p> <ul style="list-style-type: none">- “I think it also sends like a dangerous message to marginalized people that their mental health is not important, because somebody with more money or different insurance could potentially go somewhere and get exactly as much services they need or have somebody be able to advocate for that. Whereas we're kind of sending the message, that you get a fixed amount.”- “I think that we're seeing it now, our staffing rates are at historic lows and we are struggling to serve the needs of our community. More so than I've ever seen and I've been in Community Behavioral Health for a very long time now...”- “I've seen us through many difficult times in the past. I've never seen anything that has been of this nature... The clients aren't getting started. I mean it's as simple as that. And the ones that we are seeing aren't getting the level of services that they're needing to recover and there are people who are in desperate need of our services that can't get in.”
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	<ul style="list-style-type: none"> - “With SDA the way that we provide services has had to drastically change in response to that new payment structure. So, clients, it used to be that it was very client-centered how we provided services, ... we could offer weekly appointments for clients who are doing certain types of therapy and who we’re motivated and really wanted that. Now we can’t offer that to just every client, we can only offer it to clients who have been stratified by King County as meeting that type services so that’s been a pretty drastic shift in things.” - “I think a lot of agencies closed, and so a lot of the diversity for clients to be able to go to different places, right, we’ve become these homogenized agencies. It’s not sustainable for a lot of businesses to be able to be open. A lot of agencies closed due to these transitions.”
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Theme #2 – The LOC payment model as it is designed, contributes to discomfort and concern among staff, clients, and agencies.

<p>Sub-theme 2A.</p> <p>Participants noted communication about the payment model has left clients, providers, and agencies feeling</p>	<ul style="list-style-type: none"> - “I had one client who's also a low she would like to see me weekly and I think that it is clinically indicated, at least for a minute. She’s very depressed. She called her insurance company and they said, “oh no, you should be able to have counseling once a week” and I said, “sorry but that's not
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<p>unsupported, uncomfortable, and frustrated.</p> <p>-</p>	<p>how it works. Here's the number to call.” ...It's confusing for the client getting mixed messages.”</p> <ul style="list-style-type: none"> - “So that makes it hard for the client to hear that we can't see them as often as we were. That's probably like the biggest challenge that I've had to face, explaining it to a client.” - “That to me is something that they should be informing all of their members about here's what your benefit is here's what it will get you. Instead, they've really put that on providers to do all of the communication to very unhappy individuals.” - “I would feel more comfortable with it if everyone's kind of on the same page I feel like there's a lot of mixed messages with all the changes and that's what stresses me out the most.” - “I know that our senior leadership meets with King County regularly to give them feedback on what's not working very well for our staff and for our population that we serve. I have not heard about any action that has actually been taken based on any of that feedback.” - “...when they were given very clear direct feedback repeatedly, from lots of different people, in lots of different forums. They did nothing with it like that still has gone nowhere. “Oh, yeah well, we'll have a group meet to discuss
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	<p>it." They said that a year ago, but that's meaningless. So, I would say they haven't been very feedback-informed in their decision making, and there has been an absolute lack of transparency, which has made it difficult at the agency level to be transparent, because it's like, because there's just so much unknown."</p>
<p>Sub-theme 2B. Participants emphasized poor reimbursement through the LOC payment model causes barriers to the sustainability of the mental health workforce and agencies.</p>	<ul style="list-style-type: none"> - "The payment model is really flawed and we're being penalized in a way that just doesn't make sense ... had to go in for emergency gum surgery. Why does that mean for the rest of the year, now she's not going to meet SDA for an issue that doesn't make sense." - "We do not have control over clients that do not come in for appointments. Yet, we're held responsible. Our appointments could look very full but if clients do not show up, what are we supposed to do? I have to scramble to go find a list of who might be available that I need to do engagement with... That creates stress and is a burden on staff to try and make up for stuff when clients don't show up... there is this burden to be at a certain level of productivity that creates a certain stress for staff at times when some of the things are out of their control..."

	<ul style="list-style-type: none">- “I think that’s where like the morale hit comes because we know that we're in a very unique time of life right now with the pandemic having just wrecked everybody to an extent, and we have just in general, I feel like our turnover historically has been a lot, but I feel like more so in recent time, so those of us left, we're having to really bear the brunt of a lot of systemic problems and to be an agent of another problem, at least for some people, that in itself feels like a problem. I think it's also really difficult.”- “Then there's the other piece of I think we're going to run a lot of clinicians out of this work, out of the community mental health field, just because if we can't meet SDA by design, which hopefully they will change, but if we can't make it as designed, then agencies can't pay us at a rate that is livable... And so, if we are a situation or a system where we're having to feel degraded ourselves and feel as if we are degrading clients for little money, it's not going to be a real recipe for longevity. And we already do struggle in this system, with holding on to clinicians who have done the job for a long time, and I think that impacts care.”- “As an agency as a whole, we're not hitting the numbers that we need to hit to be able to keep our doors open. This is not sustainable.”
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	<ul style="list-style-type: none">- “Either the model itself and how it goes, or Valley Cities policies and procedures responses to the payment model have really led to a lot of burnout, a lot of people feeling really demoralized, people feeling like they can't offer the clinical care that they want to their clients, and feeling like they have just kind of lost control over their clinical decision making. So, it's been really hard for our therapists and clinicians and has resulted in people leaving the agency and we are not getting applicants to fill those vacant spots. So, I don't know how much of it is getting out there that like maybe Community Behavioral Health is not the place to work that it used to be. And I think pandemic is a piece of this, but I also think that what we're currently doing with SDA is also a part of it.”- “I see the benefit of it, I also see more agencies closing not being able to provide services for people. When King County has said anybody that wants to get these services can get these services, but they're also not allowing space for people to actually do this in any sort of thoughtful way. So, it's kind of like they're not, there's a disconnect in what they're promising and what they're delivering. And really, they can't deliver because of how they've set up the model.”
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Theme #3 – The co-occurrence of the COVID-19 pandemic and implementation of the new payment model presented unique challenges and benefits for both providers and clients in adapting to the LOC payment model.

<p>Sub-theme 3A.</p> <p>Participants emphasized the co-occurrence of the COVID-19 pandemic and implementation of the LOC payment model as contributing to a negative experience for providers in adapting to the new payment model.</p>	<ul style="list-style-type: none">- “Although we knew that these changes were coming in 2020, having it coupled with COVID and then wanting this adherence and productivity, and all this during COVID when we're really kind of dying on the inside. In some ways, it was very, very challenging.”- “And, particularly when we're serving folks that have complex needs, I think some of the boundaries are the limits that we have right now. Because of COVID, we don't have enough staffing to actually serve the clients. When they have a high-level stratification, we don't have staff, we can't meet those hours because we're not staffed to meet those hours. So that has created challenges.”- “I think that’s where like the morale hit comes because we know that we're in a very unique time of life right now with the pandemic having just wrecked everybody to an extent, and we have just in general, I feel like our turnover historically has been a lot, but I feel like more so in recent time, so those of us left, we're having to really bear the brunt of a lot of systemic problems and to be an agent of another problem, at least for some people, that in itself feels like a problem. I think it's also really difficult.”
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	<ul style="list-style-type: none">- “But also, it came at a time when there's a pandemic. When people are dealing with stuff in their own personal lives because of COVID. That is really, really tough and I think it just added a lot of extra pressure that was above and beyond what people could do during the pandemic.”- “I have thought a lot about the concept of Allostatic load during this time and like just the pandemic alone and trying to absorb that and understand what that means for you and your family is enough to put somebody at the edge of their allostatic load, where they really can't absorb any more at that point or adjust to anymore, and then we have this change and that change, and SDA, and productivity, it's just too much. No wonder people forget and are making mistakes on documentation because who can absorb that much information.”- “Asking people to be resilient and nimble in their learning in ways that we would have historically, like yeah, our field changes all the time, but during a pandemic, people's ability to rapidly absorb new information and adjust and be resilient—we haven't acknowledged the diminished capacity and I don't mean that in a negative way but, the genuinely diminished capacity that we all have to be resilient has not been acknowledged and the timing of this
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	<p>could not be more awful in terms of King County changing the payment model and then two months later, the pandemic hits or three months later, at a time where it's really, just really hard to incorporate more change.”</p>
<p>Sub-theme 3B.</p> <p>Participants emphasized the ability to provide services by telehealth or phone, due to the COVID-19 pandemic, as beneficial for engaging clients in services and adapting to the LOC payment model.</p>	<ul style="list-style-type: none"> - “It just made things more accessible and more flexible, so I really appreciate it. I would say if they wouldn’t have had the state laws change for us to do full phone and telehealth it would have been horrible for clients and it would have been horrible for staff. I feel like clients would have been left hanging...” - “I think access to telehealth during COVID has really been a game changer in terms of client engagement.” - “I do think that the ability to quickly pivot to Telehealth and phone appointments has helped with service delivery. We have had significantly less cancellations and no shows since being able to offer Telehealth and phone services in a more robust kind of way, so that means we're then more easily able to meet SDA, with being able to better meet clients where they're at.” - “I think it's definitely helpful to allow remote services, because I think it's really good that people are able to now engaged by phone because a lot of clients don't want to

	<p>come into the clinic and it could be like a big barrier to them. To transport and everything like that, so I think that's really important, that there is a flexibility to deliver services remotely mainly for the clients, but also like for the clinicians as well.”</p> <ul style="list-style-type: none"> - “It makes sense. It removes barriers for an awful lot of people and it's my hope that it has helped with staff mental health, maybe not staff morale but certainly mental health and emotional wellbeing and all of those types of things.” - “Some clients prefer just to do telehealth. They like telehealth groups and staying connected and reducing isolation.”
<p>Sub-theme 3C. Participants acknowledged that changes in agency policies and actions in response to the COVID-19 pandemic had both positive and negative effects in terms of providing support for staff with adjusting to</p>	<ul style="list-style-type: none"> - “I think some people really use them and other people, they just don’t even exist for. And I would expect that in any organization.” - “It makes it easy to understand where we’re at with meeting that need for the client.” - “Well, you know paying more attention to what level they’re at just and making those phone calls to engage and get them in, more than we were before. And just being more mindful of like where they’re at.”

<p>the LOC payment model.</p>	<ul style="list-style-type: none"> - “But also, organizing staff to make sure that we have groups and then making sure that we’re listening and referring clients to those groups, whether it’s health management, anxiety and self-esteem, or depression, or an evidence-based therapy group, like DBT or CBT. All of these kinds of things, where we can group clients together help for the client, to be able to meet their hours, in addition to staff meeting productivity.” - “I think it’s been a cultural shift at our agency, we had been trying to ramp up for groups for years and then, after COVID happened and the payment model has changed, it has turned on the switch for culture change. It really helps for the staff if we've got that culture.” - “I believe our organization has pivoted to try and meet the need, which I think is great and we’ve been talking about it for years, is really having more of a groups-based approach and a group culture. Where we’re talking to clients when they walk in the door about participating in group-based activities. Whether it’s via zoom or in-person or in a hybrid group and whether its evidence based or just a drop-in group hosted by peers or Case Managers, which we’re being asking to do more group activities to serve clients more and to meet productivity.”
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	<ul style="list-style-type: none">- “I think one thing that’s been beneficial on this, I would say is the ability to see and understand what is happening with your clients, like the data side.”- “I think, having language to use is helpful and I think, at the same time, it’s hard to kind of craft these responses or to be very effective with them without like adequate time. I think there’s a lot of factors that make it hard, but I guess it’s definitely better than having to just come up with that stuff from scratch.”- “If I hadn’t been able to work from home via telecommuting and flex my hours the way that I have been, there would have been no way I could have kept my job so it’s been hugely helpful.”- “With the high turnover and the high caseloads and it’s a stress on that, you know, there’s a fault line. And the systemic burnout, it’s something that’s ongoing and needs to be talked about more and this kind of drives that hard-working productivity model that’s going to run us into the ground I think.”- “There is this burden to be at a certain level of productivity that creates a certain stress for staff at times when some of the things are out of their control like someone not answering.”
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	<ul style="list-style-type: none">- “I do know that plenty of staff have left working in community mental health during the time that I’ve been here, and during COVID, we lost a lot of good staff because of some of the pressures for productivity and feeling like you’re kind of a broken record for clients and not able to move forward in some of the ways that would be meaningful for them.”- “There’s been a lot more emphasis from leadership on productivity, for our clinical staff as well, which has been a very difficult shift for a lot of people and I think that that has sometimes been to the detriment of our evidence-based therapy programming.”- “Especially with productivity, I think I find that very demoralizing I find that like difficult too. It makes me feel like I’m not doing I’m not working hard enough when I feel like I’m working really hard. Definitely if other people feel like that thing that could definitely be a problem with like retention and staffing and stuff.”- “It turns out in practice, it’s like almost impossible. I don’t know how to do that. So, like it does make me feel like I guess, dissatisfied or disappointed in myself... I feel like I’m working really hard to feel stressed, I feel like I’m seeing a lot of people and, like I don’t think I can really
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	<p>cope with seeing any more people... it takes me a long time to like think things through. I need to write the notes, I need to plan my next session. I just, it takes me time to think it through... I want to be a helpful employee, I want to like do the best that I can do... so it like just makes me feel guilty and like demoralized, like I'm not, I'm not doing like what the expectation is.”</p>
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